Association for Palliative Medicine
of Great Britain and Ireland

Annual General Meeting

Thursday 13 March 2014
14:45 – 17:10

Queen Suite A, Harrogate International Centre, Kings Road, Harrogate
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Queen Suite A, Harrogate International Centre, Kings Road, Harrogate HG1 5LA

AGENDA

1. **Welcome from Chair**

2. **Minutes of 2013 Annual General Meeting** **ENC A**

3. **Committee Reports**

a)	President	Dr David Brooks	**ENC B**
b)	Treasurer *Ratification of APM Accounts for year ended 30 November 2013*	Prof Irene Higginson	**To follow**
c)	Ethics Committee	Dr Tim Harlow	**ENC C**
d)	Professional Standards Committee	Dr Sarah Cox	**ENC D**
e)	Education Committee	Dr Chris Farnham	**ENC E**
f)	Science Committee	Professor Patrick Stone	**ENC F**
g)	Specialty Staff Grade & Associate Specialists Cttee	Dr Anna Hume & Dr Sally Middleton	**ENC G**
h)	Trainees' Committee	Dr Milind Arolker	**ENC H**
i)	Workforce Committee	Dr Stephanie Gomm	**ENC I**
j)	Specialist Advisory Committee	Dr Alison Coackley	**ENC J**

4. **Representatives' Reports**

NEoLCP Acute Hospitals Steering Group **ENC K**

5. **Special Interest Fora Reports**

a)	Neurological Palliative Care Special Interest Forum	**ENC L**
b)	Undergraduate Medical Education Special Interest Forum	**ENC M**
c)	Transitions Special Interest Forum	**ENC N**

6. **Proposed Junior Membership category and Junior Members' Committee** **ENC O + P**

7. **Committees**

Thanks to committee members who have demitted:

Executive Committee: Dr Tim Peel, Dr Victoria Wheatley, Dr Regina McQuillan

Ethics Committee: Dr Rosaleen Beattie, Dr Ian Cairns

Professional Standards Committee: Dr Chris Baxter, Dr Alison Gordon

Specialty Staff Grade and Associate Specialists Committee: Dr Berni Mountain (SSAS Rep to the Workforce Committee), Dr Jane Stickland (SSAS Rep to Professional Standards Committee)

Trainees Committee: Dr Kim Steel, Dr Sarah Mollart (Trainee Rep to the Education Committee), Dr Liz O'Brien

Workforce Committee: Dr Bernie Corcoran

Ratification of elected members:

Executive Committee: Dr Tony O'Brien, Dr Aoife Gleeson

Ethics Committee: Dr Rachel Bullock, Dr Paul Clark

Professional Standards Committee: Dr Vandana Vora

Education Committee: Dr Dylan Harris

Science Committee: Dr Helen McGee

Trainees Committee: Dr Rebecca Lennon, Dr Miranda Kronfli (Trainee Rep to the Education Committee), Dr Kathleen Mark, Dr Ros Marvin, Dr Katrien Naessens

Workforce Committee: Dr Julie Doyle

8. **Announcement of APM award winners**

Napp Research Bursary 2013

Twycross Research Prize 2013

Undergraduate Palliative Medicine Essay Prize 2013

9. **Any other business**

10. **Date of next AGM**

Venue to be confirmed.

The Association for Palliative Medicine

Annual General Meeting
24 April 2013
Aston Business School Conference Centre
Aston University, Birmingham

01/13 **Welcome from Chair**

Dr Bee Wee welcomed those present to the meeting.

02/13 **Minutes of 2012 AGM**

The minutes were accepted as a true record.

Proposed: Dr Andrew Davies
Seconded: Dr Regina McQuillan

03/13 **Committee Reports**

a) President

Dr Bee Wee, President, explained that the Executive Committee was considering how best to support members and ensure APM remains relevant and helpful. With regards to communication, she noted that there had been problems with the Presidents' blog but that the new e-bulletins were proving successful. The Education Working Group is reviewing the annual study days programme with the aim of producing an advance programme of study days to assist with booking of study leave etc. Some progress has been made with regards to negotiating deals with various journals. Revalidation has continued to be an important issue, and APM has collaborated with Help the Hospices and the National Support Team on this area. National benchmarking tools are being piloted. Special Interest Fora (SIF) are taking off and provide an opportunity for like-minded members to promote areas of interest. APM has received more offers of representation on other bodies. A Junior Members' section is proposed. Dr Wee thanked members for contributions to the Membership Survey and focus group. She also noted that recent media activity provided an opportunity to highlight palliative medicine and shift the focus from assisted dying onto wider issues of palliative care.

b) Treasurer

Prof Irene Higginson, Treasurer, introduced the accounts for 2011-12. She noted that the restricted fund balance at year end was £49k. The unrestricted fund balance was £175k, including approximately £98k which was available for special projects. APM's main income is from subscriptions, with a small amount also received from mailings and study days etc. Prof Higginson drew members' attention to page 8 of the annual accounts, which showed a small overall surplus from study days, and noted that the Executive Committee had looked more critically at study days to ensure break-even. Expenditure was in line with previous years.

The accounts for the year ended 30 November 2012 were ratified.

Proposed: Dr Regina McQuillan
Seconded: Dr Tim Harlow

Dr Higginson explained that there had been no subscription increase since 2009. Inflation for the period since the last increase is approximately 9% and Dr Higginson has modelled 5% and 10% increases as it was felt that a percentage increase was fairer to members. It is proposed that the Junior Members Working Group will look at the issue of charges for junior members prior to any financial commitment from APM There was discussion regarding provision of journals and it was noted that some negotiations are ongoing.. A show of hands indicated that most of those present would want access to the JPSM if there was no further increase in subscription, while slightly fewer wanted access if a subscription increase was necessary. It was noted that an opt-out option for journal provision would not be possible due to negotiations with JPSM and admin costs to APM. Following further discussion, it was agreed to seek approval for a subscription increase of 10% with effect from 1 December 2013, while acknowledging separate agreement, in principle, that those present would be prepared to pay extra for JPSM but that a clearer mandate is needed from other APM members. The Executive Committee can then continue negotiations with JPSM and poll all members before the next AGM.

A 10% subscription increase was ratified with effect from 1 December 2013, with in principle agreement that a further increase for JPSM provision was possible following a ballot of all members.
Proposed: Dr Victoria Wheatley
Seconded: Dr Benoit Ritzenthaler

The proposed increase to advertising charges was agreed.
Proposed: Dr Alex Nicholson
Seconded: Dr Fliss Murtagh

c) <u>Ethics Committee</u>

Fundamental ethics was the subject of the last Ethics Study Event in London. The next will look at the ethics of the interface between NHS and private sector. Some position statements had been updated and Dr Tim Harlow, Ethics Committee Chair said that the committee was always interested in members' views of these documents: both purpose and content. He noted that the statements can only reflect broad views of the APM membership.

d) <u>Professional Development Committee (PDC)</u>

The Executive Committee had recognised the need to split the work of the PDC into two areas, and two separate working groups have been operation. Dr Christina Faull, PDC and Education Working Group Chair, expressed her thanks to Dr Sarah Cox for chairing the Professional Standards Working Group and producing the consultants document. A training event for appraisers is planned. Dr Faull drew members' attention to calls for involvement in the e-ELCA review work. Forthcoming educational events include ethics, science, trainees and SSAS study days as well as PCC in 2014. Dr Martine Meyer asked whether an SSAS role document should be produced along the lines of the consultant document. Dr Wee noted the need to produce the consultants document quickly as some would be appraised by people outside the specialty. Dr Sally Middleton, SSAS Committee Joint Chair, noted that the SSAS Committee has recently written a short newsletter article to explain SSAS roles.

The terms of reference of the new Education Committee were ratified.
Proposed: Dr Chris Farnham
Seconded: Dr Regina McQuillan

The terms of reference of the new Professional Standards Committee were ratified. (Note that the terms of reference should read '7 elected members).
Proposed: Dr Chris Farnham
Seconded: Dr Regina McQuillan

e) Science Committee

Thirty-six entries were received for the Undergraduate Essay Prize, and the top nine entries were outstanding. No applications were received for this year's Twycross Prize. There was also a lower number of applications for Napp Bursaries. Dr Claire Butler, Science Committee Chair, encouraged people to enter and put themselves forward for awards. A project worker is assisting with the NCRI research portfolio and has put together details of regional resources, eg places to go for advice, support and signposting. The 2013 research and literature review study days will be held in Scarborough during the summer.

f) Specialty, Staff Grade and Associate Specialists (SSAS) Committee

Dr Anna Hume, SSAS Committee Joint Chair, said the committee supports SSAS doctors: approximately a quarter of the membership. The last study day organised by the committee had shown a profit. The next event would be held in Bristol. Dr Hume summarised changes to committee membership, including the joint Chair-ship with Dr Sally Middleton.

g) Trainees' Committee

The committee is preparing materials for a forthcoming medical careers day at the RCP. A survey of those who sat the first SCE was conducted. Whilst encouraging members to complete the workforce survey it was noted that there are many trainee non-members in the London Deanery. Dr Milind Arolker (Trainees' Committee Chair) asked how London Trainees could be encouraged to join. Dr Andrew Davies suggested advertising on the deanery website or via Synapse.

h) Workforce Committee

Dr Stephanie Gomm, Workforce Committee Chair, said that the committee is indebted to all members and the SAC for providing workforce data. The committee now has SSAS and Trainee Representatives. The workforce report is long as it is important to see data submitted to the APM and RCP censuses. A summary report will be posted on the website. Two further reminders will be sent. Dr Gomm said the response rate is currently 67% and it would be good to improve this to at least 70%. The committee is attempting to target non-members also. The next survey will be circulated at the end of June. Consultant and trainee numbers continue to expand. The majority of trainees are finding substantive or locum posts, while some take non-consultant posts due to geography etc. Workload activity data is historic and Dr Gomm stressed the need to think about the structure of teams and workload in this context. To maintain matching CCT to consultants depends on funding for posts.

i) Specialty Advisory Committee

Dr Penny McNamara presented the report on behalf of Dr Fiona Hicks, SAC Chair. She drew members' attention to the specific issue of recruitment and requested feedback on questions to be sent to Rebecca Tunstall.

04/13 Quality and Outcomes Working Party

Dr Andrew Davies gave an updated on this project that was set up approximately 18 months ago to conduct national audit evaluations. The pilot survey of bereaved relatives, and carers was very successful and would be rolled out nationally in June. Details will be put on the website shortly. Participants will be invited to circulate the FAMCARE 2 questionnaire to relatives 4-6 weeks after bereavement, for Freepost return to the Secretariat. Questionnaires will then be scanned and individual reports produced for services and compare against others. The audit will run for two months but cover a three month period, and has been timed so as not to clash with VOICES. A pain control audit is also to be piloted. This will be an online survey and if the technology works a further pilot will be conducted and the audit will roll out in autumn.

05/13 **Representatives' Reports**

NEoLCP Acute Hospitals Steering Group

The report was noted.

06/13 **Special Interest Fora**

a) Neurological

The report was noted.

b) Undergraduate Medical Education

The report was noted.

07/13 **Junior Members Working Group**

This initiative arose from a meeting held by the Undergraduate Medical Education SIF, where a group of students wanted to form a junior section. It is proposed that the section would include junior doctors as well as medical students. The Working Group would work up the concept and practicalities.

The Junior Members Working Group proposal was ratified.
Proposer: Dr Esther Waterhouse
Seconder: Dr Martine Meyer

08/13 **Committees**

Dr Wee thanked members who are demitting, as follows:

Executive Committee: Dr Andrew Davies (Honorary Secretary), Dr Christina Faull, Dr Julia Riley

Ethics Committee: Dr Eleanor Grogan (Chair)

Professional Development Committee: Dr Christina Faull (Chair)

Specialty Staff Grade and Associate Specialists Committee: Dr Alison Gordon (Chair)

Science Committee: Dr Claire Butler

The members expressed their thanks to the demitting committee members with a round of applause.

Dr Wee expressed her thanks to all APM members and committees. Dr David Brooks, new President of APM, thanked Dr Wee for her work as President and wished her good luck in her new role as National Clinical Director.

Dr Wee duly demitted office and Dr Brooks took over the chairmanship of the AGM.

Elected members were ratified, as follows:

Vice President: Dr Rob George
Proposed: Dr Rosemary Lennard
Seconded: Dr Victoria Wheatley

Executive Committee: Dr Iain Lawrie, Dr Martine Meyer, Dr Mike Stockton
Proposed: Dr Rosemary Lennard
Seconded: Dr Andrew Davies

Education Committee: Dr Emily Collis, Dr Chris Farnham, Dr Derek Willis, Dr Sarah Yardley
Proposed: Dr Martine Meyer
Seconded: Dr Andrew Davies

Ethics Committee: Dr Tim Harlow (Chair), Dr Derek Willis
Proposed: Dr Irene Higginson
Seconded: Dr Victoria Wheatley

Professional Standards Committee: Dr Fiona Bailey, Dr Chris Baxter, Dr Margred Capel, Dr Sarah Cox, Dr Andrew Davies, Dr Tim Peel
Proposed: Dr Victoria Wheatley
Seconded: Dr Tim Harlow

Science Committee: Dr Elaine Boland, Dr Oliver Minton
Proposed: Dr Irene Higginson
Seconded: Dr Victoria Wheatley

Specialty, Staff Grade and Associate Specialists Committee: Dr Anna Hume (Joint Chair), Dr Sally Middleton (Joint Chair), Dr Jane Stickland (SSAS Rep to the Professional Standards Committee), Dr Alison Gordon (SSAS Rep to the Education Committee)
Proposed: Dr Martine Meyer
Seconded: Dr Bee Wee

Trainees' Committee: Dr Cliona Lorton (Trainee Rep to the Professional Standards Committee), Dr Sarah Mollart (Trainee Rep to the Education Committee)
Proposed: Dr Irene Higginson
Seconded: Dr Victoria Wheatley

09/13 **APM award winners**

Dr Brooks announced the following APM award winners.

Napp Research Bursary 2012: Dr Laura Clipsham for 'How do nurses working within an inpatient adult palliative care unit identify children, aged 18 years and under, in need of additional pre-bereavement support when they have a parent who is expected to die?'

Undergraduate Essay Prize 2012, "What are the challenges in applying the Liverpool Care Pathway for the Dying?": first prize to Ms Lucy Robinson of Cardiff University Medical School; second prize to Miss Kathryn Lunnof Glasgow University Medical School; highly commended to Dr Kieran Gillick of St Georges, University of London.

Dr Brooks encouraged members to enter the next Twycross prize, as no entries were received in 2012.

10/13 **Any other business**

Dr Brooks encouraged members to email him or Dr Wee with comments prior to Monday's meeting on the LCP consultation. He also encouraged members to feed back to other consultations.

11/13 **Date of next Annual General Meeting**

1545-1710 on Thursday 13 March 2014 in Queen Suite A, Harrogate International Centre, Kings Road, Harrogate HG1 5LA (during Palliative Care Congress).

President's Report

As I reflect on the last year I am conscious that it has been hugely dominated by a few days. The last few days of life. The spring months in responding to the avid media interest and producing the survey of professionals for the Neuberger panel. The summer providing initial responses to the *More Care Less Pathway* report and trying to guide you as to how to respond. The Autumn and Winter working with the Leadership Alliance on Care of the Dying Patient to attempt to inform and influence their response. And now we are into spring trying to keep you informed as to what to expect while being sworn to secrecy about large parts of what we can say. And a frustration that has underpinned all of this that even when we are told we can say what to expect the whims of the political process often mean that what we say does not actually materialise. Suffice it to say, while the APM is not represented on the LACDP it is represented on all the subgroups and has been actively responding to all the drafts of all the outputs that will eventually come from this process. Thanks to all of you who have supported in this team effort either by being on some of the subgroups or responded when we have asked for comment. Of all the hundreds of pages of consultation feedback that the LACDP and its subgroups received at a recent joint meeting it was the few pages of feedback of the consensus from comments from APM members collated by our Honorary Secretary Ellie Grogan that attracted most praise amongst the group. Through this process we have been able to feed things into the response which will hopefully improve not just last days of life care but palliative care more broadly.

As part of her role the Honorary Secretary collates feedback on all consultations to which the APM is party. On many of these APM responses significantly influence the RCP feedback, particularly where the focus is on Palliative Care issues. We have responded to two or three consultations a month over the last year and I would like to thank Ellie for all her hard work in co-ordinating this. I know her role is made much easier when she has feedback from members so I encourage you to do so. Locally we have sometimes developed responses in a journal club setting which makes the response even richer and allows us to engage critically with developing guidance.

There has, of course been more to the year than the last days of life. We negotiated with the Peer Review team to agree to suspend the current peer review measures and work on developing better measures that more adequately measure quality of palliative care services. This has resulted in a back to the drawing board approach where we have worked with the advisory group to develop a Service Specification for Specialist Palliative Care services which will be out for consultation shortly. Hopefully this will influence not only Peer Review but the commissioning of Specialist Palliative Care services. We are also involved in the Steering Group for the next phase of the Palliative Care Funding review which will be developing this work following on from the reports from the pilot sites.

Another piece of lobbying that we have been doing on your behalf has been in relation to funding of training. There were some very poorly communicated changes to the funding structure of training due to take place in April 2014 that would have meant Hospices needing to fund 50% of the salaries of all trainees. When we got wind of these we tracked down the department in HEE responsible and lobbied strongly for hospices to be excluded. The workings of HEE have been so opaque that it has been difficult to know what influence we have had but I have been reassured by one Deputy Dean that there has been a national directive that Palliative Care Specialty Training posts are excluded from these charges. We still await to hear from HEE directly and specifically if this includes VTS, CMT and foundation posts in hospices. The other training report that has raised concerns is the Shape of Training. We have been working with the Coalition of Specialist Societies to inform a consensus response to the report. We have also been working together through the Coalition with the RCGP to support the development of a new national process for accrediting and reaccrediting GPwSIs which is to be piloted by the British Association of Dermatologists.

As I write this report I am on a train back from a workshop developed in partnership with the Joint Specialty Committee of the RCP and the RCP Clinical Fellow on Shared Decision Making. The College has decided to invest some of its resources in developing models of shared decision making and has chosen Palliative Medicine (both the JSC and the APM) to partner in this work. I am delighted that we can support the college in this work. It has been a stimulating day and look forward to sharing more of this with you through the coming year.

There have been many other exciting and important things that the APM has been involved with throughout the year but most of them are well covered by the committee reports so I will not duplicate. But one of the most exciting things for me is the development of Junior Membership.

When I was a medical student the APM had not formed. Palliative Medicine was not a specialty. As a Houseman Jed Corcoran (now a leading consultant in Palliative Medicine) was my Surgical SR. I didn't get a day of teaching on palliative care before having to do it during house jobs. Thankfully the world has changed and I am delighted to announce that today we will be proposing new categories of membership for Medical Students and Junior Doctors and a new Juniors committee to support those who are interested in exploring whether a career in Palliative Medicine is for them or who are wanting to enhance their knowledge and skills in palliative care to use as they develop a different career path. Many thanks go to Dan Knights and his band of helpers for working so hard to develop this. I hope you will all join me in supporting this new initiative.

Despite all these new initiatives the ongoing work of the APM such as supporting EPACCs, NCDAH audit, maintaining e-ELCA, assessing national CEA applications, running study days has all continued in the background. We have endeavoured to keep you informed through the e-bulletin, the APM Post and the Website. Ellie Grogan is leading a piece of work to develop our website and would welcome any suggestions for improvement.

This year has been a challenging year for the secretariat due to prolonged periods of absence. Sabine who has been our Executive Administrator for six years has left us to move on to new things. I am sure you will all join me in thanking her for her work for the APM and wishing her well for the future. I also want to thank Becki and Sheila for their wonderful support during this time.

Finally I would like to thank all the officers, executive, committee members and all of you as members who make this Association and this Specialty what it is and have worked so hard for it in many different ways throughout the year. But in particular I would like to thank Rob George who has been a wonderful Vice-President.

David Brooks
President
March 2014

APM Ethics Committee Report

Membership
We have been fortunate to have had the contributions of Ros Beattie and Ian Cairns on the committee but they have now left. Andrew Shuler has finished training so the Trainee representative post is now open for election.
Current membership:
Idris Baker, Rachel Bullock (new member), Paul Clark (new member), Craig Gannon, Rob George, Tim Harlow (chair), Derek Willis.

Ethics study days
The Committee organised a debate on Physician Assisted Suicide at the APM conference in Birmingham 23/4/13 which was well attended and received, allowing a respectful and careful discussion of some of the important issues.
AS has delivered (with CG, RG, DW and Matt Makin) a fully subscribed-2 day Ethics course in Telford 28-29/1/14- detailed evaluations very positive. Basic ethical theory then discussion of giving, assisted dying, autonomy and rationing. A case discussion by mock ethics committee was held. Next event 27th/28th January 2014- same venue

Assisted suicide
The Committee continues to reflect the APM view that the law should not be changed and acts both individually and collectively to ensure that the debate is both reasoned and the ethical issues are fully understood. Lord Faulkner's bill has had its first reading in the Lords' but seems stalled at present- we are watching this.

Position Statements
The committee has produced a position statement on relations with industry which has been considered by the Exec and is now accepted for reference by members.

LCP
We have contributed to the APM response to the LACDP and continue to do so

Adverts in BMJ
We raised what we saw as a mercenary attitude to adverts in BMJ: we received a disappointing response both from BMJ –missed the point- and the profession at large –apathy- so we will see if there is a chance to draw attention to this again

Changing hospice Remit
The committee perceives a move towards End of Life Care rather than Specialist Palliative Care and this is important both for patients and for the future of Palliative Medicine. We'll look into this in more detail and keep the Exec appraised

SAC Curriculum
The committee will be involved in the ethics part of this curriculum when it is revised.

Other Matters
We have set and marked the Undergraduate Essay prize. The committee continues to assess survey/research requests to members not for research ethics matters but to check there is no potential for embarrassment to the APM

Tim Harlow
Ethics Committee Chair
March 2014

Professional Standards Committee Report

The committee was ratified at the last AGM and this is the report from the first year of the committee.

Membership

Sarah Cox (chair)	Elected member of PDC
Tim Peel	Elected member of PDC
Vora Vandana	Elected member of PSC
Chris Baxter	Elected member of PDC
Andrew Davies	Co-opted to PSC from audit group
Fiona Bailey	Elected member of PDC; revalidation rep to RCP
Margred Capel	Elected member of PDC
Jane Stickland	SSAS rep
Cliona Lawton	Trainee rep

The committee is grateful to Chris Baxter who will be standing down this year after lengthy and valuable contribution to the PSC and previously on the Professional Development Committee. The committee welcomes Vora Vandana who has taken up a vacancy after an open application process. We are also grateful to Alison Gordon who has demitted as our SSAS representative and who's place has been taken by Jane Stickland. We have liaison with the APM juniors group through Hannah Billett who is currently in a CT1 post in Northumbria.

Re-validation

Tim Peel and Fiona Bailey have led on revalidation, with Fiona elected to be our revalidation rep to the RCP. A survey early in 2013 gave us a baseline for preparedness and concerns amongst APM members. We have followed this with "useful tips" on the website. Discussions continue about how to fulfil the quality improvement requirements and whether we can identify appropriate outcomes to support appraisal for palliative medicine doctors. A Task and Finish group has been set up jointly with the JSC to consider this and related issues.

Audit

Famcare II has been rolled out after the successful pilot and 74 sites registered to take part. Results were received from 32 hospice inpatient units (733 responses), 22 hospice home care teams (489 responses), and 11 hospital support teams (127 responses). The audit was completed for a lower cost than had been projected. Andrew Davies is drafting a paper for submission to a medical journal. The plan is to repeat the FAMCARE II audit in the future.

Pilot service evaluation pilot of pain control has been completed. The number of follow up assessments was low, and so the methodology may need to be amended. Andrew Davies is contacting the units involved to receive feedback on the problems. It appears that Survey Monkey will be suitable for the definitive service evaluation, but some work needs to be done to simplify the analysis process. It is planned to perform a further pilot in the next couple of months (using the new methodology).

Mentoring

The list of mentors has been updated on the website.

I should like to express my thanks to the members of the PSC for their work and enthusiasm this year

Sarah Cox
Professional Standards Committee Chair
March 2014

Education Committee Report (est April 2013)

Chair

Chris Farnham

Members

Emily Collis
Sarah Yardley
Derek Willis (PCC rep)
Ali Gordon (SSAS rep)
Sarah Mollart (Trainee rep –resigned 12/13)
Miranda Kronfli (Trainee rep –appointed 1/14)
Dylan Harris (CPD rep appointed 1/14)

Activity

The Education Committee
The Terms of Reference have been agreed
The Standard Operating Policy has been ratified by the Executive committee

We have also now set out a commitment to employ an Events Organising Company to be employed to support organisers in delivering high quality successful events. This has become ever more important with the biannual mini Conference as well as increasing numbers of education events being 'badged' as APM events.

E-elca

The closing date for applications has just passed and we have not yet appointed to this exciting new post but hope to be able to announce the new post holder in the next e-bulletin!

Events

May 13th	London St Joseph's Hospice	Ethics
June 20th & 21st	Scarborough	Research skills
September 18th	Leicester De Montfort University	Addressing the challenges in care needs of teenagers and young adults
November 12th	London Royal College of Physicians	Pain and older people
March 12-14th	Harrogate International Centre	Palliative care Congress
November 2013 SSAS	Bristol	Disadvantaged and vulnerable patients and practical therapeutics
November 2014	York	SSAS
November 13-14th 2014	Scarborough	Science
Easter 2015	London	Mini Conference
November	Newcastle	Trainees
January 27 -28 2015	Telford	Ethics

Chris Farnham
Education Committee Chair
February 2014

Annual Report of the Science Committee: April 2013 – March 2014

Membership

Dr Jason Boland	
Dr Elaine Boland	
Dr Claire Butler	Resigned from Committee end April 2013
Prof Miriam Johnson	
Dr Ollie Minton	
Dr Paul Perkins	
Dr Helen McGee	
Prof Paddy Stone	Chair
Dr Gareth Watts	Trainee Representative
Dr Rebecca Fisher	Junior member liaison

The role of the Science Committee is to support, encourage and enhance the scientific profile of palliative medicine for the APM membership. Here is a summary of our activities over the past year:

Study days

Our two-day study events: 'Appraising the Literature' and 'Research – Getting Started' are aimed at the whole APM membership and are now established annual events. A successful event was held at St Catherine's Hospice in Scarborough on 20th/21st June 2014 attended by 14 Specialist Trainees. The course was well-evaluated by participants. The next course will run 13th – 14th November 2014 at the same venue.

Task groups

The task groups are designed to provide some seed-corn funding to facilitate the undertaking of systematic reviews. There is a budget of up to £450 available for each Task Group, to cover literature searches, photocopying, postage, etc. One application has been received this year; A Davies et al - Development of evidence based recommendations on oral care in patients with advanced cancer and in terminal phase. The Science Committee intend to re-launch the task groups later this year to encourage more members to utilise the resources that are available.

NappResearch Bursaries

Two Napp research bursaries (each worth up to £2000) may be awarded annually by the Science Committee. The aim is to support new researchers in small or pilot projects and they are awarded to support the development and execution of these projects. The bursaries are funded by an unrestricted educational grant from Napp. This year the Science committee awarded two bursaries. One bursary went to Dr Kate Mitchell for, "A study to validate a symptom scoring tool (C-SAS) for use in patients who are very unwell". The other bursary was awarded to KatrienNaessens for a study entitled, "Antibiotics for hospice inpatients at the end of life; a qualitative study of the views of patients, their carers or relatives, and healthcare professionals". Guidance and application forms for the Napp Research Bursariesare available on the APM website. The closing date is in early November each year.

Twycross research prize

The Twycross Research Prize, worth £500, is awarded annually for the best report of a completed piece of original research. The prize for 2014 was awarded to Jamilla Hussainfor her research entitled, "Comparison of survival in patients aged over 70 years choosing conservative management or renal replacement therapy in advanced chronic kidney disease". The prize winner is invited to present his/her research at the APM annual meeting. Guidance and application forms for the Napp Research Bursariesare available on the APM website. The closing date is in early November each year.

Research champions

The APM has been sponsoring a Project Officer to(among other things) develop and maintain a Palliative Care research "champions" database as a resource for APM members. The database is available on the APM web-site.

Acknowledgements

I would like to thank the members of the Science Committee for their hard work, time and commitment to the above activities and also the APM Secretariat for administrative support.

Paddy Stone
Science Committee Chair
March 2014

Report from the Specialty Staff Grade and Associate Specialists Committee 2014

Dr Anna Hume [co-chair], Associate Specialist, Countess Mountbatten Hospice, University Hospital Southampton NHS Foundation Trust.
Dr Sally Middleton [co-chair], Specialty Doctor, Epsom and St Helier University Hospitals NHS Trust, Surrey
Dr Alison Gordon Associate Specialist, St Columba's Hospice, Edinburgh
Dr Helen Bonwick, Associate Specialist, Marie Curie Hospice Liverpool and Liverpool Heart and Chest Hospital
Dr Berni Mountain, Specialty Doctor, St Catherine's Hospice, Crawley
Dr Reema Pal, Specialty Doctor, Cynthia Spencer Hospice, Northampton
Dr Jane Stickland, Associate Specialist, Sir Michael Sobell House, Oxford
Dr. Simon Brooks ,Associate Specialist , Royal United Hospital , Bath .
Dr .Alison Talbot, Associate Specialist, Duchess Of Kent House, Sue Ryder, Reading

Our continuing aim is to represent SSAS doctors working in Palliative Medicine in the UK and Ireland. About a quarter of the APM membership are SSAS doctors many of whom work in the independent sector often in quite isolated environments.

Committee work in 2013

The committee worked on the organisation of the SSAS Conference, which has become an annual event at the members request, we canvassed opinion on future learning needs at the last conference, .using feedback and questionnaire, and a programme was developed. Therapeutic Challenges in Palliative Medicine SSAS Conference was held on November 6th 2013, at the Armada House in Bristol. The morning explored the practical aspects of the therapeutic management of Diabetes Mellitus, seizures and Parkinson's disease in palliative care. , while the afternoon was devoted to delivering palliative care to hard to reach / challenging patient groups including the homeless, people with leaning disabilities and those with drug dependency. The event was well received with overwhelmingly positive feedback on the whole day. The day was also a financial success, clearing a profit of almost £4000.

The questionnaire and feed back from this event has allowed us to devise our next conference, Integrating Clinical and Ethical Aspects of Decision Making in Palliative Medicine. This will be held in York at the Hospitium on November 6th 2014. The conference plans to look at some of the ethical aspects of our work, including withdrawal of treatment and resuscitation orders. We will also use complex case studies to consider and discuss various challenges in symptom control. Although these events are ostensibly for SSAS doctors the conference is open to any interested parties, who may or may not be members of the APM. Previous conference attendees have included SSAS doctors, consultants and registrars.

We have again been considering our web pages on the APM site in an attempt to share information. We have included the presentations from our conferences, access to the APM mentoring scheme, and helpful links to the BMA on contract issues, deaneries for funding and the Joint Royal Colleges of Physicians Training Board (JRCPTB) for further details on applying for a CESR. We also hope to develop the SSAS Forum as a more confidential arena for discussion and networking.

The committee has had some changes to its membership;
Berni Mountain and Jane Stickland have come to the end of their term in office. Advertisement has gone out to seek new candidates. We are extremely grateful for all Berni and Jane's work on the committee.

For their support, we are very grateful to the Executive Committee who never forget our group of doctors and make us feel an important part of the APM.

Anna Hume
SSAS Committee Chair
March 2014

Trainees' Committee Report to AGM 2014

Key points for AGM

- We look forward to working with the proposed APM Juniors Committee and welcome Dr. Matthew Lloyd who will act as liaison officer
- The Trainees' Committee organised a stand at the annual RCP Medical Careers Day, held at the College in September. It also coordinated the production of two careers information leaflets. These are currently available on the public part of the APM's website, under the "Committees" tab, in the "Trainees' Committee" section. All Training Programme Directors should have received hard and electronic copies for distribution. The Trainees' Committee will take responsibility for keeping the information on these leaflets up-to-date
- The Committee felt it important to highlight to trainee members three key annual surveys to complete, including the APM Workforce Survey. These were summarised in a short piece published in the September edition of the APM Post

Committee Work

1. Our primary aim remains that of acting as a conduit for networking and supporting trainee members of the APM. Facilitating the organisation of study days is a key part of this work and one such study day in Leicester in autumn 2013. There will be a trainee-focussed study day in Birmingham later in May 2014.

2. Various members of the Trainees' Committee continue to appraise and highlight key events and interests of the respective committees upon which they sit. Our regular face-to-face meetings and conference calls are a vital part of our work to keep each other informed of these opportunities and help to network with the wider trainee membership about the work of the individual APM committees.

3. We continue to rely on regional trainee representatives, themselves APM members, in order to communicate with the wider trainee membership. We propose to invite regional representatives to the APM Doyle Forum, which is an online discussion forum (yahoo group) currently set up for members of the Trainees' Committee.

Current membership of the APM Trainees' Committee

Officers

Chair	Dr. Milind Arolker
Secretary	Dr. Tom Middlemiss
Education Committee Representative	Dr. Miranda Kronfli
Regional Representative Co-ordinator	Dr. Katrien Naessens
Website Officer	Dr. Ros Marvin

Members

Ethics Committee Representative	Dr. Andrew Shuler
Professional Standards Committee Representative	Dr. Cliona Lorton

SAC Trainee Representatives trainees)	Dr. Siwan Seaman (for Wales and N. Ireland Dr. Kirsten Donnelly (for England trainees) Dr. Kate Mark (for Scotland trainees) Science
Committee Representative	Dr. Gareth Watts
Workforce Committee Representative	Dr. Mary McGregor
Observer to BMA Junior Doctors' Committee	Dr. Rebecca Lennon
Palliative Care Research Society Representative	VACANT

I would like to take this opportunity to thank the following ex-Committee Members and Officers for their hard work and dedication: Dr. Sarah Mollart for her work with the Education Committee and her secretarial support, Dr. Kim Steel in her role as Website Officer, and Dr. Liz O'Brien in her role as Regional Representative Coordinator.

This will be the last AGM I attend as Chair of the Trainees' Committee, and I wish Tom Middlemiss every success in taking over the reins.

Dr. Milind Arolker
Trainees' Committee Chair
March 2014

ASSOCIATION OF PALLIATIVE MEDICINE
ANNUAL GENERAL MEETING MARCH 2014

APM WORKFORCE COMMITTEE REPORT

I would like to thank colleagues for their support on the APM Workforce Committee, the APM membership; specifically the contribution from Bernie Corcoran for Northern Ireland and to welcome Julie Doyle in her place. Also the members of the SAC Palliative Medicine for their on-going contributions to workforce data.

APM Workforce Committee members are as follows:

Chair:	Stephanie Gomm
England Representative:	Benoit Ritzenthaler
Scotland Representative:	Jane Edgecombe
Wales Representative:	Caroline Usborne
Northern Ireland Representative:	Julie Doyle
Ireland Representative:	Feargal Twomey
Trainee representative	Mary McGregor
SAS representative	Berni Mountain
SAC representative	Penny McNamara

The APM workforce survey data for 2012 has been analyzed (full report will be available shortly on APM website). The 2013 survey will close 31st March 2014. The workforce survey for 2014 will be circulated in June.

For the APM, Benoit Ritzenthaler and myself attended the RCP workforce meeting on 5th December, 2013, jointly with Alison Coackley, Chair of the SAC Palliative Medicine, to present the palliative medicine report of the RCP 2012 workforce census, along with other medical specialties. Discussions focused on current consultant numbers, expansion, recruitment and unfilled posts; current trainee numbers, recruitment, with an opportunity to raise issues for our specialty and to make predictions for workforce planning over the next 5 years.

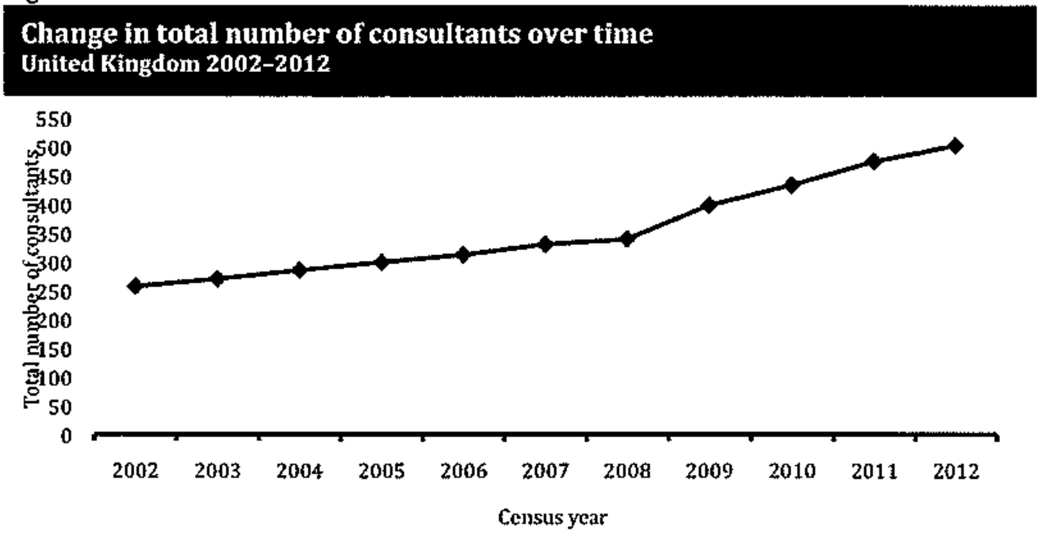
RCP Census 2012 reported a fall in the overall UK Consultant Physician expansion rate from 10.2% in 2009 to 5.2% in 2011 and further to 3.5% in 2012 .The major concern remains the shortage of recruitment into acute medicine and geriatric medicine and the impact of dealing with the influx of acute medical admissions and the frail elderly.
The Academy of Royal Colleges published their reports on the Commission of the Future Hospital in the summer 2013 and the Shape of Medical Training both of which the APM responded to. These proposals will impact on the format of the delivery of 7-day access to palliative medicine, continuity of care, our relationship to the wider hospital and community service provision, and the promotion of (general) internal medicine skills across the medical workforce.

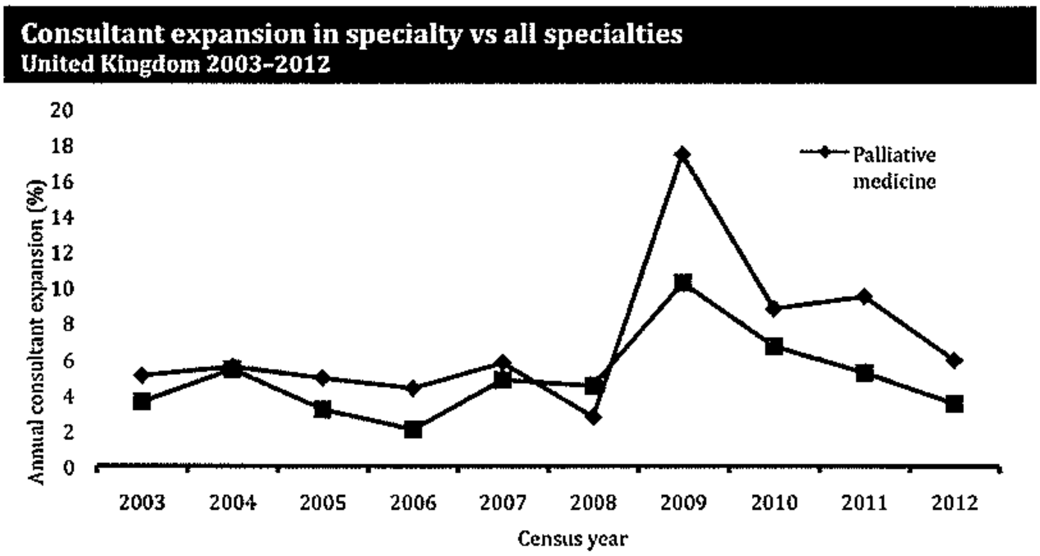
For England The Centre for Workforce Intelligence (CfWI) published their report in July 2011, http://www.cfwi.org.uk/intelligence/in-shape-of-the-medical-workforce-informing-medical-speciality-training-numbers/palliative-medicine. The CfWI recommended that no change be made in palliative medicine to either the number of training posts or their current geographical distribution and included the recommendation to retain the Hewitt & Johnson posts. The majority of which are not being replaced.
In England ,the consequences for education, training and workforce planning even after amendments to the NHS White Paper are still a major concern, in particular the impact of the Learning, Education and Training Boards (LETBs) taking over the role of the SHAs with no commitment to national workforce planning or standards. In addition, the proposed changes to MADEL Funding of basic salaries for FY2 and Registrar trainees from 100% to 50% and a £12000 placement fee by HEE which the APM and SAC have made representations re impact on training funding .
For Scotland: Re-shaping the medical workforce in Scotland consultation of specialty trainers from 2000 – 2015 has indicated that palliative medicine sets a target to reduce training numbers nationally from 16 to 11, with workforce representatives trying to maintain these at 14, currently there are 13 in training.
Wales: The medical workforce in Wales following the Sugar Report 2008 has recently had significant expansion in consultants posts and is unlikely to significantly increase further or its training capacity.
Northern Ireland: Workforce issues are under discussion with currently no proposed changes in trainee numbers.
Éire: Expansion in consultant posts is likely to be slow over the coming years. Allied to the fact that none of the consultant body is over 56 years old, this will impact significantly on the availability of consultant posts.

Eire workforce information has been submitted to RCPI as part of a workforce review, the impact on trainee numbers is under discussion.

Consultant Workforce

The RCP Census 2012 of consultant physicians identified 502 consultants in palliative medicine across the UK; less than FT overall 48%.
Responders were: - 143 (28.5%) were male and 359 female (71.5%).
414 Consultant posts in England, 28 in Wales, 43 in Scotland and 16 in Northern Ireland. Average retirement age was 60.8 yrs.
The annual UK expansion of our consultant numbers showed a decrease from 9.5% in 2011 to 5.9% in 2012. This compares to an overall fall in expansion rates for medical specialties from 10.2% in 2009 to 3.5 % in 2012.
Figs 1 & 2..





APM Workforce Survey 2012 was undertaken from 28th August 2012 to 27th May 2013 obtaining information for UK and Eire on numbers and grade of post-holders, age, gender, ethnicity and full-time and less than -time working. Overall response rate was 70.0 % hence under-reporting workforce numbers.

Table 1. APM data 2012: Consultants fte by gender and country

Gender	England	Northern Ireland	Scotland	Wales	UK totals	Republic of Ireland
Female WTE posts	154.4	9.3	8.5	8.0	**180.2**	8.0
Male WTE posts	75.9	-	7.7	7.5	**91.1**	6.2
Total WTE posts	**230.3**	**9.3**	**16.2**	**15.5**	**271.3**	**14.2**
Total consultant posts by country	*284*	*12*	*23*	*29*	*348*	*11*
Substantive Headcount	265	11	21	28	325	11

Table 2. APM data 2012: Consultants by hours of working and gender

Gender by full time and less than full time (consultant posts) – UK

Gender	Full-time		Less than full-time		Totals
Female consultant posts	**98**	**39.5%**	**150**	**60.5%**	**248**
Male consultant posts	**77**	**77.0%**	**23**	**23.0%**	**100**
Total consultant posts	**175**	**50.3%**	**173**	**49.7%**	**348**

SAC Palliative Medicine September 2013
An interim report of an expansion rate of 5.3 % in UK Consultant numbers from 507 (408.6 fte) in 2012 to 538 (436 fte). Vacancy rates have fallen in all countries except Northern Ireland .

Table 3. Consultant workforce SAC data September 2013

SAC 2013	UK	England	Scotland	Wales	N Ireland	Eire APM 2012
Number Consultants	**538**	**438**	**45**	**36**	**19**	**30**
fte	**436**	**321.95**	**39.65**	**29.2**	**16.6**	**28.6**
Participation ratio	**0.81**	**0.74**	**0.88**	**0.81**	**0.87**	**0.95**
Vacant posts N	**39**	**33**	**2**	**1**	**3**	**0**
fte	**36.4**	**30.6**	**2**	**1**	**2.8**	**0**
% Vacancy rate	**↓7.2%**	**↓7.5%**	**↓ 4.4%**	**↓ 2.7%**	**↑15.8%**	**0%**

Table 4. Comparison of APM Consultant 2012 with RCP and SAC data

Consultants 2012	England	N Ireland	Scotland	Wales	UK	Eire
APM	**325**	**11**	**21**	**28**	**385**	**11**
APM Response rate	**80%**	**61%**	**45%**	**78%**	**76%**	**37%**
SAC	**404**	**18**	**47**	**36**	**507**	**30**
RCP	**414**	**16**	**43**	**28**	**502**	**N/A**

Working Hours

The RCP 2012 census reported that working patterns for palliative medicine are similar to those found in other specialties with regard to direct clinical care.
Palliative Medicine Consultants worked on average 45 hours with the mean number of PAs contracted = 9.2. However due to the high percentage of Consultants working <FT, Tables 5 & 6 show that a full-time Consultant is contracted for a mean of 10.7 PAs and works on average 12.1 PAs. A less than FT Consultant is contacted to work a mean of 7.5 PAs and works on average 8.6 PAs.
However, palliative consultants were retaining their contracted supporting activities (mean 2.5) compared to the mean of 2.0 in other medical specialties, recognising the strategic role required for the majority of the Consultant workforce. Compared to other specialties on average there is less contracted time for academic activity, and work fewer PAs in academic work than the mean for all specialties (reflecting the small number of university consultant appointments). This has an impact on the potential for expansion of the training programme for academic fellows. This is also reflected in the APM Survey 2012.

Tables 5 & 6.

Mean programmed activities (PAs) contracted per week for whole-time consultants
UK – all medical specialties
Source: RCP consultant census – census date 30 September 2012

Specialty	Responses	Total	Clinical PAs %	Academic PAs %	Supporting PAs %	Other PAs %
Palliative medicine	129	10.7	7.3	0.5	2.5	0.4
Summary	**4,259**	**11.3**	**7.9**	**0.7**	**2.1**	**0.5**

Mean programmed activities (PAs) contracted per week for less-than-whole-time consultants
UK – all medical specialties
Source: RCP consultant census – census date 30 September 2012

Specialty	Responses	Total	Clinical PAs %	Academic PAs %	Supporting PAs %	Other PAs %
Palliative medicine	120	7.5	5.5	0.1	1.8	0.1
Summary	**884**	**7.3**	**5.2**	**0.3**	**1.5**	**0.2**

Mean programmed activities (PAs) worked per week for whole-time consultants
UK – all medical specialties
Source: RCP consultant census – census date 30 September 2012

Specialty	Responses	Total	Clinical PAs %	Academic PAs %	Supporting PAs %	Other PAs %
Palliative medicine	126	12.1	7.6	0.5	3.5	0.5
Summary	**4,198**	**12.5**	**8.6**	**0.9**	**2.8**	**0.3**

C18b. Mean programmed activities (PAs) worked per week for less-than-whole-time consultants
UK – all medical specialties
Source: RCP consultant census – census date 30 September 2012

Specialty	Responses	Total	Clinical PAs %	Academic PAs %	Supporting PAs %	Other PAs %
Palliative medicine	119	8.6	6.0	0.1	2.2	0.3
Summary	**877**	**8.3**	**5.8**	**0.4**	**1.9**	**0.2**

APM Workforce data 2012
Table 7 Consultants' contracted hours

Full-time / less than full time	*PAs (mean)*				
	Clinical	*Supporting*	*Academic*	*Other*	*Total*
Full time	7.0	2.6	0.6	0.5	10.7
Less than full time	5.2	1.9	0.2	0.2	7.5
Totals	**6.1**	**2.3**	**0.4**	**0.4**	**9.1**

Table 8 Consultants' actual hours

Full-time / less than full time	*PAs (mean)*				
	Clinical	*Supporting*	*Academic*	*Other*	*Total*
Full time	8.6	3.7	0.5	0.3	13.3
Less than full time	5.6	2.3	0.2	0.1	8.9
Totals	**7.3**	**3.2**	**0.3**	**0.3**	**11.1**

Table 9.Academic posts by country

Academic posts	England	Northern Ireland	Scotland	Wales	UK Totals	Republic of Ireland
Clinical Lecturer	19	-	2	3	24	3
Lecturer	11	1	-	3	15	-
Professor	7	-	-	1	8	-
Reader	3	-	-	-	3	-
Research Fellow	14	-	1	1	16	2
Senior Lecturer	22	1	2	2	27	1
Total academic posts	76	2	5	10	93	6
Total respondents by country	532	21	51	49	653	18

SSAS Doctors APM Survey 2012

SSAS doctors were defined for the purpose of the survey as Associate specialist, Staff grade, Clinical assistants, Medical officers, GPwSI, Specialty Doctors and other non-training grades. Total numbers who responded were 157.
80% were female and 20% male. Overall 27% were >50years of age.
In total, 75% were working less than full-time.

Table 10.Grade of SSAS Doctor by country

Clinical posts	England	Northern Ireland	Scotland	Wales	UK Totals	Republic of Ireland
SSAS and other non training posts						
Associate Specialist	32	-	3	4	39	-
Clinical Assistant	4	-	-	-	4	-
GP with Special Interest (GPwSI)	2	1	-	-	3	-
Macmillan GP Facilitator	1	-	-	-	1	-
Medical Director ONLY	3	1	1	-	5	-
Medical Officer	7	1	-	-	8	-
Specialty Doctor	51	1	11	3	66	-
Staff Grade	13	-	-	-	13	-
Other non training post	15	-	2	1	18	1
Total SSAS and other non training posts	128	4	17	8	157	1

Table 11.SSAS Doctors working hours
Gender by full time and less than full time (SSAS and other non-training posts) – UK

Gender	Full-time		Less than full-time		Totals
Female SSAS and other non-training posts	31	25.4%	91	74.6%	**122**
Male SSAS and other non-training posts	8	26.7%	22	73.3%	**30**
Total SSAS and other non-training posts	**39**	**25.7%**	**113**	**74.3%**	**152**

Table 12. SSAS Doctors mean contracted hours

Full time or less than full time	Contracted Programmed Activities (PAs) (mean)				
	Clinical	**Supporting**	**Academic**	**Other**	**Total**
Full time	8.3	1.0	0.6	0.5	**10.3**
Less than full time	5.3	0.6	-	0.1	**6.2**
Total contracted PAs	**6.8**	**0.8**	**0.3**	**0.3**	**8.3**

Trainees

Specialist Advisory Committee (SAC)
In September 2013, the SAC reported 240 palliative medicine registrars in the UK (Table 13) with 84.4% female. Overall, 37.5% of registrars were working < FT. The breakdown for these posts was: 209 (177.4fte) in England, 13 (11.6 fte) in Scotland, 12 (11.5 fte) in Wales and 7 (6.7 fte) in Northern Ireland. The number OOP trainees increased to 19 post-holders (excluding maternity leave).In England there were 12 academic fellows at registrar grade.
Annual expansion rate of registrar posts JRCPTB fell in 2011 to 5.8 % but increased to 10.5% in 2012 (Table 15) compared to the overall expansion rate of 54.1% between 2001 and 2010.
In Eire there were 14 full-time Registrars in training (2 out of programme); 13 female and 1 male (APM data).

Table 13 SAC Trainee Registrar Data September 2013

Sept 2013 SAC	UK	ENGLAND	SCOTLAND	WALES	N IRELAND
TOTAL REG FTE	240 206.2	209 177.4	13 (10.6) 1 vacant NTN	12 (11.5)	7 (6.7)
REG FT	154 64%	132 63%	5 38.5%	11 92%	6 86%
REG <FT	86 36%	77 37%	7 61.5%	1 8%	1 14%
LAT	9	8	1	0	0
OOP	19	18	1	0	0
ACF	12	12	-	-	-

Table 14. APM Workforce survey Registrars September 2012

Clinical posts	England	Northern Ireland	Scotland	Wales	UK Totals	Republic of Ireland
F1 Post	-	-	-	-	-	-
F2 Post	-	-	-	-	-	-
GP Specialty Trainee	-	-	-	-	-	-
Specialist Registrar	**24**	-	**2**	**2**	**28**	**2**
Specialty Registrar	**109**	**5**	**8**	**11**	**133**	-
Specialty ST1/ST2 post	-	-	-	-	-	-
Other training post	**2**	**1**	**1**	-	**4**	**4**
Total training posts	**133**	**6**	**11**	**13**	**165**	**6**

Table 15. Expansion of Registrar posts (JRCPTB database)

No. UK Registrars	Year	% expansion
135	2001	-
179	2005	32.6%
208	2010	16.2%
220	2011	5.8 %
243	2012	10.5%
240	2013	-

Outcome of achieved CCT holders:

Overall, it takes on average 5 years to train a Palliative Care Physician (Note: this figure modified from 4 years full-time training because of the number of less than full-time trainees).
For the period 1st August 2012 to 31st July 2013 37 certificates of completion of training (CCTs) in palliative medicine were awarded 25 recipients in substantive posts, 7 in locum consultant posts, 4 in their periods of grace and 1 other .

Projected numbers of CCTs for the next 5 years are taken from JRCTB data for UK between 2014 and 2017. (Table 16) and for Eire (Table 17).These projected numbers will vary year on year affected by changes to less than full-time working, periods out of programme etc .The average number of CCTs estimated per year between 2014-2017 is 50/year.

Table 16 JRCPTB Projected CCT data September 2013

Year	England	Northern Ireland	Scotland	Wales	UK
2014	54	0	4	6	64
2015	57	1	8	2	68
2016	39	2	1	0	42
2017	25	1	0	0	26
2018	5	0	0	1	6
Totals	**180**	**4**	**13**	**9**	**206**

Table 17. Projected CCTs for Eire (APM data 2012)

Year CCT due	2013	2014	2015	2016
Number	2	3	4	5

Development of the Consultant Workforce
The following factors will influence the numbers and development of the consultant workforce:

- The increase in workload due to the higher prevalence of cancer, and patients with long-term conditions
- A predicted 20% increase in mortality rates for patients aged 85 years or older.
- The high proportion of women trainees (greater than 80%)
- The percentage of doctors working less-than-whole-time (48% for Consultants and 37 % for trainees)

However the number of posts available may increase due to trainees moving abroad, entering whole-time research or leaving medicine, an increase in the rate of retirement among older consultants, and the impact of the retirement age for those currently younger than 50 years increasing to the age of 67.
The most important variable, though, is the creation of new posts (ie expansion in consultant numbers) within the current financial climate.

Consultant Expansion and Retirements.
RCP Census 2012:
<u>Consultant expansion rate.</u> The annual UK expansion of our consultant numbers showed a decrease from 9.5% in 2011 to 5.9% in 2012 . This compares to an overall fall in expansion rates for medical specialties from 10.2% in 2009 to 3.5 % in 2012.
Using SAC data increase % expansion from 2012 t0 2013 was 6.1%.
Consultant appointments in 2012/13, advisory appointments committees (AACs) appointed consultants in 70 out of 83 cases (84%), with 13 appointments not made

<u>Consultant retirements.</u>

APM data 2012 for UK between 2013 and 2017.estimated 32 retirements on average 6/year. In 2013 the average age of retirement is 60.2 years .

Table 18 Consultant retirements per year by country
(fte indicated by figures in brackets)

Year	England	Northern Ireland	Scotland	Wales	UK Totals	Republic of Ireland
2012	3 (2.8)	-	1 (1.1)	-	**4 (3.9)**	-
2013	10 (7.9)	1 (1.5)	-	1 (0.9)	**12 (10.3)**	-
2014	5 (5.0)	-	2 (2.1)	1 (0.6)	**8 (7.7)**	-
2015	9 (8.1)	-	2 (2.2)	-	**11 (10.3)**	-
2016	5 (4.7)	1 (1.0)	-	-	**6 (5.7)**	-
2017	3 (2.8)	-	-	-	**3 (2.8)**	-
2018	5 (4.4)	-	-	-	**5 (4.4)**	-
2019	5 (5.1)	-	-	1 (0.7)	**6 (5.8)**	-
2020	11 (11.9)	-	-	2 (1.5)	**13 (13.4)**	-
2021	11 (10.4)	1 (0.7)	2 (2.0)	1 (1.0)	**15 (14.1)**	1 (1)
Totals	**67 (63.1)**	**3 (3.2)**	**7 (7.4)**	**6 (4.7)**	**83 (78.4)**	**1 (1)**

RCP 2012 The estimated number of consultants in UK due to reach age of 65 years for the period 2013–17 is 21 or 4/yr and is 56 between 2018□2022 ie 10/yr.

Number of consultants who will reach 65 years of age over the next 10 years – by specialty

Specialty	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total	% of specialty
Palliative medicine	2	1	7	4	7	14	11	8	12	11	11	88	*17.5*
All specialties	137	159	175	186	210	258	261	304	340	338	384	2,752	*0.2*

In Eire in 2012 there were no consultants > 56years of age and one predicted retirement at 65 yrs in 2021 (APM data).

Consultant vacancy rate has fallen to 7.2% for 2013 (SAC) compared to 8.8 % in 2010 and 12.3 % in 2009.

Workforce issues for the specialty in the UK 2013-17

The projected average number of CCTs per year = 35 to 40 which can be used as a model to match number of Consultants needed.

A simplified predictive model (Table 18) with the need to interpret with caution as it is dependent on historical consultant expansion being maintained tempered by the annual number of retirements and the fluctuation in CCT holders each year

Table 18 .

	Per annum 2013-17			Per annum expansion 2011-13	Potential excess CCT holders in 2017 if historical expansion maintained
	New CCT holders	Consultant retirements	Consultant expansion required		
Palliative Medicine	50	6	44	35	45 Average 9/yr

Estimated Consultant workforce requirements:

The estimated workforce requirements are 2 fte consultants for a population of 250,000 representing 497 fte working across the UK. Consultant Physicians working with patients: (5th ed revised) Royal College of Physicians, 2012. The most important variable in the current financial climate is the creation of new consultant posts and the continued funding of consultant vacancies. Overall there is the potential risk in the next 5 years that there will be an over production of CCT holders in regard to available consultant posts.

One of the consequences of this may be the facilitation of recruitment of consultants to regions that are currently under supplied

Table 19 Estimates for each country in UK and Eire

Based on 2 full-time equivalent (fte) per 250,000 population Consultant Physicians working with patients: The duties, responsibilities and practice of Physicians in Medicine. (5th Ed) Royal College of Physicians, 2011.[1] With a participation ratio (0.74-0.88) for fte and headcount in each country using SAC 2013 data.

Country	Population Millions (2012)	Headcount	Est RCP * fte	SAC 2013 Headcount	SAC fte	Particip ation ratio
Wales	3.1	31	24.8	36	29.2	0.81
N Ireland	1.8	17	14.4	19	16.6	0.87
Scotland	5.25	48	42.0	45	39.65	0.88
England	53.0	573	424.0	438	323	0.74
UK	62.15	612	497.0	538	436	0.81
Eire	4.05	34	32.0	30	28.6	0.95

Dr Stephanie Gomm Chair
APM Workforce Committee
March 2014

SAC Report to the APM AGM, February 2014

I have taken on the role of SAC Chair since autumn 2013 and am very much looking forward to working with colleagues from across the UK to continue to develop the specialty training programme

I would like to make a special mention of the enormous contribution made by Dr Fiona Hicks who has chaired the SAC for the previous six years. On behalf of the SAC I would like to express our gratitude for all her hard work, commitment and enthusiasm during some challenging times. Her wisdom and knowledge about the specialty and training has been very much valued by members.

The following is a brief summary of the developments this year. Please contact me or your regional head of specialty training for further information.

Recruitment
Recruitment to higher specialist training is co-ordinated from the Royal College of Physicians (RCP) in England and Wales, led by Polly Edmonds and Claire Hookey for the SAC. There is a system of a single, cascadable application which enables all eligible candidates to be interviewed, widening the pool of applicants considered. We continue to have two recruitment rounds per year with a national format being used in Round 2 in 2013. For 2014 we will be using a cluster approach for Round 1 and will then need to evaluate the process. Flexibility in the advertising of vacancies and more gaps in rotations as a result continue to be a significant issue. The person specification is currently being reviewed so that other entry qualifications can be considered

Quality
The GMC has published surveys of trainees again in 2013. Information on training and outcomes is improving year on year and we continue to develop and refine the specialty specific questions which are included. And provide valuable information about training across the UK

Curriculum Review
Alison Mitchell and Bisharat el Khoury lead on curriculum issues. Changes to the number and type of WPBAs have been approved by the GMC and will be formalised in summer 2014.

Assessments
The Specialty Certificate Exam (SCE) was introduced in November 2011, ably led by Prof Karen Forbes, and is conducted annually. The results from the first three years suggest that it is a fair and discriminating exam.

CESR
We continue to have a very small number of applications for CESR each year and some enquiries. Applicants are assessed against the most recent, published curriculum. Prospective applicants should read the GMC guidance very carefully. Advice is available from CESR assessors via the SAC, the GMC and from the certification department at the RCP.

Workforce Planning
The SAC has a workforce lead and collects data annually from each deanery. This includes data on trainee numbers (full-time and less than fulltime), CCTs achieved and expected consultants (fte), consultant vacancies and destinations of CCT holders for each of the 4 countries. This feeds into the APM workforce group to provide as complete a view as possible of workforce issues.

Shape of Training Review
This review has some interesting recommendations many of which could have an impact on the specialty and on the training programmes. The SAC will be considering a response to the report in the next few weeks

National Tariffs for Training

There has been concern from Hospices about the changes to funding arrangements for registrars which could in turn adversely affect the training programmes. The exact position is still not entirely clear but it is likely that Hospices will be excluded from these changes. Final clarification is still awaited.

Alison Coackley
Chair, on behalf of the SAC, Royal College Physicians
February 2014

TRANSFORM End of Life Care Acute Hospitals Programme Report 2013/14

The Transform End of Life Care Acute Hospitals Programme and Electronic Palliative Care Co-ordinating System (EPaCCS) are the two pieces of work carried forward from the National End of Life Care Programme into the new NHS Improving Quality organisation which was launched in April 2013. This brings the robust methodology, knowledge of whole systems change and improvement in organisations to join with the work of the former end of life care programme.

There are now 71 Acute Trusts participating in the Acute Hospitals Transforming End of Life Care Programme with a coverage of 100 hospitals and 13 Community Hospitals committed to improving compassionate end of life care both within their organisation and, if recovery is very unlikely, ensuring transfer of care to that which is preferred if possible.

The programme is about recognising those people who may be in the last months of life so that appropriate assessment, planning and co-ordination of care takes place; involving patients and families in discussion about planning for their future care; considering how best to manage those whose burden of disease already renders their prognosis short, yet they are admitted acutely unwell; respecting the choices, of those who have already made their wishes clear, if time is short, and supporting the care of the dying and their family at stressful and emotional times.

Several Cluster events have taken place across the country between September 2013 and January 2014 bringing together neighbouring Trusts signed up to the programme to share and learn from each other. Common themes coming out of these are that whilst the focus is on acute hospitals, whole system and cross boundary co-ordinated working is key. There is a fantastic enthusiasm and energy for improving the quality of end of life care in acute hospitals, ambitions set by the Trusts themselves are exceptionally high and realistic measurement inspires continual improvement. The programme is working hard to empower patients and their families, particularly as they cross boundaries, and to help clinicians and clinical teams to recognise those who are acutely unwell in addition to already significant advanced disease and help to encourage open and realistic discussion and multiprofessional care planning.

The enthusiasm, expertise and commitment the outgoing Chair of the Transform Steering Group, Professor John Ellershaw (former Deputy Clinical Director for End of Life Care) is replaced by the energy and drive of Dr Bee Wee, National Clinical Director for End of Life Care and Chair of the Leadership Alliance for the care of Dying People, who will take this work forward into 2014.

Karen Groves
March 2014

Neurological Palliative Care Special Interest Forum

We are palliative care clinicians with a special interest in providing high quality care for patients with progressive neurological disorders and their families, working together as a group and with other colleagues to increase understanding of the issues involved. Our numbers have increased over the year, including interest from non-medical colleagues who are involved in caring for this group of patients. The group communications predominantly by email – there is an online discussion forum through a yahoo groups account but this has not been straightforward!

Nationally there is significant interest in the role of palliative care in non-malignant disease and long-term conditions, and hence many opportunities to be involved and lead on projects. Current areas of interest shared within the Special Interest Forum include, amongst others, withdrawal of ventilation at the request of patients with Motor Neurone Disease (Christina Faull cmf50@me.com) and identifying triggers for end of life care in patients with advanced neurological conditions. (Jamilla Hussain jah553@york.ac.uk.) The Department of Health has asked NICE: 'to develop a clinical guideline on the assessment and management of motor neurone disease' and members of the group will be involved with this.

On November 27th 2013 we held a highly successful inaugural meeting and day conference on palliative care in progressive neurological disease at LOROS Hospice, Leicester; It was over subscribed and unfortunately we had to turn some people away. Talks covered a range of different progressive neurological diseases including Parkinson's disease and related conditions, MND and MS.
There were a number of presentations of original research, service development and evaluation, including the recently developed Edinburgh Cognitive and Behavioural ALS Screen and prevalence of pain in MS. Debi Adams from Scarborough discussed the review of their specialist palliative care neurology service against the recommendations of the National End of Life Care Programme Framework for Progressive Neurological Conditions. This has led on to work looking at identifying triggers for end of life care.
In the afternoon, Christina Faull presented her study of the issues for palliative medicine doctors around the withdrawal of non-invasive ventilation at the request of a patient with motor neurone disease. This, along with an overview of respiratory management in MND by Robert Parker, prompted lively discussion about the ethical and practical issues in the use and withdrawal of NIV. The meeting also provided a forum for sharing ideas and David Oliver gave an impassioned plea for people's involvement in future research.

The next meeting of the Special Interest Forum is planned for Thursday 13th March, 12:45 – 13:30 at the Palliative Care Congress at Harrogate International Centre, Queens Suite B. Please feel free to come along and share your thoughts / projects etc. Looking further into the year Jane Neerkin has organized a Neuropalliative care study day in association with the APM Neurological Palliative Care Special interest Forum to be held on June 23rd2014 at the National Hospital for Neurology and Neurosurgery, Queens' Square, London. This plans to cover an interesting variety of topics including Dementia and Palliative care, seizures in brain tumours and managing compassion fatigue.

Anyone interested in Neurological Palliative Care is welcome to join the Special Interest Forum – please feel free to contact me – email and telephone numbers below.

Annette Edwards
Neurological Palliative Care SIF co-ordinator
February 2014

Annette.edwards@suerydercare.org
Tel: (Wheatfields Hospice, Leeds) 0113 2787249

Association for Palliative Medicine: Undergraduate Education Special Interest Forum Annual report to APM AGM February 2014

The Undergraduate Education SIF has been rejuvenated over the past 18 months under the joint leadership of Prof John Ellershaw (Liverpool) and Dr Stephen Barclay (Cambridge).

Annual conference.

The first of our annual conferences was held in Cambridge in February 2013: 30 doctors and 15 medical students came for a full and stimulating one-day meeting. In a keynote address from Dr Diana Wood, Cambridge Clinical Dean, we were reminded that Sir William Osler regarded teaching medical students as "the most useful and important part of my work".

Delegates gave presentations concerning current teaching in their medical schools: we were encouraged with accounts from some of real progress and reassured with accounts from others of struggles to secure curricular time and resources. Delegates' presentations of their education research stimulated discussion of measurement instruments and the need for multi-school studies.

Revising the 2006 APM curriculum for undergraduate medical education.

Work on this project started at the conference and has continued subsequently by email discussion with SIF members. The previous APM curriculum has been revised to take into account recent changes in policy and practice: it outlines the key areas to be addressed and is describes a comprehensive course for those leading teaching.An accompanying two page document mapsthe revised curriculum onto the GMC's "Tomorrow's Doctors". This is designed to be of use in discussions with school Deans and curricular committees. Both documents will be launched at a Palliative Care Congress workshop in March 2014.Contact: Stephen Barclay sigb2@medschl.cam.ac.uk

Formation of new APM Junior Member's Forum.

A very welcome outcome of the February conference was the formation of an APM group for medical students and junior doctorsin Foundation and Core Training years. Warmly endorsed by the APM Executive, this enthusiastic group is establishing reps in every medical school, a presence on the APM website and are running their first national conference in Cambridge on March 9th, with over 60 registered to attend at the time of writing. Contact: Dan Knights dphknights@gmail.com .

Developing the SIF presence on the APM website.

SIF members are developing their presence on the APM website. Each medical school will have a front page detailing their lead for Palliative Care teaching and brief course summary, with opportunity to upload additional documents concerning course components. This is being created at the time of writing and will be demonstrated at the PCC in March 2014

Annual conferenceThursday April 3rd 2014, Liverpool.

The next annual day-conference of the SIF will focus on methods of undergraduate teachingand educational research. An opportunity to learn about teaching and research methods, for delegates to present local developments and to network and support each other in what at times can be a lonely task to develop teaching in our medical schools. Contact: Jo Davies davies79@liverpool.ac.uk

Stephen Barclay sigb2@medschl.cam.ac.uk
John Ellershaw J.E.Ellershaw@liverpool.ac.uk
March 2014

Report from the Transition SIF

Coordinator Dr Amelia Stockley, ST6 Palliative Medicine, Severn Deanery
(previously Dr Victoria Lidstone until November 2013).

The Transition SIF was created in August 2012 and I would like to thank the APM Secretariat for coordinating the invitations to join and the creation of an online forum. To date we have 20 members registered. However, I note that there has been little 'noise' online of late and feel the need to inject some energy and vigour into the forum!

Having taken over as coordinator I am keen to address the aims of the SIF proposed by Dr Lidstone and will do so with reference to the list of activities she anticipated at its inception. In the first instance I intend to organise an inaugural meeting and in so doing hope to raise the profile of the group amongst APM members and therefore stimulate discussion, debate and the creation of ideas on the online forum. In the coming year I will focus on Dr Lidstone's proposed objectives for the Transition SIF by seeking to

- create an opportunity for collaborative working, practice sharing and policy-making
- encourage development of services appropriate to the needs of young adults
- support the APM by responding to requests for expert advice an opinion in this area

I look forward to a busy 2014.

Dr Amelia Stockley
March 2014

Proposal For Establishment of Junior Membership Tariffs for APM AGM

1. Medical Student Membership

- Eligibility:
    - Open to all medical students at any recognised medical school in Great Britain & Ireland
    - Students of any year of study, including intercalating
- Verification:
    - Students would be required to register using a university email address
- Cost:
    - FREE
- Registration:
    - Online form accessible through apmjuniors.org and/or apmonline.org
    - It would be important to consider how the membership database would be managed between the Juniors Committee and the APM Secretariat
- Benefits:
    - Right to vote in elections for membership of the APM Juniors Committee
    - Eligibility to stand for election to any APM committee
    - Full access to the password protected section of apmonline.org
    - Full access to the password protected section of apmjuniors.org
    - Member's rates for attending APM conferences and educational events
    - Receipt of the APM e-bulletin
    - Receipt of a copy of the quarterly APM Post (TBC whether electronic or hard copy)

2. Junior Doctor Membership

- Eligibility:
    - Junior doctors with provisional or full GMC registration in one of the following categories:
        - F1 or F2
        - Core Medical Trainee
        - Core Surgical Trainee
        - ACCS Trainee
        - GP Trainee
        - On a year out of training at any point in career prior to entry to specialist training

- Verification:
    - GMC number
- Cost:
    - £30 per annum – payable in the same way as other paying APM membership packages
- Registration:
    - Online form accessible through apmjuniors.org and/or apmonline.org
    - Pending receipt of payment
    - It would be important to consider how the membership database would be managed between the Juniors Committee and the APM Secretariat
- Benefits
    - Right to vote in elections for membership of the APM Juniors Committee
    - Eligibility to stand for election to any APM committee
    - Full access to the password protected section of apmonline.org
    - Full access to the password protected section of apmjuniors.org
    - Member's rates for attending APM conferences and educational events
    - Receipt of the APM e-bulletin
    - Receipt of a copy of the quarterly APM Post (TBC whether electronic or hard copy)

3. Associate Membership

Any medical student or junior doctor who also wanted to benefit from access to the journals would be free to purchase the existing Associate Membership package, as is already the case.

PROPOSED TERMS OF REFERENCE OF THE APM JUNIORS COMMITTEE APM AGM 2014

Purpose

The APM Juniors Committee replaces the Junior Members Working Group, which was set up in April 2013. In light of the high level of interest in such a group established by the Working Group, the Committee's remit is to stimulate interest in the speciality amongst medical students and pre-speciality training (ie. pre-ST3) junior doctors, providing educational opportunities, peer support and representation, information and signposting and a means for coordinating and channeling their interest in palliative medicine.

Terms of reference:

1. To identify and facilitate mechanisms for stimulating and harnessing interest in palliative medicine amongst medical students, foundation programme doctors and core medical/surgical trainees and GP trainees.
2. To establish and facilitate mechanisms for communication and coordination amongst this group of medical students and doctors who are interested in palliative medicine, including establishing regional and national networks, organisation of conferences and educational events and using online media as a focus.
3. To establish and act as a central information hub about elective and special study component opportunities, careers advice, resources and events.
4. To facilitate networking between junior and senior members of the APM, particularly in the areas of mentorship, careers advice and research opportunities
5. To liaise with APM standing committees to identify ways in which junior members can contribute to, and benefit from, those areas of interest
6. To represent the views of Junior members to the Executive Committee and wider Association

Membership

Membership is open to any Junior Member of the APM, or Associate Member who fulfils the requirement for Junior Membership.
Terms of office will be two years, with an ideal minimum period of service of one year. Members may stand for re-election as long as they still fulfil the membership requirements. The Chair should ideally have served on the committee previously.

Chair (& Liaison to APM Executive Committee)
Secretary
Undergraduate Membership Coordinator
Postgraduate Membership Coordinator
Communications Coordinator
Education Coordinator (& Liaison to APM Education Committee)
Student-Selected Components and Electives Coordinator
Research Coordinator (& Liaison to APM Science Committee)
Careers & Mentorship Coordinator (links with APM Workforce & Professional Standards Committees)
Liaison to APM Trainees Committee
4 General Committee Members for a one year limited period April 2014-15

Ex Officio Committee Memberships (as above):

- APM Executive Committee (Chair)
- APM Education Committee (Education Coordinator)
- APM Science Committee (Research Coordinator)
- APM Trainees Committee (Trainees Liaison)

Election

Year April 2014-15:

Committee Chair: Anyone fulfilling the criteria for Junior Membership may submit a written statement of motivation to the APM President, who will review applications and select the Chair 2014-15 (prior to other committee positions)
Other Committee Positions: Anyone fulfilling the criteria for Junior Membership may submit a written statement of motivation to the APM Juniors Committee Chair, who will review applications and select committee members for the term 2014-15. The APM President will review and approve selected applicants prior to final decision to maintain objectivity.

Thereafter:

Ballot of all Junior Members of the APM through the Secretariat
Members apply for specific committee positions and may apply for more than one position
Liaison Officers (Exec, Education, Science & Trainees) to be voted by Junior Members but to hold full voting Ex Officio membership of the respective committees.

Conference
The Education Coordinator will be responsible for organising a one day annual conference with the help of a specially recruited local organising committee. Whereever possible, this should be run at minimal cost and with external fundraising. The Education Coordinator will liaise closely with the Chair of the APM Education Committee in regard to the event.

Communications
The Juniors Committee will manage and run their own website (www.apmjuniors.org) which will be linked to from the main APM website. This will act as a hub for specific information for juniors. The website will display a disclaimer that views expressed do not necessarily represent the position of the APM. The Juniors Committee will also manage their own Facebook Page and Twitter Account, in accordance with APM guidance on proper and professional use of social media.

Local Representation
The Undergraduate Membership Coordinator is responsible for recruiting and liaising with a representative from each medical school and will coordinate two-way communication with these representatives. The Postgraduate Membership Coordinators is respondible for recruiting a representative from each postgraduate deanery and will coordinate two-way communication with these representatives. Local representatives should be Junior Members of the APM and are responsible for dissemination of information regarding the APM and palliative medicine, representing local views to the Juniors Committee, and will be supported to establish and run local palliative care groups where possible.

Meetings
Face-to-face meetings 3 times per year with conference calls three times per year.
One of the face-to-face meetings should be in conjunction with the annual conference and should be open to all Junior Members of the APM.
Quorum is 50% of the membership, either in person (at face-to-face or telephone conference meetings) or via email. The Chair or secretary must be present.

Funding
Venue for meetings and travel expenses for committee members are funded by APM, including attendance of Liaison Officers to their respective committees. A junior representative may be funded to attend meetings of other committees if deemed appropriate at the discretion of that committee Chair.
Where possible a free meeting venue should be sought.