Association for Palliative Medicine

Annual General Meeting

Thursday 10 March 2016

1530 – 1655

Room: Lomond Auditorium

The Scottish Exhibition and Conference Centre, Glasgow

The Association for Palliative Medicine of Great Britain and Ireland

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1. **Welcome from Chair**

2. **Minutes of 2015 Annual General Meeting**

3. **Committee Reports**

    a. President .....Prof Rob George

    b. APM Vision and Values 2016 .....Prof Rob George

    c. Treasurer .....Dr Mike Stockton

    d. Education .....Dr Andrew Davies

    e. Ethics Committee .....Dr Idris Baker

    f. Juniors Committee .....Dr Anna Street

    g. Professional Standards Committee .....Dr Sarah Cox

    h. Science Committee .....Dr Jason Boland

    i. Specialty Staff Grade & Associate Specialists Committee ...Dr Helen Bonwick & .....Dr Esraa Sulaivany

    j. Trainees' Committee.....Dr Amy Proffitt

    k. Workforce Committee .....Dr Stephanie Gomm

    l. Specialist Advisory Committee .....Dr Alison Coackley

4. **Shape of Training**

5. **Special Interest Fora Reports**

a) Neurological Palliative Care Special Interest Forum.....Dr Aruna Hodgson

b) Undergraduate Medical Education Special Interest Forum .....Dr Stephen Barclay &
.....Professor John Ellershaw

c) Transitions Special Interest Forum .....Dr Amelia Stockley

6. Committees

Thanks to committee members who have demitted

Ethics Committee
Dr Tim Harlow (Chair of the Ethics Committee)

Executive Committee
Dr Fiona Finlay (Scotland Representative)

Juniors Committee
Faye Johnson (Postgraduate membership coordinator)

Professional Standards Committee
Dr Andrew Davies, Dr Esraa Sulaivany (SSAS Rep to the Professional Standards Committee)

Specialty Staff Grade and Associate Specialists Committee
Dr Anna Hume (Joint chair of the SSAS committee), Dr Sally Middleton (Joint chair of the SSAS committee)

Trainees' Committee
Dr Katrien Naessens (Secretary and Regional Reps Coordinator), Dr Mary McGregor (Trainee Rep to the Workforce Committee), Dr Kate Mark (Specialty Advisory Committee Scotland Rep)

Workforce Committee
Dr Julie Doyle (Northern Ireland Representative), Dr Feargal Twomey (Republic of Ireland Representative), Dr Kathleen Sherry (Scotland Representative)

Ratification of elected members

Ethics Committee
Dr Idris Baker (Chair of the Ethics Committee

Executive Committee
Dr Annabel Howell (Scotland Representative)

Juniors Committee
Anna Robinson (Education Coordinator), Virginia Lam (Student-Selected Components and Electives Coordinator), Frank Wang (Research Coordinator), Laura Norris (Careers & Mentorship Coordinator)

Science Committee
Dr Katherine Webber

Specialty Staff Grade and Associate Specialists Committee
Dr Esraa Sulaivany (Joint chair of the SSAS committee), Dr Helen Bonwick (Joint chair of the SSAS committee), Dr Rebecca Akroyd, Beth Williams (Professional Standards Representative)

Trainees' Committee
Dr Claire MacDermott (Trainee Rep to the Professional Standards Committee), Dr Rebecca Lennon (Secretary), Dr Sharon Twigger (Regional Reps Coordinator), Dr Felicity Dewhurst (Trainee Rep to the Education Committee), Dr Joanna Prentice (Specialty Advisory Committee Scotland Rep), Dr Heidi Mounsey (Trainee Rep to the Workforce Committee)

7. Announcement of APM award winners

a. Undergraduate Palliative Medicine Essay Prize 2015
   Miss Eika Webb – First Prize
   Miss Lucy Gray – Second Prize

8. Any other business

9. Date of next AGM

March 2017

The Association for Palliative Medicine of Great Britain and Ireland

Annual General Meeting

Friday 24 April 2015

Ludgate Suite
America Square Conference Centre, London

01/15 **Welcome from Chair**

David Brooks welcomed all those present to the meeting.

02/15 **Minutes of 2014 AGM**

David Brooks explained that the minutes were circulated electronically for the first time this year and that we will continue to send AGM papers electronically in the future.

The minutes were accepted as a true record.

Proposed: Iain Lawrie
Seconded: Tim Harlow

03/15 **Articles and Memorandum of Association**

Rob George explained that the memorandum and articles are a very historical document. These documents were written when the Association for Palliative Medicine was formed. Rob George explained the differences between the two documents. The Memorandum of Understanding tells the outside world what we do and list the objectives of the organisation. The Articles of Association determine the internal processes. We have to comply with both charity and company law. In terms of the articles Rob George explained that we need to tidy up the legal compliance which Iain Lawrie is going to take the lead on. The key things that matter moving forward is that

we need to strip out as much administration and become as efficient and effective as possible. We will be moving forward to electronic means of payment and communications.

One of the proposals/suggestions is to have a role for the exiting president to continue and support for a period of time. It was felt that sharing the work out is important to ensure we stay on top of what is happening within the organisation. Rob George explained that the updated copies of the articles and memorandum will be made available on the APM website.

04/15 **Ratification of Terms of Reference for all APM Committees**

David Brooks explained that all of the committee terms of reference have been revised. Part of that work was to gain some control over costs. We have reduced the number of face to face meetings to help bring costs down. Rob George explained that there will only be remuneration for the role of the president.

The terms of reference were agreed.

Proposed: Sarah Cox
Seconded: Iain Lawrie

05/15 **Committee Reports**

a) <u>President</u>

David Brooks submitted a report that explains all the work that has been done over the year. We have been trying to respond to things that you wanted the APM to do for the membership. David Brooks asked the members if they all receive the APM ebulletin that is sent monthly. By show of hands the majority confirmed that they were receiving the bulletin. It was reported that there are still problems with bulletins going into spam. David Brooks explained that the APM will be looking into solving the problem with a paid for bulk email provider. David Brooks explained that Eleanor Grogan, Secretary does a huge amount of work responding to consultations on behalf of the APM. David Brooks encouraged members to comment on future consultations. David Brooks explained that the new website will be up and running shortly and urged the members to forward any comments on to ensure it is an up to date and useful resource.

b) <u>Treasurer</u>

Mike Stockton was officially ratified as the new treasurer

Proposed: Andrew Davies
Seconded: Tim Harlow

By show of hand all were in favour.

Mike Stockton introduced himself to the members. Mike Stockton explained that he felt it was important to give the membership more detail and to allow more time for questions in relation to the finances. It is important to look at the future plan.

Historical analysis

2010: Influx of significant funds from profits of the EAPC conference in the region of £140,000 - £150,000.

2010 to 2013: £143,000 was transferred from restricted to general funds. Cumulative deficit on general fund of £118,000. Deficit rose partly due to increase in general costs. £51,000 cost increase (2013 costs compared to 2010 costs). Offset by the transfer from the restricted fund

2013: General reserves were marginally sufficient to cover 6 months running costs

Last years' accounts

Mike Stockton explained that the financial year runs from December to December to allow us time to produce the accounts ready for the AGM. General Activities sustained a loss of £93,638. The loss was reduced to £63,026 after transferring funds from the restricted reserve. The General Fund Balance has reduced from £111,481 (2013) to £48,455 (2014). This covers less than 3 months running costs. There will be no further transfers from the any of the restricted funds. The APM will need to generate sufficient income from its regular income streams to cover general operating costs. Mike Stockton explained to the membership why the general costs have increased.

Financial actions

The financial goal for this year is to get as near a balanced as possible. The actions we have achieved are; the vice president salary has stopped. Journal subscriptions have been negotiated to a lower rate. We have made changes to the committees in terms of the amount of committee members and amount of meetings held per year. Event profitability has also been improved.

Consultation

Mike Stockton reported that there will be no further transfers from restricted funds and that the money there is set aside to support projects. With this in mind there will be no further luxury to transfer if we overspend. Mike Stockton has produced a draft budget to work from. The biggest expenditure is the journals. The membership had an increase to cover the JPSM subscription. There has never been an increase for the Palliative Medicine journal and the BMJ. The cost of journal is 2014 was £82,263 (38% of total unrestricted income per year). Mike Stockton explained the negotiations with the different journal providers and reported that members will need to meet the journal fees by way of a membership subscription increase. It was agreed to increase membership fees in line with inflation. Mike Stockton welcomed any comments from the membership. Comments were received from members about expanding the specialty and membership, support for obtaining sponsorship at events and extending new markets.

Mike Stockton explained the journal negotiations;

JPSM: £35k electronic. Reduced down to £25k.
PMJ: negotiated for electronic journals only
BMJ: there was no room to reduce costs.

Mike Stockton explained how many hits there were through the website per week in relation to online journal access. The consultation results from the survey email were; 65% for. 35% against. No journal appears to be more popular than another. 220 people voted via the survey. David Brooks explained that votes and consultations are online and that this is the sort of voting population we receive when a vote is put out to the membership. The majority of members showed that they were happy to receive journals by electronic access only.

Mike Stockton asked the membership, by show of hands, who would be willing to pay extra. All were in favour. The notion was passed.

When asked about quarterly costs rather than a one off payment in December it was reported that the APM want all members to move to direct debit payments. Due to the time and cost involved to process cheque payments it was agreed to charge an admin fee of £15 to non-direct debit payers.

It was proposed and agreed to increase the membership fees by £20 (not including juniors). The Junior membership fee of £30 will stay the same.
Proposed: Tim Harlow
Seconded: Rob George

New APM Membership Fees for 2016 will be:

Full Membership	£260
Full Membership with Reduced Subscription	£170
Associate Membership	£147
Junior Doctor Membership	£30 (stays the same)
Medical Student Membership	Free (stays the same)

The accounts for the year end 30 November 2014 were ratified.
Proposed: Rob George
Seconded: Tim Harlow

c) <u>Education Committee</u>

Chris Farnham asked the membership to start thinking about the conference in 2 years' time and explained that we would welcome any ideas. Sponsorship is virtually non-existent so we need to start thinking about where we are going and what type of conference we want. Chris Farnham asked for members to start emailing in any ideas.

Chris Farnham reported that the Education strategy is almost complete and will be available on the website once agreed. The strategy will be a 3 year programme so that you can see 3 year's ahead what events are coming up. There will be a conference in 2016 with the RCP looking at dying in hospitals. Chris Farnham asked for all those interested to get in contact to make it a good and worthwhile conference. Chris Farnham reported that Christina Faull is now the editor of e-ELCA. Christina Faull needs help from the membership with reviewing the modules already on e-ELCA and the development. Chris Farnham reported that the Trainees' have already been a great support.

d) Ethics Committee

Ethics study days continue to be successful and well evaluated. The Assisted Suicide survey numerical results will be available on the website next week. The qualitative comments have to be anonymised. The committee are hoping to publish something on those comments. The committee will continue to respond to ethical issues as and when they occur. Ilora Finlay thanked the Ethics Committee for all the work they have been doing and asked if they have been looking at DoLS (Deprivation of Liberty Standards). The BMA have produced a statement and professional guidance. Ilora Finlay asked if the APM would like to be a part of the wider consultation of the document coming from the BMA. Tim Harlow reported that we would like to be a part of a wider consultation. This has been discussed at Ethics study days and meetings, however, there is confusion and different views around it. The latest guidance has been helpful but there is still much confusion. The official guidance from the law commission will not be released until 2017. David Oliver has produced a survey which the APM has had some input towards to ask the members what experience they have had with it to gain people's views.

e) Juniors Committee

David Brooks welcomed Anna Street, the new Chair of the Juniors Committee. Anna Street reported that the committee is almost complete with just 1 position left to be elected. The APM Juniors hosted their second annual conference which had a high level of attendance and received great feedback. The APM Juniors have some projects they will be working on over the next year and would welcome any help from anyone that would like to be involved. The juniors are looking for free venues to hold their conference for the next 2 years. AS reported that it is important to try to obtain a free venue to keep the ticket prices low. The ticket cost at the last conference was between £8 - £12. The juniors are hoping to have the next conference in the North of England or Scotland. The last 2 conferences have been held in Cambridge and London. If anyone is able to offer a free venue please contact the APM Juniors Committee. The APM Juniors would like to hear from people to help with various projects;

a. If you have access to helping arrange SSC's and electives
b. If you are interested in becoming a mentor.

The juniors are also trying to set up a research hub which connects experienced palliative care researchers who need man power with juniors who would love to do some research but have no idea where to start. David Brooks expressed that we need to talk and support the APM Juniors. It was suggested to highlight the APM Juniors on the website. Eleanor Grogan reported that the juniors currently have a separate website, however, this is due to link with the new APM website. It was also suggested to have 1 downloadable slide available on the website that can be passed on to students. Congratulations were given to the group followed by a round of applause.

f) Professional Standards Committee

Sarah Cox reported that Famcare will continue to run on an annual basis. Registration for Famcare 2015 starts in June. In the future the Professional Standards committee will run some audit prizes. The first prize being developed with the trainees' committee is an undergraduate audit prize. There will then be a general audit prize. The committee are developing some lists of guidelines around symptoms which can be found on the website. The committee are working on a list of symptoms which does have potential to be expanded. The committee will also be collecting national intelligence around palliative and end of life care. These will be highlighted in future e-bulletins as links.

g) Science Committee

Jason Boland thanked the Science committee for all of their work. The Study Day which was ran in 2014 was very successful. The committee are working with Mike Bennett as the curriculum is being reviewed in terms of research so we are looking at gearing the study days up to what will be needed for the trainees. Jason Boland urged members to submit towards future prizes. The committee will start looking at collating all the information on how to do research every day in hospices. This piece of work will be made available on the Science page of the APM website.

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

Anna Hume, co-chair with Sally Middleton thanked the committee for all of their hard work. The next study day organised by the SSAS Committee will be on 5 November at BMA House in London. The study day is going to be very topical, looking at palliative care issues by changes in cognition. The highlight will be the speaker Rob Wheeler who is the director of clinical law in Southampton. Rob Wheeler will be specifically addressing DoLS and is inviting any delegates to submit any cases that can be discussed. The committee has run a survey of the SSAS membership particularly looking at employment issues. The survey has now closed. The survey highlighted employment issues and as a result Hospice UK and the APM will be sending out a joint letter to independent units advocating that the 2008 specialty doctor contract is offered to those relevant. Anna Hume will be compiling a list of advantages for both employers and employees. The SSAS Committee are looking for a committee member with a particular interest in Education to have representation on the Education Committee.

i) Trainees' Committee

Tom Middlemiss thanked the committee for all of their hard work and reported that the Trainees will have a formal relationship with the APM Juniors Committee. The committee has engaged with the BMA and Shape of Training. A Facebook page has been set up by the Trainees' Committee. The next Trainees study day event will take place in Glasgow, September 2015. TM officially handed over to Amy Proffitt who will now chair the Trainees' Committee.

j) Workforce Committee

Stephanie Gomm thanked the demitting members of the Workforce Committee and welcomed the new members. The committee have completed and published the 2013 analysis of the Workforce survey which is now available on the website. The 2014 analysis has also been completed with some of the draft data included in the report. The workforce planning issue is discussed within our own society, at the college and at Health Education England. Some of the data from the survey has been used successfully to make sure that people recognise what our workforce consists of and what the issues are. The 2015 survey is due to come out at the end of June. Stephanie Gomm asked the membership to let us know of any issues to be included or taken out of the survey. Our expansion rate in Consultant numbers is falling both from the RCP and our own survey compared to the previous decade. Workforce is about what we are planning for and is about the models of service we want to deliver which is completely different to what it was 20 years ago.

k) Specialty Advisory Committee

Alison Coackley chair of the SAC sent a report but wanted to focus on the Shape of Training. Alison Coackley explained that Shape has been talked about for many months, it did hit a bit of uncertainty with what was going to happen with it. It is going to happen. As a specialty we cannot ignore Shape. It has the potential to change how trainees work. It is going to impact on how we deliver clinical services and it is going to potentially change the way that consultants in palliative medicine work in the future. As a specialty we need to decide what our view is. The time to have an influence is getting shorter by the minute.

06/15 **Representatives' Reports**

a) Acute Oncology Service CRG

The report was noted.

07/15 **Special Interest Fora**

a) Neurological

The report was noted.

b) Undergraduate Medical Education

John Ellershaw highlighted that the forum which is co led by himself and Stephen Barclay and has been going for 3 years with an annual meeting. The 3rd annual meeting was in Cambridge and was focused on assessment. One of the key things that came out of that is that Stephen Barclay is now actively working to get questions around palliative medicine into the national database which are then put into the national finals for medical students. It is important that palliative medicine is in the final assessment. The undergraduate medical education do have a website. John Ellershaw asked that any members from a medical school that is not listed on the website to please send details. There is a new website which is going to be a resource around access for all medical students. John Ellershaw asked to send details if anyone has content that could contribute. The meeting for 2016 will be on 7 April in Liverpool and the theme is going to be technologically enhanced learning.

c) Transitions

The report was noted.

08/15 **Committees**

David Brooks thanked all the committee members that have demitted this year.

Education Committee: Dr Emily Collis

Executive Committee: Professor Irene Higginson (Treasurer), Dr Simon Coulter (Northern Ireland Rep)

Juniors Committee: Leila Platt (Junior Committee Chair)

Science Committee: Professor Paddy Stone (Science Committee Chair)

Specialty Staff Grade and Associate Specialists Committee: Dr Reema Pal (Workforce Committee Rep)

Trainees' Committee: Dr Andrew Shuler (Trainee Rep to the Ethics Committee), Dr Gareth Watts (Trainee Rep to the Science Committee)

Workforce Committee: Dr Jane Edgecombe (Scotland Rep)

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

Elected members were ratified, as follows:

President: Professor Rob George

Vice-President: Dr Andrew Davies:

Executive Committee: Dr Mike Stockton (Treasurer), Dr Dee Traue, Dr Neil Jackson (Northern Ireland Rep), Dr Paul Paes, Professor John Ellershaw

Education Committee: Dr Aruna Hodgson:

Juniors Committee: Dr Anna Street (Junior Committee Chair), Emma Bailey, Victoria Green, Faye Johnson, Emma Rudsdale, Lucy Ison (Liaison to the Trainees' Committee)

Professional Standards Committee:

Science Committee: Dr Jason Boland (Chair of the Science Committee)

Specialty Staff Grade and Associate Specialists Committee: Dr Esraa Sulaivany (SSAS Rep to the Professional Standards Committee)

Trainees' Committee: Dr Guy Schofield (Trainee Rep to the Ethics Committee), Dr Amy Proffitt (Trainee Rep to the Professional Standards Committee), Dr Richard Kitchen (Trainee Rep to the Science Committee)

Workforce Committee: Dr Kathleen Sherry (Scotland Rep)

Proposed: Iain Lawrie
Seconded: Mike Stockton

David Brooks officially handed over to Rob George as the new president of the APM.

09/15 **APM award winners**

Rob George announced the following APM award winners.

Twycross Research Prize 2014

Dr Amara Nwosu with The assessment of hydration states in advanced cancer patients using novel technology: the evaluation of bioelectrical impedance vector analysis (BIVA) in the palliative care setting

Undergraduate Essay Prize 2014

Essay subject: Can we measure patient related outcomes in palliative care that are meaningful?

1st prize – William Brierley
2nd prize – Kristina Paige

10/15 **Any other business**

No further business discussed.

11/15 **Date of next Annual General Meeting**

Thursday 10 March 2016
Scottish Exhibition and Conference Centre, Glasgow

President Report

"It was the best of times, it was the worst of times … the age of wisdom … the age of foolishness … the epoch of belief … the epoch of incredulity … the season of light … the season of darkness, it was the spring of hope, it was the winter of despair."

Charles Dickens, A Tale of Two Cities

In my first report in June last year, I reflected on the increasing presence that the APM had on the media and national stages along with the influence that brought. David had worked hard to establish it. He concluded his presidency by saying *"It feels like the wind is in our sails for Palliative and End of Life care."* I also closed last year's conference with a call to arms and quoted Henry V as he addressed his *'few, we merry few'* prior to Agincourt and I started wondering whether the insatiability for sound bites and commentary of our media was to dominate my tenure. It certainly has been prominent, but not dominant. I believe that we are learning to manage the relationships proportionately. From journalists' feedback, we are certainly seen as the sweet voice of reason when it comes to life-threatening and life-limiting illness, death and dying and are often the first port of call when stories break.

Julia Neuberger also threw out a challenge to us to become thought leaders and I believe that is coming to pass. It has and will continue to be a feature of this time and I hope our growing and effective position as such is having some benefit for you both in your strategic roles and at the coalface. So what have we done and how are we seeking to sustain this?

This year we have moved entirely to digital communication. It is necessary for financial reasons, but makes sense anyway in keeping you all up to date:

- We have invested time and money in our mailing system to bring it up to the standards of our respective Royal Colleges. If you are not in regular receipt of information, then please look on the website for guidance or contact the secretariat. The problem will not be at our end as has been the case in the past
- As the website grows you should find an increase in the quantity and quality of resource there to help you, but we need feedback to keep it fresh and relevant. Please check it regularly and if you're not benefiting, then tell us and offer a solution by giving us ways in which we can improve. We welcome criticism but only when there is a constructive alternative offered. If you come across material that we have missed or that will enhance what we offer, then let us know. We are concerned particularly to meet the needs of all our membership equally across our nations
- Our presence on social media is growing slowly and I encourage you to contribute to this influence by cascading out to your individual networks and linking with others of us who disseminate research and opinion regularly via Twitter and Facebook. It is a very powerful and quick way to get new work out and respond to controversy and hot topics. Mark Taubert taking the opportunity of the death of David Bowie to speak of completing a life well is a case in point and may be the reason that Radio 5Live came to us for comment the weekend that Paul Daniel's family disclosed his malignancy. They wanted to know what palliative care had to offer to people in his position and not to talk of death and dying. So use it and be bold: this is how public opinion is being shaped these days. Facebook and Twitter feeds are on the website and links to our key interviews and comments on current affairs programmes and in the broadsheets are kept up to date and then archived.

Again don't hesitate to notify us if we are missing anything or links are broken. Thanks to Becki in the Secretariat for maintaining things and the intrepids who take their turn to monitor Twitter and maintain our feed @APMPostTweets

- So as a result, rather than having to fight for our voice to be heard, we are now seen as a definitive voice and approached and asked as a matter of course for comment. However, this traditional media work comes at a price for those of us who present the public face of the Association because stories come and go quickly and we need to be responsive and nimble. I am most grateful to the small but committed band who are willing to respond to requests, but we need more people to learn media skills and inject fresh energy, fresh voices and new ways of communicating. We will support and train you in this.
- Finally, through relationship and mutual commitments and vision, we are developing effective strategic alliances with our national charitable partners, the Royal Colleges and specialist societies to amplify our voice and advocacy and ensure we are coordinating what we do.

However, our visibility in the public space of verbal, written and social media is not just window dressing - it has a whole building behind it: I summarised much of this in my Christmas report. Mixing metaphors, you will see from the Committees' reports for this AGM that our public presence is only the visible point of an iceberg of hard work and perseverance that gives you, as individual members, a platform from which to influence your organisations, local health and social care systems and for us collectively as an Association to influence the professions and society at large. I will not list the Committees' achievements as the respective reports speak for themselves and you will hear more in our presentations at the AGM. I pay tribute to each team, its leader and members, and encourage every one of you to consider volunteering for our Committees, special interest and working groups. A number of places are coming up, and we are revising our structures in response to your strategy for the year. Details will be on the website,

It would be disingenuous, though not to acknowledge the worst of the year – 'foolishness, incredulity, darkness and despair' as Dickens had it in my opening quotation, but I see no purpose in dwelling on the continued reports of problems with the provision of care, its cost, the litany of failures and the spectre of legalised medically assisted suicide that we saw off in the Scottish and British Parliaments. They remain present, and will return, but I refuse to be overwhelmed whilst we continue through vision, experience and hard work to deploy their stated antidotes: 'wisdom, belief, light and hope'. So I'd like now to highlight a handful of examples of our work and impact across our member nations in which I have had a direct part and to thank the other officers in the APM:

- We have updated the entry for palliative medicine in RCP (UK)'s encyclopedia of medical specialties in its latest edition. I am most grateful to Wendy Makin for leading on this through her role as chair of the Joint Specialty Committee in the College. When published this will be a web resource that can be used by you all to make clear to your management structures, commissioners and providers what it is we do as physicians and why we are needed in all parts of the health economy.
- In England, we have also built on the foundations of the 'National Care of the Dying in Hospitals Audit' and were instrumental through lobbying and our political influence, along with our strategic partners, in having it recognised as one of the core, centrally funded elements of the National Audit cycle. The contract for running this is now with the RCP London and we have been approached by the College to continue our core advisory role. David Brooks continues with this on behalf of the Association, for which we must thank him.

- In Scotland we have supported our APM members and other colleagues in the successful rejection of assisted suicide legislation by their Parliament. Following on from this, the Scottish Parliament established an inquiry into provision for those at the end of life that ran through 2015 and at their Health Committee's request, the APM made written submissions and I gave oral evidence alongside the Scottish Partnership for Palliative Care.
- Between Scotland and England, Dr Juliet Spiller and I continue to do a lot of work with Resuscitation Council UK, the RCN and BMA colleagues in revising the national guidance on CPR following on from recent landmark judgments, and several of us in the Association have supported Wales in the development of its own material over the last two years.
- Seeking to move advance care planning on pragmatically, I and other APM members are active participants in work on an Emergency Care and Treatment Plan that may be adopted in several of our nations. Its consultation phase is in full swing.
- In Ireland, our members anticipate the assisted suicide debate to come before their Parliament soon and are beginning now to engage with and prepare for it. Because of our clear position on this, we are able to give unambiguous and clear support and assistance to them based on our survey and the experiences in the Scottish and UK Parliaments in this and previous years. I have just returned from a day briefing them. We are also supporting our international colleagues in Canada and I assisted in a recent case in New Zealand on behalf of their Attorney General and was able to draw on our evidence based position. Many of us of course were also active participants in the DELPHI that produced the EAPC position statement that is just published.
- For those of you who are members of the BMA, this year's ARM conference in Belfast will have a substantial time devoted to end of life care and there is expected to be fresh debate over AS as part of that and a concerted lobby will doubtless seek to bring the BMA to a neutral or pro position. As I said, this doesn't go away. Please engage actively in this and we will be keeping you abreast via the website.

I now want to recognise our officers specifically,

- Ellie Grogan's work as secretary with consultations and requests by Select Committees etc. for our opinion stacks up to over a response a fortnight. Thank you!
- Andrew Davies as VP is forging ahead with our ambitious plans for next year's conference in Belfast. Information is available on our stand at the PCC and will be on the website. Thanks Andrew and good luck.
- Mike Stockton has done an incredible job with our finances that must not go unacknowledged. Without him, we could have been in a parless state. We are extremely grateful, Mike.
- All three have been incredibly supportive to me personally through recent personal challenges as my mother spent December and January dying. Much of the preparation for this AGM is down to them and of course the incredible Becki Munro and the CSS team led by Heather Enticott. Thanks so very much to you all too.

Perhaps most significant this year, for England at least, has been the publication of the Ambitions for Palliative and End of Life Care, most ably led by Bee Wee, and again supported and crafted by a strategic coalition of partners of which we were one. It has opening up care of the dying as everybody's business, it has offered a visionary map of what a truly national endeavour may resemble and expresses aims in language that is inclusive and challenging.

So to end this report I would like to conclude with the fruit of this year's overall existential challenge that we explored at last year's conference – who are we, why are we and where are we going? Heady stuff. The task I set myself over and above the routine responsibilities of leadership, was to articulate what might be a vision and values document to take us into the future. In this I have been guided and supported by the Exec, Committees and John Ellershaw and Ben O'Brien in particular. However ultimately I carry the can for two sides of A4 that seek to encapsulate our essence. Those of you at the AGM can call me to account then, others can reflect on the document in coming months via the website. Needless to say, no one can please all of the people all of the time, but I hope this is a viable rallying point for us all as we forge into the future. Below I give a taster with the central vision statement, which is supported by our values, and aims in the full document that follows this. Here it is:

"We seek to create a future where all people with life-limiting and life-threatening illnesses live as well as possible for the duration of their natural lives and in which no one need die in distress or discomfort for lack of the best palliative care."

By way of explanation, it was always going to be a vision sentence that might cause us to stumble and indeed, we have anguished as a group over every jot and tittle. So to be clear:

- the purpose of a vision statement is to encapsulate sentiments and aspirations,
- it must be intelligible, accessible, punchy, memorable and, if not directly quoted,
- it must be adaptable and expandable for any audience (public, other colleagues and the media in particular) to reflect the aspect of our specialty that is under discussion at the time.

We have also chosen palliative care, rather than palliative medicine in the vision statement because it is

- inclusive and holistic - we work in teams, and
- not elitist - we have members who are specialist and/or generalist (by default, we are specialist *ipso facto* by being classified as such by the Colleges)

On our quality of care and the claim that we make, there are two points:

- this is not to say that all suffering can be sorted, but that none should be tolerated that the best palliative care might remove or mitigate had it been available and
- best is what we would want for ourselves and our families and so should be available for everyone who needs it.

We hope you can all live with this – time will tell in the real world. In the meantime, I shall wear a metaphorical tin hat at the AGM as a precaution!

So to end by reminding ourselves that we care for people and not just their pathologies and as attendees of the PCC rediscover holism and enjoy its broad coverage of our specialty, I leave you with Dickens' Two Cities again:

"A wonderful fact to reflect upon, [is] that every human creature is constituted to be that profound secret and mystery to every other."

Enjoy the conference, embrace our Vision and Values and thank you to all who have helped to get us through this year.

Association for Palliative Medicine
Of Great Britain and Ireland

What is Palliative Medicine?

Palliative medicine provides clinical leadership, care and support to prevent and relieve suffering for people with life-limiting and life-threatening illness.

- Its diagnostic and therapeutic priorities focus on meeting every individual patient's goals through shared decision-making with them and those important to them
- It is practiced both as part of multidisciplinary palliative care teams and in partnership with other relevant specialties to deliver individualised, holistic care
- It is a medical specialty recognised by the respective nations' Royal Colleges of Physicians

Palliative Medicine's specific expertise is in:

- Assessing and managing physical, psychological and spiritual symptoms and in mitigating distress
- Clinical analysis of and decision-making in complex scenarios, such as when a patient's clinical needs, preferences and interests are finely balanced and may require skilled application of relevant ethical and legal guidance
- Skilled communication about and co-ordination of care, especially at disease transitions and boundaries between care settings
- Working with partners, colleagues and organisations across multiple sectors to provide excellent multidisciplinary care for patients and those important to them
- Care and support to those important to the patient, including facilitating their bereavement care

The Association

The Association for Palliative Medicine of Great Britain and Ireland (APM) is the world's largest representative body for doctors practicing or interested in Palliative Medicine, with a growing membership of over 1,000. We welcome international members.

- **Full and Associate membership** is open to doctors practicing or interested in palliative medicine
- **Student membership** is open to undergraduate medical students
- **Affiliate membership** is being developed for other clinicians with an interest in palliative medicine

We work in strategic alliance with those who can contribute to achieving our vision, supporting our values and delivering our aims.

Our Vision

We seek to create a future where all people with life-limiting and life-threatening illnesses live as well as possible for the duration of their natural lives and in which no one need die in distress or discomfort for lack of access to the best palliative care.

Our Mission

We will promote professional development, societal debate and advocate with and on behalf of all those who are involved in palliative medicine in order to promote, facilitate, advance and develop excellence for the benefit of every individual patient and those important to them.

Our Values

Our membership and all our work is driven and bound by a contract of shared values through our **Leadership PACTE**. We strive to be:

Leaders:

- Bold, innovative and boundary-breaking, while accepting the complexity of the area in which we serve
- Active participators in professional and societal debate surrounding health, care, wellbeing, illness, death and dying

Person-centred:

- Focused on patients' goals and concerns above and beyond their disease(s) alone, including the related needs of those important to them

Academically excellent:

- Inquisitive, evidence-led and willing to challenge and advocate where fresh evidence and experience are counter to or challenge established opinion or the *status quo*
- Advocates for and, where feasible, participators in relevant research into contentious and neglected areas of palliative care
- Skilled in ethical analysis, complex problem solving and shared decision-making

Clinically excellent:

- Expert in assessing and managing the clinical aspects of patients' suffering
- Skilled in helping individual patients and those important to them to engage with their unique circumstances and the uncertainty, complexity and finely balanced interests and decisions that are part of their life's conclusion
- Professionally objective and tempered with compassion that supports and empowers those in receipt of our care

Transparent and collaborative:

- Able to embrace multi-professional practice
- Collegiate and accountable within multidisciplinary teams
- Willing to assist colleagues with their professional challenges around death and dying and its personal impact
- Collaborative with other specialist organisations and disciplines
- Open to change and scrutiny
- Progressive and willing to engage with the opinions and perspectives of others

Educators and trainers:

- Advocates for all professional communities across health and social care to be confident and competent in understanding and meeting palliative care needs where they find them that includes the relevant mandatory education and training to achieve this
- Committed to our own learning and development and working with the Royal Colleges of Physicians

Our Aims

Through the expertise of our members and our partners, the APM:

- Drives excellent, person-centred palliative care services
- Sets professional standards
- Promotes education and training
- Promotes research and development
- Influences policy development, commissioning and its implementation
- Influences planning of the palliative medicine workforce strategically, subject to our national approaches
- Develops and works in strategic partnerships and
- Ensures its own effective governance

The APM's Leadership PACTE and our aims inform the structure of our organisation, our strategic priorities and specific position statements in all relevant areas of health and social care in order to promote the interests of our patients and those important to them.

For further information, visit our website:

www.apmonline.org

Treasurer Report

The 2015 period

Introduction

The APM has faced financial challenges over the past number of years.

The APM executive committee has implemented a number of important financial changes over the year that have resulted in improved financial performance and stability.

This report will focus on the results for the 2015 financial year and the forecast for the 2016 financial year.

The Accounts for 2015

In 2015 the APM incurred a loss in respect of its general activity of £12,354 (2014: loss of £93,636, 2013: loss of £64,074). The 2015 loss was eliminated by the transfer of Palliative Care Congress profit share (£30,000). This results in an end of year surplus of £17,646.

Members should note that further significant transfers of money into the APM account, (from the Palliative Care Congress or other external sources), are unlikely in 2016 and beyond. Consequently the APM needs to generate sufficient income from its general activities to cover its general operating costs.

The 2015 balance sheet indicates that the general fund balance has increased from £48,455 (2014) to £66,101 (2015). However, this only covers around 4 months' running costs for the APM and this is below the Trustees' aim of having reserves sufficient to cover 6 months' running costs. Consequently, over the coming years, a primary aim of the Executive Committee will be to generate surpluses in order to replenish the reserves.

Financial Actions Taken in 2015

Income Generation:

1. Agreement to increase the membership fee by £20 across all membership categories except for junior doctor members. This came into effect December 2015.

Expenditure Reduction:

1. Reducing Journal costs from £82,263(2014) to £64,891(2015). This is a part year effect and the projected journal costs for the whole of 2016 are £56,000

2. Stopping the vice president payment – saving around £12,000 per annum

3. Committee meeting efficiencies saving c£10,000 over the year

Looking Ahead: Plans for 2016

There is a continued need to increase income and reduce expenditure to ensure that we generate an end of year surplus to replenish the general financial reserve.

Income Generation Plan:

1. Establish an income generation lead as part of the APM executive committee

2. A new education strategy that will increase the probability of making a profit. In 2014 the charity made a profit of £5,034 on education provision but in 2015 there was a loss of £898.

3. Improved income generation through advertising and marketing via the APM website and other systems.

The Cost Reduction Plan:

1. Reducing overall administrative costs:
   - This will be through efficiencies created by utilising Compleat Secretariat Services [c£20,000].
   - Monitoring and reducing the number of hours worked by Compleat Secretariat Services.

2. The President's salary to be reduced from 2 to 1 programmed activity per week – saving £12,000 per annum

Budget for 2016

For purposes of clarity and simplicity, education will be dealt with as a separate area of finance.

The forecast income for 2016 is c£206,000.

The key assumptions are:

- Membership numbers maintained and new fee rates
- Marketing and advertising at 2015 rate

There may be further income from the PCC profit and other education events. However, this has been excluded from the forecast income given the unpredictability.

The forecast expenditure for 2016 is c£196,000.

The key assumptions are:

Area	Expenditure
Administration, organisation and telecommunications	c£91,000
All journals	£56,000
Travel and accommodation	c£19,500
President salary	£13,000
Contingency	£10,000
All other costs	c£6,500
TOTAL	**c£196,000**

The forecast is therefore to generate a surplus of £10,000 in 2016 that will increase the year-end reserves by the same amount. The forecast will therefore achieve the Executive Committee's two primary aims of generating sufficient income to cover general expenditure and increasing the reserves.

Summary

The APM continues to face financial challenges.

In the 2015 period the executive committee implemented changes that significantly reduced the financial loss compared to previous years. In addition, due to the influx of funds from the Palliative Care Congress, the end of year general fund balance has improved from 2014.

Changes have also been introduced that have improved financial clarity, governance and oversight.

However, the APM still generates insufficient income to cover its general expenditure so further action is required. The plan for 2016 is for further cost reduction and a drive towards improved income generation so that the APM is able to generate a surplus and rebuild its reserves.

The APM executive committee will lead and monitor this change.

Dr Mike Stockton
Treasurer to the APM, 2016

Ethics Committee Report

Membership

Dr Idris Baker
Dr Paul Clark
Dr Craig Gannon
Professor Rob George
Dr Derek Willis
Dr Rachel Bullock
Dr Guy Schofield
Emma Bailey

After 11 years' service, including three as Chair, Tim Harlow left the committee in November 2015. We are grateful for his wisdom and hard work. Guy Schofield was elected to the committee as trainee rep but as he is currently on an extended period out of training we propose to move him into the position vacated by Tim's retirement so as to free up the trainee rep position which we hope to advertise soon.

Ethics study days

The committee has again organised a highly successful study course in Telford, attended by a good cross section of grades. The course was again oversubscribed and well evaluated. It is designed to cover the ethics elements of the palliative medicine specialty training curriculum and build from theoretical basics up to practical application. We hope to repeat the course and some of those unable to get places this year have expressed an interest.

Assisted suicide

The committee continued to support the APM's public engagement in the run up to the debate on the Marris Bill last September, expressing the view that the Bill was not safe.
Following the survey of APM members, committee members are working on further analysis of the data with a view to future publication

BMA consultation on end of life care

The committee is continuing to monitor the output from this consultation and consider how it can support the APM's engagement with it.

DNACPR

We have watched with interest the implementation of new national policy in Wales and are considering what can be learnt from it for ethically sound DNACPR decision making in general.

Position Statements

The committee has offered further reassurance and comment on the implications of the APM statement on the withdrawal of ventilation.

Other Matters

The Committee has considered proposed surveys and other matters from time to time as the Exec or President thought necessary.

Dr Idris Baker
Ethics Committee Chair, 2016

Juniors Committee Report

Membership

Anna Street	Chair
Emma Bailey	Secretary
Victoria Green	Undergraduate Membership Coordinator
Faye Johnson	Postgraduate Membership Coordinator
Emma Rudsdale	Communications Coordinator
Anna Robinson	Education Coordinator
Virginia Lam (Yuk Chun)	Student-Selected Components and Electives Coordinator
Frank Wang	Research Coordinator
Laura Norris	Careers and Mentorship Coordinator
Lucy Ison	Liaison to the APM Trainees Committee

Since last year, the APM Juniors group has grown from 50 members to 176! We recruited our first full committee and are working hard to continue to build our group. In particular, our goals for the next year include redesigning our website, expanding our databases of SSCs and electives and connecting juniors interested in research with more experienced clinicians.

Our third annual conference is being held in February in York this year on the subject of "The Future of Palliative Medicine" with Dr Derek Willis doing the keynote speech. There will be 16 posters displaying research by juniors in palliative medicine, with the best being presented. Delegates will be able to choose from nine different workshops during the day, with topics including Research and Policy, Careers Q&A, Communication skills done differently and Assisted Dying – the human story. We are very excited about the day and want to thank everyone who has helped us arrange it!

Dr Anna Street
Juniors Committee Chair, 2016

Professional Standards Committee Report

Membership

Sarah Cox	Chair
Tim Peel	Elected member
Vora Vandana	Elected member
Andrew Davies	Elected member; audit lead
Fiona Bailey	Elected member; revalidation rep to RCP
Margred Capel	Elected member
Esraa Sulaivany	SSAS rep
Claire MacDermott	Trainee rep
Laura Norris	Junior rep

The committee would like to express their thanks to Andrew Davies and Esraa Sulaivany who have stepped down from their roles in the committee this year, and Tim Peel who will step down in April. Their contributions to the work of this group have been significant and important.

Appraisal and Revalidation

We have a representative to the RCP who can answer any speciality specific queries although these have been few. Members of the committee supported the writing of a guide to metrics for appraisal which will be uploaded to the APM website. There is also a top tips to getting patient feedback document on the website. We plan to survey consultant/SSAS members to pick up concerns and issues in late 2016/early 2017 when most will have been through revalidation.

Audit

1. FAMCARE has been run for the third consecutive year. In general, most bereaved carers were satisfied with the end-of-life care provided to their family member by the specialist palliative care service with the overall median percentage of "dissatisfied" / "very dissatisfied" responses being only 3.65% (range 2.01 – 5.29 %). The highest level of dissatisfaction was for the item "speed with which symptoms were treated".

TYPE OF SERVICE	SAMPLING RATE	RESPONSE RATE
Hospice inpatient unit (n = 27)	Median 89% (range: 56 – 100%)	Median 54% (range: 25-80%)
Home care team (n = 15)	Median 64% (range: 31 – 100%)	Median 49% (range: 33-100%)
Hospital support team (n = 10)	Median 70% (range: 27 – 89%)	Median 45% (range: 24-57%)

FAMCARE will be run annually by the APM and individual reports are provided to services which can be used for benchmarking and support consultant and SSAS appraisal. There is a small charge for the audit which may need to be reviewed to ensure this remains cost neutral. Expressions of interest can be made to Becki Munro at becki@compleat-online.co.uk. There will also be a call for registration in the ebulletin.

2. Audit prize
   The PSC is developing audit prizes for palliative medicine. The first, developed with the Trainees committee is for medical undergraduates and closes in September 2016. Please encourage your medical students to take part. Becki has the details.

   The second prize is for the general membership and will be announced in Autumn 2016 to close end 2017.

Signposting to Clinical Guidelines

The PSC has completed signposting lists for the following guidelines;

- ✓ Neuropathic pain
- ✓ Opioids
- ✓ Breathlessness
- ✓ Anorexia and cachexia
- ✓ Constipation
- ✓ Nausea and vomiting
- ✓ Fatigue
- ✓ Depression
- ✓ Terminal Agitation
- ✓ Noisy Breathing

Insufficient guidelines were found to produce references for interventional pain techniques, mouth care or sweating.

Please do use these lists and if you have comments or additions we would be happy to hear from you.

Mentoring

The APM provides a list of mentors for its members. If you would like to be a mentor or access one, please contact Becki.

Update on Intelligence for ebulletin

The PSC continues to collate important national documents and links which we publish in the ebulletin.

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

Dr Sarah Cox
Professional Standards Committee Chair, 2016

Science Committee Report

Membership

Dr Jason Boland	Chair
Dr Elaine Boland	
Dr Helen McGee	
Dr Ollie Minton	
Dr Paul Perkins	
Prof Paddy Stone	
Dr Katherine Webber	
Dr Richard Kitchen	Trainee Representative
Frank Wang	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:

Articles of the month

In view of the poor use of the APM's journals, we have started selecting and writing a synopsis on the articles of the month selected by a Science Committee member each month

Study days

Our study event: 'Appraising the Literature' and 'Research – Getting Started' is aimed at the APM membership (particularly SpRs) and are now established events. This will map onto any changes in the research curriculum. The next course will run pre-APM conference (March 2017).

APM biennial meeting

The Science Committee session at the APM 2015 Mini-conference was titled `The changing landscape for palliative medicine research: evolving from local to national coverage'.

Task groups

The task groups are designed to provide some seed-corn funding to facilitate the undertaking of systematic reviews. Elaine Boland and Helen McGee have updated the rules of entry and terms of reference for task groups. As there is currently no budget for these they have been put on hold.

Twycross research prize

The Twycross Research Prize, worth £500, is awarded annually for the best report of a completed piece of original research. Guidance and application forms for the Twycross Research Prize is available on the APM website. The closing date is in early November each year.

Undergraduate essay prize

Essay title: How can science help us to diagnose dying? 14 applicants received, high standard of essays. The winners are: Eika Webb (1st prize) who is attending the PCC and Lucy Gray (2nd prize).

Promoting/developing research

We are putting guidance and useful resources for hospices on the APM website and developing a resource document.

Palliative Medicine Journal

The science committee continues to represent the APM on the editorial board of the journal `Palliative Medicine`, feeding in the views of the membership and executive committee to the journal's board and the publishers.

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.

Dr Jason Boland
Science Committee Chair, 2016

Specialty Staff Grade & Associate Specialists Committee Report

Membership

Esraa Sulaivany	Joint Chair
Helen Bonwick	Joint Chair
Alison Talbot	APM Workforce Committee
Vacant	APM Professional Standards Committee
Vacant	RCP/APM Joint Specialty Committee
Simon Brooks	Website
Rebecca Akroyd	APM Education Committee

The SSAS Committee endeavours to represent the interest of SSAS doctors who have a wide spectrum of experience and to offer advice, guidance, mentoring for issues specific to this grade.

Annual Study Day

The 6th study day organised by the SSAS committee took place in London on 5th November 2015. 'Heads up: Palliative Care issues affected by changes in cognition and an update on oncology treatments' was the topic of the day.

101 delegates attended with a waiting list in place.

The morning session covered issues around prescribing in Dementia and DOLs. The afternoon session addressed updates on the oncological management of different cancers.

The feedback was excellent from the day and attendees welcomed the opportunity for networking.

The study day profit will reach £5000 once all money has been received.

The study day attracted a high number of SSAS Doctors, Consultants and Specialty Registrars. Following this very successful event, the SSAS Committee would welcome the opportunity to organise further study days in the future.

Changes in Committee Membership

The committee would like to express their thanks to Anna Hume and Sally Middleton who have stepped down from their role as the Chair of the SSAS Committee. Esraa Sulaivany and Helen Bonwick have taken up Joint-Chair responsibilities. Currently the Committee functions on only 5 members. We now have the opportunity to advertise for the vacant posts and are requesting nominations for APR SSAS representatives on both PSC and RCP committees.

APM SSAS Website Page

We have updated the web page to include member contact. Our aim and roles and responsibilities links to useful BMA SSAS contracts.

APM SSAS Members Survey – April 2015

The survey was sent to all SSAS members. 172 doctors responded to a number of questions asked to clarify certain aspects of our members' employment and to look at possible ways for the SSAS committee to offer its assistance and support. The report was released through the APM bulletin. 5% of doctors approached responded they are still unable to move to the new contract. Hospice UK is to support the provision of a joint letter to non-NHS organisations encouraging the introduction of new SSAS contracts to all SSAS doctors.

CESR Support and Mentoring

We have been able to offer help and support to fellow SSAS doctors who contacted us and had been thinking of going through CESR. Having 2 members of our committee who are going through this process has helped to provide guidance and support to others.

Action Plan 2016 – 2017

- Recruitment of two new members to the vacant posts – adverts being sent out to members
- Work programme looking at the development of SSAS doctors – in conjunction with the SAC and RCP
- Positive encouragement for employment of SSAS doctors on a formal contract

Dr Esraa Sulaivany and Dr Helen Bonwick
SSAS Committee Chair(s), 2016

Trainees' Committee Report

Membership

Dr Amy Proffitt	Chair
Dr Rebecca Lennon	BMA Junior Doctors committee observer/Secretary
Dr Ros Marvin	Website Officer
Dr Mary-Ann McCann	SAC Rep (NI and Wales)
Dr Kirsten Baron	SAC Rep (England)
Dr Joanna Prentice	SAC Rep (Scotland)
Dr Claire MacDermott	PDC Rep
Dr Mary McGregor	Workforce Committee Rep
Dr Sharon Twigger	Regional Rep coordinator
Dr Guy Schofield	Ethics Committee Rep
Dr Richard Kitchen	Science Committee Rep
Dr Felicity Werrett	Education Committee Rep
Dr Lucy Ison	Junior APM Rep

It has been an extremely busy time for the Trainees committee with radical changes in training and working conditions on the horizon. We have been engaged in the following work:

Shape of Training

All trainees were invited to share any thoughts and concerns regarding 'Shape of Training'. These were assimilated and included in the response of Wendy Makin, Chair of the Joint Specialties Committee, to the RCP council to further inform their discussion.

Engagement with BMA and Contract information

There has been increased engagement with the BMA Junior Doctors Committee and Multi-Specialty Working Groups. This included being joint signatory on the Junior Doctors Committee response to Junior Doctors contracts and highlighting common issues for trainees.

We have continued to supply trainees and junior members with up to date information regarding this We have complied a survey on the potential impact of the contract imposition on Trainees and Juniors intending to train in palliative medicine.

We are currently engaged in promoting this in the media would like to thank Dr Rebecca Lennon for leading in this work.

Website and Social Media

The Website Officer, Ros Martin, has been involved in the development of the new APM website and has set up a Facebook page for trainees. It is a closed group to allow trainees to share views, discuss pertinent issues and arrange social events around education days. We have been engaging in Twitter, tweet chats and journal clubs on line

Frequently asked question for Trainees

Led by two trainees in the oxford region, we have developed a FAQ document for palliative medicine trainees. This includes useful courses, textbooks and tips for success. This has been linked to the APM website and sent to trainees though regional reps.

Royal College Careers Days

Careers days at the three colleges for prospective trainees in all specialties took place in September. Palliative medicine was show cased in the specialty of the month in London. I presented to delegates, a brief presentation on "How to succeed in the specialty" .Palliative medicine was represented by both trainee and consultant APM members. The leaflets that were developed in 2014 were up-dated for use at these days. They are entitled 'getting into Palliative Medicine' and 'Palliative Medicine: What is it like being a trainee and consultant?' Other material available included the 'The Role of the Palliative Medicine Consultant' document from 2012, and previous issues of the APM newsletter. These leaflets are available on the APM website for use by members.

The next Careers day is February 27th again I shall represent the Trainees with input from consultants Dr Denise Traue and Dr Rina Patel

Interaction with APM Juniors Committee

A new committee of 'APM Juniors' has been formed. It has been agreed that the Trainees' Committee will play a more active role in the mentoring of this committee to ensure that any difficulties are addressed and the APM juniors are able to have a strong support network. Lucy Ison, a core medical trainee, is an active member on the Trainees Committee and acts as the key link between the two committees.
We are currently developing FAQ's section for juniors aspiring for a career in palliative Medicine as well as stronger mentoring links

Education Events

Autumn APM Trainees' Study Day – 30th September 2015, Glasgow
'Challenges in Palliative Care: Building from a New Foundation' An update of palliative oncology treatments, techniques in interventional pain management and ethical challenges" Feedback was over whelming positive

Research development

We have developed a survey of trainee to ascertain the involvement in research. We are keen to understand how many of the trainees are currently involved in research in its many forms and the ease of developing this. We believe that good evidence based medicine is crucial to the development of Palliative medicine and wish to promote this through our trainees.

Committee Work

Our primary aim remains that of acting as a conduit for networking and supporting trainee members of the APM.

Various members of the Trainees' Committee continue to contribute to the respective committees upon which they sit.

Our regular face-to-face meetings and conference calls keep each other informed of the work of these committees and help to inform the wider trainee membership about APM activity in all its forms.
We continue to rely on regional trainee representatives, themselves APM members, in order to communicate with the wider trainee membership. We are currently arranging a series of face to face meetings and phone conferences to increase this engagement and instil the importance of this role on regional reps.

I would like to recognise the work of past committee members: Tom Middlemiss, Katrien Naessens, Miranda Kronfli, and Kate Mark

I would like to thank the committee for their hard work and enthusiasm in representing the Trainee Body. I look forward to another year of working with you all.

Dr Amy Proffitt
Trainees' Committee Chair, 2016

Workforce Committee Report

Membership

Dr Stephanie Gomm	Chair
Dr Benoit Ritzenthaler	England Representative
Dr Kathleen Sherry	Scotland Representative
Dr Caroline Usborne	Wales Representative
Dr Julie Doyle	Northern Ireland Representative
Dr Feargal Twomey	Republic of Ireland Representative
Dr Mary McGregor	Trainee Representative
Dr Alison Talbot	SSAS Representative
Dr Polly Edmonds and Dr Alison Coackley	SAC Workforce Lead(s)

A new addition to the membership is Laura Norris representing the APM Junior Members Committee.

Workforce Report

- The APM workforce survey data for 2014 has been analyzed and written commentary (full report Nov 2015).
- The APM 2015 survey closed on 31st January 2016.
- A shorter workforce survey for 2016 will be circulated in June 2016.
- Collaborative work with SAC palliative medicine on response to Shape of Medical training
- Submission of evidence for palliative medicine to HEE on demand, drivers for service change and demand, patient population, models of care and future workforce.

Key messages:

- As a medical specialty we have the highest % of female trainees 88% and similarly 74% for Consultants.
- Overall 61% of Consultants are <FT rising each year and for trainees <FT = 35.3%.
- Current rate of expansion is falling for UK Consultants is 471 FTE compared to 454 FTE in 2014 an increase of 3.6 % compared to 10% increase by head count with the need to focus on this message to deaneries/LETBs.
- Vacancy rate is 7.6% of Consultant workforce and increase in anticipated retirement rate of 10/year for 2015-19.
- Expansion of NTNs current estimate of need UK 641 FTE (832 headcount) based on 2.5 FTE per 250,000 populations i.e. a shortfall of 170 FTE for a 5-day service and an additional 135 FTE for 7- day service.
- Impact of loss of LATs in 2016 for hospices re; funding LAS posts for maternity leave and OOP experience and the reductions in tariff make the potential withdrawal of training posts if hospices are disadvantaged. Major risk of not meeting the curriculum if hospices financially become less willing to train.

- No current recruitment problems all ST3 posts filled and no vacant NTNs. There are insufficient NTNs given the existing Consultant vacancies of 46 posts (7.5%), the overall unmet need and major geographical variation. RCP data for 2013/14 - East Midlands has the lowest number of 1FTE Consultant > 215,000 population followed closely by Eastern and Wessex. Consideration needs to be given to recruiting additional funded NTNs in these geographical areas, and specifically in LETB areas where Consultant recruitment is difficult and a greater increase in both training numbers and capacity are required.

- Despite detailed data from APM and SAC, HEE and LETBs use Information from Trusts that underestimates both the headcount and FTEs for palliative medicine trainee/Consultant and their required expansion e.g. 272 FTE Consultants for England but SAC data report 385 FTE. Across England engagement with LETBs has been difficult, in many places there is either disinterest or lack of understanding about NHS and voluntary sector workforce.

- It remains challenging to interface with deaneries and LETBs re palliative medicine workforce needs but vitally important we do so for 2016/17 e.g. submission of information to HEE on workforce numbers and planning.

- Just over half (51%) of the SSAS doctors who responded to the SSAS 2015 survey are on the new 2008 contract and only 90% have a regular appraisal.

- Need to determine the impact of implementation of Shape of Medical Training whilst we have agreed to deliver training and future hospital services as part of acute medical care with other physician colleagues, there must be clear recognition of maintaining and expanding both training and service delivery in the community and for hospices. This will change the distribution of our medical workforce undertaking palliative medicine and those who will also practice acute medicine.

- The junior doctors contract in England as currently stands the pay for non-resident on call structure is set to significantly change. This combined with the changes to pay progression may affect the choices juniors make about entering the specialty, and the choices made about taking time out of programme for research etc.

The APM workforce committee links closely with the RCP Workforce Unit and our specialty report for 2013-14 was presented at the College meeting in London in November 4th 2015.

In addition, we have the invaluable support of the training programme directors on the SAC Palliative Medicine who do a sterling job in providing up-to-date workforce data each October in regard to the numbers of trainees and consultants in their Deaneries/LETBs.

In 2015, the most significant challenge to all medical workforces remains the current financial climate in the public sector and its impact on the voluntary sector. As predicted there has been a significant slowing of consultant expansion.

As well as '"crunching" workforce numbers it is vitally important as a specialty that we define the purpose of our medical workforce especially in the context of 4 significant publications in 2013 and their subsequent implementation: Future Hospital Commission Caring for Medical Patients - RCP; The Shape of Medical Training - Academy of Medical Colleges; The 2022 GP Provision for General Practice in the Future - RCGP; and the Hospice Commission - Help the Hospices 2013.

RCP Medical workforce meeting 4th November 2015

For the APM, Benoit Ritzenthaler, Stephanie Gomm attended jointly with Alison Coackley for the SAC Palliative Medicine, to present the palliative medicine report of the RCP 2014-15 workforce census, Discussions for each specialty focused on current consultant numbers, expansion, recruitment and unfilled posts; current trainee numbers, recruitment, with an opportunity to raise issues for our specialty on 7-day services and on changes proposed on general internal medicine and specialty training and to make predictions for workforce planning over the next 5 years.

Harriet Gordon RCP workforce Lead highlighted the following from the RCP census 2014-15

- There is significant slowing of consultant expansion in Palliative medicine.
- Expressed concern about the decision that LAT posts would disappear at the next recruitment in England which will lead to difficulty in relation to cover for 'out of programme experience' (OOPE), sickness and maternity leave and for the smaller specialties reduce opportunities for 'taster' experience.

RCP Census 2014-15

The overall UK Consultant Physician expansion rate of 3.2% decreasing compared to 4 % in 2012-13.The major concerns remain 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. Overall expansion of medical HST decreasing over last 4 years and declined to 2.3 % over last 12 months.

Academy of Royal Colleges publications the 'Commission of the Future Hospital' and the 'Shape of Medical Training' continue to be debated see www.jrcptb.org.uk and their indicative impact on the format of 7-day access to palliative medicine, continuity of care, our relationships with the wider hospital and community healthcare provision, and the promotion of (general) internal medicine skills across the medical workforce.

APM Workforce Commentary

For England: HEE published investing in people: Developing people for health and healthcare. Proposed Education and Training Commissions for 2015/16: Workforce Plan 2015/16 which despite extensive information from the APM and Palliative Medicine SAC published underestimates of numbers of training posts and consultants. As a specialty there has been no reduction in training numbers in 2015 and 2016. It remains challenging to interface with LETBs re palliative medicine workforce needs but vitally important we do so for 2016/17, and submit information to HEE on workforce numbers and planning for England.

National tariffs for training

Since April 2014 the change by HEE to MADEL funding of basic salaries for FY2 and Registrar trainees in reducing funding from 100% to 50% and a £11,400 placement fee which could adversely affect training programmes across England. The APM, SAC and Hospice UK made strong representations of the impact of this funding reduction for training placements. Currently those provided by hospices remain outside of the national tariff and LETBs should now be receiving guidance to maintain the status quo for funding in 2015/16.

For Scotland: Following the decision approved by the Reshaping Medical Workforce Project Board that NES should work with whole time equivalent (wte) numbers rather than trainee establishment numbers. The Scottish training Programme has been given one additional trainee, which increases the number of trainees on the Programme from 13 to 14 and included in National Recruitment from April 2015.

For Wales: It is not anticipated that there will be a significant further expansion in medical workforce in Wales. These calculations are based on the existing models of service delivery and workforce. There remains uncertainty, depending on the outcome on the current consultation on the 'Shape of Medical Training' in making future projections difficult for the medical workforce.

For Northern Ireland: Workforce issues are under discussion with the Medical Workforce Planning Lead at the Public Health Agency, currently no proposed changes in trainee numbers.

For Ireland: Expansion in consultant posts remains slow and impacts significantly on the availability of consultant posts for qualified trainees. Workforce information has been submitted by RCPI to HSE as part of a workforce review. The National Clinical Programme for Palliative Medicine is seeking to develop a model of care for palliative care delivery in Ireland. A workforce planning exercise across all disciplines including Palliative Medicine will be required to inform and develop this model of care. The National Clinical Lead and Dr Feargal Twomey are working up the Palliative Medicine Workforce component of this which will include sense-testing existing national policy (2003) and the 2012 UK Commissioning Guidance for use in the Irish setting. We are keen to learn from the experiences of colleagues in Northern Ireland, England, Scotland and Wales.

Trainees

Registrars

Specialist Advisory Committee (SAC): In October 2015, the SAC reported 236 (204 FTE) palliative medicine registrars in the UK. Overall, 35% of registrars were working < FT. The breakdown for these posts was: 202 (174.7 FTE) in England, 14 (10.4 FTE) in Scotland, 13 (12.5 FTE) in Wales and 7 (6.4 FTE) in Northern Ireland, 15 (14.5 FTE) registrars in Republic of Ireland. The number of OOP trainees in UK was 25 post-holders and 20 on maternity leave. In England there were 7 academic fellows and 4 academic clinical lecturer posts occupied. ST3 recruitment for August 2015 was 35 posts.

CCTs achieved in 2015 = 43. Expected CCTs for 2016 = 37. The projected average number of CCTs per year over next 3 years is 45-50.

Table 1. Comparisons of Trainee Numbers RCP and SAC data

Registrars	RCP 2014-15	SAC 2015
UK	219	236
England	192	202
Northern Ireland	6	7
Scotland	12	14
Wales	9	13
Ireland * RCPI	15	

RCP Census reported 88% of trainees were female the highest medical specialty.

SSAS Doctors APM Survey 2014

Clinical assistant, Medical officer, GPwSI, Specialty Doctors and other non-training grades. Total numbers who responded were 153. 78% were female. Overall 38% were >50 years of age. In total, 47% were working less than full-time. Of 163 SSAS doctors responding to the 2015 survey just over half (51%) are now on the new 2008 contract and only 90% having a regular appraisal.

Trying to identify SSAS doctors working in palliative care who are not members of the APM is difficult, and they could be designated as a 'lost tribe' in that we have no information about them or from them.

Consultant Workforce

- SAC 2015 Consultant numbers UK 609 (471 FTE) compared to 555 (454 FTE) in 2014 due to more accurate data. Consultant expansion of 3.4% compared to 5.3% in 2012.
- RCPI expansion rate of 0 % no change in 35 Consultant posts.
- UK Consultant % vacancy rate slightly lower 7.6%, 46 posts (31.45 FTE).
- AACs 2014 for England, Wales and N Ireland: - 68% appointed compared to last year 67%.
  Note this applies only to those with a RCP representative. Average AAC appointments 2010- 2014 = 44/year.
- 50 Expected retirements for 2016 -20 = average 10 per year increasing over last 5 years from 4-5/yr

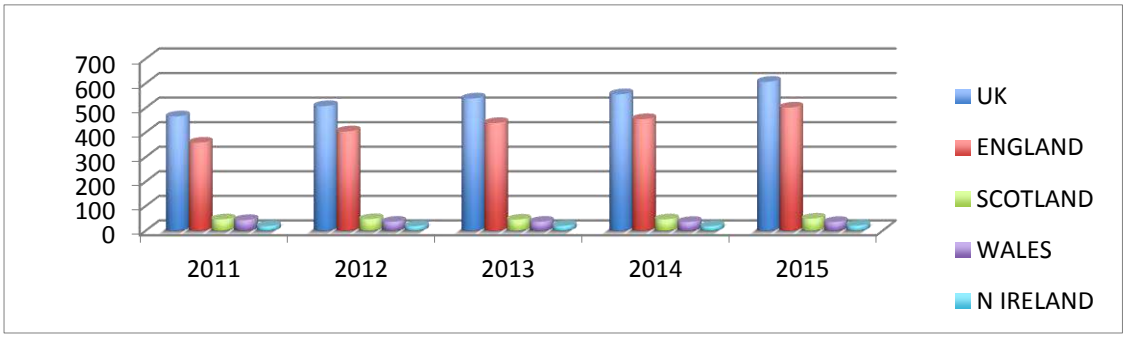
Table 2. Comparisons of APM Consultant headcount 2014 with RCP 2014 and SAC 2014-15 data.

Consultants	England	N Ireland	Scotland	Wales	UK	Eire
APM 2014	296	14	25	20	351	20
SAC 2014	454	20	46	35	555	-
SAC 2015 *	505	20	49	35	609	
RCP 2013-14 RCP 2014-15 RCPI 2015**	 414 427	 15 15	 48 51	 25 26	 502 519	- 35**

*Note * SAC data 2015 compared to 2014 under-reporting of consultant numbers hence 10% expansion compared to RCP increase of 3.4%.*

For Ireland Consultant headcount remains at 35 (33.6 FTE) with three working LTFT. There are up to four new full-time consultant posts due to come on stream this calendar year. SpR numbers are 15 (14.5 FTE) at present with no immediate plans to expand the number of higher specialist training posts.

Fig 1 Changes in Consultant headcount 2011-15 (SAC data)



The RCP census 2014-15 (2013) of Consultant physicians identified 519 (502) palliative medicine consultants working in the UK, with 427 (414) in England, 26 (25) in Wales, 51 (48) in Scotland and 15 (15) in Northern Ireland. Expansion rate of 3.4% compared to expansion rate for all specialties of 4%.

The palliative medicine workforce has a higher proportion of female consultants (74%) than most other medical specialties. Across the specialty 61% of female Consultants are working less than full time and 14% of males.

The average intended retirement rate (at age 65 yrs) of 10/yr (2015-19) and 11/yr in each of the next 5 years. Between 2014 and 2018 average intended retirement age ranges from 59.8 to 61.7 yrs reflecting the high % of female Consultants.

Geographical distribution of Consultant posts across UK: The East Midlands, Eastern and Wessex LETBs have the lowest FTE Consultants i.e. 1 FTE for > 215,000 population, however across UK the published RCP estimated need is 1 FTE for 160,000 population, however >40% work LTFT represents a need of 2.5 FTE /250,000 population.

Table 3 shows estimated Consultant workforce numbers and FTE for 2015 for each country on the basis of 2.5 FTE/250,000 in UK compared to current provision (SAC data 2015). With participation ratio of (0.76 - 0.95) for FTE and head count in each country.

Table 3. Estimates for each country in UK and Eire – < 40% full time

Country	Population Est.ONS Millions (2013)	RCP estimate[1]		SAC 2015 data		Participation Ratio
		Headcount	FTE	Headcount	FTE	
Wales	3.1	37	31	35	29.2	0.83
N Ireland	1.8	20.7	18	20	17.3	0.87
Scotland	5.3	66.3	53	49	39.2	0.80
England	53.9	709	539	505	385	0.76
UK	64.1	832	641	609	471	0.77
Republic of Ireland	4.05	42.5	40.5	35	33.6	0.95

Overall significant cumulative consultant expansion occurred in the last decade but has declined over the last 5 years. Noting that there has been an increase in the proportion of Consultants working less than FT, and using 2.5 FTE/250,000 population would represent 641 FTE needed for UK (Table 3). A significant shortfall exists in England with 385 FTE Consultants in 2015 compared with an estimated need of 539 FTE. There is a discrepancy between RCP and SAC data for the UK in terms of consultant headcount and FTE likely to represent those who do not hold a NHS contract.

Currently there is no problem in recruiting to NTNs but probably insufficient NTNs given the existing Consultant vacancies of 46 posts, overall unmet need and major geographical variation. Consideration

needs to be given to the recruitment of additional funded NTNs in these geographical areas, recognizing the effect of the large proportion of female and LTFT trainees who may not be able to apply outside their training region.

The most important variables in the current financial climate remain the creation and funding of new consultant posts and the continued funding of existing consultant vacancies. Overall there remains a potential risk of a mismatch of CCT holders in regard to available consultant posts although there is a consistent Consultant vacancy rate of >40 posts and no mismatch in trainees obtaining Consultant posts over the last 5 years. One of the consequences could be the facilitation of recruitment of consultants to regions that are currently under supplied.

Main issues confronting workforce planning are extending the current patterns of 7/7 day working and the potential added commitment to acute medicine, in the context of delivering out of hours cross-site working in community, hospice and hospital settings and securing the recognition that additional consultant numbers will be needed to achieve this.

Challenges

In all countries, the consequences of financial restraints and envisaged changes to education, training and workforce planning are still a major concern; in particular in England the impact of the Learning and Education Training Boards. There is currently no commitment to national workforce planning or standards. In addition, there is the impact of changes to the Model funding of basic salaries for FY2 and Registrar trainees, by Health Education England. The APM made representations to HEE and our current understanding is that hospice placements and less than full time training will not be subject to the changes in national tariff in 2015/16; however, we await clarification from local LETBs as to how future funding arrangements will be implemented.

For all countries in the UK and Ireland a major question is do our current and proposed future models of medical care meet the current need and the unmet need for access to Palliative Care services?

The current proposed changes to medical training may shorten the length of specialty training and that more medical specialties will have involvement in acute general medical intake. These are being considered by the specialties and Colleges but will ultimately be determined by the response of the different Departments of Health. The anticipated changes in service provision and in the Shape of training review will influence the traditional roles of hospices, community and hospital palliative care teams and the type of medical workforce. 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 in hospital and community, in meeting the needs of the frail elderly and the rising tide of acute medical admissions.

Overall, it is important that although we may know the current numbers of our workforce but we do need to identify the future need and anticipate unmet need so that we train, develop and deliver a workforce that is fit for purpose. There remains uncertainty, depending on the outcome on the implementation of 'Shape of Medical Training' about what the impact of this will have in making future projections more difficult for the medical workforce at this juncture.

Dr Stephanie Gomm
Workforce Committee Chair, 2016

Specialist Advisory Committee Report

The SAC is a subcommittee of the Joint Royal Colleges Postgraduate Training Board (JRCPTB). The SAC contributes to the development of specialist training policy as it affects Palliative Medicine and supervises the delivery of training to standards set by the JRCPTB / General Medical Council.

The following is a brief summary of the key developments this year.

Demographics

In 2015 there were 236 registrars working in the specialty. 153 trainees were working full time and 83 were working less than fulltime. This equates to 204 wte registrars. Palliative Medicine has the highest number of female trainees (88%) compared to other medical specialties.

Recruitment

Recruitment to higher specialist training is co-ordinated by the Royal College of Physicians. The SAC lead for recruitment is now Dr Laura Chapman. In 2015 recruitment to specialty training posts was very successful with no NTN posts left unfilled. Recruitment was also very successful for the LAT posts. Unfortunately despite strong representation from our specialty and others, LAT posts have now been discontinued. The impact of this on training and service delivery remains uncertain but has the potential to be significant.

National recruitment is now in place for all training posts and in Palliative Medicine is led by the West Midlands Deanery. There have been no further changes to the person specification whilst we review the impact of Shape of Training. The anticipated number of trainees gaining their CCT in 2016 is 36.

As in previous years there are insufficient National Training Numbers (NTNs). Some regions struggle to recruit to vacant consultant posts. There needs to be additional funded NTNs in these areas. The estimated shortfall of 170 wte Consultant posts is based on a five day service. It has not taken into consideration the impact of Shape of Training on the distribution of workforce between palliative medicine and acute medicine.

Formal Academic Training (NIHR funded)

There are currently seven Academic Clinical Fellows (ACFs) across the UK. ACF posts are for doctors in the early years of specialty training and are aimed at preparing the doctor to undertake a training fellowship for a higher degree or a postdoctoral fellowship.

There are five Palliative Medicine Academic Clinical Lectureships (ACLs) in post across the UK and two vacant positions. These provide opportunities for doctors working towards completion of specialty training, There is a support group for academic trainees which is facilitated by Professor Mike Bennett

Quality

The GMC trainee survey has identified difficulties in handover in palliative medicine for the past few years. This is a complex topic to survey as in some areas trainees cover more than one unit when on call. Trainees may also be on call in a unit where they do not undertake daytime work. A working group led by Polly Edmonds has developed national guidance on handover for trainees working in the specialty. We have also designed some additional specialty specific questions for the 2017 GMC survey which we hope will give us further clarity about the handover issues.

Curriculum Review

Alison Mitchell is the Vice Chair of the SAC and the curriculum lead. Alison and members of the working group have been developing draft Competencies in Practice for the specialty training programme which will form the basis of the new curriculum. The emphasis is on the core skills that trainees should have at the end of training i.e. what they need to be able to do rather than the current approach of multiple assessments on component skills. [1]

Specialty Certificate Exam

The Specialty Certificate Exam (SCE) was introduced in November 2011. It consists of two three hour exam papers each with 100 best-of-five questions, displayed in a random order.

For 2015 the pass mark was set at 65%. 80% of UK graduates passed at their first attempt. (35/44) 25% of international medical graduates passed at their first attempt.(2/8) UK trainees had a pass rate of 73% (49/67).

Certificate of Eligibility for Specialist Registration (CESR)

The number of applications for CESR increased markedly towards the end of 2015 and into 2016. The reasons for this are not clear but the associated workload for members of the SAC is significant.

CESR applicants are assessed against the current curriculum and need to provide extensive evidence of their competence and experience. It is absolutely essential that any doctor considering this route receives the most up to date information and advice about requirements. Advice is available from CESR assessors via the SAC, the GMC and from the certification department at the JRCPTB.

Workforce Planning

Polly Edmonds is the workforce lead. The SAC collect data annually from each TPD. This includes data on trainee numbers (full-time and less than fulltime), non-training doctor numbers, CCTs achieved and expected consultants (fte), consultant vacancies and destinations of CCT holders for each of the 4 countries. The results feed into the APM workforce group to provide as complete a view as possible of workforce issues. The SAC data has proved to be very accurate and is becoming increasingly important in making the case for increased NTNs.

Shape of Training Review

Many APM members will be aware of the ongoing discussions about the Shape of Training Review and the potential impact on our specialty. A paper published in the APM post is attached to this report outlining the current position. Change in some format now seems inevitable.
The proposed model aims to produce doctors capable of providing more general care. It comprises 2 years of foundation training followed by three years of core medical training and one further year of general medicine during specialty training.

Current work streams within JRCPTB are defining the new internal medicine curriculum which contains a core set of competencies. Members will be pleased to know that one of these is palliative and end of life care skills and the SAC is providing input as to what this should include and how it should be assessed.

The credentialing question has gone very quiet at the moment. However it will no doubt remerge at some point during 2016.

National Tariffs for Training

For three years there has been concern within the specialty about the changes to funding arrangements for registrars, which could in turn adversely affect palliative medicine training programmes across England. The SAC continue to receive individual reports of threats to training posts. The current guidance suggests:

- All charitable hospice posts should be 100% funded by the local LETB when a trainee is there
- If there is a gap it is up to the local LETB whether they wish to send the funding for a hospice to appoint a "trust grade" equivalent doctor
- Hospital posts should be tariff funded as per any other specialty and managed accordingly

New Developments in Training

The use of simulation in delivering training has been employed in several localities including Yorkshire Humber and Mersey.

Dr Fiona Hicks

It was with great sadness that members of the SAC heard about the death of Dr Fiona Hicks in autumn 2015. Fiona was an inspirational and influential colleague and was Chair of the SAC for six years. She made many significant contributions to the development of training and was always a great source of wisdom and advice. We are very grateful for everything she did and we will miss her enormously.

References

1. Caverzagie KJ, Cooney TG, Hemmer PA, Berkowitz L. The Development of Entrustable Professional Activities for Internal Medicine Residency Training: A Report From the Education Redesign Committee of the Alliance for Academic Internal Medicine
Academic Medicine 2015; **90(4):** 479-484

Alison Coackley
Chair, on behalf of the Palliative Medicine Specialty Advisory Committee, 2016

Shape of Training. A New Direction for Palliative Medicine

Background

As many members will be aware the Shape of Training review has been underway for some time. It now appears likely that Shape will happen. It will create an entirely new landscape for training and for how trainees and future consultants in Palliative Medicine work.

We must ensure that training equips doctors for the job they will be doing. We must also maintain the relevance and the ethos of our specialty in the new world. Hard work over the past twenty years to ensure palliative medicine is recognised as being essential across all care sectors must not be wasted. We now have 550 consultants across the UK, a robust training programme and an ability to effectively influence national policy agendas.

Proposed JRCPTB Framework for New Training Model

In the summer of 2015 we circulated a briefing paper about Shape and the potential impact on Palliative Medicine. At the same time the APM conducted a survey of members which highlighted concerns about aspects of Shape including our future role in acute take. The survey formed the basis for discussions with JRCPTB who then produced a framework describing how the 29 medical specialties would operate within the new model of training.

This new framework left us sitting apart from all of the key and relevant medical specialties. It was clear that we were in real danger of losing our ability to directly influence patient care. This position generated real concern for many, including training leads and those representing our specialty.

Options Appraisal

An options appraisal was generated to facilitate further discussion. The two options are summarised in Figure 1. There was widespread constructive debate within the APM, the JSC the SAC and with trainees, supervisors and consultants across the UK. Notwithstanding the concerns, the consensus was that the specialty needed to change position and to support Option 1 in order to avoid being marginalised.

This has also been the conclusion reached by many of the other medical specialties such as medical oncology. This relates to training and it does not mean that future consultants would be expected to routinely be part of acute medical takes in hospitals. We do need to be able to assess an acutely unwell patient in any care setting to reach the best management plan; in this way we play a part in the acute care pathway but in the context of our services.

Figure 1 Summary of Options Appraisal

	Option 1	Option 2
Input to acute medical care	Yes. May include direct contribution to acute take	No contribution to acute take
CMT training	Three years using new Internal medicine curriculum	Two years. Curriculum unclear
Specialty training	Four years. 12 months would focus on Internal medicine	Four years. Only focused on Palliative Medicine
Dual accreditation	Yes	Unlikely
Future Consultant role	Negotiated according to local need e.g. level of input to acute take. More flexibility in career development	No option for negotiation. Potentially few employment options in acute Trusts. Focus on community and hospice settings. Less flexibility
Selection criteria	May make MRCP the desirable entry pathway	Could remain broad to include MRCGP etc
Potential to change specialty during training	Yes	Unlikely
Position of other medical specialties	Respiratory, cardiology, geriatrics, medical oncology	Audio vestibular medicine, ophthalmology, genetics

Way Forward

The RCP and JRCPTB understand our reservations but have welcomed our decision to join with other key specialties in focusing on the development of a new internal medicine curriculum to link with a new curriculum for specialty training. Both of the new curricula will be concise with a focus on defining what a competent physician can do. There will be approximately 10-14 Competencies in Practice for each curriculum with key descriptors for each competency. How we assess competency is being reviewed with a real determination to move away from box ticking and multiple assessments.

Embedding a competency in palliative and end of life care in the new internal medicine curriculum will help to ensure that all future physicians, whatever their specialty, have appropriate training, experience and competence in looking after patients at the end of life. The new curricula will require pilots. These could start as early as 2017 with 2019/2020 suggested as the target for rolling out the new model of training.

We know that there will be further changes and some uncertainty remains. The APM, JSC and SAC will work together to ensure that Palliative Medicine is represented, influential, protected and developed. We will continue to provide members with regular updates via this newsletter and the APM website. Training Programme Directors will remain a key contact point in each locality

There are real opportunities and exciting times ahead. We are confident that as a specialty we are now in a better position to influence both patient care and the training of doctors in all medical specialties.

Dr Alison Coackley
Chair of Palliative Medicine Specialty Advisory Committee

Dr Stephanie Gomm
APM Executive Member and Chair of Workforce Committee

Dr Idris Baker
Member of Palliative Medicine Specialty Advisory Committee

Dr Wendy Makin
Chair of the Joint Specialty Committee for Palliative Medicine

Neurological Palliative Care SIF Report

The Neurological Palliative Care Special Interest Forum has now been running for approximately 4 years. It aims to share ideas and good practice around palliative care in patients with advanced progressive neurological diseases, such as MND, Parkinson's disease, multiple sclerosis and Huntington's disease.

The forum consists mainly of Palliative Medicine doctors, but is also open to other professionals with an interest in this area. The group has continued to maintain email contact over the past year, discussing interesting clinical questions and sharing ideas about audits and other pieces of work.

The group co-ordinator is now Aruna Hodgson, who took over from Annette Edwards in November 2015. Thanks are extended to Annette for all her work in establishing the forum and co-ordinating it over the past few years.

Publications

Members of the group have led on the development of several key resources which have been published in the last few months.

APM Guidance for Professionals on the Withdrawal of Assisted Ventilation at the Request of a patient with MND

Hopefully many APM members will already be aware of this document which was published in November 2015. The Guidance was developed by a multi professional and interspecialty group, chaired by Christina Faull. It gives detailed information about the key components for safe and effective withdrawal of ventilation at the request of patients who are ventilator-dependent. It has been endorsed by a number of organisations including the GMC, RCP, MNDA and Hospice UK.
In addition to the guidance document, a list has been compiled of people with experience of withdrawing assisted ventilation who are willing to offer support to professionals facing this situation for the first time. An audit of process and outcomes in regard to withdrawal of ventilation has also been developed, which aims to evaluate the usefulness of the guidance and increase the evidence-base in this area of care. The guidance, audit tool, and information about how to contact those with experience in the area are all on the APM website.

NICE Guideline on Motor Neurone Disease: assessment and management

This was published in February 2016, the Guideline Development Group having been chaired by David Oliver, with Annette Edwards as a group member. The guideline describes good practice in care from diagnosis to end of life, and includes helpful recommendations in areas of symptom management such as saliva problems, nutrition and gastrostomy, communication and respiratory problems.

EAPC / European Academy of Neurology Taskforce on Neurological Palliative Care Consensus Review on the development of palliative care for patients with chronic and progressive neurological disease

David Oliver chaired this review, which concluded that there is increasing evidence that palliative care and a multidisciplinary approach to care lead to improved symptoms and quality of life of patients and families. The full publication can be found on the EAPC website.

Study Days

Following the successful Study Day on "What's New in Progressive Neurological Diseases?" held in Manchester in March 2015, there are plans for a joint study day with the APM Transition SIF in June 2016. The aim is that this will cover topics of relevance to both groups, including management of spasticity and dystonia, caring for people with challenging behaviours, and managing gut failure. Further information will be available shortly.

Ongoing and Future Work

Jamilla Hussain has been continuing her work looking at triggers for end of life care in progressive neurological conditions. There has also been recent email discussion amongst forum members about what data different units collect about interventions and outcomes in patients with MND, with a view to considering whether this could be collected in a standardized format to allow for benchmarking.

The area of neurological palliative care is continuing to develop, and if anyone is interesting in joining the SIF and contributing to our work, you would be very welcome.

Dr Aruna Hodgson
Neurological Palliative Care SIF, 2016

Undergraduate Education Special Interest Forum Report

The Undergraduate Education SIF continues to flourish under the joint leadership of Prof John Ellershaw (Liverpool) and Dr Stephen Barclay (Cambridge).

Annual conferences.

We continue to hold annual conferences, alternating between Cambridge and Liverpool. The third conference was held in Cambridge in March 2015 and was attended by 35 colleagues: Consultants, Junior Doctors, medical students and representatives from the GMC. In a keynote address from Dr Mark Gurnell, Cambridge Associate Clinical Dean and Chair of the national Medical Schools Assessment Alliance Finals Clinical Review Groups, we were reminded how often assessment drives learning.

Mark also led an afternoon workshop on writing Single Best Answer exam questions: the group are to submit a sizeable number of SBA questions to the national question bank, some of which will appear in all UK medical school finals exams in the near future. Do contact Stephen Barclay if you'd like to be involved in this project sigb2@medschl.cam.ac.uk

We also had a number of delegate presentations on assessment innovations in their medical schools and educational research studies, which stimulated lively debate.

Fourth annual conference: Wednesday May 11th 2016, Liverpool.

The next annual day-conference of the SIF will focus on e-learning in undergraduate teaching and educational research. An opportunity to learn about novel 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

SIF pages on the APM website.

The SIF now has several pages on the APM website: see http://www.apmuesif.phpc.cam.ac.uk/ Each medical school has a front page detailing their lead for Palliative Care teaching and brief course summary, plus additional documents concerning course components from many schools. Further pages include the new APM Curriculum for undergraduate teaching and details of past and future SIF meetings.

Stephen Barclay sigb2@medschl.cam.ac.uk
John Ellershaw J.E.Ellershaw@liverpool.ac.uk
Undergraduate Education SIF Coordinator(s), 2016

Transitions Special Interest Forum Report

Coordinator Dr Amelia Stockley, Locum Consultant Palliative Medicine, Douglas House (Young Person's Unit), Oxford

I am pleased to report that the inaugural meeting of the APM Transition SIF, which took place in May 2015 at The Carrs Centre in Birmingham, was a great success. It comprised a small (30 delegates) but auspicious gathering of adult palliative medicine healthcare professionals and GPs intent on improving the experience of young people graduating from children's palliative care services. The theme of the day was Perspectives: speakers were invited to share their own perspectives on transition and included those from a young person's hospice, an adult hospice with a transition service, the Together for Short Lives' (umbrella charity for children's hospices in the UK) Transition Task Force, the young adults themselves, primary care, secondary care and research. Lively discussions were stimulated and valuable opportunities for networking were created.

This year we are joining forces with the APM Neurology SIF for our annual meeting. We are still in the planning stages but hope to hold the meeting in June in Birmingham. A rich variety of speakers have kindly agreed to attend and topics will include an update on transition between children's and adult hospices, management of spasticity and dystonia, management of gut failure in non-malignant conditions, Duchenne's Muscular Dystrophy and seating/positioning/sleep methods from a transition physiotherapist. A children's wheelchair charity has also agreed to attend.

In the last year the Transition SIF was able to assist a research fellow working with Dr Christina Faull at LOROS by answering questions about the feasibility and scope of a research project and grant application for a study on transition. Group emails have kept members abreast of developments and pertinent documents or conferences pertaining to transition.

Dr Amelia Stockley
Transitions SIF Coordinator, 2016