Shape of Training (SoT) Information for AGM

The Shape of Training (SoT) review was launched through an agreement between the organisations responsible for the regulation, commissioning and delivery of medical education and training in the UK. These are Health Education England (HEE), Academy of Medical Royal Colleges (AoMRC), The General Medical Council (GMC), The Medical Schools Council (MSC), Council of Postgraduate Medical Deans (COPMeD), NHS Education Scotland (NES), the Northern Ireland Medical and Dental Training Agency (NIMDTA), and the Wales Deanery.

Senior representatives from these bodies formed the Shape of Training Sponsoring Board, which was responsible for setting the review's strategic direction including its scope, timelines and outputs. Several reports (Future Hospitals, Francis, Keogh) prompted and informed its instigation. **The Sponsoring Board appointed Professor David Greenway to lead this independent review. In October 2013 he published the Shape of Training Report. Important themes running through the report include patient need as a driver of doctors' training, a change in the balance between specialism and generalism, the need for a broader approach to postgraduate training, the tension between service and training, and the need for more flexibility in training**.

It includes recommendations of particular relevance to all medical specialties, including Neurology. Currently the basic training in medical specialties starts with two years of core medical training (CMT 1&2) followed by four or five years of specialty training (ST3–ST7 or ST3–ST8). In SoT, instead of CMT 1&2, trainees will do three years of internal medicine (IM1–3) before embarking on specialty training (ST4–7 or ST4–8) but this specialty training will include one year's worth of more internal medicine. How this is achieved will vary with specialty and local circumstances but will not be directed by the curriculum.

From 2014 onwards, in meetings with the Joint Royal College of Physicians Training Board (JRCPTB), the Specialist Advisory Committee (SAC) in Neurology, led by the then chair Dr Richard Butterworth, put forward a strong case for doing a year of acute stroke and acute neurology during specialty training instead of a year's worth of more internal medicine. The ABN Council and the ABNT supported this proposal. These plans put Neurology in what subsequently became known as Group 2.

Group 1 specialties are all the major specialties such as Gastroenterology, Cardiology and Renal, but also now Rheumatology and Genitourinary medicine, all of whom have agreed to do the extra year's worth of internal medicine during specialty training, leading to dual accreditation in specialty and internal medicine.

Group 2 specialties included Palliative Medicine, Medical Oncology and Dermatology. They put forward proposals for opting out of continuing with the unselected take and of continued training in internal medicine during specialty training. With Neurology, these specialties formed Group 2. These specialties felt that they could contribute more to acute medicine by doing specialty on call rather than the unselected take.

Group 3 specialties include Audiological Medicine, Neurophysiology, and Aviation Medicine. They are planning to recruit to specialty training earlier, perhaps after only one or two years of internal medicine rather than three, i.e. after IM1 or IM2 rather than after completion of IM3. Haematology is in Group 3 as a result of their engagement with laboratory services and the Royal College of Pathologists.

The SAC Chairs of the four Group 2 specialties were asked to attend a meeting on 31st Jan 2017 with the Shape of Training Steering Group, to explain their proposals.

Tom Hughes (Chair SAC), Anthony Pereira (Deputy Chair SAC), Phil Smith (President ABN), Mary Reilly (President-elect ABN) and Richard Butterworth (immediate past Chair SAC) worked together closely during December 2016 and January 2017 to reach a consensus about how best to present our case, mindful of the need to present a strong case about which we were all in agreement.

The meeting entailed a 10-minute presentation and then a question and answer session for 45 minutes.

On the panel were (we give their affiliations to ensure that the breadth of representation on the panel is appreciated): Prof Ian Finlay (Chair, UK Shape of Training Steering Group), Dr Paddy Woods (Deputy Chief Medical Officer, Northern Ireland), Prof Stewart Irvine (Deputy Chief Executive, NHS Education for Scotland), Andrew Matthewman (Senior Manager, Health Education England), Namita Kumar (Health Education England representative), Sarah Parsons (Medical Workforce Manager, NHS Employers), Prof Stephen Powis (Medical Director, Royal Free London NHS Foundation Trust), Prof David Black (Medical Director, JRCPTB), Dr Alastair Miller (Deputy Medical Director, JRCPTB), Zoe Fleet & Vicky Ong (Curriculum & Assessment Officers, JRCPTB), Dr Iain Findlay (Vice President (Medical), Royal College of Physicians of Glasgow), Dr Mike Jones (Director of Training, Royal College of Physicians of Edinburgh), Dr Gerrard Phillips (Vice President, Education & Training, Royal College of Physicians of London).

We made it very clear that we strongly supported three years of internal medicine (IM1-3) before specialty training, but that we thought continued engagement with internal medicine during specialty training in neurology would be damaging to the standards of neurology and neurology training in the UK and therefore damaging to standards of patient care. We focused on the rising demand for acute neurology services (including stroke), the current workload, the complexity of modern treatments, rising expectations, and the limited neurology workforce in the UK compared to Europe and the United States. We included data from the most recent Acute Neurology Survey in the presentation.

In a letter of 30th March we were informed that the SoT Steering Group had rejected our proposals. The proposals of Medical Oncology and Palliative Medicine were also rejected and like us they were asked to submit alternative proposals. Palliative Medicine has now agreed to continue with internal medicine throughout specialty training. Medical Oncology are considering their position. The proposals of Dermatology were accepted; they may do just one year of internal medicine (IM1) and then four years of Dermatology (ST2–5). This may lead to the development of an alternative to full MRCP. They are doing an options appraisal.

The Neurology community now needs to discuss how best to proceed. Some of the options suggested so far have already been described as impractical or unrealistic, but for completeness they are included.

a. To stick with the proposals we have put forward already, to do acute neurology and acute stroke rather than another year's worth of internal medicine during the four years of specialty training.

b. To suggest that we be treated like Dermatology, who appear to have been allowed to do only one year of internal medicine before specialising.

c. To break away from the Royal College of Physicians to form a College of Neuroscience.

d. To engage with Group 1. This could involve requesting an extra year of training in order to complete the internal medicine curriculum. Cardiology have done this.

e. To design a run-through programme in neuroscience that would be started after completion of Foundation Training. It would replace IM 1–3 with two or three years of basic neuroscience followed by four years of more mainstream neurology and stroke training.

The SAC and ABN are currently pursuing only our original proposal (option a in the above list) and we are engaged in further discussions with Prof Ian Finlay (Chair, SoT Steering Group) and Prof Jane Dacre (President, RCP London).

I am grateful to all the people who have made valuable contributions to this information sheet.

Tom Hughes, SAC Chair.

ADDENDUM: Health Education England (HEE) and their equivalents in Scotland (NES), Northern Ireland (NIMDTA) and Wales (Wales Deanery) fund postgraduate medical education. In Scotland, Northern Ireland and Wales the deaneries are the local versions, in England the Local HEE teams e.g. HE Thames Valley and HE Wessex. Local Education Training Boards (LETBs) are HEE committees at regional level in England (there are four: North, Midlands and East, London and South East, South).

Some trainees are funded by Health Boards which, like HEE and its equivalents, receive their funding from the government. Training is delivered by Local Education Providers (LEPs), which can be a hospital or Primary Care Facility. Each LEP has a Director of Medical Education (DME) to oversee its provision of education.

Quality Assurance (QA) for curricula, assessments, and training sites is provided by the GMC.

Quality Management (QM) is led by Postgraduate Deans and their teams, with support from the JRCPTB and the Specialist Advisory Committees (SACs).

Quality Control (QC) is provided by local Training Programme Directors, Educational Supervisors and Clinical Supervisors.