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SUPPLEMENT

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Modernising Medical Careers—an interview with Shelley Heard

The six month stand alone A&E SHO post has been a robust feature of British hospital life for very many years. This may all change as a result of the implementation of the government paper Modernising Medical Careers *in August 2005. Unlike the Calman reforms of the registrar grade, these reforms have come with only with very broad guiding principles laid down. There is much work to be done to decide the way or ways in which these changes will be introduced. All the deaneries are running pilot schemes this year to prepare the ground for full implementation. We talked to Dr Shelley Heard, Postgraduate Dean for London, who is leading on this for the London Deanery.*

HOW DID YOU GET INVOLVED WITH MMC?

I have been a postgraduate dean in London since 1996, so I have done lots of things in my time at the deanery. Most deaneries have MMC leads—sometimes newly appointed associate deans. I was looking for a new challenge so within the deanery it was agreed I should take this on. I lead on MMC and will be developing the strategy for MMC for London half the time—I have been seconded to the NHSU for the other half to work on educational programmes to support the foundation programmes in MMC: the first two are in team working and communication skills.

WHY IS MMC NECESSARY?

It's the result of a recognition that something had to be done about the SHO grade, which was not well managed educationally and did not really meet patient or service needs. Patients were often being seen by quite junior doctors at the frontline but it was also clear that there was an imbalance between the numbers in the SHO grade and those getting into SpR posts: at one end of the grade the work was perhaps not as suitable as it might be for quite junior doctors, at the other end there were experienced people stuck in the grade who could not move on. The *NHS Plan* promised a review of the SHO grade for these reasons.

The result of this review was a document from the CMO called *Unfinished Business*. After widespread consultation, a response from the four Secretaries of State for Health culminated in the publication of *Modernising Medical Careers* (2003) or ''MMC''. This sets out major changes for postgraduate medical education, encompassing the SHO years and beyond. It requires the development of a two year foundation programmes for UK medical graduates, covering the current pre-registration house officer year (PRHO = FP1 year) and the current first SHO year (FP2 year).

AND BEYOND THE FOUNDATION PROGRAMME?

The Royal Colleges and Faculties are heavily involved in looking at proposals for what post-foundation training will look like. There are likely to be many different approaches, depending on the specialty and it is likely that a ''run-through grade'', following on from the foundation programme, will be introduced. Training will be competency based and assessed, rather than based primarily on the ''time served'' model we currently have. There are the European minimum durations of training for each specialty which will have to be met, but a number of UK specialties take considerably longer than these. Part of the review by the Colleges will no doubt be to clarify why, for example, Europe, America, and Australia train specialists in less time than the UK. Are we looking at very specialised training, or are we looking at a more general training, with more specialised training for some people afterwards? These are the discussions being undertaken by Colleges as they consider the best way of structuring further training programmes. At some point their proposals will need to be considered by the new Postgraduate Medical Education Training Board (PMETB) since this is the ''competent authority'' which will need to approve and agree the Colleges' recommendations around the curriculum, the areas of competence to be assessed, and the standards that have to be reached. Legislation to enable these changes has been laid and will be implemented over the next year to 18 months—this is a very important and fundamental change for postgraduate medical education.

WHAT IS HAPPENING ABOUT FOUNDATION PROGRAMMES?

There has been a lot of activity nationally around this. The Deputy CMO, Professor Aidan Halligan is leading the implementation of MMC and has been particularly keen on getting work on the foundation programmes going.

Prototypes or pilot programmes are being developed around the country by deaneries and trusts in order to explore

the shape and potential of Foundation Programmes. The key aims of Foundation Programmes are that doctors who complete them have:

- Robust acute medical skills and are safe doctors who can identify a sick patient, know how to resuscitate, and can arrange further management as needed.
- Good generic professional skills, around delivering some of the key elements of good medical practice, including teamworking, understanding patients' rights, honesty, integrity.
- Had the opportunity to explore to a range of career options—called ''tasters''—which will include exposure to general practice, the diagnostic and other specialties.

The foundation programmes will be quality assured against what Professor Halligan calls the ''seven pillars of MMC''—competency assessed, service based, trainee centred, flexible, structure and streamlined, coached, and quality assured.

London's approach to foundation programmes is based on a large consultation exercise which we undertook with trusts which endorsed the view that many people thought the second foundation year should largely be delivered around an A&E base, perhaps with a medical assessment unit, because of the emphasis on core clinical skills.

Some consultants in A&E are very concerned about discussions suggesting that during the FP2 year only four months might be spent in A&E instead of the current six months. I don't have a fixed view that 4 × 3 month appointments is necessarily the only way to configure the FP2, although that is what a lot of people are saying. In London we are running with some pilots that offer six months in A&E and two three month periods in other specialties. The critical point of course is that the areas of clinical competence identified for the foundation years are achieved; we have yet to determine the best way to do this.

A great deal will depend on what FP1 will look like, but this is getting relatively little attention at the moment since everyone is very challenged looking at year 2, not least because it is not known whether there will be additional resources for new posts to implement it. In London we have 10 pilots (we call them ''structural pilots'') that are considering how to implement the FP2 year with very few new posts being brought in—by using existing stand alone SHO posts, some trust doctor post conversions and a lot of good will from clinical colleagues! Given that any proposals must also be European Working Time compliant, this is a challenging agenda. We also have a number of educational pilots looking at particular facets of the foundation programme, for example one on safe prescribing, another on how to teach professional skills, another on career support, etc.

The foundation programmes proposed in *Modernising Medical Careers* offer important opportunities to ensure that doctors starting their careers in the NHS have a firm foundation in clinical and professional skills. It is what patients need and deserve. It is likely also to help support more confident and well prepared doctors for the future.

This is a very exciting time for everyone involved in medicine. As Dr Heard illustrates, emergency medicine can be at the heart of training for all doctors and we should embrace this opportunity to lead the field rather than being threatened by change. This is our chance to ensure all doctors are exposed to the high quality training our specialty offers.

Consultant appointments September to November 2003. The information for the consultant appointments is provided by the Faculty and any errors should be notified to them and not the journal

Name	Hospital	Previous post
Olumuyiwa O Abe	King George Hospital	Locum consultant, North East London
Ashis Banerjee	University Hospital of Lewisham	Locum consultant, University Hospital of Lewisham
Jonathan R Benger	Bristol Royal Infirmary	Locum consultant, South Western
Brian John Burgess	Southend Hospital	—
Tim Coats	Leicester Royal Infirmary	Royal London Hospital
Brian M Flavin	Southampton University Hospital	Locum consultant, Bolton
Geoffrey Hughes	Salisbury District Hospital	Consultant, Wellington Hospital, New Zealand
Turan S Huseyin	Barnet and Chase Farm Hospital	Locum consultant, Whittington Hospital
Wendy Matthews	Chelsea and Westminster Hospital	Locum consultant, North West Thames
Maya K Naravi	Leeds General Infirmary	SpR, West Midlands
Mark Poulden	Princess of Wales Hospital	Locum consultant, Princess of Wales Hospital
Mark D C Simpson	Hull Royal Infirmary	SpR, Hull Royal Infirmary
John P Sloan	Countess of Chester Hospital	Consultant, Leeds General Infirmary
Alison Walker	Pinderfields General Hospital	Locum consultant, Leeds General Infirmary
Sarah L Woolley	Bristol Royal Infirmary	SpR, Russells Hall Hospital

Note from the Tsar: next steps

What next? The 90% "in and out" target was reached at the end of March—and in general is being sustained. This is a major improvement over previous years and obviously beneficial to patients. Trolley waits are a relatively rare phenomenon and major changes have been made in the way we deliver the service to emergency patients in emergency departments. Much remains to be done—particularly in the commmunity and in other parts of our acute hospitals—but changes are occurring.

However, 2004 is now upon us. To many people 2004 means only one thing—that is, 100%. This was the emergency department target set for 2004 in the NHS Plan. When the latter was written 2004 seemed a long way ahead, but not now! Many comments have been made and a rapidly rising crescendo of questions are being asked about the 100% target. Is it a sensible target? Will it be of benefit to patients?—and above all is it feasible?

These are of course serious questions—and whatever else is decided our prime goal must remain to improve care for patients—both clinically and in terms of patient "experience". This is clear to all of us in the Department. Some emergency departments are indeed now close to 100%, but not many, and no type 1 departments have sustained this level consistently, although many stand-alone urgent care centres (minor injury units and walk-in centres) are achieving this.

I and my clinical colleagues in the Department have heard many heartfelt comments from many of you about the difficulty or indeed impossibility in hitting 100% consistently. We have passed these messages on to our Ministers and it is up to them now to make a political judgment.

We also believe that it may be harmful for some patients to be moved out of the emergency department just to achieve the four hour cut off. We have consulted widely on these "clinical exceptions". This is a relatively small number of patients (certainly fewer than 1%) but the principle has been accepted and a definitive document will appear shortly. It will not, however, be acceptable to exclude patients who are waiting for more appropriate accommodation—for example, mental health patients or those waiting for a specialty bed.

One major bonus for patients is the acceptance that many patients after the first assessment are more appropriately looked after in an observation unit or assessment ward. If these are properly appointed areas with beds, lockers, etc then these are outwith the target, although they should be monitored closely to ensure that they do not just become a convenient dumping ground. They and the patients should be actively managed—they should not just lie there waiting for something to happen.

If you do not have such facilities use the pressure of the target to negotiate for them with your management and the PCT. My own efforts now are heavily directed to "whole system" improvements. It is obvious that we need to solve the before and after problems if we are to help emergency departments and garner overall benefits for patients. I will be talking to many of you about this and would indeed welcome views. The next year will be challenging—again! But hang in there—slowly but surely the care of patients with emergency needs is improving due largely to your efforts—and in the end that is what we are all about.

SIR GEORGE ALBERTI
National Director for Emergency Access

Round up of forum news from FASSGEM

This is a summary of the report presented to the FASSGEM AGM in Wakefield by Dr Andrew Newton (Chair of FASSGEM).

In February representatives of FASSGEM were involved in a National Health Service Confederation Sponsored Focus Group held in London to look at redefining non-consultant career grade posts. The discussions which took place at this workshop have been used as the basis for a draft consultation document published recently by the Department of Health entitled *Choice and Opportunity, Modernising Medical Careers.*

Choice and Opportunity represents a major hope for the future for non-consultant career grade doctors and while there are still some elements of the document that could be improved upon it is my belief that it represents a major step forward in righting many of the inequalities that have affected staff grades and associate specialists over the past 10–15 years. I believe we should welcome it with open arms and look forward to its implementation because it offers us opportunities to improve our professional standing and also to draw us closer to mainstream training posts in terms of rights, opportunities, and remuneration.

The newly formed Postgraduate Medical Education Training Board (PGMETB) will offer individuals (on a case by case basis) the opportunity to put their own individual circumstances forward and through a process of competency based assessment there will be the chance for individuals to have their professional status re-evaluated. This system will bring a degree of equity previously unknown with the traditional Royal Colleges system, and again this is something to be welcomed.

Inherent within the new order which we are going to become part of is a requirement for us all to be totally compliant with processes of personal professional development and reaccreditation through an appraisal based system (with superimposed competency based assessment). While some may see this as threatening, intrusive and unnecessary, it is my firm belief that we should welcome it as the opposite of all of these things, because the introduction of such systems will usher in a new era for the profession where those that can demonstrate that they are in possession of appropriate skills and knowledge can be rightly rewarded for the same.

Another very positive development this year has been the introduction of the FASSGEM website, and with an increasing awareness of its presence it is my hope that will develop into a stronger and stronger tool for the dissemination of information around our group over the next year or so.

Academically FASSGEM is going from strength to strength; our conference in Portsmouth in 2002 was an outstanding success, and I am sure that everyone who attended the 2003 conference in Wakefield would agree with me that it was of a similar excellent standard (both in terms of its academic quality and also in terms of its social programme). Thanks are due to Juan Ballesteros for all of his hard work as local conference organiser.

The FASSGEM Spring conference held in Chichester was of similar high standard, although unfortunately not attended by as many delegates as we would have liked (it is to be hoped that as the Spring programme becomes more firmly established within our annual timetable we will see more and more interest in the academic opportunities that this one day meeting offers).

Notwithstanding all of the above good news there are still problems for non-consultant career grade staff and

perhaps the major problem is still the niggling issue of remuneration. As I stated in last year's report it was my belief that our remuneration would not be sorted out until the consultant contract had been finally agreed and this has definitely proved to be the case. The Department of Health are expressing every sympathy with our situation but they are adamant that they will not consider any reappraisal of non-consultant career grade remuneration until after the recommendations of *Choice and Opportunity* are implemented.

I have been working through BAEM and Faculty and also through Professor Sir George Alberti (the Tsar for emergency care) who has been a very firm supporter of our needs; but despite all of this high level involvement we have been unable to secure a favourable outcome in negotiations. Efforts will continue!

From a personal point of view my three year term as Chair of FASSGEM is growing towards its end. Under the constitution I would be eligible for re-election and I would like to take this opportunity of stating my intent to stand for re-election next year, but at the same time to invite any other interested parties to put themselves forward. It is my hope and my desire that you as a membership would all seek to support me in re-election, as I would like to continue with the work that I have been doing on your behalf over the forthcoming three years.

In conclusion I would like to pay a vote of thanks to all of the officers of the committee, especially to Dr Carolyn Hargreaves for her unstinting work as secretary (we are still searching for somebody to act as a replacement for her in this role). I would also like to thank all the regional representatives for their involvement and their commitment over the past year.

ANDREW NEWTON
Chair of FASSGEM (Forum for Associate Specialists and Staff Grades in Emergency Medicine); apnewton@fairviewshipham.fsnet.co.uk

News from BAETA

Happy New Year to you all. I hope that you have survived another round of festive parties, turkey induced chest pain, and family feuds. As for your patients, let's hope that these problems of yours didn't affect their care.

The start of the year is always a busy time in medicine. House officers are coming to the end of their posts thinking they know it all. SHOs are wondering how their next job will go. Those SHOs lucky enough to be doing a post in emergency medicine in February are probably wondering how they will cope with full shift work as well as the knowledge that they are part of the most important specialty in the hospital. For their part, consultants and middle grade staff will have their anxieties driven by the fact that there is another cohort of juniors to train and support while keeping an eye on the government's empirical targets. This combination of factors, it would seem, accounts for the relative lack of courses in the next couple of months.

The Royal Society of Medicine has an accident and emergency section that hosts three meetings per year. The first meeting of the year is on the 30th January and is titled ''Acute medical emergencies''. It has the ''usual suspect'' topic list including cardiac chest pain, headaches, and confusional states. These meetings are usually good value educationally and this is also good value financially at £35 for the day. Further details can be obtained from Lulu Ho at the Academic Section of the RSM or you can book online at www.rsm.ac.uk/a&e.

The Royal College of Surgeons of Edinburgh are holding another ''Early trauma and critical care'' event at the college on the 25th and 26th of February. These are reported to be useful affairs aimed primarily (although not exclusively) at SHOs. Email l.judge @rcsed.ac.uk for further details.

BestBets have been published in the *EMJ* for some time now. They are shortcut reviews performed to answer specific questions posed by clinicians in practice. As with any review there are three chief stages in their development: formulation of a question, an appropriate search for the evidence (in the form of publications), and then the critical appraisal of those papers to (hopefully) provide an answer. This process is integral to modern medical practice, especially for UK emergency medicine trainees who have to produce a clinical topic review for the FFAEM (the specialty exit examination). The BestBets group are better known for supporting and publishing these shortcut reviews but are also involved in the teaching of these essential techniques. Courses this year are to be held around April, June, July, and October. For more information, specific dates and further contact details take a look at the website www.bestbets.org.

EMTEL is the Emergency Medicine Trainees E-mail List. It provides trainees nationally with essential information on current matters of concern. To be included on the distribution list contact me at the address below. I will need to know your name, email address, grade, region, and (if appropriate) CCST year.

In addition to this if there are any issues that concern you please do not hesitate to contact me. Have a great year.

STEVE JONES
President of BAETA; steve.r.jones@bigfoot.com

Chelsea FFAEM course

The Chelsea FFAEM course, now in its 4th year, has relocated to the West Middlesex University Hospital, Twickenham Road, Isleworth, London TW7 6AF.

The course date is 26–27th February 2004

Course details and application form can be obtained from:
FFAEM Course Secretary
Miss Denise Phillips
Postgraduate Centre
Denise@wmuhpgmc.demon.co.uk
Tel: 0208 565 5406