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SUPPLEMENT

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The new President of the BAEM

At the BAEM annual meeting in Liverpool Martin Shalley took over from John Heyworth as president. We talked to him about his background and view of the future of the specialty.

Tell us about your career so far

My parents are not medical but I always wanted to be a doctor from early childhood—our GP had a very nice shaped car—a Standard Vanguard. My parents were always supportive, though. My father was made redundant while I was at medical school and I offered to stop doing medicine, but he insisted I stay on. Though I come from Yorkshire I trained at the London Hospital, and after working as a surgical registrar I became the third A&E senior registrar in the West Midlands. I became a consultant in East Birmingham, now Birmingham Heartlands, in 1984. We now have 10 consultants providing 8.3 WTE covering the two A&E departments in the trust so we provide 12 hour consultant presence a day, with six hours at weekends.

How did you get involved with BAEM?

I was elected regional representative for the West Midlands, and also elected to FAEM so I sat on both at one time. In BAEM I got seconded to the College of Surgeons quality assurance committee, and chaired the BAEM clinical effectiveness committee. I watched successive presidents and wondered how they did that. Then when the post became vacant people tried to twist my arm and John said you can do it, put yourself forward.

Will John Heyworth be a hard act to follow?

Yes, he's been tremendous, when you think of all the things that have happened over the last three years. But he's not just going to fade away—I shan't give him the chance.

What will your style be?

It will be friendly—I will try and be very supportive and encourage people to do things. That's not delegation, its involvement. I want to try to involve as many people as we can in the activities of our specialty.

What are your views on the future of BAEM?

There is overlap with the faculty of course and whether the clinical effectiveness committee is BAEM or FAEM doesn't really matter. But I think the trade union aspect of BAEM is probably going to increase dramatically with the new contract. Our trust wants to know what we are doing in our flexible sessions and may insist that we are actually in the hospital. I think the Association in its trade union sense will become busier.

What are your aims for your three years as President?

I think we need to look outside the UK. Europe is a big opportunity for us and we need to get involved in emergency care in Europe. I'd like to see us getting fully involved with a much stronger European society. Whether we like it or not there are lots of doctors in Europe who will come to this country, and we are going to be short of doctors for some years. If we want people to come and work here in emergency medicine we have to get involved in setting pan-European standards.

What do you do to relax when you're not at work?

I play golf very badly. Someone once asked me why I don't have any old golf balls—I don't keep any long enough! The other thing I've been doing for a few years now is a wine studies course. I sometimes wonder if when I stop working as a doctor maybe I will start doing wine tastings for people or working for a wine dealer.

West Mid Chelsea FFAEM course

"This course was instrumental in me passing the exam"

"This course brought my SpR training years together for the exam"

"Friendly, exam oriented young faculty who had all passed the exam"

The course, in its fifth year, is at the West Middlesex University Hospital, Twickenham Road, Isleworth, London TW7 6AF

The course date is 23–24 September 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)

Musings of a Tsar

Winter is now officially behind us! Slightly surprisingly the Winter Report appeared on the day after the official ending of winter—equinoctally at least. Just as surprising the news was good and accepted as such by the media. One of the main headlines was that more than 92% of people were in and out of emergency departments in under four hours—a sustained and steadily improving figure. This is of course a tribute to the very hard work by departments up and down the country with many new innovative approaches being taken. The ambulance service also received a good mention, as did our surgical colleagues. There has indeed been a noticeable surge in four hour performance recently, which could just possibly be related to the ''bonus'' available to those trusts averaging 94% for March.

Despite the upbeat note of the Winter Report and the modestly optimistic messages sent out by the Secretary of State and myself, I also delivered a cautionary note for the immediate future. This was also the tenor of the message given to the press by John Heyworth—albeit he spoke a little more forcefully—as he tends to!!

The hard reality is that we still have to reach 98% by the end of the year; this is a major further improvement for many, some of whom are struggling to reach or sustain 90%. It is worth emphasising none the less that there has been a large shift to the right in overall performance and several departments are now consistently hitting more than 97%. Even so the last few percent is really challenging. It would not be so hard if we had all the staff and facilities needed—but that will take years rather than the months available. There are also several boobytraps to be negotiated in the near future. Thus the new out of hours arrangements for primary care have sent a frisson of worry through emergency departments; the new consultant contract also has the ability to derail arrangements for admitted emergencies; the European Working Time Directive comes into force on 1st August; and finally the creation of foundation trusts could alter local priorities.

The biggest concerns have been focused on the new out of hours arrangements. These could result in increased activity for emergency departments. There is some evidence of this occurring already due to media gloom being picked up by patients, although some of the increase is undoubtedly due to the public knowing they will be seen rapidly in emergency departments. The true extent of GP withdrawals from out of hours services will not be known for some time, and the problem may have been overemphasised. I have been impressed by some economies, however, where GP out of hours services are being collocated with walk-in centres or urgent care centres, and are planning to work closely with the new emergency care practitioners (nurses or paramedics) who will do much of the first contact care with the GP as medical back-up. This model may well become the norm for the future with urgent care centres (walk-in centres/minor injury units) being either next to emergency departments in acute hospitals or free-standing in the community. Hopefully they will absorb some of the load currently being managed by emergency. All we can say at present is ''watch this space'' but all of you could helpfully be discussing the future with your PCTs.

The other big worry is the European Working Time Directive. Emergency departments are chronically short of SpRs but many do have experienced staff grades who are already sharing much of the burden out of hours. Of more concern are medicine and surgery where maintaining appropriately experienced staff on a 24/7 basis will be extremely challenging. Even more ''challenging'' is the situation in obstetrics and paediatrics where the calculated deficits in SpR numbers to mount fully compliant rotas run in the hundreds. All of this could derail our efforts to improve the workings of the interface between the emergency department and the rest of the hospital. Much better integrated working between specialties will be needed.

Despite all this I remain not totally down-hearted! We (you!!) have moved a long way in the last two years and patient care and experience has improved beyond recognition. We need to continue to press for the changes which will further improve matters. Major attention is being paid to the interface between emergency departments, medicine, and surgery and to overall bed management where major advances can be made even with current resources. There is also much to be gained by establishing active, aggressive emergency care networks involving all partners. These can and should focus on the whole system and identifying where both short term and long term gains can be made.

We shall shortly be publishing further checklists on mental health emergencies, the emergency department/medicine, surgery interface, and networks. All of these have had considerable input from professionals such as yourselves. I of course welcome comments and suggestions from you. I have had many already, some of which were constructive!!

SIR GEORGE ALBERTI
National Director Emergency Access

To contact the editors:

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Consultant appointments January to March 2004. 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
David Alao	Derriford Hospital	SpR, South Western
Francis J Andrews	Whiston Hospital, Mersey	SpR, Mersey
Herman Chui	Weston General Hospital	Consultant, Australia
Matthew W Cooke	Birmingham Heartlands Hospital	Honorary consultant, Coventry
Sarah Crawford	Alexandra Hospital	SpR, West Midlands
Melanie C Darwent	John Radcliffe Hospital, Oxford	SpR, South West
Angela J Feazey	Maidstone and Tunbridge Wells	SpR, South Thames
Ramzi M Freij	Queen's Medical Centre, Nottingham	Consultant, Kent and Canterbury Hospital
Fiona K MacMillan	Furness General Hospital	Consultant, Queen Mary's Hospital, Kent
Julian Redhead	St Mary's Hospital, London	Consultant, Ealing Hospital
Michael Sach	Torquay Hospital	Consultant, West Suffolk Hospital
Daranee Saungsomboon	Derriford Hospital	Consultant, Gloucestershire Royal Hospital

Valedictory presidential pearls

Timing, I understand, is everything. I am therefore completely mystified as to how I found myself in the presidential hot seat during a period of spectacularly frenetic activity in emergency care.

The past three years have seen an absolute tsunami of change. We have all embraced a new lexicon as a result of the reforming emergency care initiatives. Previously I don't remember ever using the word ''breach'' as a verb or a noun. I could use the words target and four hours together or individually without any coronary artery spasm. ''See and Treat'' was over the horizon. George Alberti was still best known as the President of the Regents Park College.

Things have changed …….

There is no doubt that the four hour target has been the absolute driver for change in our departments on a scale that is unprecedented. Much of this has been to our patients' and our departments' advantage, with increased (although still limited) resources. At long last, the emergency department has achieved the highest priority in Chief Executives' consciousness. All of this is, of course, long overdue and there is still much catching up to do, but the increased focus and investment in emergency departments has reinforced to all parties the pivotal and fundamental role which our departments have in the management of the emergency patient. The profile, reputation, and position of our specialty have achieved new levels.

Of course, the waters have not always been smooth. The initial ''See and Treat'' proposals generated real concerns regarding the lack of additional staff to deliver this service consistently and the potential distortion of priorities within emergency departments, with senior medical and nursing staff being taken away from the critical care areas to see less seriously ill and injured patients. The four hour target has expedited the progress of many patients through our departments, but there remains concern with regard to the impact on the quality of care which patients receive. We are all aware of examples where patients have been transferred from our departments precipitously, not always in their best clinical interest, to stop the clock ticking. The inadequacy of time *per se* to provide accurate measure of the quality of care provided has been promoted at meetings with the Department of Health representatives and we are pleased to note that CHAI is developing measures to address the quality issue. During the mad March measuring period of 2003, particularly, there were concerns with regard to the ''creative interpretation'' of data to create a far rosier picture that was in fact the case, and the *ad hoc* designation of corridors as wards to satisfy the time criteria! I hope those manoeuvres are now essentially historical.

We are not there yet by any means. Emergency care in general and emergency departments in particular have been a major focus in the media and Government thinking. I believe that we have and will continue to make the absolute most of this once in a generation opportunity. However, the collaboratives are concluding this year and there are concerns that the drive for change, additional investment etc, will lapse if there is any reduction in the level of pressure from the centre to deliver sustainable changes. Certainly George Alberti recognises the timescale required and his forthcoming document ''Vision 2010'' reflects the period which will be necessary to change a system that has been neglected for 25 years. Similarly, the impact of Modernising Medical Careers and other training initiatives will ensure that the Presidents of the Association and Faculty will be kept busy for the foreseeable future!

Being President is a quintessential team effort. It would simply be impossible to perform without the unstinting efforts of the Executive Committee, the Council, and the Gibraltar-like rock of support that is Julie Bloomfield in the BAEM office.

Much done. Much still to do. Ours is the most vibrant, dynamic, and rewarding specialty. It has been a privilege and an honour to serve as President during these past three years. As I disappear into the sunset, the reins are handed over to Martin Shalley who I know will be a superb President of the Association.

JOHN HEYWORTH

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News from BAETA

BAETA Conference 2004

The BAEM meeting in Liverpool was a raging success and our attention now turns now to BAETA's own annual conference which this year is taking place in Cardiff. The dates are the 6th to 8th of October and, as usual, the programme is a mixture of mainstream, and non-mainstream, emergency medicine topics. The price will include accommodation and will represent the best value for your study leave budget of any event that I am aware of. All trainees, of any grade, are welcome to attend and as usual there will be a poster session and presentation prize. This is an excellent way to gain valuable presentation practice, especially if you are contemplating going to the Faculty meeting in November. Application forms and a full programme will appear on the website (www.baeta.co.uk) shortly.

Courses

The course ''season'' slows down soon as the academic summer holidays approach. The Accident and Emergency Section of the Royal Society of Medicine is holding a meeting titled ''Sports injuries in A&E'' on Friday the 27th June. If the sports topics at the BAEM meeting in Liverpool are a guide then this should be an informative day. The meeting covers various topics on the theme including doping and legal issues. The event is a bargain at £35 for non-RSM members so is worth a look just on the basis of cost alone. Further details are available from the RSM on 020 7290 2987 or email at a&e@rsm.ac.uk.

We all use our study leave budget on different events and I hope that some of the courses listed here are of use and interest to most of you. If you do go to any courses or meetings, especially if they aren't mentioned here, then please do give me some feedback if you found them beneficial.

News

As ever the EMTEL mailings provide the up-to-the-minute news for you to be aware of. There are, however, some topics currently on the boil that we as emergency medicine trainees should be aware of, as they will invariably have an effect on our practice. I will not give full details here as this would take up too much space, however full details can be found on the web.

The European Working Time Directive will profoundly affect our working lives, patterns, and training. As emergency medicine trainees we will be used to full shift working, but some middle grade rotas still use an on call pattern. From later this year this will not be an option as it will be too expensive for trusts to run. Most trusts have a middle grade tier that is dependent on non-training grade doctors. Many of these doctors will be affected by this ruling too. If there has not been change already, it will be imminent. Involve yourself early with your consultants and human resources departments or change will be foisted upon you. You have been warned.

The European Working Time Directive and the changes in staffing (in the face off too few doctors) have directly spawned the Hospital at Night Project. This is a joint effort by the Department of Health, the BMA, and the Royal Colleges to provide acute services

overnight in hospitals. The main driver for this project was the recognition that not every task that occurs during the night-time period needs to be performed by a medically qualified person. As a result, a series of core competencies have been identified. When the project rolls out, a team with these competencies will be developed in each hospital to provide this hospital at night cover. The reason that you need to be aware of this project is that the core competencies look very much like emergency medicine/anaesthetic/critical care based. Beware.

EMTEL

EMTEL (the Emergency Medicine Trainees E-mail List) continues to flourish as one of the core sources of information for trainees nationally. If you want to be included on the list to receive the quarterly messages then contact me at the address given below. A copy of the current EMTEL message can be seen on the BAETA website (www.baeta.co.uk).

I look forward to meeting you later in the year in Cardiff. In the meantime if there is any matter that I may be able to assist with please get in touch.

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

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Round up of forum news from FASSGEM

First and foremost I would like to thank the membership of FASSGEM for their vote of confidence in re-electing me for my second term as Chair of FASSGEM. During my next three years in office I sincerely hope to see the national reformation of the non-consultant career grade (NCCG) structure come to pass and with it the improvements in working conditions for staff grades and associate specialists that we have been campaigning for. It is also my intention to institute a process of constitutional reform within FASSGEM to alter the representative structure to improve our ability to represent ourselves at key medicopolitical meetings.

The recently received report from the Doctors and Dentists Pay Review Body 2004 has been a great disappointment. Once again it had been hoped that the Doctors and Dentists Pay Review Body would have seen fit to dramatically increase the level of pay given to staff grades to rectify some of the gross inequalities that exist between staff grades and other sections of the medical workforce. Regrettably the Department of Health is clearly sticking firmly to their decision not to restructure the pay scale for NCCG doctors until the process of restructuring those posts have been completed. A double disappointment therefore is the fact that the negotiations on the new NCCG contract appear to have been delayed (at the current time there is no indication as to when these negotiations will actually start).

FASSGEM are continuing to apply pressure to the Department of Health to move issues forward with all expediency as the recruitment and retention of staff grades and associate specialists within emergency medicine will shortly become even more challenging a task than it has been of late (as a result of the implementation of the new GP contract on the 1st April 2004).

The delay in implementing changes to remuneration and also contractual changes has led to the British Medical Association advising all staff grade doctors who are in a position to do so to seek immediate regrading to associate specialist. The following is a summary of what they have recommended:

Regrading from staff grade to associate specialist: the current advice from the BMA

Many staff grade doctors (and other NCCGs) are working at associate specialist level. This has been shown through various surveys. It is therefore unfortunate that these doctors are not being properly rewarded or recognised for their work. This is both unfair and demoralising, and has a negative impact on trusts as well as the individual doctors concerned.

The benefits to trusts of regrading staff grades to associate specialists are numerous and far outweigh the small cost involved. The benefits include:

- Retention of experienced, highly skilled senior medical staff.
- Improved medical staff morale.
- Recruitment of new doctors—a commitment to career progression for SAS doctors will attract new staff doctors to the trusts.

The BMA's Staff and Associate Specialists Committee (SASC) has urged all trusts and employing authorities to regrade to associate specialist all those staff grade doctors and others who are already performing at the level of associate specialist.

Current procedure for regrading

The minimum entry criteria to the associate specialist grade are:

(A) Ten years medical work (either a continuous period or in aggregate) since obtaining a primary medical qualification which is (or would at the time have been) acceptable by the GMC for full, limited, or temporary (but not provisional) registration; and

(B) A minimum of four years in the staff, registrar, specialist registrar or equivalent* grade, at least two of which should be in the relevant specialty.

In addition to satisfying the minimum criteria for entry to the grade, applications are usually judged on a range of other criteria such as experience, clinical expertise, quality of patient care, multidisciplinary team working, and audit work. These criteria can be assessed through the applicant's CV, from referees and, if one is held, at interview.

The regrading procedure is now standardised in Scotland, Wales and Northern Ireland, although there are differences between each country. In England, however, there are significant differences between trusts. The BMA's SASC has advised all trusts in England to adopt a model procedure for regrading to associate specialist.

In conclusion I would like to remind all members that our Annual Conference will take place at the Kensington Close Hotel in London between Wednesday 24th and Friday 26th November 2004. The constraints on booking accommodation in London have meant that we have had to make a significant down payment at to cover our anticipated accommodation booking. We therefore need registrations for the conference as soon as possible so that we can cover our costs. In addition it maybe difficult for those who make late bookings to secure accommodation within the conference hotel and therefore if it is your intention to attend and be resident within the hotel early booking is highly recommended. Full conference details and booking information can be found on the FASSGEM website www.fassgem.org.uk.

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

* Equivalent service is acceptable with the agreement of the appropriate college or faculty regional adviser and of the postgraduate dean.