SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

We had the first meeting with specialist groups joining the fray and it was very productive, with considerable overlap between the groups. One of the aspects that provoked a lot of interest is the Core Medical Training proposal that would mean that all Core trainees would spend three months in ICM. If this comes to pass, there will be potential for a surge in resident trainees on our units, albeit at a junior level. In our ICU we have foundation doctors contributing to the workforce, and we have found them to be an excellent addition, so I can only see the additional workforce as a positive step. I can also only see positives in training all our future physicians to feel more in tune with the deteriorating patient, and giving them a feel of what patients or relatives might realistically expect from escalation to Intensive Care.

So how do you organise your resident staffing? The out-of-hours workforce on our unit has changed over the years and has F2, F3, ACCP and ACCS trainees as a core group, supplemented by anaesthetists and perhaps one ICM trainee. Most of the Anaesthetic SpRs in Wales do their three month ICM blocks in tertiary centres so the availability of more senior anaesthetists for ICM is restricted in the DGHs. Although we do have some excellent staff grades already in post, recruitment is not easy at present even if funding is available. We have certainly found it easier to staff an extra tier with non-airway trained doctors (although they are ALS trained) and they work alongside the theatre anaesthetists and the obstetric anesthetist as a team during out of hours. We have been very impressed with the way that this in-hospital support works, and we have also experimented with trying to keep the same three together, to develop stronger team working.

The anaesthetic trainees have been great, very supportive, and spend their time on the unit if quiet elsewhere so it does seem to build some extra resilience into the system. The skill set varies depending on the doctors, of course, but one of the plus points is that in a DGH everyone knows each other, so there is no mystery about the resident on call or the consultant on call, and this helps communication greatly. Although some of the trainees are relatively junior a big plus point is that they are trained in your unit, so they know the system, when to call and what is expected of them. We find them excellent, enthusiastic, diligent and sensible.

Lastly there have been a number of requests for guidance from smaller units, and a decision was made to develop some interim guidance on governance until GPICS v2 comes out with a more definitive take next year. This was duly put to the Board and released for general consumption. This is a dynamic document and we are happy to work with any feedback to adapt the guidance with time.

Faculty Calendar

2nd February
FICM/ICS Joint Standards Committee
5th March
Regional Advisor/Faculty Tutor Day
12th March
FICM Careers, Recruitment & Workforce Committee
20th March
FICM Training, Assessment & Quality Committee
9th May
FICM Board
24th May
FICM Annual Meeting: Mind the Gap
8th June
6th Annual ACCP Conference
11th June
FICM Careers, Recruitment & Workforce Committee
21st June
FICM Training, Assessment & Quality Committee
11th July
FICM Board