SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

The three chapters for GPICS V2 on remote and rural, cardiothoracic and neurocritical care units have been submitted. Next up is editorial adjustment and review, and hopefully the new version will be out in January 2019. I thought it might be useful at this point to go over some aspects of the remote and rural chapter. It is not, in the end, anything to do with smaller units vs big units. In fact, there has been a bit of a change over the last 10 years anyway, and a vague atmosphere of mutual acceptance and support has gently crept into the specialty.

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One of the elements of difficulty for smaller remote hospitals is maintenance of competencies for critical care staff. Staff may be required to look after all age groups, from neonates to adults, and may be required to look after them for a prolonged period of time. Furthermore, some conditions may occur very infrequently and keeping knowledge and skills up to speed is crucial to providing safe care to their population. Solutions such as cross-site working are more feasible for hospitals in close proximity, and periodic attachments to larger units may be more appropriate. Networked solutions such as telemedicine and video-linkage are areas that need stronger development, and could provide a key for better integration across a region.

Transfer services are an integral part of the system, not an add-on. For example, there can be difficulties in getting prompt attention for time critical transfers if the ambulances are overloaded. In our region, ST elevation MIs are not regarded as a priority by the ambulance service once through the doors of ED (they are now in a place of safety) and therefore getting onward transfer to our PCI centre is not necessarily straightforward. In smaller hospitals, transfers also deplete essential staff and systems need to ensure that this is minimised.

Lastly, sustainability of the service is an important part of future planning. Elements of the new chapter explore this area in the context of staffing and support in smaller hospitals. Inevitably, the link with the wider services in the hospital is an essential part of this, and work is ongoing to explore acute services more holistically such as the acute medicine take. Trainees vary in where they see themselves in the future; while some want a big hospital or urban area, others want a rural lifestyle. Talking to our trainees, we have a very substantial group that want to stay in the area and inevitably they graduate to general practice that allows them to stay local, both for training and their eventual permanent job, buy a house and get on with their lives. Can we offer this sort of stability to our trainees? It's difficult. Clearly they need to have rotation as part of their training but perhaps we can look at improving the lifestyle for those wanting to base themselves in one area. I have had foundation trainees who love ICM (and are very good) who have said their ideal job is GP/ICM in our area. It would be interesting to explore the possibilities. I suspect this is an extra cohort and would swell the potential numbers of ICM clinicians but, I can't see an easy way to develop this. Although some parts would be excellent, I'm not entirely sure of the skill mix. Perhaps in the first instance, we should increase rotations to remote and rural areas for those interested, and in the meantime explore innovative solutions.