Smaller Units Advisory Group

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Smaller units are generally situated in smaller hospitals, exceptions being specialised units. Withdrawal of critical care services to these hospitals is clearly a non starter and so we are left with two options: either the hospital should close and amalgamate with another to form a bigger acute hospital, or we look at how best to deliver the critical care to the hospital as it stands.

As we do not work in isolation, we need to make sure we see the wood clearly through the trees. The population is getting older and there are an increasing number of elderly, frail patients requiring hospital care. This group benefit from having care as close to home as possible. Quite apart from the difficulty for relatives and partners once a patient is admitted, there is evidence for a distance decay effect where patients are less likely to utilise care with increasing distance. This effect is particularly seen in vulnerable groups such as people on low incomes, the elderly and those with disabilities.

The Nuffield Trust has an active campaign at present challenging the accepted view that 'bigger is better'. The Academy of Medical Royal Colleges and the Nuffield Trust recently held a meeting which looked at services in smaller hospitals and geographically remote locations. The meeting was attended by a surprisingly large number of the great and good and the conclusions of the day were overwhelmingly in favour of supporting these hospitals and exploring ways in which effective care can be delivered, accepting that models may be different from those in larger hospitals. The King's Fund published a paper in 2014 looking at evidence for reconfiguration and found no evidence that there were any financial savings in reconfiguration, and that increased quality was limited to a very small number of specialties such as vascular and trauma care.

With the background of wider support for local hospitals to retain acute care, we have to provide sensible support to those patients who either present with critical illness or develop it once in hospital. It is not financially or logistically realistic to provide this to tertiary centre standards, and this is a conundrum for us. All care should be provided to the same standards, which is reasonable as long as those standards are causally linked to outcomes. In many smaller, or medium sized, hospitals they come up shy of one or two standards but outcome measures are good.

So to the Smaller Units Advisory Group (SUAG); we tried to define a 'smaller unit' which led to quite a wide-ranging discussion. We found a lot of the issues we are looking at affect many medium size DGHs as well. The discussion to date has resonated with specialist and military units who also have also contacted us. It is a term therefore used loosely to include any unit that feels they need support and although perhaps aimed principally at DGHs initially, it is clearly a broad church.

We have reviewed the GPICS document and looked at areas of difficulty for smaller hospitals. We have heard from a number of hospitals and units with a variety of problems and potential solutions. Our next step will be to work with the Joint Standards Committee to explore how these units can help by contributing to further editions of GPICS.

Thanks to the group for their input which has been refreshing and edifying. We are all very keen to hear what is happening at the grass roots level. Do get in touch if you want to discuss things.