Smaller Units Advisory Group

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Chair
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The group had their second meeting in November and several strands are coming together. We met with the Joint Standards Committee in December and discussed the opportunity to include of a chapter on smaller and rural units in the next version of GPICS, an approach that seems sensible. As I have previously mentioned in Critical Eye the SUAG have reviewed the GPICS document and in fact the majority of the document is helpful to units of all shapes and sizes. There are elements however that are not so easily met for some units, and focus will need to be brought on how to address these.

The CQC has been visiting units around England as part of their hospital visits. Wales, Northern Ireland and Scotland have different arrangements; in Wales unit visits have begun through the Critical Care Delivery Group, a collection of clinicians, nurses and managers working under the auspices of the Welsh Government. Results from the CQC visits are freely available on the website; the summaries can be clicked on to give a decent overview but there is real meat in the full report.

Assessment against GPICS is only a portion of the report which is divided into 5 sections namely Caring, Responsive, Well led, Effective and Safe. These sections are scored as Excellent, Good, Requires improvement or Inadequate and are then combined to give an overall rating along the same scale. Out of 194 responses we had 15 outstanding, 112 good, 62 requires improvement and 5 inadequate. To reach an overall rating of 'requires improvement' at least two of the subcategories must be at that level or worse. Reading through some of the reports it is clear that there is a sticking point with some aspects of GPICS but in most there are additional reasons why a 'requires improvement' assessment is given.

The Nuffield Trust continues to provide a solid forum for rural and remote healthcare, and the latest meeting in London brought together clinicians, managers, nurses and politicians to discuss how to support and develop these essential services.

In Scotland one of our SUAG members, Catriona Barr from the Shetland Islands, has to deliver a critical care service for a population of just 23,000. The context of delivering a service in this geographically isolated hospital is clearly different to that of an urban hospital. Although most patients can be dealt with independently one of the integral parts of the solution is networked contact with larger mainland units. An interesting paper on this came out of the Dutch networks in 2015[1]. Essentially all units in Holland were included in a revamp of critical care services. Units were separated into 3 sections according to size and staffing requirements, common QA processes were introduced and an annual report was required. Patients anticipated to be ventilated for >72hours in a Level 1 unit (the smallest) were to be discussed with a higher-level unit.

Following introduction of the system it was found that outcome measures were as good in smaller as they were in bigger units, with transfers at 4.2%. I like the way they went about it: introduction of robust common QA processes and increased communication seem obviously sensible. We also have the prospect of telemedicine raising its hand eagerly at the back of the class. Or perhaps the front. And I suspect this will be an integral part of networked critical care in the not too distant future.

1. The association between ICU level of care and mortality in the Netherlands. GH Kluge, S Brinkman et al. Intensive Care Medicine 2015: 41; 2: 304-311