Ivory Towers and the Coal Seams: Are smaller units being ignored?

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How is policy formed within the critical care community? Are consultants from large teaching hospitals setting the agenda for how critical care should be delivered in all hospitals? Did the Core Standards for ICUs, and subsequently GPICS simply reflect what large hospitals already do? Are critically ill patients best cared for in tertiary centres? Are there other models to run a sustainable effective critical care service in smaller hospitals? Should all acute hospitals have an Intensive Care Unit? Is 'stabilisation and transfer' a realistic prospect for acute hospitals? Is teaching better in bigger than smaller hospitals? What is a smaller hospital anyway? Does SMR matter and can we use it to compare hospitals? And how on earth can we get more trainees, residents, consultants, nurses, beds in this time of financial constraint?

In reality we are all at the coalface. Speaking to colleagues in different hospitals I certainly do not get the impression that either bigger or smaller units have the monopoly on hard work. In fact the overriding consideration appears to be when demand outstrips supply – when the dose of critical care expertise available is not enough. This critical factor seems to dominate most units and there is certainly not enough 'dose' to go around, and we are stretched beyond sensible workload. We have made substantial inroads over the last 30 years and obtaining resource locally has been aided by high profile national campaigns that have raised awareness of ICM as a cornerstone of acute care. The FICM and the ICS have therefore been essential voices to establish our specialty. Combining national support with local pressure has helped improve resources for all sizes of units. We are still behind the curve though.

So is there a separation between big and small hospitals? There is no doubt that there is a cohort of consultants who feel that ICM should be delivered in centralised units, perhaps supported by stabilisation and transfer services in smaller hospitals. It is probably of no great surprise that these voices emanate from bigger rather than smaller hospitals. While they are obviously committed to developing ICM they do have an inherent bias, as of course do we all. Can someone working in a large hospital really represent the needs of a smaller DGH? Partially, of course – in the same way that someone in a small DGH can understand the problems in a large teaching hospital – but clearly all are influenced by their own experience.

Does GPICS favour big hospitals over small hospitals? We must bear in mind that development of Intensive Care Medicine as a specialty in its own right has been a battle fought over an extended timescale. It has been an essential part of the battle to draw a firm line in the sand to distinguish what makes up properly delivered Intensive Care Medicine. This line in the sand has developed over the years and finds its way into recommendations and standards that clarify to all the perceived essentials of the specialty. Use of standards and guidelines are a way of exerting pressure for change and are very helpful but there are risks. One risk of standards is when they are formed by a group who look inwardly at what they already do and use this as a template for what all should do. While this has advantages of clarity, it loses an aspect of Darwinian evolution – other potential models are closed off. Standards have also been used for self-interest since medieval times when the Guilds used them to put

competitors out of business. So yes, they do favour big hospitals. Many units will struggle to meet the standards and it remains to be seen how this will be addressed. It is worth looking beyond the black and white of standards however and exploring the discourse accompanying the GPICS headlines, for example Gould and Danbury's section on Consultant Staffing helps to provide context.

Is this important? Despite our progress we are still a young specialty, and as such it is essential that all units and staff feel supported by the national bodies. We need a strong, cohesive base to build over the next decade. The FICM has no intention of positioning itself as a national body that supports only big units. The number of smaller units within the UK is surprisingly large. Furthermore there is little evidence that larger hospitals provide better outcomes in the UK. Support from national bodies must therefore be pitched at a level that is helpful rather than a hindrance to our wide base of units. Start with a broad base, and build tall. Chop your base down at the start, and watch it all topple down around your ears.

Training is another area of contention. Clearly trainees need a programme that gives them the opportunity to sample the variety of units that serve our hospitals. Most trainees end up in hospitals where they have spent time during their training, and it makes sense to give them a broad exposure. Trying to centralise training to just a few units when a large amount of work goes on in other units is a strategy that supports the few at the expense of the rest. There is no evidence that training is better in big hospitals, and there are substantial benefits of having training as part of your unit's activities. Large units are particularly valuable for higher-level trainees, but the DGH can give a great combination of individual mentorship and experience at earlier stages. One of the differences between big and small units is that bigger units tend to need enough trainees to staff complete tiers and are therefore 'trainee hungry' whereas smaller units use multiple sources for their resident rota of which trainees may contribute 2 or 3 slots. Of overwhelming importance is the ethos of the unit.

Are there other models for delivering critical care? Yes, without a doubt. Given the scarcity of resource perhaps the time has come to be more open about other models of delivering effective care in smaller hospitals. Following a template used by big hospitals can be constraining and potentially not sustainable. Having a workable structure that grows over time is more important. The truth is that we do not currently know how best to deliver cost effective Intensive Care and while it may turn out that big centralised hospitals are best it might equally well turn out that this is not the case. I suspect that both bigger and smaller units can be equally effective and outcomes depend more on the quality of the staff than a given size per se. Let's explore what is out there at the moment and see what lessons can be learned.

So what next? There is within the Faculty a growing understanding that we need to understand and work with smaller units to ensure broad based expertise feeds in to national committees. There are many aspects of working within a DGH that may not be accurately represented in the working groups that make up the FICM. This is something that the FICM takes seriously, and there is now a plan to develop a smaller units working group. The remit of this group will be to inform the board of successes and difficulties in providing critical care services in smaller units, to comment on relevant documents produced by the FICM and how they fit with current and projected care within smaller units and to provide a conduit for smaller units to access advice and practical guidance.

So in drawing all this together – we are taking steps in the right direction and standards and guidelines have been helpful in this. We are moving at a fast pace ideologically within the FICM but resource is slow to back up ambition and there will be inevitable gaps. There has been a preponderance of large unit input into national bodies, and the Board is keen to address this potential bias by the formation of a smaller units working group to inform and discuss issues that affect these units. Both Larger and Smaller units can deliver safe, effective critical care but we need to openly explore sustainable models in more detail.