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EDITORIAL

In networks we trust

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The best care for critically ill patients depends on several factors, such as the availability of care within a certain distance and time, and offering care on a scale that ensures caregivers will remain adequately skilled. In the Netherlands, we are fortunate to have hospitals, intensive care units (ICUs), and caregivers in the close vicinity for most of the population. Furthermore, in 2016, the National Health Care Institute of the Netherlands - Zorginstituut - Nederland recommended working together in networks of ICUs as part of an implemented quality standard to improve care for patients.[1] Networks are a complex of organisations that work together to achieve a specific goal. The goal here is to strive for an adequate amount of beds occupied during an optimal percentage of the time, as close as possible to a patient's place of residence.

In past years, we have seen that within these networks, care for ICU patients is transferred to larger and more centrally located hospitals (i.e., regionalisation). One of the consequences of the regionalisation of care is that several ICUs have been closed down. Some evidence supports the rationale of regionalisation and transferring care. For example, there is a volume-outcome relationship among subsets of critically ill patients that supports the regionalisation of care for specific groups of patients to improve patient outcomes.[2,3] On the other hand, closing ICUs can lead to several risks, such as the best care not being available in all parts of the Netherlands.

In this issue of the journal, Van der Voort et al. describe the trust in contemporary Dutch ICU networks.[4] Trust is defined as the ability to allow your work processes to be influenced by others and is a condition that is present in these networks as an organisational form.[4] The authors performed a survey completed by 85 respondents and concluded that caregivers' trust in the networks and each other is reasonable. Cooperation between intensivists provides the opportunity to discuss care for critically ill patients and to visit ICUs within the network to exchange knowledge informally. Every ICU in the Netherlands has certain specialties in which their care is organised, such as additional training for teams of caregivers, treating specific patient categories, and successful improvement programs. Thus, contact between caregivers allows for optimisation of care in all ICUs by implementing elements of the specialties of others into their own care system, a real example of trust. Regionalisation may result in a reduction of opportunities to cooperate and, therefore, may lead to a decrease in the exchange of knowledge. The ability to consult each other and provide sufficient communication between caregivers may be a reason to strive for an adequate number of ICUs within a network.

Trust in the networks is there. However, in a second article in this issue, Van der Voort et al. show that the governance structure is not optimal at the moment in any of the 15 ICU networks in the Netherlands.[5] The authors concluded that the Dutch ICU networks have different types of governance structures and that these differences can be a risk for the effectiveness of the networks. The method used to study the governance structure was defined by Provan and Kenis and stated that the success of governance depends on several factors of which trust is an important one. Also, the number of organisations within the network, e.g., the ICUs, is a factor as well. The interaction between perceived trust and the number of ICUs has not been studied, and we do not know whether the regionalisation of care leads to a reduction in trust between caregivers.

Another reason to strive for a sufficient number of ICUs within a network is a possible suboptimal occupancy rate of beds. An occupancy rate higher than optimal or even so high that patients can no longer be admitted to the ICU of a hospital in the network does not contribute to the best care. In this case, transferring the patient to an ICU of another hospital is necessary, and by closing ICUs in hospitals, it might be that the next available bed is not nearby. Transfers between hospitals are not uncommon. However, little is known about the influence of inter-hospital transfers on

patient outcomes in patients transferred for logistic reasons only. Most of the data on the effects of regionalisation of ICU care are based on the American healthcare landscape. This system is characterised by a wide variation in the quality of care between hospitals, which leads to a difference in observed mortality, partially attributed to a difference in experience with critical care.[6] The quality of critical care in the Netherlands is frequently monitored, and within networks differences in the outcome of care among ICU's discussed. Furthermore, in the Netherlands, the distance between hospitals is smaller. Some restraint is needed to directly generalise and extrapolate the available evidence to our unique system. On the other hand, this also calls for obtaining data with regards to the influence of regionalisation of ICUs in the Netherlands.

Several years ago, intensivists were questioned in a survey regarding the perceived barriers to the regionalisation of ICU care. The survey had an effective response rate of 569 out of 1200 intensivists (53%). The most prominent perceived barriers were a personal strain on the patient's family, the lack of strong central authority, and the potential to overwhelm capacity at large hospitals.[7] Another perceived barrier was the risks accompanying the transport of patients between hospitals.[7] As previously cautioned, these data were obtained in the American system, and not all perceived barriers may be directly transferable to the system in the Netherlands.

Regionalisation is a fact in the current networks. Physicians have trust in these networks, but there is still room for improvement regarding governance structures.[4,5] Nevertheless, we believe that the optimisation of communication between ICUs, intraregionally and even interregionally, is also necessary to distribute care more efficiently. For this to work, trust is essential, as well. We believe it is an illusion that single ICUs in a large area can take care of all patients in a region. Communication on future strategies of regionalisation and collaboration within the networks seems mandatory too. All of these barriers need to be addressed to allow the success of the currently implemented system and to ensure its sustainability.

Disclosures

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