



Modernising Patient Pathways Programme

High Dependency Unit (HDU) Critical Care Small and Remote Pathway

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Background



Access to all levels of critical care in small and remote hospitals* can be challenging - particularly for High Dependency Unit (HDU) care. While there are well established pathways for Intensive Care (ICU) transfers, HDU-level care is not always clearly defined in small and remote settings.

This pathway and accompanying guidance have been developed to cover the following:

- Outline quality and safety considerations for patients in small and remote critical care units across Scotland, including the safe transfer of patients between units.
- To provide the key capabilities needed to deliver HDU care in small and remote settings.
- To ensure equity of access to high dependency care in small and remote critical care units, and to support these areas to deliver safe, effective and person-centred critical care.

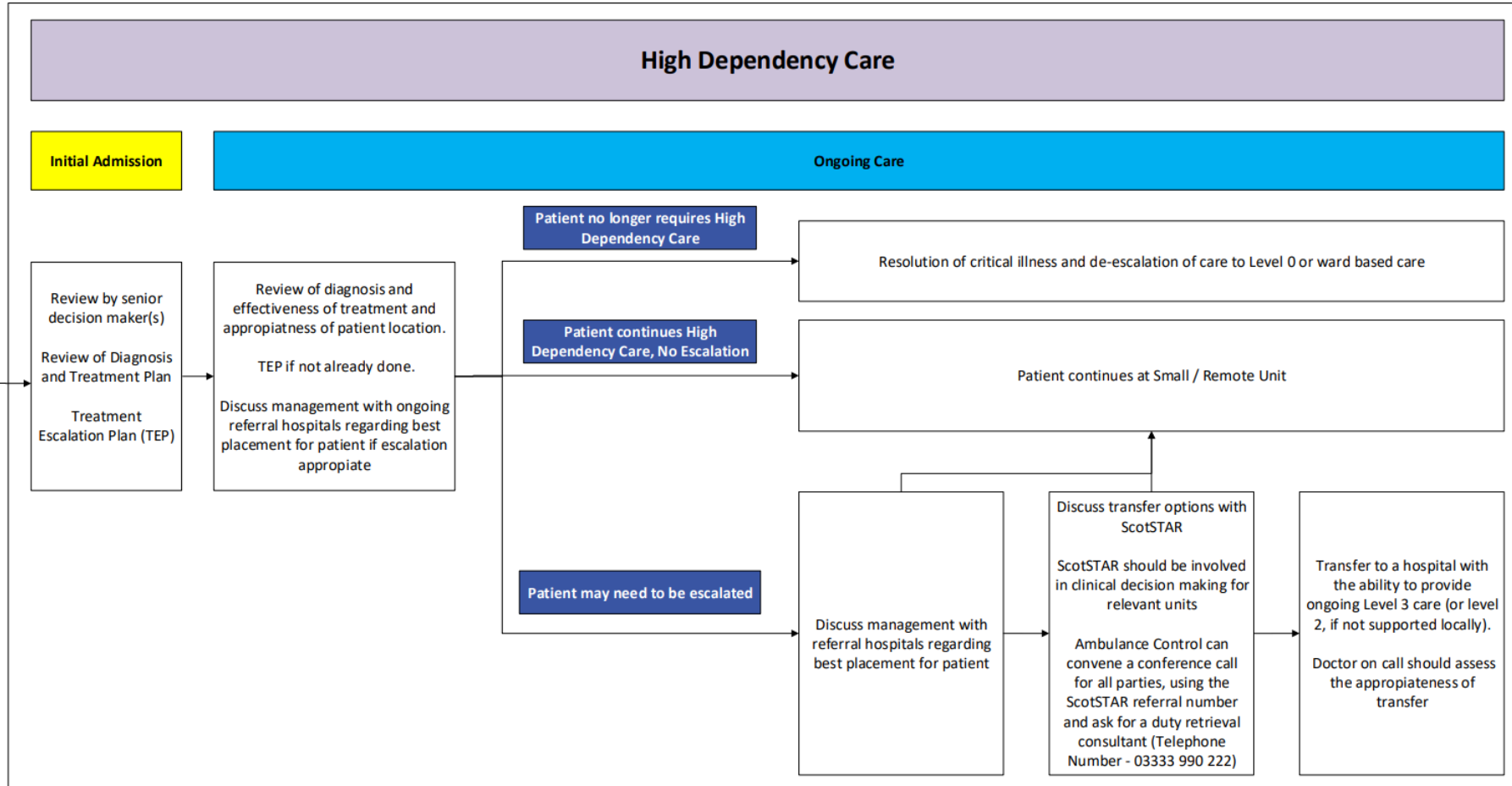
While paediatric and neonatal care is beyond the scope of this document, the principles described may be useful when considering how to escalate care for these groups of patients in remote hospitals as well.

* These are defined in GPICS (Guidelines for the Provision of Intensive Care Services) as small and remote level 2 units with stabilisation and transfer capabilities.

Pathway recommendations



Pathway Overview:



Key Pathway Recommendations

1. Daily review of diagnosis and Treatment Escalation Plan (TEP) for HDU patients in small and remote units

A full review of the patient's condition must be undertaken daily by a senior decision maker(s) (please see definition in Appendix 1) and the Multi-Disciplinary Team.

The review should consider:

- Diagnosis
- Severity of illness
- Reversibility of the illness and existing co-morbidities
- Treatment Escalation Plan (TEP)
- Patients and family preferences for where they wish to be treated
- Capabilities of the receiving hospital
- The trajectory of the patient's condition (i.e. static, improving or deteriorating)

A TEP must be established on admission to the critical care area and may be amended depending on the patient's progress.

Based on this daily review, deteriorating patients should be considered for escalation of care within the small and remote unit, and/or transfer to another facility.

2. Small and remote units should have agreed Standard Operating Procedures (SOPs) with receiving hospitals

All patients with increased level of care requirements and considered suitable for escalation by the Senior Decision Maker, should be discussed with the appropriate intensive care clinician(s) at the receiving hospital.

This process should:

- Support and advice for HDU patients not yet requiring transfer
- Help review the TEP for specific patients

In cases of escalation, the referring hospital must know who to contact and how (e.g. an on-call designated clinician).

If transfer is being considered, the rationale must be clearly documented in the patient's notes.

The final transfer destination will be agreed by all parties and coordinated by, and involve ScotSTAR/EMRS (Emergency Medical Retrieval Service) early in decision making.

A transfer letter must accompany the patient to the receiving hospital.

Receiving hospital specialists must be involved in care escalation and fully aware of the transfer.

Small and remote clinicians should have knowledge of specialist referral pathways (e.g. Neurology, Neurosurgery, Liver and Cardiology).

3. Small and remote units should have protocols in place to support de-escalation of care

These protocols should support patient step down to ward-based care to free up critical care beds and ensure care continues in the most appropriate setting.

Ongoing support should also be arranged as part of de-escalation planning.

4. Health Boards should consider and agree formal transfer pathways for care escalation

Health Boards should confirm formal pathways between partner hospitals and establish Service Level Agreements (SLAs).

During transfers, the required level of care must be maintained. Referring hospitals should ensure that SAS (Scottish Ambulance Service) or accompanying hospital staff have:

- The necessary knowledge, skills and experience
- Appropriate equipment and medications
- Insurance coverage and transport options

They should also be prepared to manage any deterioration during transfer.

Referring hospitals should have strong clinical, operational and governance links with local and regional SAS teams. This should include a joint review of incidents and outcomes (e.g. adverse events, complaints, deaths and failed transfers).

Responsibility for the transfer of a patient lies with the referring hospital, until such a point that the patient is in the receiving hospital. The only exception to this would be where the care of a patient has been accepted for transfer and comprehensively handed over to a retrieval team or one of its members, e.g. an air paramedic.

Further guidance can be found in the [Intensive Care Society Transfer of the critically ill adult guidelines](#).

5. Small and remote units should work with partner hospitals to design, agree and resource sustainable support

This may include:

- Appropriate SLAs in place (as above)
- Ongoing team development
- Access to telemedicine tools (e.g. Microsoft Teams, conference calls)
- Digital tools to support communication and share imaging/results
- Site visits in both directions

High Dependency Unit (HDU) Critical Care Small and Remote Pathway

- Joint training
- Sharing clinical assessment and clinical management tools (e.g. shared documentation)

Appendix 1 – Definitions

Small and Remote Units – Small and remote critical care units are those of a small size (catchment population of less than 200,000) or their remoteness (more than 30km from the next nearest intensive care unit). For the purpose of this group, these small and remote hospitals provide Level 2 beds accompanied by a stabilisation and transfer service for Level 3 care. This definition has been taken from the '[Guidelines for the Provision of Intensive Care Services, The Faculty of Intensive Care Medicine V3](#)'.

Senior Decision Maker - Refers to a clinician, typically a consultant or other highly experienced healthcare professional, who is responsible for making timely, informed decisions about a patient's care, especially at critical points such as admission, discharge, or escalation of treatment.

Specialty and Specialist (SAS) Doctors – SAS doctors (Specialist, Associate Specialist and Specialty Doctors) are experienced doctors in permanent posts. There are two current SAS contracts available:

- Specialty doctors have at least 4 years of full-time postgraduate experience, including 2 years in their relevant specialty.
- Specialists have at least 12 years postgraduate experience, including 6 years in their relevant specialty.

Specialists work independently within their clinical areas. Please note that the below definitions have been taken from the Adult Critical Care Second Edition Consensus Statement:

Level 1 (Enhanced Care) Definition

- Patients requiring more detailed observations or interventions, including basic support for a single organ system and those 'stepping down' from higher levels of care
- Patients requiring interventions to prevent further deterioration or rehabilitation needs which cannot be met on a normal ward
- Patients who require ongoing interventions (other than routine follow-up) from critical care outreach teams to intervene in deterioration or to support escalation of care
- Patients needing a greater degree of observation and monitoring that cannot be safely provided on a ward, judged on the basis of clinical circumstances and ward resources
- Patients who would benefit from Enhanced Perioperative Care

Level 2 (Critical Care) Definition

- Patients requiring increased levels of observations or interventions (beyond level 1), including basic support for two or more organ systems and those 'stepping down' from higher levels of care
- Patients requiring interventions to prevent further deterioration or rehabilitation needs, beyond that of level 1

High Dependency Unit (HDU) Critical Care Small and Remote Pathway

- Patients needing 2 or more basic organ system monitoring and support
- Patients needing 1 organ systems monitored and supported at an advanced level (other than advanced respiratory support).
- Patients needing long term advanced respiratory support
- Patients who require Level 1 care for organ support but who require enhanced nursing for other reasons, in particular maintaining their safety if severely agitated
- Patients needing extended post-operative care, outside that which can be provided in enhanced care units: extended postoperative observation is required either because of the nature of the procedure, and/or the patient's condition and co-morbidities.
- Patients with major uncorrected physiological abnormalities, whose care needs cannot be met elsewhere
- Patients requiring nursing and therapies input more frequently than available in level 1 areas

Level 3 (Critical Care) Definition

- Patients needing advanced respiratory monitoring and support alone
- Patients requiring monitoring and support for 2 or more organ systems at an advanced level
- Patients with chronic impairment of 1 or more organ systems sufficient to restrict daily activities (co-morbidity) and who require support for an acute, reversible failure of another organ system
- Patients who experience delirium and agitation in addition to requiring level 2 care
- Complex patients requiring support for multiple organ failures, this may not necessarily include advanced respiratory support

For further exemplars and context in relation to these levels, please refer to the Levels of Adult Critical Care Second Edition Consensus Statement.

References and further resources



[Levels of Adult Critical Care Second Edition, Consensus Statement](#)

[Guidelines for the Provision of Intensive Care Services | The Faculty of Intensive Care Medicine](#)

[Intensive Care Society | Transfer of the critically ill adult](#)

[Who we are SAS drs 081024.pdf](#)

[BMA Website – Doctors' titles explained](#)

[Guideline for the Provision of Intensive Care Services Version 3](#)

Scottish Intensive Care Society Audit Group (SICSAG) Minimum Standards and Quality Indicators*

*Please note that this new document is due to be published in 2026



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