A report from the conference

Conference design group
November 2010
Critical care: Luxury or necessity?
A report from the conference

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## Conference Agenda

**08.15** Conference registration opens  
Exhibition viewing (Highbury Suite)  
Tea, coffee & pastries

### Session one – The overall climate for critical care

**09:15** Chair for morning: **Nigel Edwards**

**Introduction to the day**  
_Nigel Edwards_  
Acting Chief Executive NHS Confederation

**09:30** Providing high quality critical care in a changing healthcare landscape  
**Candy Morris**  
Chief Executive South East Coast SHA

**10:00** The view from a vertically integrated Provider: what are the implications for critical care?  
**Nick Hulme**  
Chief Executive Croydon Health Services/Mayday Healthcare NHS Trust

**10:30** Questions and discussion

**10:45** Refreshments, exhibition & networking (Highbury Suite)

### Session two – Adapting to financial climate change

**11:15** Understanding the Environment  
**Nigel Edwards**  
Acting Chief Executive NHS Confederation

**11:45** Value driven quality and productivity in critical care  
**Maureen Davies**  
Deputy Chief Nurse NHS London

**12:15** Questions and discussion

**12:30** Lunch, exhibition and networking (Highbury Suite)

### Session three – Financial climate control: emerging models of care and delivery

**13:35** Chair for afternoon: **Dr. Jane Eddleston**

**Introduction to the afternoon**  
_Dr. Jane Eddleston_  
Critical Care Advisor, Department of Health

**13:40** Extending the ICU: problems & solutions  
**Professor Tim Evans**  
Vice President Royal College of Physicians

**14:10** Stretching the boundaries of respiratory support  
**Maria Buxton**  
Consultant Physiotherapist, NWL Hospitals NHS Trust

**14:25** Major trauma and critical care – a networked approach  
**Dr. Bob Winter**  
President ICS

**14:45** Questions and discussion

**15:00** Refreshments, exhibition & networking (Highbury Suite)

### Session four – Weathering the storm

**15:30** Olympics 2012 – the challenge and scope of a national NHS response  
**Russ Mansford**  
Strategic Ambulance Advisor Department of Health

**15:50** Terrorism and critical care  
**Dr. Steve Brett**  
Consultant ICM, Hammersmith Hospital Imperial College Healthcare Trust

**16:10** Critical care evacuation  
**Dr. Ganesh Suntharalingam**  
Medical Lead, Critical Care Network North West London

**16:25** Questions and discussion

**16:35** Key overall themes for Networks

**16:55** Close of conference & vote of thanks  
**Dr. Loua Shaikh**  
**Dr. Ganesh Suntharalingam**

**17:00** Keith Young, Critical Care Lead (DH)  
Retirement Presentation  
**Dr. Jane Eddleston**  
Critical Care Advisor, Department of Health
## 2. Key themes and messages from the conference

### The overall climate for critical care and adapting to financial climate change

1. **Political context:** “Big society” i.e. devolution of power to the lowest level possible, using markets when able and regulation through payment by outcomes when not; held to account through transparency of information.

2. **Implications for health:** commissioning mechanisms; configuration of services and patient flow; emphasis on outcomes, engagement across clinical pathway

3. **Future “big picture”** sets great store in _clinically led_ not just clinically driven services and with clinicians in charge.

4. Much greater influence of primary care (GPs but also many other primary care staff) - individual patient interest via pathways, and collectively via consortia/commissioning mechanism

5. NHS has not had to undertake major changes while also contracting, in a long time. There may be more momentum soon to divert from health to social care.

6. Challenge to keep services running whilst developing new models and achieving radical cost savings.

7. Examples given of horizontal integration (centralisation of speciality services including trauma) and vertical integration (merging of community and acute condition management along clinical pathways). _What will be the impact of locally-led decision-making? What happens to patients who do not fit into a single pathway?_

8. Hospitals are likely to become smaller and ‘hotter’ in terms of acuity. However, shrinking of individual sites may not deliver sufficient savings due to fixed costs.

9. Implication: redesign is high on agenda but will unavoidably involve decommissioning, which is new.

10. Meanwhile: arms length national and regional bodies are being dissolved. Networks are closer to the patient and can provide rational joining up of services and bring clinical expertise to primary care decision-makers. Must not act as forum for competing monopolies.

11. **Future role of commissioning GPs** – it is _not_ a repeat of fund-holding methodology and its not just GPs – other clinical staff must be included.

12. **NICE will be publishing detailed clinical guidelines for commissioning**

13. **Redesign and decommissioning** of some services is high up on the agenda. Decommissioning is relatively new and will be unavoidable.
14. With reduction in “admissions to hospital” there are still the overheads at hospital site - minimal savings so need to change services more radically if funding shift/reduction to happen.

15. Innovative pathway models being developed - driven by Trusts covering both primary care and acute care. May involve a service commissioning utilisation of critical care capacity as part of their pathway.

16. Specialist areas not overly prominent in the white paper – bit of a gap

17. Education /facilitation needed locally to inform /engage with primary care/GPs as potential commissioners of critical care – what level at which to do this? Need to identify the “leads” and the mutual interests

18. Outcomes focus in the future (SMR, LOS, unplanned readmissions, choice of place of death, care bundles CQUIN) - but don’t forget the process measures in critical care given the time lag to outcome.

Financial climate control: Emerging models of care and delivery

**Extending the boundaries of critical care within and outwith acute organisations**

19. Royal College of Physicians targeting pre-ICU care and changing training programmes

20. Use of early warning systems - can be effective

21. Poor pre-ICU care affects outcome for patients

22. Should be Consultant led - so needs to change

23. Importance of MET, Outreach and Hospital at night teams

24. Need to develop models of critical care to support A&E

25. Challenge of more selective resuscitation - consider and debate locally

26. Community outreach can keep patients at home avoiding unnecessary admissions

27. Helps to maximise care out of hospital

28. Extended scope of practice for clinical staff within an acute setting – roving teams with skills – and who cross hospital/primary care boundary

29. Need to increase community based critical care skills and practice

30. Need further development and training for skills delivery in primary care

**Networking with Trauma**

31. National Trauma CAG working on specific areas of trauma care and delivery mechanisms e.g. pre-hospital and network organisation – report with recommendations being released Autumn 2010
32. Networks key to effective trauma management – develop pathways, governance and transport arrangements

33. Are there opportunities to merge some work-streams to deliver economy of scale locally?

34. Importance of rehabilitation - and the challenges it poses

35. Responsibility for patient – needs to be clear

36. Informed commissioning needed – money in the wrong place at present for most trauma care

37. Networks should contribute to and, where appropriate, lead on major incident planning and management of mass casualties within overall EP context and existing structures

Weathering the storm: Emergency preparedness: Olympics, terrorism and evacuation of critical care

**Olympics**

38. Olympics – huge work in progress. Many challenges not least the scale and multiple locations. NHS national response will be required.

39. Many additional events around the country in association with Olympics – not just the big sites affected

40. Funding implications – health care commitment to Olympic family.

41. Incident risk - make sure know the planning locally and that staff availability enhanced (remember its traditional holiday time) for duration

42. National equipment strategy – ensures planning re equipment and some drugs – stockpiles kept

43. HART teams now successfully rolled out with additional skills and equipment

44. Terrorist attack risks are heightened and evidence of Mumbai style attacks planned for Europe

**Critical care and terrorism**

45. Communications challenge – first thing that’s lost - in major and multiple site attack/incident

46. Types of attack changing – more injury and multi sited – also high velocity guns used

47. Need to identify and consider casualty load – critical care activity can be escalating when the ED is empty.
48. Don’t forget forensics and evidence

49. Need to identify locally key staff, right skills in place, roles, training and local solutions.

50. Audience: need for clinical event on handling of response to and clinical management of injuries associated with these types of incident

**Critical care evacuation**

51. Need to plan for evacuation of critical care – at local unit level and at network

52. Learn from previous incidents – reports from Trusts, SHAs and other critical care networks available

53. Varies from evacuating other buildings – need to match patient need to other facilities not just decant outside – critical care understands this – but not all emergency planners do – networks have role in educating emergency responders and planning

54. Build on normal practice, usual roles – don’t create complete reinvention

55. Recognise dependency within and outside the critical care unit – independent patients, dependent patients, very dependent patients. Aim to reduce dependency.

56. Decision making key – activate plan to point of committing

57. Role for networks in coordinating, shared approach, capacity management, sharing learning and supporting exercises

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**Overarching messages for Networks**

**Networks – set up**

58. Networks provide clinical engagement, leadership, and expertise at proportionately very low cost.

59. May be optimally placed in terms of devolution to lowest logical level: clinical networks provide benefits of integration and specialist communication/collaboration training between sites, shared development, and provision of specialist expertise/education to primary care commissioners.

60. Networks can be highly efficient and ‘light’ in resources and funding, close to patient flow and delivery of care.

61. Networks may be best placed to provide clinical leadership and enable/inform new models: regionally optimised staffing (internal bank, skills certification), lean methodology, reconfiguration.

62. With critical care staff costs being paramount, savings to commissioners may easily exceed the relatively low costs of Network infrastructure.
63. May be economies of scale for networks – balanced with key local needs and functionality. Potential for greater collaboration between networks, and/or with trauma in some areas

64. Unlikely to achieve national mandate for critical care Networks – likely to be reduction in overall NHS statutory requirements not an increase

65. No specific answer available on future for networks - may need to gauge this at local level

66. Importance of networks emphasised in relation to clinical engagement, leadership and expertise

67. A need to demonstrate clinical leadership and confidence – at service and at Network level

68. Variation in security felt by networks palpable within conference. Concern from some delegates that more certainty on networks not yet forthcoming

69. Variation in thinking where networks might sit – including
   - commissioning board
   - provider supported
   - Social enterprise approach
   - Public health
   though some delegates thought satisfactory governance arrangement paramount

70. Networks need to ensure they are not working in anti-monopolistic way

**Network behaviours**

71. Need to think differently and in places behave differently and be creative

72. Not get distracted - strong overall mandate for clinical leadership – take advantage of this – opportunities are local. Focus on these.

73. Demonstrate value - at every level.

74. Bringing workforce with us within overall "bigger"change
3. Background to the conference - Introduction and purpose

75. Each year the critical care networks organise a national critical care conference for networks and clinical leads. In 2009, the South East and the North West London Networks agreed to host the 2010 conference. A design team was subsequently established, led by Surrey Wide and North West London Critical Care Networks, with input provided by neighbouring critical care networks.

76. This report provides a summary of the key themes arising from this national critical care conference held on 23 September 2010 at the Emirates Stadium, London.

77. The conference highlighted a range of uncertainties raised by clinical staff and managers. It also spotlit some of the opportunities and challenges for critical care (and for critical care networks) to consider (if they are not doing so already).

78. In writing up this report the design group has also reported on some themes and underpinning messages about networks.

79. The messages and themes are not intended to be exhaustive and many of those attending may well have captured some specifically relevant to them and/or their network.

80. Copies of the detailed presentation slides have been included in handout format in Annex 1.

4. Conference Objectives

81. The objectives set for the conference by the conference design team Terms of Reference in January 2010 were

Conference content
a) To provide a multi-disciplinary strategic and strategic operational themed conference for critical care network leads and lead clinicians within critical care or critical care related services in England;

b) To provide a networking opportunity for all critical care network leads and clinical leads at a national level

c) To consider critical care issues within a national, regional and service related context, linking strategic thinking to opportunities for operational outputs at Network and at unit/Trust level;

d) To provide an opportunity to identify, share and discuss the political and nationally driven DH/NHS context impacting on critical care post election;

e) To consider and share the key challenges, opportunities and threats for critical care within the context of a financially challenged environment;

f) To provide an opportunity for wider critical care engagement in the launch of national guidance relating to critical care and critical care related services;

82. The voluntary design team delivery principles were

a) to maximise access to the conference through smart venue choice with full option appraisal

b) to actively maximise sponsorship to provide a minimum of 200 “free” conference places to critical care networks.

c) to avoid/mitigate any financial risk to the organising critical care networks undertaking the voluntary role of conference organisers.
5. Evaluation

83. The event was attended by 249 staff with the majority from clinical backgrounds and at consultant or senior nurse/AHP level.

**Free places from sponsorship**

84. The design team aimed to provide 250 free places at the conference. All “free places” were fully funded through actively raised sponsorship. The design group’s active sponsor management strategy was both effective for delivering the funds to run the conference and in delivering a very well received exhibition.

**Paid for places**

85. The option of paying for additional places was available to networks who wished to utilise more places than their allocated quota. 30 “paid for” places (at cost) were made available.

**Feedback**

86. Feedback for the event was overwhelmingly positive.

87. Delegates were asked to complete a short evaluation form asking for scores on each presentation, a view on the relevance of and information from the conference as well as provide an overall score from 0-10 for the day.

88. **95.8%** thought the conference was both relevant and informative to their role.

89. **100%** thought the conference was informative

**Average score 7.7 (out of 10)**

90. The overall average score for the conference was **7.7** – see Table 1. **Nurses** scored **8.2**. **Service improvement leads** scored **8.1**, **AHPs** **7.7**, **Managers** scored **7.6** and **doctors** scored **7**. This confirmed the agenda had been suitably designed for a multi disciplinary audience.

<table>
<thead>
<tr>
<th>SCORE By staff group</th>
<th>“other” staff</th>
<th>Service Improvement leads</th>
<th>Managers</th>
<th>AHPs</th>
<th>Nurses</th>
<th>Doctors</th>
<th>Overall average score for the conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of 10</td>
<td>8</td>
<td>8.12</td>
<td>7.6</td>
<td>7.7</td>
<td>8.2</td>
<td>7</td>
<td>7.7 / 10</td>
</tr>
</tbody>
</table>

Table 1 – average scores for conference – by staff group and overall

**Comments made**

91. Some of the comments made that accurately reflect the prevalence of views on the day:

- Brilliant, engaging day
- Truly multi-disciplinary
- Very enjoyable informative day
Very interesting speakers
Good mix speakers
Excellent informative day
Thoroughly enjoyed speakers
 Truly fantastic day
Really thought provoking and lots of ideas – thank you
Networks have proved themselves – need to keep showing this
Broad range of topics, good Q&A all sessions relevant, food nice
Great venue – very accessible
Great facilities, impressive venue, catering v good -just right, excellent organisation
Superb organisation, excellent venue, AV aids v useful.
Allowing contribution from delegates enlightening.
Wonderful to have AHP speak /present
Very good day with high quality speakers. Some reference to devolved regions would help to engage all of the audience as there were several delegates from Wales and NI
Morning hard going. Not clear about commissioning services.
More information/planning on future needed
Venue cold in places, strange acoustics at times

6. Acknowledgements

Speakers
92. The design team would like to formally thank the speakers who gave their time and expertise to the event and provided excellent presentations.
- Candy Morris
- Nick Hulme
- Nigel Edwards
- Maureen Davies
- Professor Tim Evans
- Maria Buxton
- Dr Bob Winter
- Russ Mansford
- Dr Steve Brett
- Dr Ganesh Suntharalingam

Chairs
93. The design team would also like to thank the conference chairs for the morning and two afternoon sessions.
- Nigel Edwards (Morning)
- Dr Jane Eddleston (Afternoon)
- Dr Ganesh Suntharalingam/ Dr Loua Shaikh (Afternoon)

Administration team
94. The feedback on administrative arrangements for the conference was excellent and grateful thanks are due too, to the administration team listed in Annex 2.
**Sponsors**
95. The design team would like to thank the 19 sponsors of the event without whose support the day would not have been possible.

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**Thank you to our Sponsors – please visit the Sponsors’ Exhibition in the Highbury Suite**

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**7. Annex**

- Annex 1  Presentations  (see separate PDF file)
- Annex 2  Design and support team for conference - membership
- Annex 3  Delegates in attendance (see separate PDF file)
## Annex 1 – Presentations - see separate PDF file

## Annex 2 – Conference design and administrative support team

<table>
<thead>
<tr>
<th>Critical Care Network</th>
<th>Name</th>
<th>Job Title</th>
<th>Conference Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West London</td>
<td>Angela Walsh</td>
<td>Network Director</td>
<td>Design Team Joint Chair</td>
</tr>
<tr>
<td></td>
<td>Dr. Ganesh Suntharalingam</td>
<td>Network Medical Lead</td>
<td>Design Team Joint Medical lead</td>
</tr>
<tr>
<td></td>
<td>Gezz van Zwanenberg</td>
<td>Network Project lead</td>
<td>Conference Control Room - Emirates</td>
</tr>
<tr>
<td>Surrey Wide</td>
<td>Dr. Loua Shaikh</td>
<td>Network Medical Lead</td>
<td>Design Team Joint Medical lead</td>
</tr>
<tr>
<td></td>
<td>Jackie Huddleston</td>
<td>Network Manager</td>
<td>Design Team Joint Chair</td>
</tr>
<tr>
<td></td>
<td>Eddie Crunden</td>
<td>Network Lead Nurse</td>
<td>Speaker Timekeeping</td>
</tr>
<tr>
<td></td>
<td>Diane Tamblyn</td>
<td>Network PA</td>
<td>Delegate and sponsor coordination and Registration desk</td>
</tr>
<tr>
<td></td>
<td>Jane Cooper</td>
<td>NHS Surrey Corporate Facilities Manager</td>
<td>Registration desk</td>
</tr>
<tr>
<td>South Central</td>
<td>Maria Flynn</td>
<td>Network Manager</td>
<td>Design Team</td>
</tr>
<tr>
<td></td>
<td>Renu Mehan</td>
<td>Deputy Network Manager</td>
<td>Design Team</td>
</tr>
<tr>
<td></td>
<td>Melissa Way</td>
<td>Service Improvement Manager</td>
<td>Registration desk</td>
</tr>
<tr>
<td></td>
<td>Jocelyn Streater</td>
<td>Network PA</td>
<td>Delegate list and Registration desk</td>
</tr>
<tr>
<td>Kent</td>
<td>Catherine Plowright</td>
<td>Network Lead Nurse</td>
<td>Design Team</td>
</tr>
<tr>
<td>Sussex</td>
<td>Liz Wigzell</td>
<td>Network Audit Lead</td>
<td>Microphone running</td>
</tr>
<tr>
<td></td>
<td>Emma Tate</td>
<td>Audit Lead Nurse</td>
<td>Microphone running</td>
</tr>
<tr>
<td>Birmingham/Central England/NW Midlands</td>
<td>Stacey Hendrick</td>
<td>Network Admin Assistant</td>
<td>Registration desk</td>
</tr>
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## Annex 3  Delegates in attendance on 23.9.10 (see separate PDF file)