



Critical Care Outreach

A Community of Practice: BACCN October 2025

Natalie Pattison (co-Chair)
Debbie van der Velden (co-Chair)
Mark Wilson

Welcome to the National Outreach Forum

The National Outreach Forum (NOrF) was founded back in 2004 by a group of enthusiastic professionals involved with the first Critical Care Outreach Teams in UK. Since then, it has evolved to include Ireland, and now represents a multi-professional interest group that seeks to promote excellence in the care of acutely unwell and deteriorating patients.



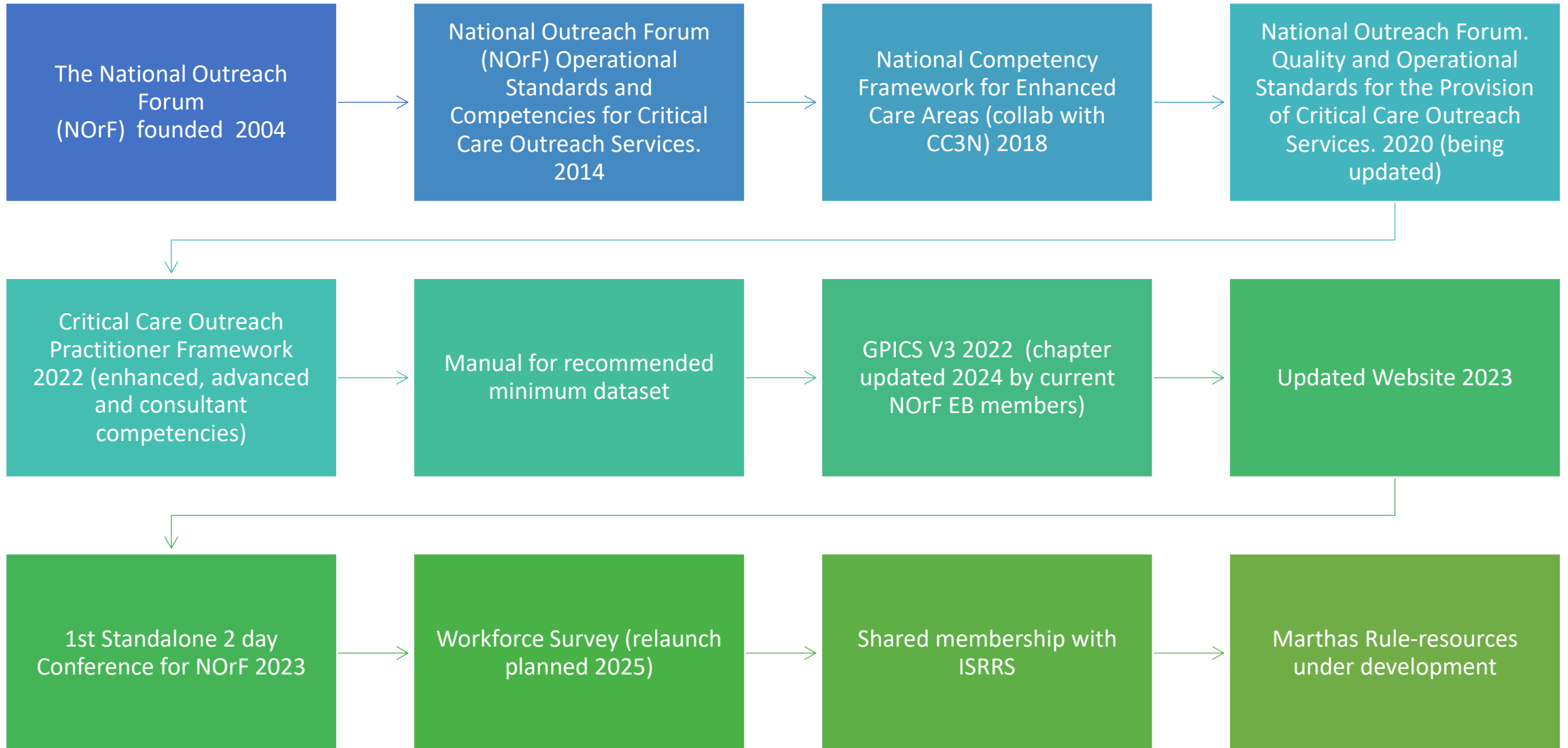
Purpose and Mission Statement

- To provide a **representative forum** for Critical Care Outreach Service providers and recipients across the country.
- To optimise the **quality of the patient's treatment**, care and experience.
- To meet the Department of Health's objectives for critical and acute care, and to ensure there is a **strategic approach to delivery of Critical Care Outreach Services nationally**, which reflects that of the National Strategy and those of the Critical Care Networks.
- To underpin **Critical Care Outreach practice and service development with the best evidence** where it is available

Core elements of CCO are defined within the NOrF operational standards in seven core elements: PREPARE

1. **P**atient track and trigger
2. **R**apid response
3. **E**ducation, training, and support
4. **P**atient safety and clinical governance
5. **A**udit and evaluation; monitoring of patient outcome and continuing quality care
6. **R**ehabilitation after critical illness (RaCI)
7. **E**nhancing service delivery through quality improvement, collaboration, and co-ordination

NOrF significant documents/publications and events



UK Critical Care Outreach

Confidential inquiry into quality of care before admission to intensive care 1998

Comprehensive Critical Care 2000

Multiple operational solutions to the problem-which one is right?

NOrF established 2004

NCEPOD 2005

NICE CG 50 2007 (reviewed in 2020)

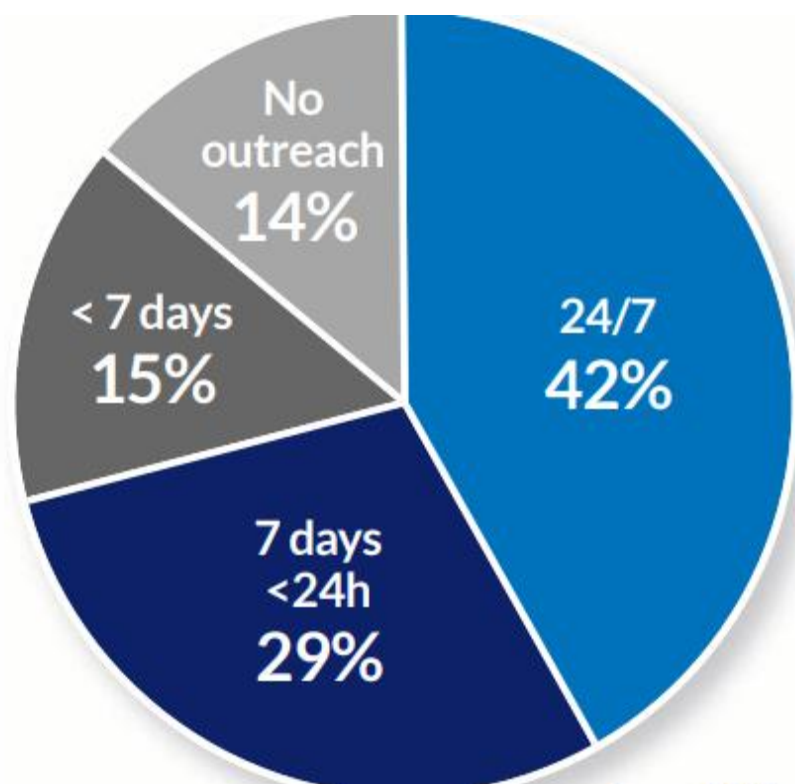
NICE CG83 2009

NEWS 2012

NEWS2 2017

GIRFT 2021

CCO Practitioner Framework 2022-collaboration (NOrF, ICS, CC3N)



Outreach: Does it work?

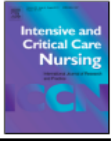


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Current insights in intensive & critical care nursing

Critical care outreach and rapid response teams: Are they the panacea to all hospital patient deterioration problems?

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EVALUATION |  **Free Access**

Critical care outreach: A valuable resource

Jaime Hyde-Wyatt RGN, BN (Hons), PG dip (Crit Care), MSc Health Studies
Joanne Garside RGN, BSc, EdD, PGC, SFHEA

First published: 20 June 2019 | <https://doi.org/10.1111/nicc.12453> | Citations: 12

SECTIONS

 PDF  TOOLS  SHARE



Journal of Critical Care
Volume 25, Issue 2, June 2010, Pages 196-204



Risks/Outcomes/Predictors

The effects of critical care outreach services before and after critical care: A matched-cohort analysis ☆

David A. Harrison PhD ^a, Haiyan Gao PhD ^{a, b}, Catherine A. Welch MSc ^a, Kathryn M. Rowan DPhil ^a

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The impact of the introduction of critical care outreach services in England: a multicentre interrupted time-series analysis

[Haiyan Gao](#) , [David A Harrison](#), [Gareth J Parry](#), [Kathleen Daly](#), [Christian](#)
Critical Care 11, Article number: R113 (2007) | [Cite this article](#)

[etric](#) | [Metrics](#)

SS) have been widely introduced
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Critical Care Outreach

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Nurses' Perceptions of How Rapid Response Teams Affect the Nurse, Team, and System

Dustin J. Williams, MSN, RN; Angela Newman, MSN, RN; Cheryl Jones, PhD, RN, FAAN; Betty Woodard, PhD, RN

Rapid response teams (RRTs) continue to be implemented in hospitals to prevent unnecessary cardiac arrests and reduce patient mortality. Although studies suggest that RRTs improve patient care, research is lacking on the perspectives of nurses who use them. This focus group study elicited nurses' experiences with RRTs in a community hospital. Study findings provide insights into why nurses believe RRTs achieve their intended purpose. **Key words:** community hospital, focus group, rapid response team

Evaluating a New Rapid Response Team NP-Led Versus Intensivist-Led Comparisons

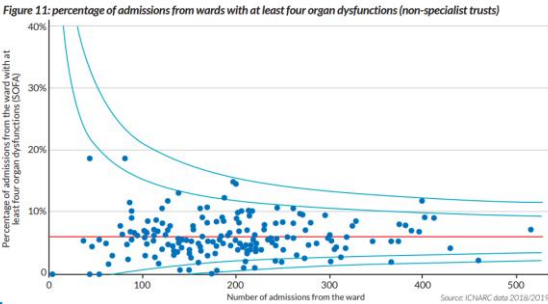
Kimberly Scherr, RN, MN, NP
Donna M. Wilson, RN, PhD
Joan Wagner, RN, PhD
Maureen Haughian, RN, BScN

ABSTRACT

vidence is needed to validate rapid response teams (RRTs), including those led by nurse practitioners (NPs). A descriptive-comparative study was undertaken to evaluate a newly implemented NP-led RRT at Canadian hospitals. On the basis of data gathered on 255 patients who received an RRT between the NP-led and intensivist physician-led RRT calls. A paper survey revealed that ward nurses had confidence in the knowledge and skills of the NP-led RRT and believed that patient outcomes were improved as a result of their RRT call. These findings indicate that NP-led RRTs are a safe and effective alternative to

Effectiveness of outreach services

As shown in **Figure 11** below, there is wide variation between trusts in numbers of patients being admitted from the wards with four or more organ dysfunctions, suggesting deterioration is not being recognised rapidly enough. The situation is complex and good practice is informed by such factors as appropriate use of early warning scores, a culture of responding to deterioration, willingness to refer to critical care and willingness (and capacity) to accept patients into critical care.



Rose

ach improves patient outcomes of deteriorating patients on
s Cochrane update.

NOrF Current Initiatives



Martha's Rule and Call for Concern - resources under development (Adults and paediatric competencies)



Survey of practice (ERACC)



Webinars launched -3 complete and uploaded to website, next one planned for



One day conference **21st November Birmingham**



Review of Quality and Operational Standards



Challenges for the Outreach community

Increasing workload and higher acuity and complexity of hospital care

Increasing demand for ICU beds

TEP and DNACPR discussions

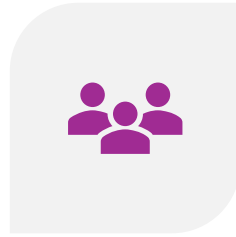
Lack of recognition and funding for the ANP role

Diversity of team structure and modelling

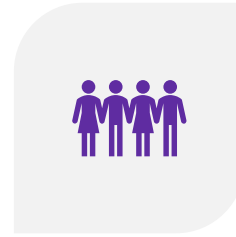
Diversity of data collection tools and datasets

Response to Martha's Rule

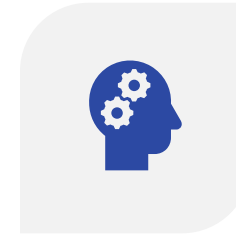
Some Opportunities



STANDARDISE AND
OPTIMISE STAFFING
WITHIN OUR OUTREACH
TEAMS



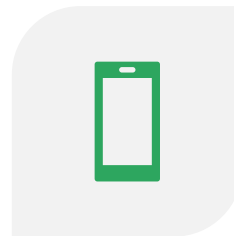
EMPOWER WARD
TEAMS TO IMPROVE
RESPONSE TO
DETERIORATING
PATIENTS



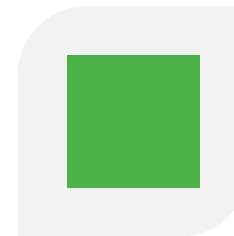
EXPLORE BARRIERS AND
FACILITATORS TO
ESCALATION-HUMAN
FACTORS AND
BEHAVIOUR



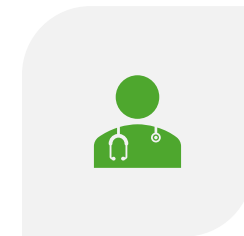
IMPROVE MDT
COMMUNICATION AND
FLOW IN ACUTE
SETTINGS-SAFETY
BRIEFINGS/HUDDLES



SMART USE OF
ELECTRONIC ALERTS
AND TRIGGERS



NATIONAL DATA
COLLECTION TOOLS AND
BENCHMARKING



IMPROVE RECOGNITION
OF PATIENTS WHO ARE
NEARING EOL CARE AND
ENCOURAGE
IMPLEMENTATION OF
APPROPRIATE CARE

SCCM 2024

Summary of Recommendations

Recommendation	Recommendation Strength, Quality of Evidence
Recognizing clinical deterioration	
1. Ward staff caring for hospitalized patients should strive to acquire a complete and accurate set of vital signs when ordered and when there is additional cause for concern, and to escalate the reporting of significant abnormalities to the appropriate clinicians in an urgent manner	Good practice statement
2. We make no recommendation regarding the routine use of continuous vital sign monitoring to recognize early clinical deterioration in unselected non-ICU patients	No recommendation
3. We suggest focused education of direct-care non-ICU hospital clinicians on recognizing early clinical deterioration	Conditional recommendation, low certainty evidence
4A. Patients, families, and care partners of hospitalized patients are able to recognize subtle differences in clinical status that may signify deterioration and should be empowered to alert appropriate personnel including the rapid response system	Good practice statement
4B. We suggest that patient, family, and care partner concerns be incorporated into hospital early warning systems	Conditional recommendation, low-certainty evidence
Responding to clinical deterioration	
5. We recommend hospital-wide deployment of rapid response systems (i.e., RRT/MET) for non-ICU patients that include explicit activation criteria for obtaining help from a designated response team	Strong recommendation, moderate certainty evidence
6. We make no recommendations regarding 1) whether an RRT/MET should be led by a "prescribing clinician" vs. a "non-prescribing clinician"; and 2) whether an RRT/MET should be led by a physician as compared to other healthcare providers	No recommendation
7A. We make no recommendation about involvement of palliative care-trained personnel as part of an RRT/MET	No recommendation
7B. We suggest ensuring that responding clinicians have expertise on eliciting patients' goals of care and establishing treatment plans that best reflect their wishes and prognoses	Conditional recommendation, low-certainty evidence
8. A process for quality improvement should be part of a Rapid Response System	Good practice statement

Society of Critical Care Medicine Guidelines on Recognizing and Responding to Clinical Deterioration Outside the ICU: 2023

Research and emerging work

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21ST NOVEMBER 2025



ONE DAY CONFERENCE

TOPICS INCLUDE:

- EARLY CAREER RESEARCHERS IN RRS/CCOT
- FPARR – FAMILY/PARENT ACTIVATED RR IN PAEDIATRICS
- HOW SHOULD ADULT NURSES BE RESPONDING TO C4C INVOLVING CHILDREN? (PANEL)
- TRANSFER GUIDANCE: IMPLICATIONS FOR CCOT
- NOVEL PRESENTATIONS OF ACUTE RESPIRATORY FAILURE IN CRITICAL ILLNESS
- WHAT ARE THE CLINICAL IMPLICATIONS FOR CCOT IN MANAGING RESPIRATORY ILLNESS IN ADULTS AND PAEDIATRICS? (PANEL)
- END-OF-LIFE CARE FOR CCOT
- BEST OF THE BEST – ORAL ABSTRACTS

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