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Outreach in the UK

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Sarah Bateman describes the development of outreach in the UK and how her team operates. **Major UK government infection control documents / campaigns & websites**

Outreach in the UK

Within the United Kingdom (UK), concerns regarding sub-optimal management of the critically ill patient outside the intensive care setting were identified during the latter part of the 1990's (McGloin et al. 1997; McQuillan et al. 1998). Contributing factors included ward manpower restrictions, increased patient acuity and the lack of education and support for ward based medical and nursing staff. Following government recommendations and in response to national policy documents examining critical care services in the UK (Department of Health, HMSO 2000), a plan for reform and modernisation was proposed. This recommended a hospital-wide approach to care of the critically ill patient, for timely critical care skills to be provided for patients, irrespective of their location.

Outreach Service at SUHT

In Southampton University Hospitals Trust (SUHT) UK, the impetus provided by these recommendations led to three initiatives to improve care of the critically ill patient:

• critical care education through the Acute Lifethreatening Events Recognition and Treatment (ALERT; Smith 2000) course – a multi professional course in the care of the acutely ill patient,

• use of the Modified Early Warning System (MEWS) to identify the deteriorating patient, and

• the introduction of the critical care outreach service.

In response to critical care service demands, a 24-hour outreach service was established in SUHT during the year 2000. The outreach service is provided by the critical care outreach team (CCOT), which is predominantly a nurse-led service with significant consultant nurse and medical intensivist input. The main focus of the CCOT is to provide a seamless service, to avert admissions to the Intensive Care Unit (ICU), to enable ICU discharges and to share and develop critical care skills through direct care delivery, advice, guidance and support. The service was initially introduced to acute care areas in November 2000 and progressed to being fully operational across all key clinical directorates by December 2000. Since its inception, the CCOT has dealt with 7264 referrals to date.

The referral process for the outreach service can be accessed by either a formal or informal pathway (see figure 1). Within this referral process and for all subsequent interventions, the benefits of inter professional working need to be demonstrated to all clinical areas. This not only encourages collaboration within the CCOT, but also between the CCOT and ward based clinical staff and, equally as important, between medical and nursing teams in different clinical areas.

Part of the CCOT role at SUHT also includes being actively involved with education programmes for both single- and multi-professional healthcare groups to educate and share critical care skills and promote collaborative working. The Immediate Life Support (ILS) (Resuscitation Council UK 2002) and ALERT (Smith 2000) courses are both taught at SUHT to educate staff in the management of the acutely ill adult, encourage a team approach and raise awareness of inter professional roles and abilities.

Referring teams are often reluctant to accept advice from the CCOT, due partly to limited understanding of the severity of the patient's acuity and associated physiological disturbances, but also reluctance to take advice from a nurse. The CCOT therefore has a responsibility to inform, update and publicly promote the service to ensure clarification and minimise misunderstandings regarding the CCOT role. Conversely, the medical profession needs to adjust traditional views and adapt to new ways of working. This means medical professionals must be prepared to receive and accept advice from outside their clinical area of expertise and recognise that the CCOT provides a complementary, not conflicting, service to integrated care.

Way Forward

The development of innovative roles as alternative models of care is essential, as public and government pressures demand a better NHS. The critical care outreach team provides one such alternative model and is being successfully utilised to develop services and improve patient care (Ball et al. 2003).

Whilst the CCOT will continue to meet the demand for critical care skills outside the intensive care setting, it is likely that the way in which this service is provided may change in response to ever changing healthcare needs. The implications associated with the European Working Time Directive (EWTD), logistical management of the higher acuity patient and the Hospital at Night programme (www.modern.nhs.uk/ hospitalatnight) could well see a review of the role of the CCOT.

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