#	Feedback
1	Denise Brooks - University of Cumbria
2	Gemma Ellis - Cardiff and Vale University Health Board
3	Keith Couper - University Hospitals Birmingham NHS Foundation Trust
4	Karin Gerber - Royal Berkshire NHS Foundation Trust
5	Mandy Odell - Royal Berkshire NHS Foundation Trust
6	Paul Dean on behalf of the Intensive Care Society
7	CH – Clinical Advisor, Acute Deterioration Programme, Public Health Wales

Please disclose any conflict of interests

#	RESPONSES
1	Nil
2	None
3	Volunteer roles with various resuscitation organisations including Resuscitation Council UK
4	No
5	No
6	ICS
7	Nil

Introduction

#	RESPONSES	NOrF response
1	Nil to add	
2	Nil to add, happy with it	
3	It would be helpful to clarify scope of document- is document intended for services that cover adults, children, or both?	Added adult/paediatric to ALS. The document should cover both adult and paediatric services
4	Nil to add	
5	Leave out the word 'enthusiastic' on page v	Agreed and removed
6	Use of SHOULD and MUST through the document as recommended vs mandated	"Should" changed for "must" in different sections
7	Nil to add	

Quality and Operational Standards for Critical Care Outreach Services: Definition and Core Elements

#	RESPONSES	NOrF response
1-7	Nil to add	

1- Patient Track and Trigger

#	RESPONSES	NOrF response
1	Nil to add	
2	What is meant by a "senior clinician with appropriate acute care competencies"? It may be better to remove acute care competencies. Systems for flagging of concerns by relatives/ patients have been successfully implemented, but I am unaware of any robust evaluation. Perhaps this should be an area where NORF highlights the need for further research. At the very least, references should be included to support this statement.	Senior clinician is considered a senior doctor, nurse or AHP with the adequate competencies that is able to recognise, treat and take decisions when looking after acutely ill patients. For a doctor a senior clinician is considered a ST3 or above. We have removed the "acute care"
3	A system for patient and carers to trigger a review if "any" concern should be implemented.	"Any" added to 1.7, thank you
4	Nil to add	
5	Section 1.6 could also include sepsis and HAP alerts	Added, thank you
6	Nil to add	
7	Points 1.3 and 1.5. Wales has not formally adopted NEWS 2 as NEWS has been in place for several years and seems to be working well. Suggested: 'Escalation protocols are determined locally based upon the nationally agreed NEWS trigger points for low, medium and high risk'	Thank you for suggestion. We would like the NOrF QOS to be used widely across UK. We understand there are differences within the devolved nations. The suggested paragraph has been accepted as less prescriptive but at the same time robust enough. Thank you for the reference sent.

2- Rapid Response

#	RESPONSES	NOrF response
1	Nil to add	
2	"CCO practitioners should consider becoming non-medical prescribers" Could we please consider calling it "independent prescribers" ???	Changed to "independent prescribers"
3	Nil to add	
4	Nil to add	
5	Include the recommendation for patient and family activated CCO	Although already mentioned on point 1.7 as a trigger, it has been added here as to initiate response
6	Nil to add	
7	Nil to add	

3- Education, Training and Support

#	RESPONSES	NOrF response
1	Nil to add	
2	Can we clarify what is meant by ALS provider? It could be someone trained to provide ALS or someone who provides training for ALS. Our resuscitation services provide the training but our CCOT provide ALS when required (hope that makes sense perhaps it's just the way it is phrased).	ALS provider means anybody trained to be able to provide advanced life support. Those training for ALS are called ALS instructors
3	3.2 and 3.3 require CCO practitioners to have certain qualifications- what is the position of individuals that are new in post and have not yet completed these courses? 3.3- Suggest you define the abbreviation ALS. Is ALS required for CCO practitioners working only in paediatric hospitals? What is competency required for individuals working with adults and paediatrics?	The expectations are that CCOP are trained to history take/examination and diagnostics. ALS abbreviation changed. If covering paediatrics expected to have Paediatric life support skills
4-7	Nil to add	

4- Patient Safety and Clinical Governance

#	RESPONSES	NOrF response
1	Nil to add	
2	Content good but please can you remove the word 'Trust' here and anywhere else in the document as only England and NI have Trusts. Scotland and Wales have Health Boards. Perhaps use 'organisation' throughout.	Agree. We have substituted the word Trust for organisation
3	Nil to add	
4	Nil to add	
5	Nil to add	
6	Nil to add	
7	Nil to add	

5- Audit, evaluation, patient outcomes and quality of care

#	RESPONSES	NOrF response
1	Unsure that 6.6 can be met, previous experience of CCO suggests patients are discharged off the case mix when out of acute stage, as keeping them on the case load would be unrealistic. Unsure how the team can be realistically part of the rehab/discharge plan from hospital. I am not aware of any models where this is achieved, although I appreciate it is part of CG83.	Thank you for comments. The ideal scenario is that the patient pathway is a continuous, and CCO could add valuable information into it prior to discharge from the acute setting/follow-up. This is set up as a recommendation. Some CCO are integrated with rehabilitation/recovery services.
2	Not sure how you would determine a 'potentially preventable cardiac arrest'? Maybe add in: number of DNACPR's discussions initiated and number of referrals to palliative care?	Some units review all cardiac arrest and deaths following cardiac arrest as part of M&M. This is a suggested data item. We have added your proposed DNACPR/TEP.
3	5.1- Appendix 2 is not included. I assume these data items are clearly defined somewhere? What is the expectation on how these data are used once collected? Please note potential overlaps of data with National Cardiac Arrest Audit and ICNARC case mix programme.	That is correct. Appendix 2 will be actually an annex as soon as the suggested data collection items. There will be overlap with NCAA and some of the information could be shared with NCAA

4	Nil to add	
5	Nil to add	
6	Nil to add	
7	Nil to add	

6- Rehabilitation after critical illness (Follow-up)

#	RESPONSES	NOrF response
1	As above	Noted
2	Nil to add	
3	Nil to add	
4	Nil to add	
5	Nil to add	
6	Nil to add	
7	Nil to add	

7- Enhancing service delivery

#	RESPONSES	NOrF response
1	Nil to add	
2	There is no mention of CCO leading research or participating in research anywhere in this document. This is an important omission. Please can this be added.	Thank you for comment and bringing it to our attention. We agree with you as research being an important part and we have added it.
3	A lead medical consultant with a qualification in either critical care or an acute care specialty must support the development and delivery of Critical Care Outreach or equivalent services. Dedicated sessions (PAs) are required to do this and should be identified within his/her job plan Does this have to be a Medical Consultant??	As part of the multidisciplinary team, we consider that a medical consultant must be part of the development of a CCO service. This should be in collaboration with Nursing/AHP senior colleagues. This contribution to the multidisciplinary aspect of CCO/RRT requires identification within their job plan. We understand that Nurse Consultant are many cases the leads for CCO services, we want

		to emphasise the contribution that medical colleagues can add.
4	Nil to add	
5	Nil to add	
6	Nil to add	
7	Nil to add	

Other Comments

#	RESPONSES	NOrF response
1	Unsure if it is worth including the level 1 comps for enhanced care areas as part of the education section. I may have missed it, apologies if so.	Level 1 competencies are a minimum entry point to become a CCO practitioner. There is a document in preparation that specifies clearly the competencies and development of CCO practitioners. CCO practitioners may be part of the delivery of Level 1 competencies but as explained on point 3.10, this should be recognised and identified as part of their job plan.
2	It would be helpful to clarify terminology throughout the document- how should readers interpret "should be used" compared with "must be used" and "highly recommended"?	Thank you for comments. We have recognised the importance of your point and changed accordingly what it is mandated ("must") and what is highly recommended ("should").
3	Nil to add	
4	Nil to add	
5	Nil to add	
6	Nil to add	
7	Nil to add	