Joint Committee

on

Public Petitions and the

Ombudsmen

OPENING STATEMENT

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Introduction

Good morning Chairperson and members of the Committee. Thank you for the invitation to return to the Joint Committee on Public Petitions and the Ombudsmen. At the outset, I wish to once again express my sympathy to the families of all those patients who lost their lives to sepsis. I also wish to express heartfelt thanks to the families who have advocated and the important contributions made by Lil' Red's Legacy Campaign who have assisted us in our work and to thank you, the committee, for your attention to sepsis. We welcome the focus you have brought to this major cause of harm and the importance of raising awareness about the prevention and early detection of sepsis.

I will give an update on progress made, by the National Clinical Programme (NCP) for Sepsis, since our attendance here this time last year.

I am joined by my colleagues:

Dr Michael O Dwyer, National Clinical Lead for the Sepsis Programme, HSE.

Dr Ciara Martin, National Clinical Advisor and Group Lead for Children and Young People, HSE

Update on Key Priorities for NCP: Sepsis

Increasing Public Awareness of Sepsis:

A new HSE sepsis campaign launched on 7th March, with radio ads on local and national radio, social media ads, and media interviews and coverage. The campaign aims to increase knowledge around the signs and symptoms of sepsis, as recent research shows that, while people are aware of the word 'sepsis', only 44% are aware of the signs and symptoms.

The research involved engaging with patient advocates to help inform the communications. The call to action encourages people to find out more information on the HSE website and to ask 'Could it be sepsis?' if they have symptoms.

The campaign is performing well. The radio ad is back on air this week to align with the International Paediatric Sepsis Awareness weeks.

The Lil Red campaign have kindly agreed to participate in media events during these weeks in addition to other families who have experienced the devastation of losing a child to sepsis. Social media reach to date has been over 1.6 million across Facebook, Instagram and TikTok, and the social media ads will continue over the next few months. Since the campaign launched, the number of people visiting the website each day has doubled, with 14,000 people accessing the information in the first four weeks. We will evaluate the impact of the campaign to ensure the objectives are being achieved.

Education & Engagement with Staff across all Services:

- A campaign website was set up so staff could access all sepsis resources.
- Reminders were sent out on HSeLanD of mandatory training requirements for all staff.
- Staff newsletters, podcasts & webinars included stories on sepsis and interviews with staff from the clinical programme for sepsis were published across multiple platforms.
- Two separate posters have been developed, one for adults, including maternity, and one for paediatrics, on the signs and symptoms of sepsis and have been sent to GPs, which also directs them to the patient information leaflet, now available in 10 languages.
- An update of the Paediatric Early Warning Score (PEWS) to reflect updated sepsis guidance was completed and fully implemented across all Paediatric hospitals and all hospitals who see children in June 2023.
- We identified a need to have PEWS trainers in regional and local hospitals where children attend – myself and my colleague Dr Ciara Martin are working with colleagues from Saolta and CHI to organise a National Train the Trainers' Day in May 2024 where each hospital will be invited to send two representatives.
- In December 2023, a Patient Safety Alert on Sepsis was sent from, the office of the Chief Clinical Officer, to all Emergency Departments which see children and all areas for unscheduled Paediatric care, to address the challenges of recognising and responding to sepsis in busy and overcrowded emergency settings.
- An additional Patient Safety Supplement was sent to all healthcare services to provide further guidance regarding the importance of early recognition and treatment of sepsis.
- Many safety and risk reduction initiatives were developed as a result of this information sharing.

- The sepsis programme is working with the National Women & Infants Health Programme to share expertise and provide guidance on improving awareness of sepsis in maternal care and women's health services.
- Regular education sessions on signs and symptoms of sepsis, and the 'Sepsis 6' bundle, are conducted across all hospitals throughout the year, with audits to assess adherence to recommendations.

Revision of the National Clinical Guidelines:

The Society of Critical Care Medicine: Surviving Sepsis Campaign have updated their international guidelines. This information provides important evidence and recommendations on the prescribing protocols for antibiotics and fluids in sepsis management. The Sepsis programme have committed to adapting the sepsis tools used in acute hospitals to reflect these recommendations, this work will be completed in 2024. The full review of the NCEC National Clinical Guideline No. 26 will take place in 2025 subject to available resources.

Resources for GPs and Primary Care Healthcare Staff:

- A quick reference guide for GPs on the recognition and treatment of sepsis in adults is currently in the final stages of review and will be implemented in the coming weeks.
- A quick reference guide for GPs on the recognition and treatment of sepsis in children is under development and will be ready for implementation in Q1 2025.
- A project to commence integration of software to GP clinics to aid with sepsis awareness and management as a pilot is planned for later this year.

Sharing Expertise:

- The 8th Sepsis Summit will take place in Dublin Castle on 3rd September. This year's summit will have national and international experts and family advocates amongst those presenting.
- Public awareness champions/groups such as the Irish Sepsis Foundation and 'Lil Red's Legacy Sepsis Awareness Campaign have been invited to the event & survivors of sepsis will be asked to speak at the summit.

- The National Sepsis Report (2022) was published in December 2023 and provides very important data on the care, management and outcomes for inpatient with sepsis in adult, maternity & paediatrics.

Quality Assurance on the Recognition and Management of Sepsis:

- Retrospective audits against the National Clinical Guideline for Sepsis were undertaken in 2023 in adult, maternity & paediatric inpatient services.
- Key learnings from the audits are used to improve care in the early recognition and management of sepsis.
- An infographic outlining data from the National Sepsis Report (2022) and findings in relation to audits undertaken across all acute hospitals was sent to Hospital Group CEOs and Chief Directors of Nursing in February 2024. The purpose of the infographic is to create an awareness of the burden of sepsis on inpatients and the impact sepsis has on hospital capacity and flow.
- The audit findings have been consistent since 2018 and identify key areas for improvement particularly around the use of the sepsis tools. The Sepsis programme team has worked with the National Centre for Clinical Audit to improve the audit tool used. This will be tested in Q2 2024 and ready for implementation in Q3 2024.
- The audits undertaken in 2024 will focus on the areas that require immediate improvement as communicated to all hospital and hospital groups through the infographic and will be reported back to all hospital executive teams with recommendations on how to improve compliance.
- All acute hospitals have a deteriorating patient committee, which has oversight on the management of patients with sepsis. This committee reports to the CEO/General Manager on an ongoing basis.

Five Year Strategic Plan:

The Action on Sepsis: Five Year Strategy is now prepared and ready for consultation. The strategy outlines a five-year strategic programme of work from 2024 to 2029.

This comprehensive strategy, grounded in Irish data and international best practices, is structured to tackle the challenges of sepsis management and prevention.

The strategy sets out a range of HSE actions aligned to the six priority areas:

1. Governance
2. Preventing Avoidable Cases of Sepsis
3. Increasing Awareness of Sepsis amongst the Public and Health Professionals
4. Improving Identification and Treatment across the Patient Care Pathway
5. Improving Support and Care for Sepsis Survivors
6. Research for Sepsis

A key priority of the strategy is to ensure that the changing structures of the health services are reflected in the delivery of its objectives. Part of the new structures will be the National Quality & Patient Safety Unit (NQPSU) reporting directly to the Chief Clinical Officer. This unit will work closely with their counterparts in the Regional Health Authorities and a key priority of this work will be the assurance that robust governance arrangements are in place with responsibility and oversight of the identification and management of sepsis, and that quality improvement processes are implemented and evaluated following audit and serious incident reviews.

I once again want to express my heartfelt thanks to the families who have advocated and the important contributions made by Lil' Red's Legacy Campaign.

This concludes my opening statement.
Thank You.