Sepsis Management Masterclass 3

Tuesday 2 February 2016

Rugby Club, Taunton

@WEAHSN

1 Overview

About the West of England Academic Health Science Network

The West of England AHSN is delivering positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy.

We are one of 15 AHSNs across England, established by NHS England in 2013 to spread innovation at pace and scale.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

About the event

There is a piece of work being led by the West of England regional sepsis group supported by the West of England AHSN which includes the support of masterclasses in sepsis. To date since February 2015 there have been three events of which the last two were opened up to primary care. Through a system wide programme in the West of England to implement National Early Warning Scores as a shared language, sepsis awareness is being promoted in the community and primary care.

Following the first regional Quality Improvement Masterclass on Sepsis Management in Swindon on 25th February 2015 attended by 30 delegates, and the second Masterclass on 10th June 2015 attended by 48 delegates, the West of England Regional Sepsis working group in association with the West of England Academic Health Science Network organised a masterclass on 2nd February 2016.

The aim of the event was to update delegates on recent national publications, particularly the NCEPOD report “Just Say Sepsis” launched in November 2015, as well as focus on the topics of paediatric and maternity sepsis. The previous masterclasses in 2015 had covered the topics of secondary care sepsis, data for improvement, community pathways, and surgical sepsis.

About sepsis

Every year in the UK there are 150,000 cases of Sepsis, resulting in a staggering 44,000 deaths – more than bowel, breast and colon cancer combined. Sepsis is the biggest direct cause of death in UK pregnancies and affects about 10,000 children every year in the UK. Improved recognition, assessment and treatment of sepsis will save lives. For more information visit http://www.weahsn.net/news/be-sepsis-savvy/

2 What our speakers said

All the presentations from our speakers are available online at https://www.slideshare.net/secret/3vDaAZj09Xb0VU

Sue Morrish, Mother of Sam Morrish

Dr Ron Daniels BEM, CEO: UK Sepsis Trust and Global Sepsis Alliance; Clinical Adviser to NHS England

Dr Mark Juniper, Consultant in Respiratory and Intensive Care Medicine, Great Western Hospitals Swindon

Dr Akash Deep, Director, Paediatric Intensive Care, King's College Hospital, London

The day opened with Sue Morrish, mum to three beautiful boys, Ben (10) Oliver (3) and Sam who died suddenly from sepsis when he was three years and 8 months old. Sue shared the story of Sam's last 24 hours and his journey through the hands of many different NHS agencies, all of whom sadly failed him before he died. In the discussion afterwards delegates agreed it was important to put information in the hands of parents, who, as Sue pointed out, are the first line of triage for sick children. Two tools mentioned include the SAM leaflet developed by NHS England South, available at http://www.southdevonandtorbayccg.nhs.uk/your-health/Documents/sam-sepsis-leaflet.pdf and the Paediatric Pocket Guide for Parents (see below) developed by the UK Sepsis Trust, available at http://sepsistrust.org/clinical-toolkit/ along with the "When Should I Worry" leaflet developed by researchers at Cardiff University: http://www.whenshouldiworry.com/

Dr Ron Daniels from the UK Sepsis Trust then updated delegates on the national programme including upcoming developments from the UK Sepsis Trust. Dr Daniels highlighted that tracking sepsis needs a systems approach, including looking at other industries for inspiration.

Dr Mark Juniper, lead co-ordinator at the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), updated delegates on findings from the recent "Just Say Sepsis" report, published in November 2015. The report is available at http://www.ncepod.org.uk/2015sepsis.html

Dr Juniper also highlighted the importance of common languages, including early warning scores for communication across different teams. The West of England AHSN is leading a system-wide implementation of national early warning scores (NEWS).

Dr Akash Deep presented the quality improvement work carried out King's College Hospital London in order to raise awareness and improve reliability of care for paediatric sepsis to develop a culture where sepsis is considered an emergency requiring urgent treatment. Dr Deep is the main author of the Paediatric Sepsis Toolkit available at http://sepsistrust.org/wp-content/uploads/2015/08/sepsis-toolkit-FINAL-09151.pdf

Professor Marian Knight, NIHR Professor of Maternal and Child Population Health, National Perinatal Epidemiology Unit, University of Oxford.

Dr Imogen Montague, Consultant Obstetrician & Gynaecologist, Plymouth Hospitals NHS Trust

Dr Kordo Saeed, Consultant microbiologist, Director Infection Prevention and Control, Hampshire Hospitals NHS Foundation Trust; Honorary Senior Lecturer, University of Southampton Medical School

Elizabeth Beech, NHS England National Project Lead - Healthcare Acquired Infection and Antimicrobial Resistance

Professor Marian Knight presented findings from the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) available at https://www.npeu.ox.ac.uk/mbrrace-uk

Dr Imogen Montague then talked through the altered physiology of pregnant women and how sepsis affects this through a series of case studies.

In the afternoon Dr Kordo Saeed presented findings on how testing procalcitonin could aid in decision-making for antibiotic usage, in particular to ensure that patients are not exposed to antibiotics unnecessarily.

Elizabeth Beech continued the theme of antibiotic stewardship, including findings from the English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report (available at https://www.gov.uk/government/publications/english-surveillance-programme-antimicrobial-utilisation-and-resistance-espaur-report) and encouraging delegates to sign up as an antibiotic guardian at http://antibioticguardian.com/ Without effective antibiotics, modern medicine will become dangerous due to the risk of infection. Setting broken bones, major surgery and chemotherapy all depend on access to antibiotics that work.

The TARGET antibiotics toolkit (Treat Antibiotics Responsibly, Guidance, Education, Tools) provides handy leaflets for primary care to give to patients with advice when presenting with an infection that does not require antibiotic treatment, these are available at http://www.rcgp.org.uk/clinical-and-research/toolkits/target-antibiotics-toolkit.aspx

NICE guidance on sepsis is currently out to consultation at https://www.nice.org.uk/guidance/indevelopment/GID-CGWAVE0686/consultation/html-content and new national definitions for sepsis are due at the end of February 2016. Other national guidance that applies includes NICE CG160, Fever in under 5s: assessment and initial management https://www.nice.org.uk/guidance/cg160 for which an audit tool has recently by launched by PRIMIS http://www.nottingham.ac.uk/primis/about/news/newslisting/feverish-illness-jan2016.aspx

Photos from the day

3 Input from the room

Sepsis Selfie taken at start of session 2

66 attendees from 32 organisations were in the room with attendees from the West of England (46) and the South West (20) regions. There was a range of roles and organisations, ranging from rapid response teams working the community, midwifes, clinical coders, quality and safety leads, nurse practitioners, consultants, registrars and critical care outreach.

World café sessions

After lunch, delegates attended two world café sessions. The feedback from these sessions is summarised below:

Paediatrics	Maternity	Community
The deteriorating child in a busy waiting room – discussed issues and solutions, including using a EWS score, and providing information for parents. Different EWS scores for paediatric patients. **Ambulance service** – febrile child protocol into ePCR. **Awareness** for parents and schools. Perhaps linking in with routine/ seasonal vaccinations. If a parent attends repeatedly then this should trigger immediate senior review.	**Data** – maternity dashboard and getting data on HDU / outreach involvement **High risk groups**- prison patients. **NEWS/ MEWS** combined with partogram. Reducing the **incidence of infection** – wound management and dressings including tissue viability nurses. **Training** – including maternity care assistants.	**Training** –education and training on the importance of observations. In Bath training for nursing homes aiming to increase hydration linking into messages about deteriorating patients. **Communication** – keep it simple – write “Sepsis – source of infection” on discharge letter and in notes. **Screening** – community screening tools, some are in place, others in development. **Point of care testing** – Gloucestershire shared that using POC testing 20 patients kept safely at home. **Primary care engagement** – challenge across the region, how do we engage GPs in our work? Developing tools for GPs (referral form, apps) and linking into CPD events. **Ambulance service** – common language using same escalation parameters for response times.

4 Poster competition

Winner of the poster competition:

- **The Obstetric Sepsis Tea Trolley**, M McDonald, L Jordan, Royal United Hospitals Bath NHS Foundation Trust, UK

Other posters displayed:

- **Sepsis Unplugged – Bristol Community Health.** Karen Crane, Advanced Nurse Practitioner
- **To Dip or Not To Dip – A patient centred approach to improve the management of UTIs in the Care Home environment**, Elizabeth Beech and Mandy Slatter, Prescribing Adviser (EB) Care Home Pharmacist (MS) NHS Bath and North East Somerset CCG
- **The Obstetric Sepsis Tea Trolley**, M McDonald, L Jordan, Royal United Hospitals Bath NHS Foundation Trust, UK
- **Where are the antibiotics?** Dr Jeremy Bewley, Stuart Knowlson, Caroline Horrobin.
- **An audit of screening for sepsis at triage**, Will Christian, University Hospitals Bristol NHS Foundation Trust
- **Improving Awareness of sepsis in the public and in primary care,** Dr Emily Lucas (FY2 RUH) Dr Lesley Jordan (Consultant Anaesthetist), Dr Elizabeth Hersch (GP ST Chads Surgery, Midsomer Norten and BANES CCG Urgent Care Lead)

5 Outcomes and next steps

The use of the National Early Warning Score (NEWS) is having a positive impact on patient safety across the West of England. At our next event on **Thursday 10th March** in Swindon we will celebrate what's being achieved, review the progress of NEWS in a range of settings, establish our ambitions for a system-wide approach and explore the relevance of NEWS in primary care, discuss the technological opportunities and obstacles and explore how NEWS supports our work around sepsis.

For more information and to register please visit https://wesharethenews.eventbrite.co.uk

6 What our participants said

There was an 83% response rate and 100% of attendees said the overall rating of the event was "good" or "excellent". 85% said excellent.

Comments from attendees:

> *"Brilliant opportunity to network and share ideas, successes and challenges."*
>
> *"Very powerful start, emotionally high impact and set the tone and rationale for the day - this is why we are here!"*
>
> *"Great mix throughout the day of interesting speakers and time to talk with colleagues"*
>
> *"Having the true life experience at the start really set the focus for the day. Really enjoyed all speakers - good variation in topics."*
>
> *"Inspired to drive forwards evaluating/ auditing/ data collecting re: sepsis in my workplace"*

Word cloud from attendees comments

As well as participation in the event, there were a lot of reactions on Twitter and support in the form of likes and retweets.

Elizabeth Beech @elizbeech Feb 2 Great day @WEAHSN masterclass learning lots about #sepsis 1 retweet 0 likes

OutreachEm @nemmayoung Feb 2 @WEAHSN @lythell_nic @SepsisUK Brain hurting, but feeling inspired. So much done already, but still so many opportunities to improve #sepsis 5 retweet 3 likes

WEAHSN @WEAHSN Feb 2 Takeaways from #sepsis event - Early recognition, standardising care and using screening tools and improving info for patients and families 5 retweet 3 likes

Kevin Hunter @pskevh Feb 2 Antimicrobial resistance will impact on us all. What will this mean for #sepsis? @WEAHSN 2 retweet 2 likes

WEAHSN @WEAHSN Feb 2 Some themes from #sepsis world cafe - common languages, NEWS, information for parents and pregnant women on symptoms, and GP engagement 3 retweet 0 likes

Septic Nic @lythell_nic Feb 2 Fascinating info on altered physiology of the pregnant woman before #sepsis complicates matters from Dr Imogen Montague @WEAHSN masterclass3 3 retweet 0 likes

Mark @MarkCJuniper Feb 2 Fishbone diagram & run charts for fluid delivery in paediatric #sepsis Great example of QI in practice @WEAHSN 2 retweet 1 likes

Dr. Ron Daniels BEM @SepsisUK Feb 2 For beautiful Sam Morrish, for beautiful William Mead, for countless others, we'll keep giving every waking hour to fixing #sepsis. @WEAHSN 22 retweet 23 likes

Vanesther Rees @Vanesther1 Feb 2 Listening to the incredibly moving and powerful story at @weahsn masterclass of mum Susanna whose 3yo died of #sepsis. How can we do more? 1 retweet 0 likes

Lesley Jordan @drlesleyjordan Feb 2 Massive thanks to all fantastic speakers sepsis masterclass today-totally inspiring us to drive improvement @WEAHSN @SepsisUK @MarkCJuniper 1 retweet 4 likes

Helen Parsons @HelenParsons_1 Feb 2 Thought provoking day starting with heartbreaking talk from mum of Sam Morrish @WEAHSN #sepsissavvy early recognition is key 3 retweet 2 likes

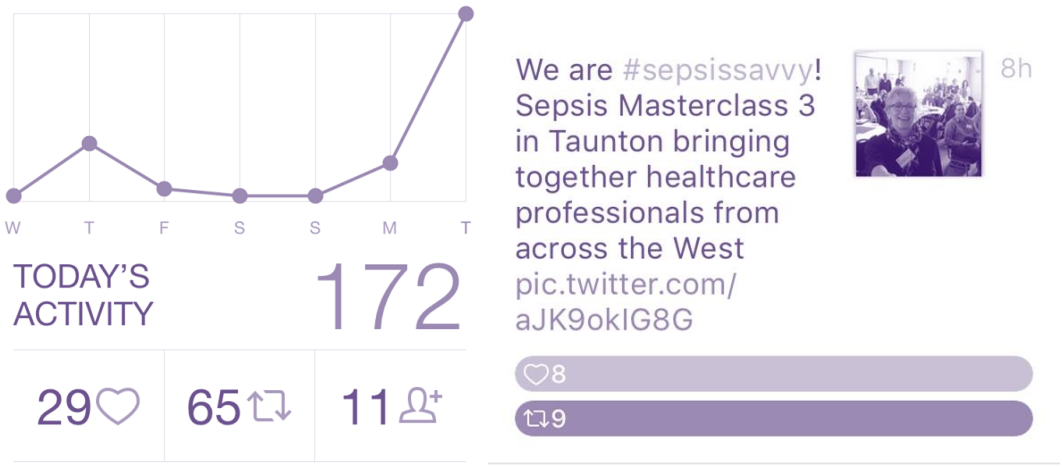
OutreachEm @nemmayoung Feb 2 @WEAHSN thought some people may like use our Red Flag Sepsis training video http://youtu.be/ZxZ-w_ncseI freely available to all on YouTube 2 retweet 1 likes

Helen @hellie66 Feb 2 @WEAHSN @lythell_nic @SepsisUK @MarkCJuniper brilliant 3rd study day thank you. Hope we can make an impact in primary care 2 retweet 5 likes

Mandy Pegden @MandyPegden Feb 2 @lythell_nic @Universityofoxf @WEAHSN measure vital signs and give antibiotics in the first hour / not rocket science but saves lives 1 retweet 0 likes

Ann Remmers @AnnRemmers Feb 2 Under recording of sepsis widespread @WEAHSN @SWSCN #sepsissavvy 1 retweet 0 likes

Septic Nic @lythell_nic Feb 2 Still can't get through the telling of Sam's story without leaky eyes, thank you Sue Morrish, you're amazing! @WEAHSN SepsisMasterclass 3 5 retweet 2 likes



Other resources mentioned include:

- APPG Sepsis Report 2015 http://sepsisappg.com/wp-content/uploads/2014/02/APPGsepsis2015.pdf
- NHS England, Improving outcomes for patients with sepsis, a cross system action plan 2015 https://www.england.nhs.uk/wp-content/uploads/2015/08/Sepsis-Action-Plan-23.12.15-v1.pdf
- MedsIQ – sharing QI resources for paediatric medication safety http://www.medsiq.org/
- Kent Surrey Sussex AHSN webpage with links to all sepsis resources by setting: http://www.kssahsn.net/what-we-do/KSSPatientSafetyCollaborative/sepsis/Pages/resources-and-links.aspx

Thank you to everyone involved in the day!