Okay. I'm anxious to get two major issues in before we have to finish, and those are on public health campaigns. The first one is going to be sepsis, led by Angela, and then hepatitis C, led by Julie. So, Angela.127

Angela Burns AM 10:27:19

Video

Thank you very much indeed. I wanted to understand how you measure the success of a public health campaign and how you believe we are doing on the sepsis public health campaign.128

Dr Tracey Cooper 10:27:36

Video

If I take the second point first, I'm sure you may be familiar with the fact that we've been doing a huge amount of work around sepsis over the last number of years, particularly through the lens of how we prevent people deteriorating rapidly, and sepsis is part of that. So, we've been doing, if you like, a professional campaign for the last number of years, and I'll come back to the public in a second. Our 1000 Lives Improvement service interacts with the NHS, and we've been putting people through substantial training and it's now part of their mandatory training modules around early deterioration and sepsis specifically.129

Angela Burns AM 10:28:14

Video

Can you just define that for us, though? When you say that you've put 'substantial numbers of people', are we talking hospital staff or are we talking about general practice?130

Dr Tracey Cooper 10:28:25

Video

It's mainly hospital staff. General practice is a really important one, because we know that a considerable number of people who will progress to sepsis are coming in at quite a late stage

from the primary and community area. So, our focus has been, over the last couple of years, more around the secondary care hospital areas, but, in the last 12 months, we've increased our approach around primary and community care, providing more guidance and providing support around sepsis screening.131

Also, through our 1000 Lives team, shortly we'll be embarking on a programme for care homes, as well, because we know, particularly around urinary tract infections, skin infections and infected pressure ulcers—. So, how do we train people up more generally around quality improvement and sepsis being part of that? So, that's a really important area.132

We've also been doing a lot around the alert. A lot of sepsis can be avoided, as you know, and some sepsis can't be avoided. So, what does an alert in a hospital environment look like? What we call the early warning score in any part of an environment in a hospital is what the signs and symptoms are of someone, at the early stages, starting to manifest sepsis and what they do about it. Because, sometimes, people watch and watch and watch, and we compensate and then we deteriorate very quickly. So, we know that, through that work, we've had a significant reduction in people requiring intensive care and people deteriorating. We're doing another round of outcome measurements around how many lives have been saved as a result of this programme, obviously, because that's going to be absolutely key.133

With the improvements around reducing sepsis, though, we were actually recognised in Wales as one of the global professional campaigns of systematising an approach to sepsis through early warning in a way that other countries haven't. But obviously that needs to translate into reducing it. At the moment we have around about 2,200 deaths per year in Wales, and 13 per cent of those are in hospitals. So, again, going back to how we've systematised this, we've been doing a lot of education and training for people. I accept your point around primary and community care, which is a really important phase for us—the surveillance, detection and alert. So, now health boards are required to alert Welsh Government if there's a person that goes into sepsis, and then demonstrate how they've learned from that, which I think is really key—134

10:30

Angela Burns AM 10:30:58

Video

Can I just ask you—? Because I'm conscious that the Chair will breathe down my neck in a minute. Can I just ask you a couple of questions on that bit of it, before we get to the public health element of it? Do you monitor how many people contract sepsis and survive, but survive poorly—i.e. they have multiple issues, they may have lost a number of limbs, they may have had mental health issues as a result, they may have had brain incapacity as a result? Because you're right; in pure terms, there is a small—and I emphasise the words 'very small'—reduction in the number of sepsis deaths. But what I cannot find out—and I'm the chair of the cross-party group on sepsis, and believe me, I've burrowed through data, but I cannot find out—is how many people are surviving, but you wouldn't necessarily say they had a great quality of life afterwards. Are you able to provide that kind of figure work? Do you measure that anywhere? Because of course that is whether or not we're being successful.135

Dr Tracey Cooper 10:32:01

Video

Absolutely. The short answer is that I'm not aware that we are—. We look at it, as you say, at that point of time, for that episode, that the patient didn't deteriorate, didn't die from sepsis. The extent to which we then do the follow ups—because it may not be just that they're in the hospital stage of subsequent complications; it could be further down the line. I'm not aware that we do, but I'm very happy to go and research it and get back to you.136

Angela Burns AM 10:32:30

Video

I'd be really interested in that. Also, when it comes to the analysis of the data, it would be very helpful to find out where people are being referred from, because we have a clear—. I think the RRAILS programme is actually very good, and I think it has made substantial changes to the way sepsis is managed within a hospital environment. However, again, what we're unable to really track well is how many people are admitted to hospital having not been handled appropriately in either a care home setting or in a GP setting. I've done quite a bit of research with GPs who—. It's very difficult. You don't know if this person's got flu, or it's going to go into sepsis, or they've got a urinary tract infection and it's going to develop. But again we could have a commonality, particularly in care homes, about who gets looked at in a care home or not looked at in a care home, particularly if it's not a medically based care home, and is left then too long and is

suddenly taken in as sepsis. So, I'd like to have a feel for that, and then I'd like to have just a brief word on whether or not you think a public health campaign to explain to people what they need to look at, the signs of sepsis, or just being sepsis aware, or asking, 'Could it be sepsis?'—whether or not you think that would be of benefit.137

Dr Tracey Cooper 10:33:51
Video

We know that 80 per cent of people who attend hospital and become septic originate from primary and community care. So, we have historically been targeted at the hospital, probably because it's actually easier to try and control people. As I was saying earlier, we recognise that, actually, primary and community care is key. My background is as an emergency medical physician, and I was a regulator in a different country, so the quality of care in care homes was fundamental to us, and I would suggest it's about building an understanding quite quickly around deterioration that could be from sepsis. It may be as a result of something else, but actually, it's the fact that sometimes people aren't detected as clinically deteriorating.138

The other challenge is about primary care, and the thresholds for calling a GP into a care home setting. So, part of the conversation we're having even around immunisation and vaccinations and flu, potentially, is whether there are opportunities to train other people up—registered nurses in care homes and others—around those early signs of deterioration. So, we are developing a quality improvement programme—not solely sepsis, but sepsis is part of that—around care homes, for that very reason, because we know it's like a rotating door. I'm very happy to give you more detail or meet with you if that would be helpful to give you some more information on that. 139

In relation to the public health campaign or public campaign around sepsis, it's a really interesting one. We have similar discussions around many campaigns, actually. You may be aware that in 2016 England launched a public sepsis campaign. Scotland did some work as well. What we don't know—we haven't been privy to it; it may be working through—is the evidence that, actually, that made a difference to reducing the incidences of sepsis and the outcome of care as a result of sepsis. We've had discussions on and off, I'd say for about a year or so, with Welsh Government officials about this very issue. We get asked quite a lot about doing public campaigns, understandably, on areas. What I would say is that there are campaigns around a lot areas that people invest a lot of public money in and, actually, that may not be the way of really getting to the people who can make a decision to control something, to prevent something. 140

Angela Burns AM 10:36:22

Video

I do totally understand that and, of course, I think one of the dangers with politicians is that we all have a little hobby horse. I'm prepared to admit that mine is sepsis, so I completely get that—you can't rush off and do campaigns around everything. However, sepsis does kill more people per year than the top three cancers. Now, you could ask almost anybody anywhere in Great Britain what cancer is, and they will tell you. You can go almost anywhere in Great Britain and say to people, 'Do you know what sepsis is?' and a huge number will not know what on earth you're talking about. Now, you cannot drive down a road in England—if you pass an ambulance it will have the sepsis warning signs. Every ambulance. I've travelled around and I've taken photos of the things to prove to Wales that there are small things that we could do. To be frank, it's—what do you call it—an orphan event; it's not one of the big ones. We all get cancer and we all understand what it means, but it's killing people. But worse than killing people—and I mean worse than killing people—is that it leaves people devastated afterwards. Very few people walk away from sepsis clean and clear. There are multiple amputations. There is always a side effect. I've yet to meet a sepsis survivor who's had it and has been A-okay afterwards. So, again, on the public health and the benefits in the long term, the pick-up that the state has to do is phenomenal, so I don't quite understand why we wouldn't want to start elevating this up the process, because of those very sort of lifestyle changes that will happen. 141

Dr Tracey Cooper 10:38:15

Video

Yes. I would say it's a priority for us. It's been a continued, very focused piece of work for 1000 Lives, and we've increased progress on that. I'd be delighted to meet and have a conversation about this, because it used to be one of my bugbears in a former world. Yes, it's about what are the messages to which audience. I think one of the challenges is that people may go to their GPs, and at that point it may not be picked up. So, it is about making sure that, actually, we don't just focus on one at the cost of another. It's what the best—we were talking a bit about behaviour change earlier—what's the best message for the public through what medium, what's the best message and guidance, support and direction to professionals through what medium. But I'd love to meet up and have a more detailed discussion about it. 142

Angela Burns AM 10:39:06

Video

Right. You're on. Just one last very small question—and again, other Members here may be more aware of this than I am. I'm chair of the group, but it was only at the last group that I heard of the early warning score. Now, that's supposed to be a public health initiative. So, essentially, we all have a card—I don't know if everybody else is aware of this—and basically it says what is your normal baseline: what is your normal temperature, what is your normal blood pressure, what's your normal— 143

Dai Lloyd AM 10:39:42

Video

Pulse rate.144

Angela Burns AM 10:39:43

Video

—pulse rate; you know, all of the things, so that if your score—. And it's on a card, so that if you then are unwell there's a baseline that a medical professional will be able to judge you from. I think that's a brilliant idea, and if everyone in Wales had one then you've got something to start measuring people on. But I'd never heard of it. How far out is that? Why isn't that kind of thing being more promoted in public health? Because that would be a good baseline for a gazillion illnesses.145

Dr Tracey Cooper 10:40:14

Video

Certainly, the national early warning score, we've embedded it in—again, it's more hospital based—for the last number of years. It is absolutely fundamental to start to understand if someone is going to clinically deteriorate in exactly the way that you've just said, particularly if it's a pregnant woman whose physiology is different. We've investigated a sepsis case of someone who sadly died in another country because the clinicians, the people looking after her, didn't understand that her body responds differently in the third trimester than it does when you're wandering around the streets. So, we have a national early warning score that is mainly—and the approach has been—in hospital. It's also about what an obstetric early warning score is and what a paediatric early warning score is. Actually, there's some good stuff that's happened, which again I'm happy to discuss with you. The challenge of having it out and about with you is that your body changes. So, my baseline today could be—. When I'm running, which I really need to do later today, my baseline would be different. The important thing is, while you have observations, if you go to your GP periodically or if you're in a hospital—the only way they can do that is baselining what's normal for you at that point in time and what are the red flags.146

Dai Lloyd AM 10:41:34

Video

Okay. I think we've done sepsis. Can we do hepatitis C now, Julie?147

Julie Morgan AM 10:41:37