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Ymchwiliad i Sepsis
Inquiry into Sepsis
Ymateb gan Fwrdd Iechyd Prifysgol Hywel Dda
Response from Hywel Dda University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Hywel Dda University Health Board Consultation Response: Sepsis

- **What understanding there is about sepsis incidence, how sepsis is presenting to services, and outcomes from sepsis:**

  All Hywel Dda University Health Board (HDdUHB) clinical staff receive annual UK Core Skills mandatory training. National statistics for sepsis incidence are included within these programs. This information is also included within any primary/social care training delivered by our Health Board staff.

  As part of annual events marking World Sepsis Day, information on sepsis is made available to both the public and our Health Board staff.

  Health Board, community and hospital-acquired sepsis incidence data is collected and collated on a weekly basis, across all four acute care sites. All four Emergency admission departments discuss and review their cases weekly. Monthly reports are disseminated to each hospital triumvirate and clinical team, and are discussed at our local governance site meetings and scrutinised at our local forums with improvement plans agreed and monitored.

  Bi-monthly reports, which include mortality rates, are presented to the HDdUHB's Resuscitation/RRAILS (Rapid Response to Acute Illness Learning Set) group. Incidence and compliance with treatment is also reported bi-monthly, to the Health Board's Operational Quality and Safety sub-group. Exception reports are presented at frequent Executive meetings.

- **Public and professional awareness of sepsis:**

  Throughout the year, many of our Health Board clinical teams organise public events.

  The teams have fed back that there is an increasing awareness of the term sepsis, and the public are becoming increasingly aware of symptoms, the people that are at risk and the lifestyle/public health choices which can minimise the risk of developing sepsis.

  Within secondary care areas, all clinical staff regularly following standard operating procedures to recognise and treat sepsis.

  A recent national RRAILS Peer Review of HDdUHB concluded:-

"Acute Deterioration Standard Operating Procedures are well defined, evidence-based and understood on all acute sites.
The Sepsis 6 care bundle is widely recognised as the standard treatment in the receiving units.

These protocols appeared to be understood in clinical areas, with formal sepsis training given to staff on induction, mandatory and ward-based."

- **Identification and management of sepsis in out-of-hospital settings, including use of relevant screening tools/guidance, and the referral process between primary/secondary care:**

  In relation to community and primary care nursing teams within HDdUHB, it has been recognised that within these teams, there is no standard practice regarding the use of NEWS (the National Early Warning Score Tool), nor regarding prevention and management of acute deterioration in the community. This situation started to be addressed a few years ago, when Eve Lightfoot (then working as a Community Infection prevention nurse), became concerned that there was no education for community staff around sepsis or the early recognition of deterioration in patients in the community. She began to raise awareness of the issue, and commenced a research internship and project which focused on sepsis recognition by district nurses. Subsequently, working closely with local community teams, Eve was supported by colleagues and the 1000 Lives RRAILS Team in further developing this work, which with her active influence, eventually resulted in the work stream becoming a national priority in 2019. Her passion, enthusiasm and drive was recognised in 2018, when in addition to winning the Community Nursing Award category, she was named the RCN (Royal College of Nursing) Nurse of the Year in Wales.

  Key changes and achievements followed, and include:

  - the establishment of a community/primary care-focused Out-of-Acute Hospital RRAILS group,
  - the introduction of a training package for Sepsis and awareness-raising for the NEWS tool, in addition to annual Basic Life Support Training for community nurses,
  - the procurement of equipment required to undertake NEWS for all community nursing teams,
  - a pilot of Community NEWS observation charts,
  - an escalation process, and
  - the development of a NEWS SBAR communication form.

  In March 2019, the Chief Nursing Officer (CNO) mandated that NEWS be rolled out and implemented by all district nursing teams across Wales. As a result, Mandy Rayani, HDdUHB's Director of Nursing, Quality and Patient Experience, and Jill Paterson, Director of Primary Care, Community and Long

Term Care asked Polly Leett, Senior Nurse, Primary Care Lead, to lead on this work programme in community/primary care settings, in tandem with HDdUHB's Out-of-Acute Hospital RRAILS group and the Public Health Wales 1000 Lives Out-of-Hospital RRAILS Programme. In accordance with the

principles of "A Healthier Wales," the focus of this work is that care is delivered to patients in their own homes and in community settings, and that they receive the same benefits of NEWS as those who are in hospital.
A review and evaluation of work to date was undertaken in HDdUHB, and a plan was designed to take this work forward using a joined up service approach across community and primary care services, starting with community nursing teams and GP practice teams. As a result a group project has been established under the umbrella of the Hywel Dda University Health Board Quality Improvement Collaborative, a quality improvement development programme which offers expert support and coaching.
The project aim is to improve practice within community and primary care teams, specifically around the identification, prevention and management of acute deterioration in the community, using the NEWS tool.
Additionally, the SBAR communication tool will aid communication between services in community, primary care and secondary care. The project team members are: Eve Lightfoot (Advanced Nurse Practitioner Primary Care (trainee) and Quality Improvement Nurse) ,Polly Leett (Senior Nurse Primary Care), Glenys Evans (Administrator), Paula George *(*Community Practice and Professional Development Nurse, Pembrokeshire), Rebecca Morris (District Nurse Team Leader, Pembrokeshire), Lorraine Handicott (Primary Care Development Nurse), Sian Hall (Senior Nurse Simulation and Resuscitation), Dr Catherine Burrell (County Associate Medical Director, Pembrokeshire), and Coach Sian Hopkins (Quality Improvement Lead).
Tenby Surgery and the local District Nursing Team in Pembrokeshire have agreed to be the first area to test the "proof of concept" of this improvement work. It is supported by the GPs in the practice, Rhian Mathias (Lead Practice Nurse), Rebecca Morris (District Nurse Team Leader) and Practice Manager and practice team. The Tenby project was launched on the 13th of September, 2019 at the practice on World Sepsis Day with planned implementation scheduled for November 2019.

All of HDdUHB's community hospitals use NEWS to facilitate the triggering of sepsis screening. The Health Board are currently reviewing the incidence of sepsis, as well as sepsis compliance within these areas, so as to inform future action plans.
It is hoped that the aforementioned project will lead to improved patient safety and empower nurses to make decisions which enhance patient outcomes.

- **Identification/management of sepsis in acute (hospital) settings:**

There is standardised practice across all four acute hospital sites.

Implementation of the NEWS system and the Sepsis recognition/treatment bundle has significantly increased the early recognition of patients with sepsis

across all emergency admission units and ward areas within our Health Board.

There has been an increasing use of the sepsis bundle, and compliance to Sepsis 6, has steadily improved over the last number of years, to over 90%.

All front-line staff are skilled in treating sepsis, but there are challenges in the Health Board Emergency Admission Units, in meeting the one-hour goal-directed treatment. Amongst the challenges are staff shortages and fluctuations in patient activity and acuity.

The Health Board's Sepsis monitoring groups regularly meet to discuss use of the bundle, sepsis compliance and reasons for non-compliance. Action plans are regularly reviewed to address any common trends regarding delays.

- **The physical and mental impact on those who have survived sepsis, and their needs for support:**

The Health Board are currently involved with a national work stream that will be establishing a Sepsis registry for patients who have been admitted into the Critical Care units. Such a register will identify a few, but not all of the patients affected (as most are not transferred to Critical Care units); however, the overarching aim is to identify these patients' needs, so as to inform their individualised supportive plans.

There is a need to widen the scope of this national workstream, in order to gain a better understanding of the actual impact on our patients, and what resources would be required.

Patient support groups have been established in some areas within Wales; there is a need to extend such support across all areas.

Patient support information has been developed by the Welsh Branch of the UK Sepsis Trust, and HDdUHB is currently discussing plans to ensure that this information will be available to all of our patients who have been treated for sepsis.