The George Institute for Global Health

Sepsis Australia

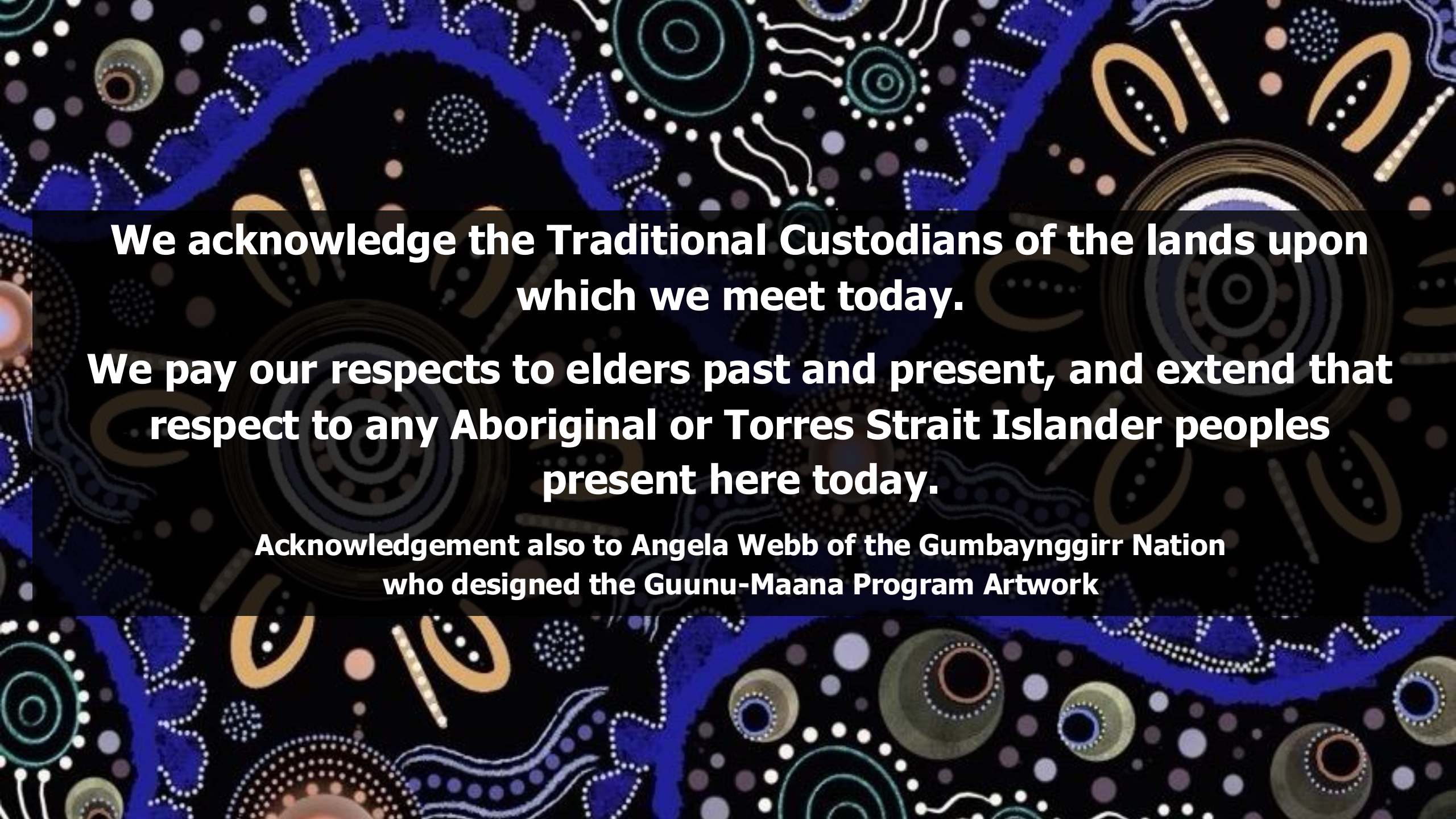
National Consumer Partner and Advocacy Symposium

Welcome

Prof Simon Finfer AO

Director

Sepsis Australia and Asia Pacific Sepsis Alliance


We acknowledge the Traditional Custodians of the lands upon which we meet today.
We pay our respects to elders past and present, and extend that respect to any Aboriginal or Torres Strait Islander peoples present here today.
Acknowledgement also to Angela Webb of the Gumbaynggirr Nation who designed the Guunu-Maana Program Artwork

Housekeeping

The George Institute for Global Health Australia

- Introductions when presenting, during question and discussion times, and to those on your table and in breakout group
- Register and collect name badge and Sepsis Australia
- Morning tea, lunch and afternoon tea, coffee, tea, water provided in the event space
- Bathrooms (accessible)
- Quiet space – see Brett and Maya
- Emergency procedure – please leave all belongings and follow the instructions of the fire wardens
- Photography/videography (Cain) – please sign the consent form or let any of the team know if not comfortable
- Travel/accommodation reimbursements when all receipts are received
- Update on the program
- Please relax and enjoy the day – get involved as much or as little as comfortable – we are just so pleased you're here!

Time	PROGRAM	Lead
10:00	Welcome and Acknowledgement of Country	Simon
10:10	Symposium overview, objectives, housekeeping, Symposium 2024 Outcomes	Brett
	SETTING THE SCENE	
10:15	Burden of sepsis and priorities for prevention, care, support and research	Simon
10:25	Sepsis landscape	Brett
	SURVIVORSHIP	
10:35	Sepsis Support Research Program – Overview & Results	Jacob & Naomi
10:45 (45 min)	Sepsis Support Research Program – Working Groups	All
	STOPPING SEPSIS NATIONAL ACTION PLAN 2.0	
11:30	Stopping Sepsis National Action Plan 2017 (SSNAP 1.0)	Brett
11:40	Australian Stopping Sepsis National Action Plan 2026 (Au-SSNAP 2.0)	
11:50	Working group session overview, discussion and questions	
1200	**LUNCH (30 MIN)**	
	WORKING GROUPS	

12:30 (45 min)	Leadership, Advocacy and Preparedness	Awareness, Education and Prevention	Coordinated Care and Post Sepsis Support	Data, Surveillance and Research
Chair	Simon	Caitlin	Naomi	Bala
Scribe	Maya	Fran	Jacob	Ash
Report	Group Nominee	Group Nominee	Group Nominee	Group Nominee
13:15	Workgroup presentations/discussion (4 X 5 min each)			
13:35	SACPAP Endorsement of Stopping Sepsis National Action Plan 2026/31 (FINAL DRAFT)			

	SEPSIS LIVED EXPERIENCE OUTCOME MEASURES	
13:45	Outcomes in sepsis trials - what are consumer priorities? ADRENAL Study (steroid therapy in sepsis)	Simon
	CONSUMER ADVOCACY AND STATE PROGRAM INITIATIVES	
14:05	Mandate Sepsis Protocols Campaign, Event and Petition	Sandra & Deb
14:20	Safer Care Victoria	Jacob
14:35	Open Forum	All
	CONSUMER SYMPOSIUM WRAP	
14:55	Closing remarks and next steps	Simon & Naomi
15:00	Meeting concludes	

Afternoon Refreshments

Objectives

- Learn about the current burden of sepsis and emerging priorities for prevention and care
- Better understand the current global and national landscape for coordinated action to tackle sepsis
- Inform the future development of sepsis survivorship support interventions and services
- Understand the progress made on the Stopping Sepsis National Action Plan 2017 (SSNAP 1.0)
- Review and further refine the consumer prioritised draft Australian Stopping Sepsis National Action Plan 2026 (Au-SSNAP 2.0)
- Endorse the Au-SSNAP 2.0 pillars and recommendations for national action on sepsis
- Inform the development and selection of meaningful outcome measures for research evaluation
- Gain insights into examples of effective sepsis awareness and advocacy initiatives

Sepsis Australia

Sepsis Australia

National Consumer Symposium
2026

Setting the Scene

Simon Finfer & Brett Abbenbroek

The George Institute
for Global Health

Sepsis Australia

The George Institute for Global Health Australia

Burden of sepsis and priorities for prevention, care, support and research

UNSW SYDNEY

Sepsis: Burden and priorities

- ACSQHC – 84,000 public hospital episodes each year, 12,000 deaths, $4 billion costs to society

- Priorities:
  - Awareness, recognition and rapid diagnostics
  - Effective treatments – mirroring Covid
  - Standardised and improved models of care
  - Education
  - Post-sepsis education and models of care
  - Reliable data
  - Research funding

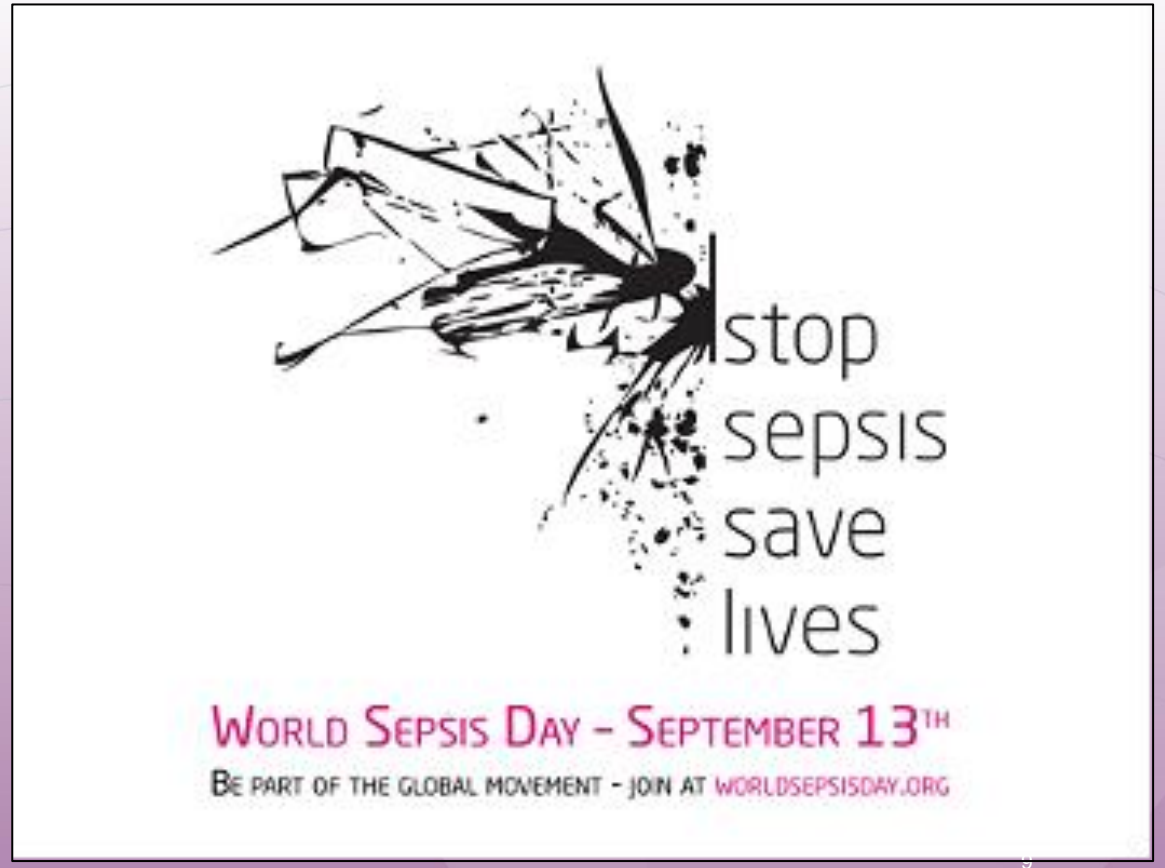
Global Sepsis Alliance

Asia Pacific Sepsis Alliance

Sepsis Australia

The George Institute for Global Health Australia

Questions?



UNSW SYDNEY

The George Institute for Global Health

Sepsis Australia

Sepsis Landscape

building global and national momentum

Dr Brett Abbenbroek
Program Manager
Sepsis Australia and Asia Pacific Sepsis Alliance

Sepsis burden

Global, regional, and national sepsis incidence and mortality, 1990–2021: a systematic analysis

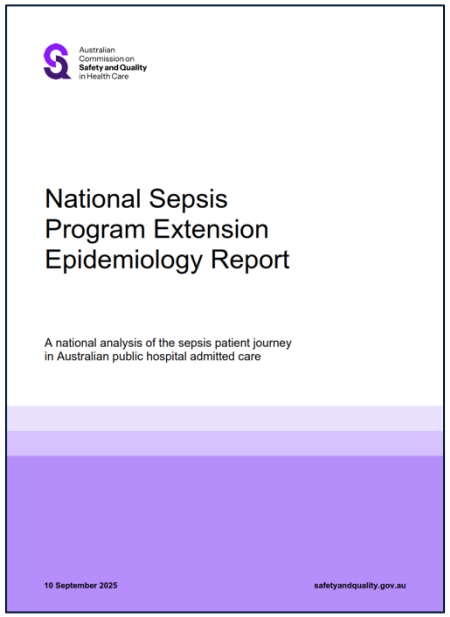
GBD 2021 Global Sepsis Collaborators*

Key findings:

- 166 million cases and 21.4 million deaths (2021)
- Nearly one-third of all global deaths
- Adults 15+ = 230% rise in incidence and 26% rise in mortality since 1990
- Older adults (70+) face the highest burden > 9 million deaths annually
- Overturn previous success in reducing deaths and underscore growing risks linked to chronic and infectious diseases

Sepsis burden (Australia) – Australian Commission and The George Institute

- Commission (data to 2023):
  - 90,000 cases annually (only public hospitals and explicit codes)
  - 12,000 deaths
  - 50% readmitted 30 days / 60% first 1 year
  - 50% increase in cost from 2013/14 to 2022/23
  - 50% long term sequelae



- The George Institute (Kumar 2023) (data to 2021):
  - 135,000 cases annually (public plus private hospitals but only explicit codes)
  - Population incidence of sepsis-coded hospitalisations increased from 18.6 / 10,000 (2002-03) to 51.3 / 10,000 (2021-21)
  - Hospitalisation cost increased at an annual rate of 20.6%, from $199M (2012) to $711M (2019)

Sepsis burden - survivorship

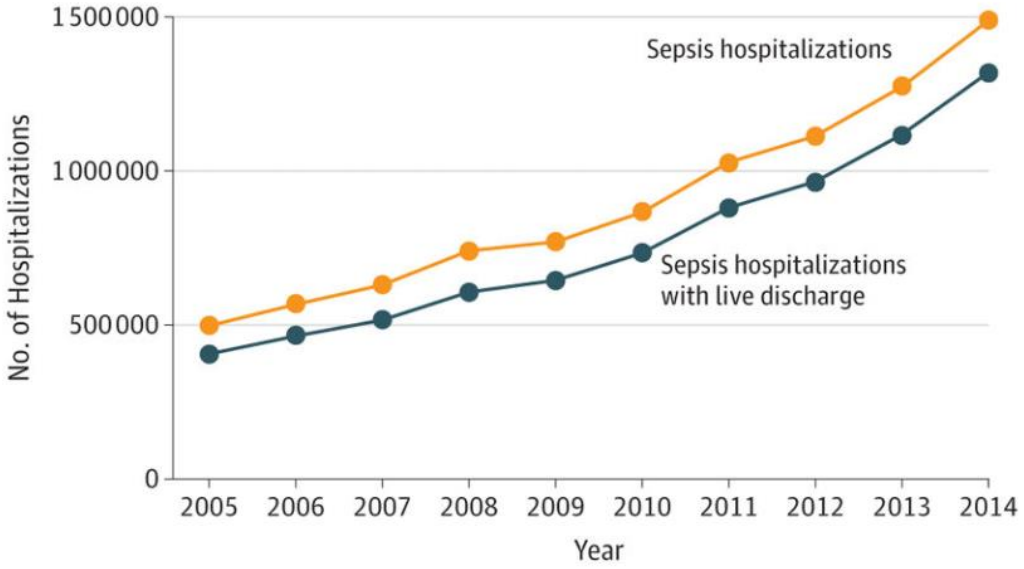


Figure 1. US Hospitalizations and Live Discharges for a Diagnosis of Sepsis, 2005–2014

Prescott and Angus 2018

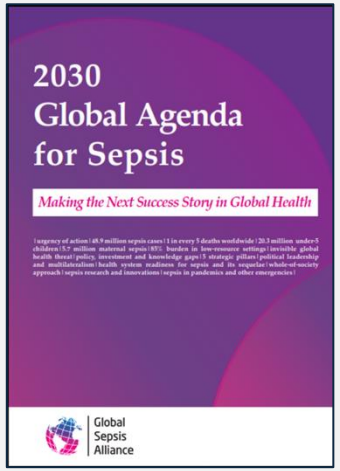
Global Survivorship – Pooled Data

Year	Estimated Mortality %	Estimated Survival %
2016	23%	77%
2017	22%	78%
2018	22%	78%
2019	21%	79%
2020	24%	76%
2021	25%	75%
2022	24%	76%
2023	25%	75%
2024	26%	74%
2025	25%	75%

Sources: GBD, WHO, World Metrics

Global progress

- Global Sepsis Innovation Platform > 36 organisations
- Global Sepsis Survivor and Family Committee
- U.S. Congress Allocates $5 Million to CDC to Expand Sepsis Programs (Feb 2026)
- European Commission pledged €244 million for new treatments for infections and sepsis (March 2026)
- GSA, Society of Critical Care Medicine and WHO launch “Saving Lives from Sepsis: From Evidence to Impact”, supported by a grant from the Laerdal Foundation (April 2026)
- Global Surviving Sepsis Guidelines (3rd revision) published April 2026 > WHO Clinical Management
- World Health Assembly (79) Side Event on Sepsis UN Geneva Palace (May 2026)
- GSA has been slated to become a permanent ‘actor’ at the World Health Assembly
- Sepsis focus in **UN level** Antimicrobial Resistance; Infection Prevention and Control; Vaccination and Pandemic Response Planning



- September 2024
- 5 Strategic Pillars
- 20 Priority Directions

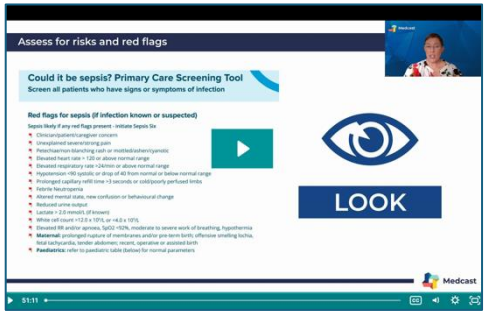
Surviving Sepsis Campaign®

Australia - National Sepsis Program Extension (concluded October 2025)

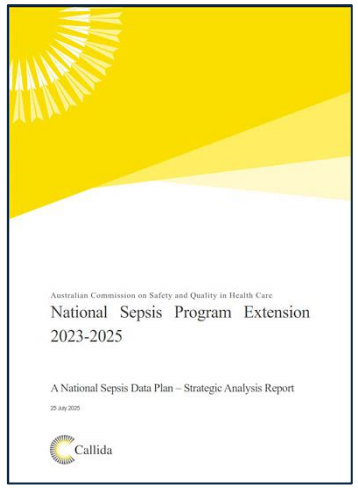
Awareness

Sepsis Recognition

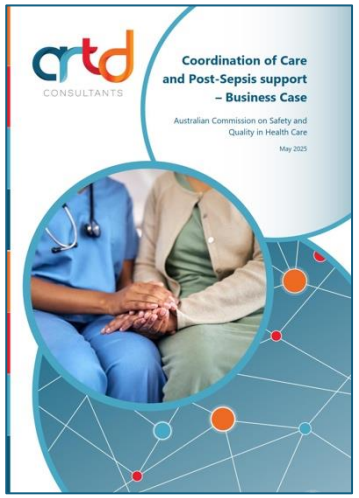
Education



Data for Quality Improvement



Coordinated care and Post Sepsis Support



Report to the Commonwealth recommending:

- Funding for an ongoing national body / agency to lead sepsis
- National Sepsis Program (No.3)
- Implementation focus

Awaiting response with potential for 2026 Budget announcement

Consumer lobbying on funding the Stopping Sepsis National Action Plan and Sepsis Clinical Care Standard

Lived experience codesign

- Sepsis Australia Consumer Partner and Advocacy Program (SACPAP)
  - Advocacy, education and prevention
  - Quality improvement in coordinated care and survivorship
  - Research

- Consumer Symposium 30 July 2026
  - Progress on outcomes from the Consumer Symposium 2024
  - Draft Stopping Sepsis National Action Plan 2nd Ed.
  - SEPSIS SUPPORT Research Program
  - Consumer led projects and research

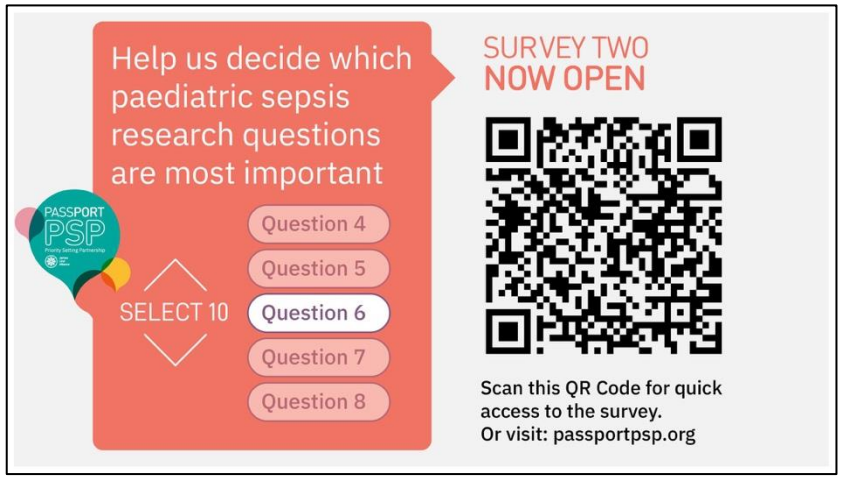
Advocacy and awareness

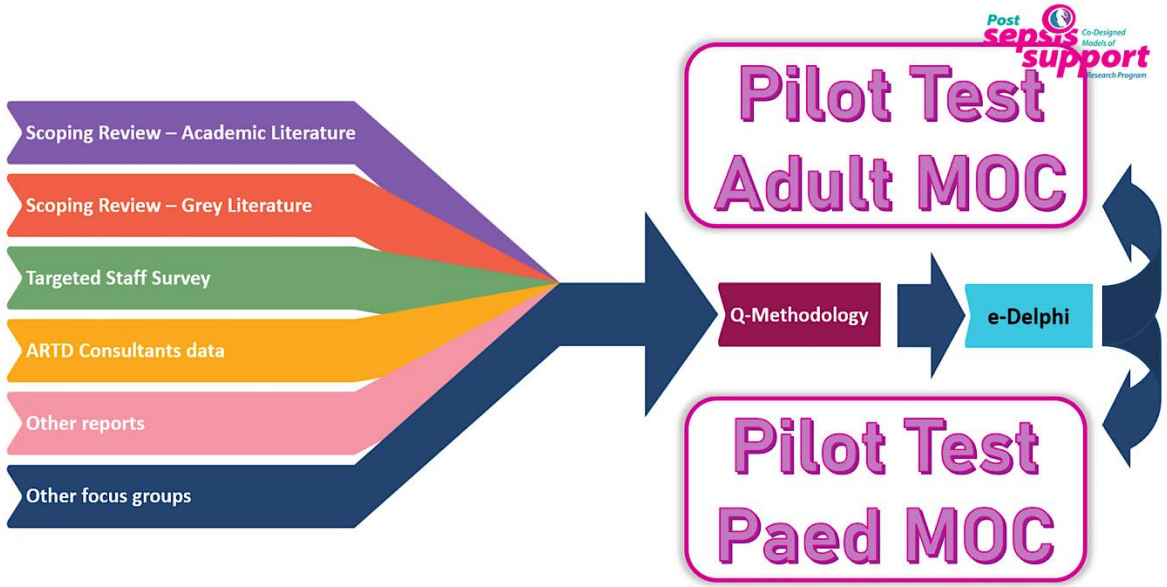
- Medical Research Future Fund Mission submission
- Canberra event and petition
- Consumer/Community led advocacy initiatives
- Paediatric Sepsis Week (19-26 April 2026)
- Influenza season “Lets tackle sepsis”
- Immunization Week
- Australian Sepsis Grand Rounds
- Maternal Sepsis Week (10-16 May 2026)
- Sept Sepsis Awareness Month/World Sepsis Day 13 Sept

	Studies (Sepsis Australia program team in all studies as partners, CI and/or AI's)	**Topic**	**Status**
1	SPOCT – Flinders consumer group	Point of care sepsis diagnostic testing device in remote clinics	Commenced
2	Long COVID study – UNSW consumer group	Impact of COVID and viral sepsis on outcomes	Commenced
3	Patient Reported Outcome Measures Review – Jake, Korina, Mick	ANZICS NCCR Systematic review of research evaluation outcomes	Complete > publish
4	Sepsis Research Priority Setting ICU (Adult) – Jake, Roxanne	Determine critical care research priorities in Adult sepsis care	Complete > publish
5	Sepsis Research Priority Setting ICU (Paed) – Mary, Jess L	Determine critical care research priorities in Paediatric sepsis care	Complete > publish
6	Sepsis Research Priority Setting ED (Pead) – Jess C, Tenielle	Determine emergency care research priorities in Paediatric sepsis	Commenced
7	FLUDRO-SHOCK Steroids – Matt, Jake, Leana, Caitlin	Steroid combinations to treat septic shock	Commenced
8	SEPSIS SUPPORT Research (Adult) – Matt, Korina, Caitlin, Jake, Mary	Coordinated care and post sepsis support	Commenced
9	SEPSIS SUPPORT Research (Paed) – Mary, Dawn	Coordinated care and post sepsis support	Commenced
10	SNAP-Long Term Follow Up – Lyn, Jake	Long term follow-up after bacterial blood stream infection e.g. PSS	Commenced
11	PASSPORT – Fluid resuscitation in sepsis (Pead)	Intravenous fluid resuscitation regimes	Commenced
12	PASSPORT Next - Paediatric Adaptive Sepsis Platform Trial (Extended)	Evaluate multiple sepsis interventions, models of care and cost	Commenced
13	Bloodstream Infection Genome Diagnostics (Pead) - Mary	Genomic diagnostic tests	Commenced
14	MERLIN Bloodstream Infection/AMR Rapid Diagnosis	Testing new rapid diagnostic technologies	Commenced
15	PREVENTS AKI – Jake plus external consumer group	Kidney damage in critical illness e.g. sepsis	Pilot complete > grant app
16	TIGERS Immunotherapies – Roxanne, Jake	Immunological therapies for sepsis	EOI success > 2nd round
17	Bloodstream Infection Outcomes - Jess (C)	Identifying best outcomes to measure	Application submitted
18	High Pressure Oxygen Therapy and ECMO – Mandy	Hyperbaric treatment for tissue damage post sepsis, injury, etc.	Application submitted
19	BALANCE Plus Bloodstream Infection Regimes – Brea, Fiona	More effective antibiotic treatments	Application submitted
20	NSW Biobank Program – Mick	Bank for biological specimens for research use	Application submitted
21	Sepsis Survivorship Centre of Research Excellence - Fiona	Organisation to coordinate multiple simultaneous studies on sepsis recovery	Application submitted
22	VIPCA-2 Trial (Adults) – Jake, external consumer	Evaluate safety and efficacy of peripheral vs central drug administration	Application submitted
23	BOOST ICU – Vaccines (Adult) - Jake	Evaluate vaccination status and efficacy of vaccine top up post sepsis	Application submitted
24	SAFETY – Fibrinolysis treatment – Korina, Jake	Evaluate treatment for dysregulated clotting and tissue damage in sepsis, illness	Application submitted
25	FRONTIERS Plasminogen treatment - Jake	Development of high-grade Plasminogen in local lab for treatment of fibrinolysis	Application submitted

Research areas – precision medicine and…

Post sepsis support Co-Designed Models of





Australian Commission on Safety and Quality in Health Care · Sepsis Australia · QUT Queensland University of Technology · Clinical Excellence Queensland · Queensland Government · The George Institute for Global Health Australia · UNSW Sydney · Federation University

MRFF Consumer Led Research Programs

Sepsis leadership – States, Territories and Community Advocacy Collaboration

- Sepsis National Action Plan > Sepsis Clinical Care Standard > implementation:
  - NSW Clinical Excellence Commission
  - QLD Paediatric and Adult Sepsis Programs
  - Western Australia Paediatric Sepsis Program and Royal Perth Hospital
  - NT Health Sepsis Management Plan
  - ACT Program Coordination
  - Tasmania Royal Hobart/Launceston Hospitals and Program Coordinator
  - Safer Care VIC (Peter MacCallum Cancer Centre)
  - South Australia Statewide Sepsis Improvement Priority Project 2026–27
- National Communities of Practice

Australia & NZ Sepsis Support Group

The George Institute for Global Health

Sepsis Australia

SEPTEMBER SEPSIS AWARENESS MONTH

Thank you

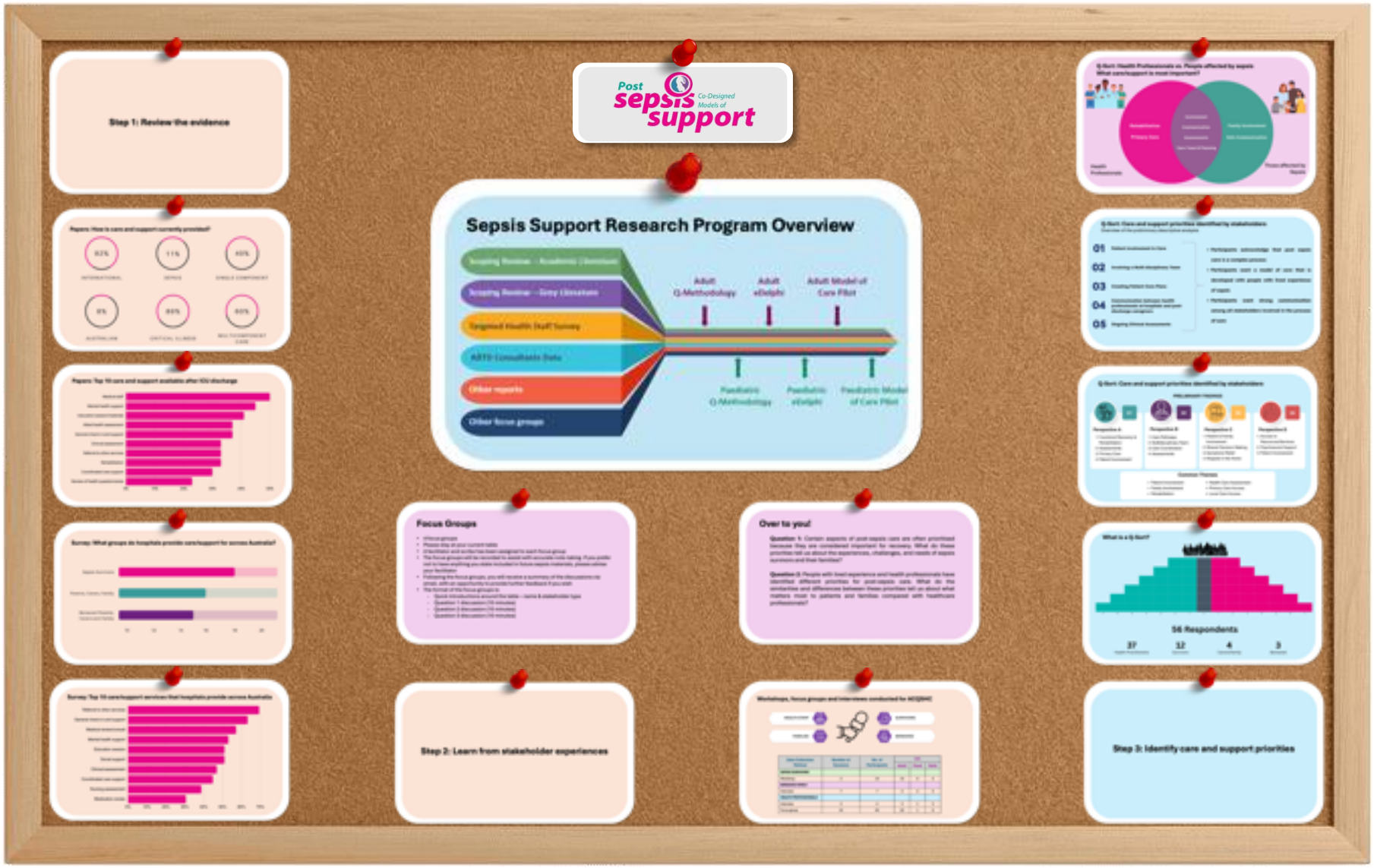
Sepsis Australia

National Consumer Symposium 2026

Survivorship

Naomi Hammond & Jacob Dye

The George Institute for Global Health



Program Partners

The George Institute for Global Health Australia

Queensland University of Technology

Clinical Excellence Queensland | Queensland Government

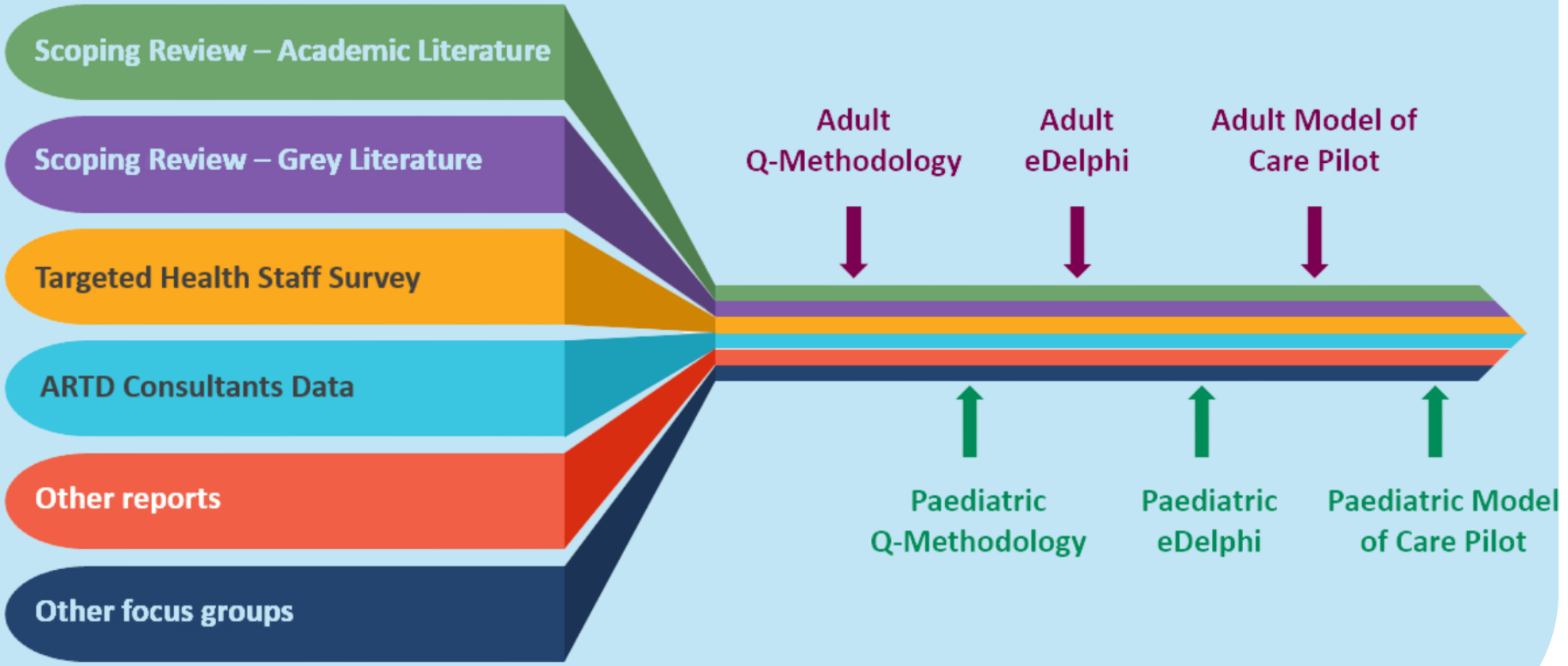
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Sepsis Australia

Acknowledgements

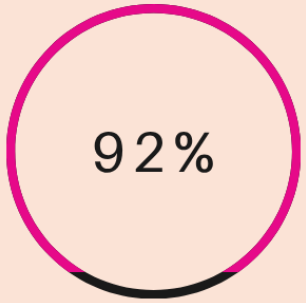
We acknowledge the Traditional Custodians of the land upon which we meet today. We pay our respects to elders, past and present. We extend that respect to any Aboriginal or Torres Strait Islander peoples present here today.

Sepsis Support Research Program Overview

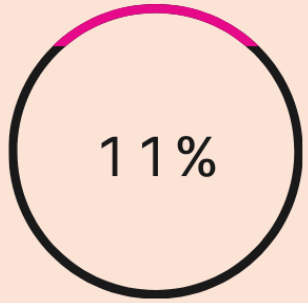


Step 1: Review the evidence

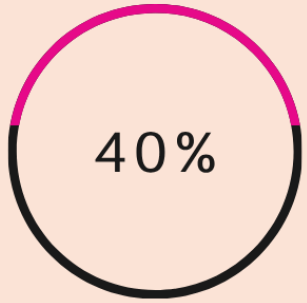
Papers: How is care and support currently provided?



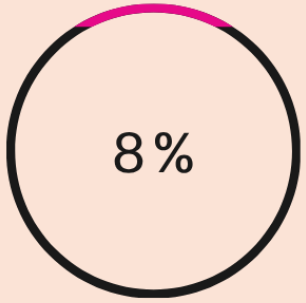
INTERNATIONAL



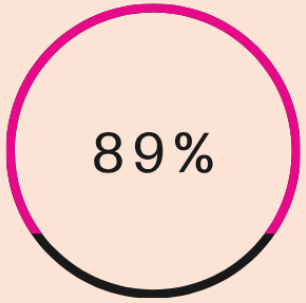
SEPSIS



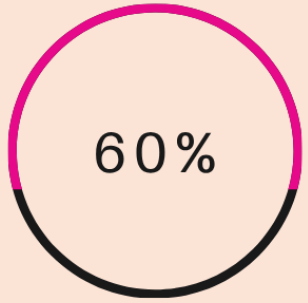
SINGLE COMPONENT



AUSTRALIAN

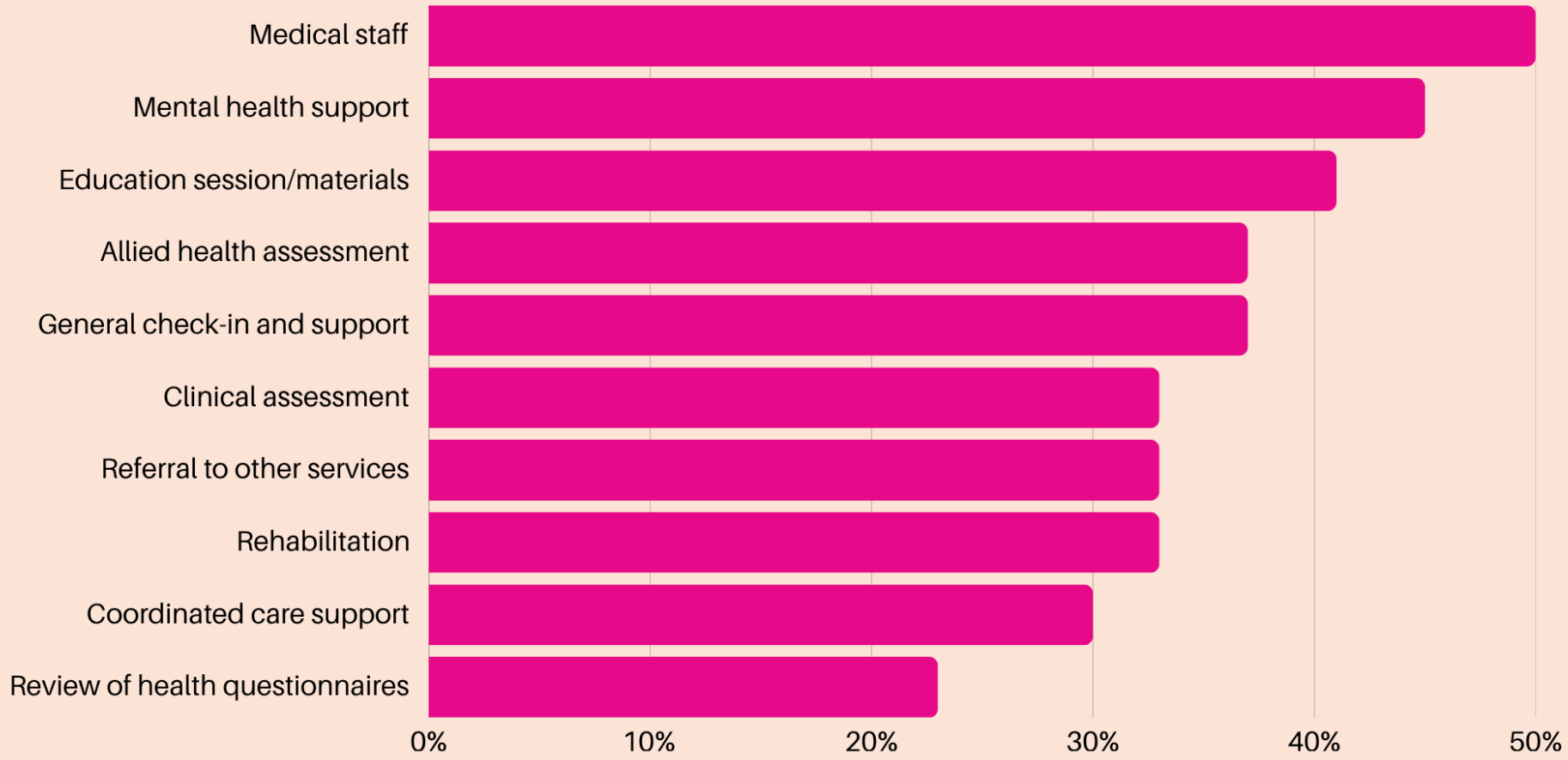


CRITICAL ILLNESS

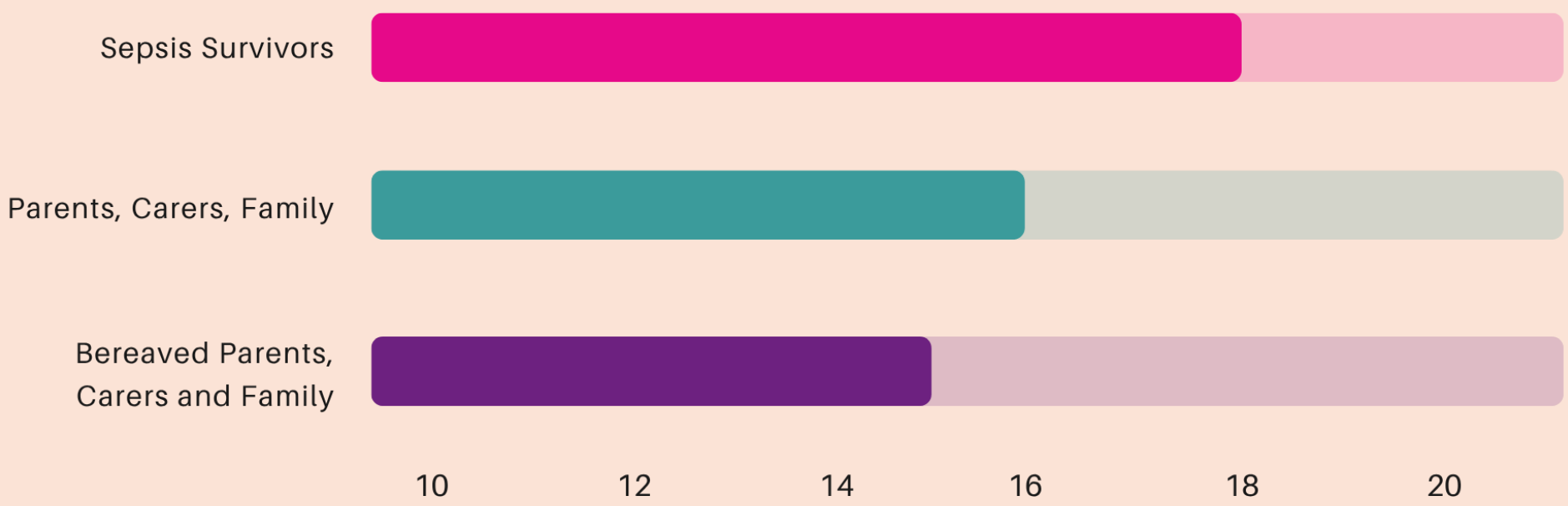


MULTICOMPONENT CARE

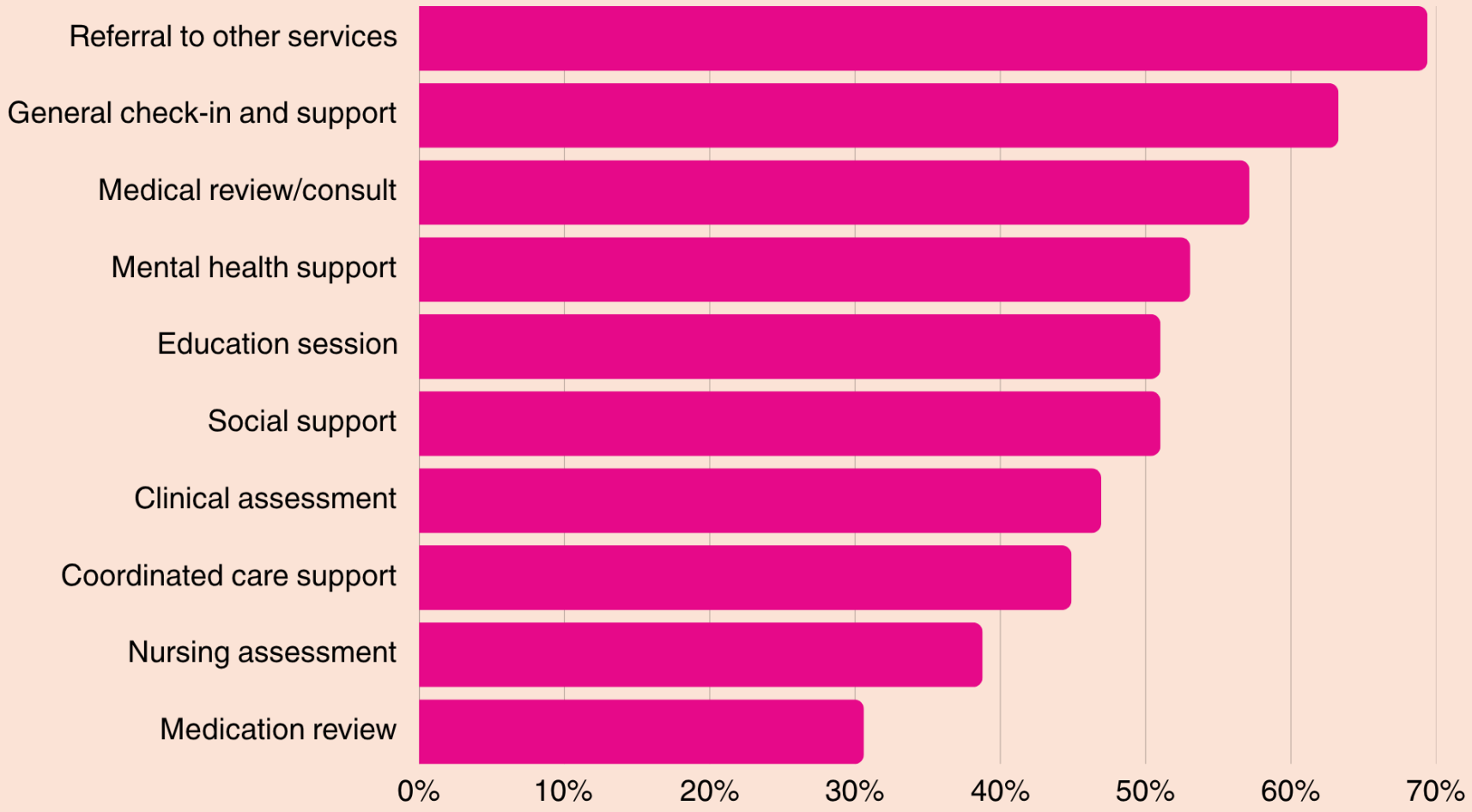
Papers: Top 10 care and support available after ICU discharge



Survey: What groups do hospitals provide care/support for across Australia?



Survey: Top 10 care/support services that hospitals provide across Australia

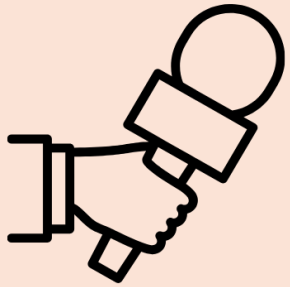


Step 2: Learn from stakeholder experiences

Workshops, focus groups and interviews conducted for ACQSHC

HEALTH STAFF

SURVIVORS



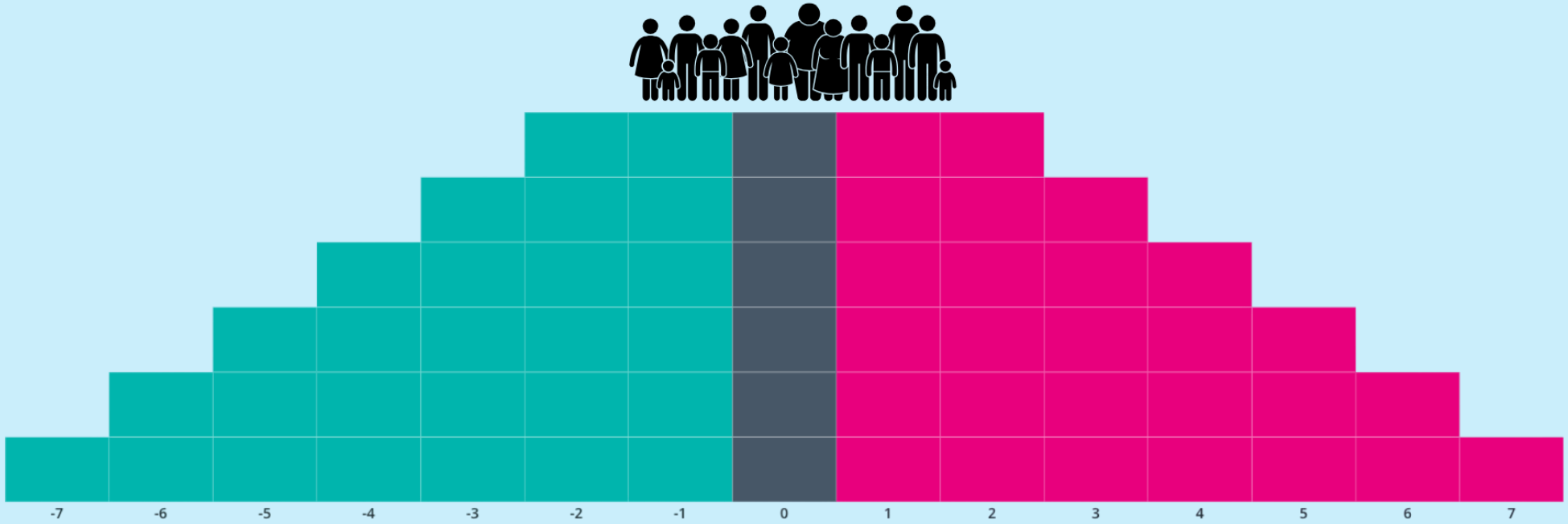
FAMILIES

BEREAVED

Data Collection Method	Number of Sessions	No. of Participants	AGE		
			Adult	Paed	Both
SEPSIS SURVIVORS					
Workshop	2	13	13	0	0
BEREAVED FAMILY					
Interview	7	7	3	4	0
HEALTH PROFESSIONALS					
Interview	3	4	3	1	0
Focus group	10	30	23	1	6

Step 3: Identify care and support priorities

What is a Q-Sort?



56 Respondents

37	12	4	3
Health Practitioners	Survivors	Carers/Family	Bereaved

Q-Sort: Care and support priorities identified by stakeholders

PRELIMINARY FINDINGS

01

Perspective A

1. Functional Recovery & Rehabilitation
2. Assessments
3. Primary Care
4. Patient Involvement

02

Perspective B

1. Care Pathways
2. Multidisciplinary Team
3. Care Coordination
4. Assessments

03

Perspective C

1. Patient & Family Involvement
2. Shared Decision Making
3. Symptoms Relief
4. Hospital in the Home

04

Perspective D

1. Access to Resources/Services
2. Psychosocial Support
3. Patient Involvement

Common Themes

- Patient Involvement
- Family Involvement
- Rehabilitation
- Health Care Assessment
- Primary Care Access
- Local Care Access

Q-Sort: Care and support priorities identified by stakeholders

Overview of the preliminary descriptive analysis

01 Patient involvement in Care

02 Involving a Multi-disciplinary Team

03 Creating Patient Care Plans

04 Communication between health professionals at hospitals and post-discharge caregivers

05 Ongoing Clinical Assessments

- Participants acknowledge that post sepsis care is a complex process
- Participants want a model of care that is developed with people with lived experience of sepsis
- Participants want strong communication among all stakeholders involved in the process of care

Q-Sort: Health Professionals vs. People affected by sepsis
What care/support is most important?

Rehabilitation

Primary Care

Involvement

Communication

Assessments

Care Team & Planning

Family Involvement

Safe Communication

Health Professionals

Those affected by Sepsis

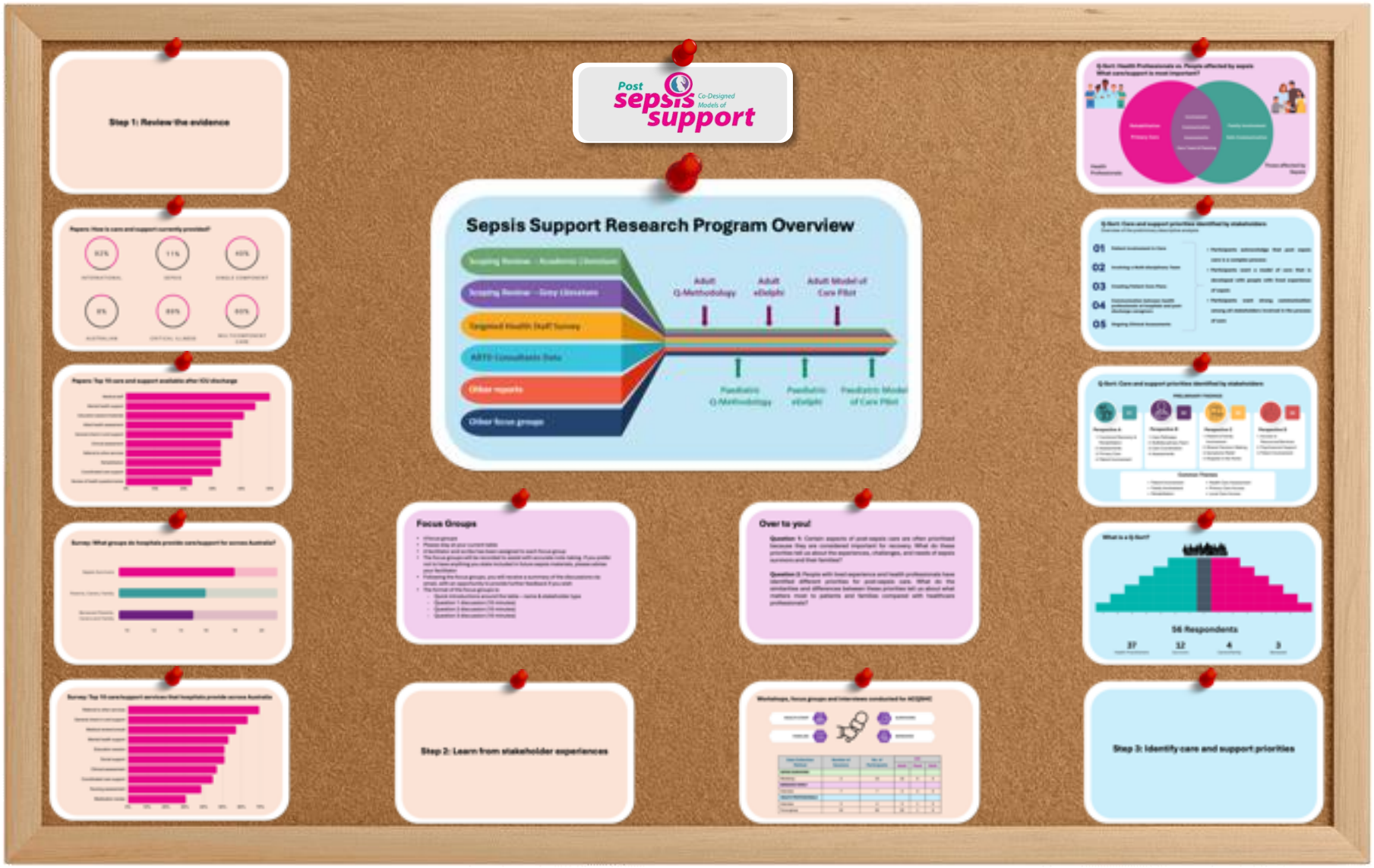
Focus Groups

- 4 focus groups
- Please stay at your current table
- A facilitator and scribe has been assigned to each focus group
- The focus groups will be recorded to assist with accurate note-taking. If you prefer not to have anything you state included in future sepsis materials, please advise your facilitator
- Following the focus groups, you will receive a summary of the discussions via email, with an opportunity to provide further feedback if you wish
- The format of the focus groups is:
    - Quick introductions around the table – name & stakeholder type
    - Question 1 discussion (10 minutes)
    - Question 2 discussion (10 minutes)
    - Question 3 discussion (10 minutes)

Over to you!

Question 1: Certain aspects of post-sepsis care are often prioritised because they are considered important for recovery. What do these priorities tell us about the experiences, challenges, and needs of sepsis survivors and their families?

Question 2: People with lived experience and health professionals have identified different priorities for post-sepsis care. What do the similarities and differences between these priorities tell us about what matters most to patients and families compared with healthcare professionals?



Program Partners

The George Institute for Global Health Australia

Queensland University of Technology

Clinical Excellence Queensland | Queensland Government

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Sepsis Australia

Acknowledgements

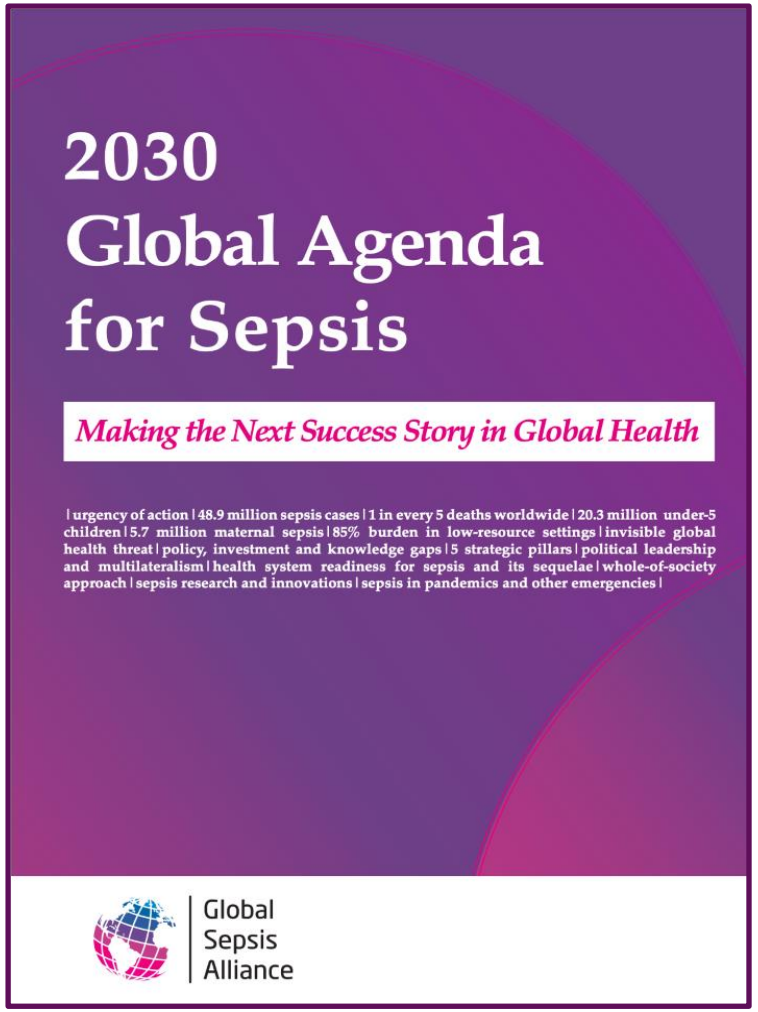
We acknowledge the Traditional Custodians of the land upon which we meet today. We pay our respects to elders, past and present. We extend that respect to any Aboriginal or Torres Strait Islander peoples present here today.

Stopping Sepsis National Action Plan

Dr Brett Abbenbroek
Program Manager
Sepsis Australia and Asia Pacific Sepsis Alliance

WHA Adopts Resolution on Sepsis

Video Address from WHO Director-General
2030 Global Agenda for Sepsis

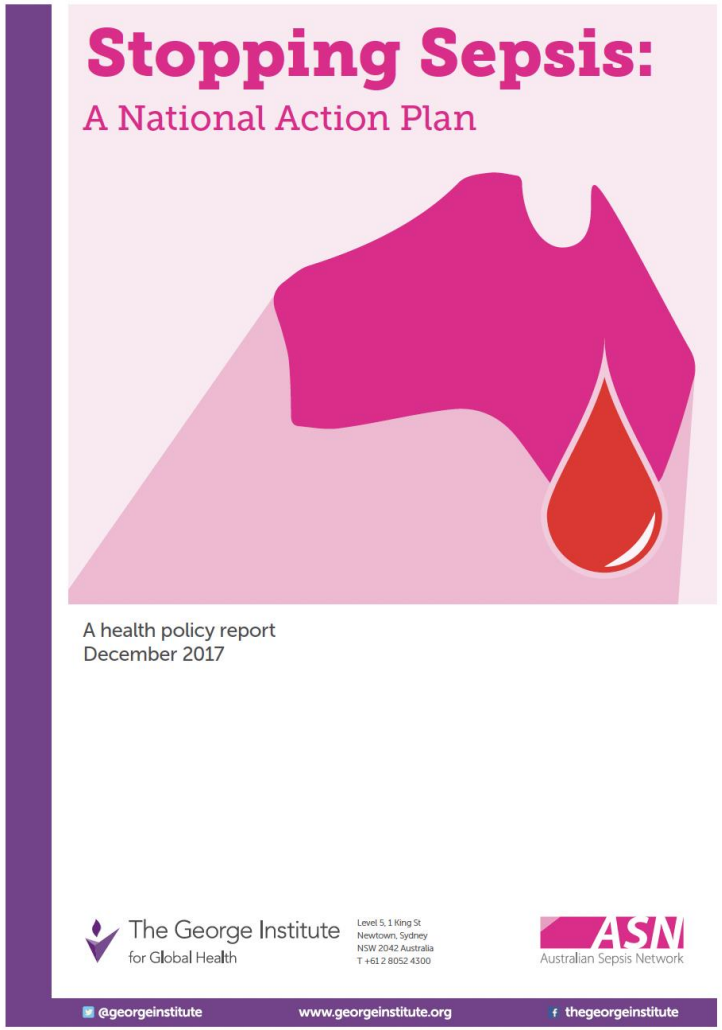


5 Strategic Pillars

2030 Global Agenda for Sepsis

- Political Leadership and Multilateral Cooperation
- Health System Readiness for Sepsis and its Sequelae
- Whole-of-Society Approach
- Sepsis Research and Innovations
- Sepsis in Pandemics and other Emergencies

National action on sepsis in Australia (SSNAP 1.0 2017)



Consensus
4 strategic priorities

1. *Establish a nationally-coordinated sepsis body to facilitate the action plan.*
2. *Invest in prevention and awareness campaigns to spur action within the community.*
3. *Establish and implement a nationally recognised clinical standard for sepsis detection and treatment.*
4. *Invest in community and peer support services for sepsis survivors and their families.*

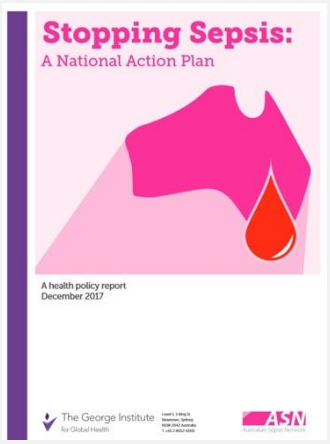
1. Advocacy ambassadors
2. National sepsis awareness
3. National World Sepsis Day
4. Documentation and coding
5. Build research capacity
6. Targeted and education
7. National standard of care
8. Pathways and tools
9. Coordinated model of care
10. Coordinated post sepsis care
11. Peer support group
12. Post sepsis resources

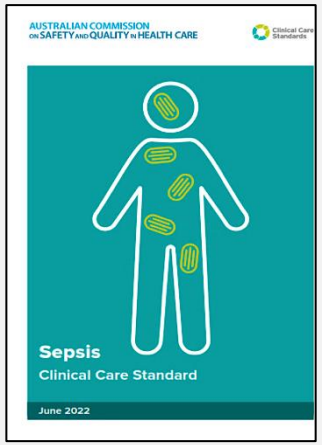
Achieved			
SSNAPP 1.0 Recommendations	**Sepsis Australia**	**National Sepsis Program (1)**	**National Sepsis Program (2)**
Advocacy ambassadors	Consumer Partners	SACPAP	SACPAP
National sepsis awareness	Ongoing program	Toolkit	Social media campaign “Sepsis Challenge”
World Sepsis Day	National coordination and support of events, social media, resources	Awareness Resources	
Documentation and coding	Research - prospective study	Medical record review	National data plan
Build research capacity	Industry, academic, health services collaboration Increasing implementation research		
Targeted and education	Digital Sepsis Pocketbook		Primary Care
National standard of care		**Sepsis Clinical Care Standard**	Implementation projects
Pathways and tools	State based pathways and tools only in some health services	Greater take up/standardisation	
Coordinated model of care	Acute focus		Coordinated sepsis care model Business case
Coordinated post sepsis care		Survivorship research	Coordinated post sepsis care model
Peer support group	Australian and NZ Sepsis Support Group (Fiona)		
Post sepsis resources	Life after sepsis package, letters		

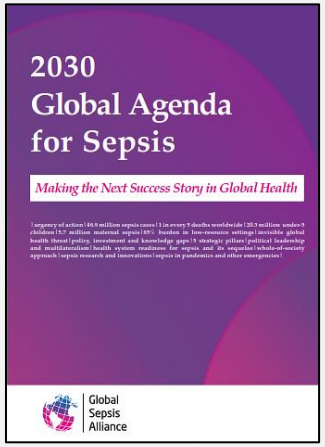
National Sepsis Clinical Care Standard

CLINICAL CARE STANDARD | PROFESSIONAL RESOURCES | CONSUMER RESOURCES | CASE STUDIES

Australian Stopping Sepsis National Action Plan (Au-SSNAP 2.0)







SACPAP consumer prioritisation based on lived experience

Supporting evidence and global best practice

Consumer & health system review and endorsement

Au-SSNAP 2.0

5 year strategy

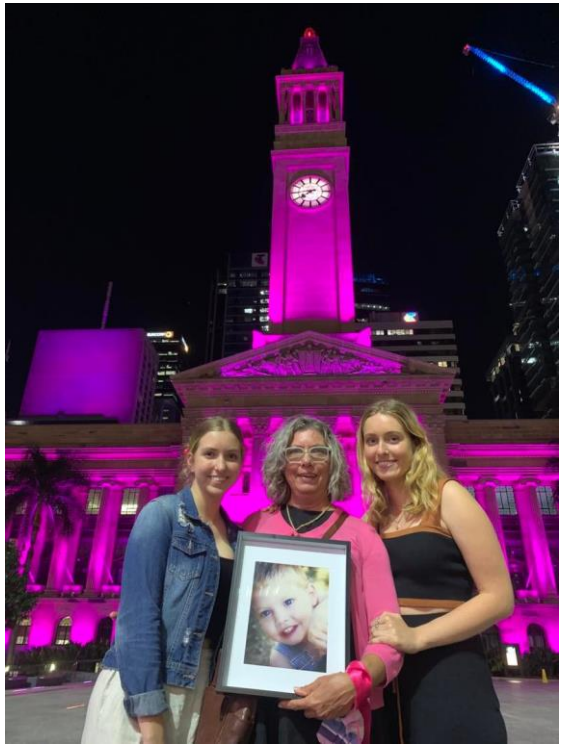
Funding

- **Consumer prioritisation** > retain recommendations, increase emphasis on digital solutions for recognition, diagnosis and post sepsis support
- Incorporate new evidence into existing recommendations to ensure latest best practice
- Pillars:

1. Leadership, Advocacy and Preparedness
2. Awareness, Education and Prevention
3. Coordinated Model of Sepsis and Post-Sepsis Support
4. Data, Surveillance and Research

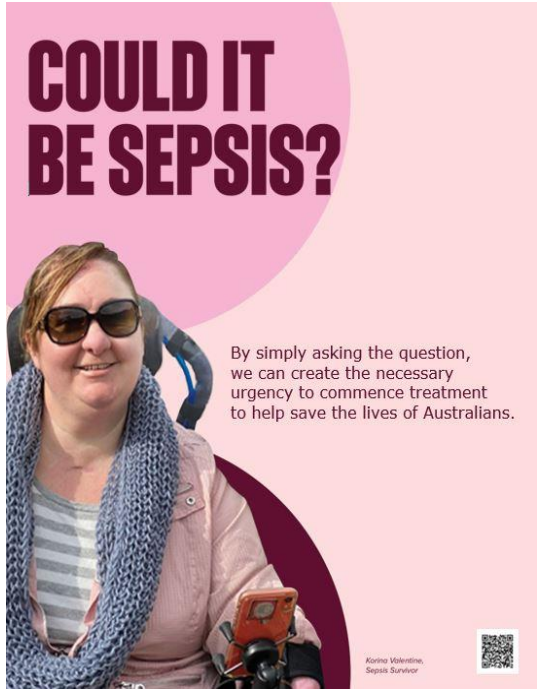
- Full implementation focus
- Barriers: leadership, funding, cultural resistance
- Enablers: funding, integrated standards, sepsis coordinator roles, community advocacy and partnerships, and consumer leadership

Advocacy




Sepsis


AWARENESS


COULD IT BE SEPSIS?
By simply asking the question, we can create the necessary urgency to commence treatment to help save the lives of Australians.
Korina Valentine, Sepsis Survivor

Australian Stopping Sepsis National Action Plan

(Au-SSNAP 2.0)

Reducing Preventable Death and Disability 2nd Ed.

(Draft v0.1)

July 2026

Contents

Methodology

Au-SSNAP 2.0 commenced with a structured review and gap analysis of the original SSNAP recommendations, evaluating progress achieved through the National Sepsis Program, implementation of the SSCS, state and territory sepsis programs, community awareness initiatives, and survivorship support activities.

The review considered:

- Achievements against the original SSNAP recommendations
- National Sepsis Program/s outputs
- Implementation status of the SCCS
- National epidemiology and awareness data
- Consumer-reported experiences and outcomes;

The gap analysis established the evidence base for consumer-led prioritisation, a defining feature of Au-SSNAP 2.0, of pillars and actionable recommendations. Consumers, including sepsis survivors, families, carers and those bereaved by sepsis, participated as equal partners in the development process through lived experience perspectives. Consistent with international best practice, consumer engagement extended beyond consultation to genuine co-design and shared decision-making.[7, 38, 41]

Summary of recommendations

Au-SSNAP 2.0 contains four strategic pillars as the foundation for a coordinated national approach to reducing the burden of sepsis in Australia, that would be implemented by 16 actionable recommendations, i.e.

- **PILLAR 1 - Leadership, Advocacy and Preparedness**
  - Recommendation 1.1 National and health service leadership
  - Recommendation 1.2 Sepsis as a major public health priority
  - Recommendation 1.3 Preparing health services
  - Recommendation 1.4 Disaster response preparedness
- **PILLAR 2 - Awareness, Education and Prevention**
  - Recommendation 2.1 Improving public literacy and changing behaviour
  - Recommendation 2.2 Public awareness and education
  - Recommendation 2.3 Building workforce skills and capacity
  - Recommendation 2.4 Screening and diagnostics
- **PILLAR 3 - Coordinated care and post sepsis support**
  - Recommendation 3.1 Standardised care across the continuum
  - Recommendation 3.2 Shared decision making
  - Recommendation 3.3 Coordinated integrated care
  - Recommendation 3.4 Post sepsis care and support
- **PILLAR 4 - Data, surveillance and research**
  - Recommendation 4.1 National data governance coordination
  - Recommendation 4.2 Iterative data system maturity
  - Recommendation 4.3 National sepsis registry and surveillance
  - Recommendation 4.4 Build research capacity

Each recommendation requires funded resources, workforce, infrastructure and operational management, as detailed in this report, for effective delivery and implementation to maximise impact and the realisation of benefits in terms of prevention and reduced sepsis burden for survivors, families and carers, and those bereaved by sepsis; demand on health services, direct and indirect economic cost; and societal loss of productivity.

WORKING GROUPS				
12:30 (45 min)	Leadership, Advocacy and Preparedness	Awareness, Education and Prevention	Coordinated Care and Post Sepsis Support	Data, Surveillance and Research
Chair	Simon	Caitlin	Naomi	Bala
Scribe	Maya	Fran	Jacob	Ash
Report	Group Nominee	Group Nominee	Group Nominee	Group Nominee
13:15	Workgroup presentations/discussion (4 X 5 min each)			
13:35	SACPAP Endorsement of Stopping Sepsis National Action Plan 2026/31 (FINAL DRAFT)			

Working Group Guidance

Au-SSNAP 2.0 Pillars, Recommendations and Core Requirments are described in the following section of this resource pack (NB. the core elements have been further refined and will continue to be based on the feedback received).

Please refer to the relevant Pillar to inform your work group discussions as guided by the questions.

The scribe will record the discussions to generate a transcript that will be used to inform create the Symposium report and distilled down to key themes, issues and suggestions that need to be further considered in the final draft of the Au-SSNAP 2.0.

The scribe will also capture any key points to feedback to the Symposium

Instructions:

1. Please **focus only on the Pillar assigned to your workgroup**
2. We want to hear your insights - you do not need to be a technical expert
3. The core requirements for each Recommendation can inform discussions
4. Note pages are provided after each Pillar if required
5. Nominate a representative to feedback key points to the Symposium
6. Decide if your workgroup would endorse the Pillar and Recommendations.

Questions:

1. Are topics grouped within each Pillar appropriate and do they make sense?
2. Are the four Recommendations made to action the Pillar appropriate?
3. Are there any amendments needed to the current Recommendations?
4. Are additional Recommendations needed to fully deliver the Pillar?
5. Are additional core requirements needed to action the Recommendations?
6. Do you have any other suggestions for Au-SSNAP 2.0?

Pillar 2 Awareness, Education and Prevention

Recommendation	Core Requirements
2.1 Improving public literacy and changing behaviour	1. Action-oriented messaging to prioritise behavioural outcomes 2. Focus on recognising deterioration from infection rather than actual recognition of sepsis itself 3. Amplify 'Faces of Sepsis' lived-experience storytelling as a central foundation of a national literacy strategy 4. Normalise help-seeking to reduce uncertainty about accessing emergency care and empower to escalate concerns confidently
2.2 Public awareness and education	1. Engage high profile sepsis ambassadors and champions 2. Deliver an annual national awareness campaign calendar aligned with current and emerging public health priorities 3. Formalise World Sepsis Day the focal point for advocacy 4. An annual September multi-modal sustained campaign leveraging commercial, earned and owned media 5. Improve access to care by promoting pathways to timely clinical advice and assessment 6. Educate about sepsis prevention through infection prevention, vaccination and initial actions 7. Evaluate awareness campaigns and education reach, behaviour change and health service utilisation
2.3 Building workforce skills and capacity	1. Clinician education as key to prevention standardised screening 2. Sepsis curriculum for undergraduate health programs 3. Postgraduate and continuous professional development (CPD) programs incorporate sepsis competencies aligned to professional standards 4. National Digital Sepsis Education Hub be established linking to jurisdiction-based training programs and resources 5. Adopt scenario-based, simulation and case-based learning 6. Clinical education should align with awareness initiatives
2.4 Screening and diagnostics	1. Standardised sepsis screening and escalation pathways across all healthcare settings 2. Invest in point-of-care testing research, development and use 3. AI-enabled digital clinical decision support systems with predictive algorithms for recognition and coordinated care 4. Develop a national "Time Zero" definition, marking the point when sepsis is first suspected clinically

Notes:

Sepsis Australia

National Consumer Symposium 2026

LUNCH
12:00-12:30

The George Institute for Global Health

Sepsis Australia

National Consumer Symposium 2026

WORKING GROUPS

The George Institute for Global Health

National Consumer Symposium
2026

SEPSIS LIVED EXPERIENCE OUTCOME MEASURES

Simon Finfer

The George Institute
for Global Health

Sepsis Australia

The George Institute for Global Health Australia

Outcomes in Sepsis Trials: what do consumers value?

UNSW SYDNEY

Outcomes in Sepsis Trials – traditional approach

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

ABSTRACT

BACKGROUND

Whether hydrocortisone reduces mortality among patients with septic shock is unclear.

METHODS

We randomly assigned patients with septic shock who were undergoing mechanical ventilation to receive hydrocortisone (at a dose of 200 mg per day) or placebo for 7 days or until death or discharge from the intensive care unit (ICU), whichever came first. The primary outcome was death from any cause at 90 days.

RESULTS

From March 2013 through April 2017, a total of 3800 patients underwent randomization. Status with respect to the primary outcome was ascertained in 3658 patients (1832 of whom had been assigned to the hydrocortisone group and 1826 to the placebo group). At 90 days, 511 patients (27.9%) in the hydrocortisone group and 526 (28.8%) in the placebo group had died (odds ratio, 0.95; 95% confidence interval [CI], 0.82 to 1.10; P=0.50). The effect of the trial regimen was similar in six prespecified subgroups. Patients who had been assigned to receive hydrocortisone had faster resolution of shock than those assigned to the placebo group (median duration, 3 days [interquartile range, 2 to 5] vs. 4 days [interquartile range, 2 to 9]; hazard ratio, 1.32; 95% CI, 1.23 to 1.41; P<0.001). Patients in the hydrocortisone group had a shorter duration of the initial episode of mechanical ventilation than those in the placebo group (median, 6 days [interquartile range, 3 to 18] vs. 7 days [interquartile range, 3 to 24]; hazard ratio, 1.13; 95% CI, 1.05 to 1.22; P<0.001), but taking into account episodes of recurrence of ventilation, there were no significant differences in the number of days alive and free from mechanical ventilation. Fewer patients in the hydrocortisone group than in the placebo group received a blood transfusion (37.0% vs. 41.7%; odds ratio, 0.82; 95% CI, 0.72 to 0.94; P=0.004). There were no significant between-group differences with respect to mortality at 28 days, the rate of recurrence of shock, the number of days alive and out of the ICU, the number of days alive and out of the hospital, the recurrence of mechanical ventilation, the rate of renal-replacement therapy, and the incidence of new-onset bacteremia or fungemia.

CONCLUSIONS

Among patients with septic shock undergoing mechanical ventilation, a continuous infusion of hydrocortisone did not result in lower 90-day mortality than placebo. (Funded by the National Health and Medical Research Council of Australia and others; ADRENAL ClinicalTrials.gov number, NCT01448109.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Venkatesh at the Department of Intensive Care, Wesley Hospital, 451 Coronation Dr., Auchenflower, Brisbane, QLD 4066, Australia, or at bvenkatesh@georgeinstitute.org.au.

*A full list of investigators in the ADRENAL Trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on January 19, 2018, at NEJM.org.

N Engl J Med 2018;378:797-808.
DOI: 10.1056/NEJMoa1705835

- Traditionally have focussed on survival – compare two treatments and count how many people survive are alive at a certain point e.g. 28, 30 or 90 days
- Also collect secondary outcomes which may include how many left hospital alive, how long in the ICU / hospital, how long on ventilator or dialysis or drugs to support blood pressure, sometimes collect measures of how well the survivors are at 6 months or a year later
- Traditionally can have only one primary outcome and determining if that improved defines whether a treatment works or not.

Outcomes in Sepsis Trials – win ratio approach

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

ABSTRACT

BACKGROUND

Whether hydrocortisone reduces mortality among patients with septic shock is unclear.

METHODS

We randomly assigned patients with septic shock who were undergoing mechanical ventilation to receive hydrocortisone (at a dose of 200 mg per day) or placebo for 7 days or until death or discharge from the intensive care unit (ICU), whichever came first. The primary outcome was death from any cause at 90 days.

RESULTS

From March 2013 through April 2017, a total of 3800 patients underwent randomization. Status with respect to the primary outcome was ascertained in 3658 patients (1832 of whom had been assigned to the hydrocortisone group and 1826 to the placebo group). At 90 days, 511 patients (27.9%) in the hydrocortisone group and 526 (28.8%) in the placebo group had died (odds ratio, 0.95; 95% confidence interval [CI], 0.82 to 1.10; P=0.50). The effect of the trial regimen was similar in six prespecified subgroups. Patients who had been assigned to receive hydrocortisone had faster resolution of shock than those assigned to the placebo group (median duration, 3 days [interquartile range, 2 to 5] vs. 4 days [interquartile range, 2 to 9]; hazard ratio, 1.32; 95% CI, 1.23 to 1.41; P<0.001). Patients in the hydrocortisone group had a shorter duration of the initial episode of mechanical ventilation than those in the placebo group (median, 6 days [interquartile range, 3 to 18] vs. 7 days [interquartile range, 3 to 24]; hazard ratio, 1.13; 95% CI, 1.05 to 1.22; P<0.001), but taking into account episodes of recurrence of ventilation, there were no significant differences in the number of days alive and free from mechanical ventilation. Fewer patients in the hydrocortisone group than in the placebo group received a blood transfusion (37.0% vs. 41.7%; odds ratio, 0.82; 95% CI, 0.72 to 0.94; P=0.004). There were no significant between-group differences with respect to mortality at 28 days, the rate of recurrence of shock, the number of days alive and out of the ICU, the number of days alive and out of the hospital, the recurrence of mechanical ventilation, the rate of renal-replacement therapy, and the incidence of new-onset bacteremia or fungemia.

CONCLUSIONS

Among patients with septic shock undergoing mechanical ventilation, a continuous infusion of hydrocortisone did not result in lower 90-day mortality than placebo. (Funded by the National Health and Medical Research Council of Australia and others; ADRENAL ClinicalTrials.gov number, NCT01448109.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Venkatesh at the Department of Intensive Care, Wesley Hospital, 451 Coronation Dr., Auchenflower, Brisbane, QLD 4066, Australia, or at bvenkatesh@georgeinstitute.org.au.

*A full list of investigators in the ADRENAL Trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on January 19, 2018, at NEJM.org.

N Engl J Med 2018;378:797-808.
DOI: 10.1056/NEJMoa1705835

- Win ratio analysis is intuitively attractive
- It recognises that all the outcomes collected may be important, but some may be more important than others
- Ranks the outcomes in order of importance – i.e. prioritises
- So, for a study that collected how many people are alive at a certain point AND how long people spent in the ICU / hospital AND on ventilator AND dialysis AND drugs to support blood pressure AND how well the survivors are at 6 months or a year later, we can ask the question which is 1st, 2nd, 3rd , etc most important outcome in a patient's priorities.

Win ratio comparing 100 patients given treatment A and 100 given treatment B

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

ABSTRACT

BACKGROUND

Whether hydrocortisone reduces mortality among patients with septic shock is unclear.

METHODS

We randomly assigned patients with septic shock who were undergoing mechanical ventilation to receive hydrocortisone (at a dose of 200 mg per day) or placebo for 7 days or until death or discharge from the intensive care unit (ICU), whichever came first. The primary outcome was death from any cause at 90 days.

RESULTS

From March 2013 through April 2017, a total of 3800 patients underwent randomization. Status with respect to the primary outcome was ascertained in 3658 patients (1832 of whom had been assigned to the hydrocortisone group and 1826 to the placebo group). At 90 days, 511 patients (27.9%) in the hydrocortisone group and 526 (28.8%) in the placebo group had died (odds ratio, 0.95; 95% confidence interval [CI], 0.82 to 1.10; P=0.50). The effect of the trial regimen was similar in six prespecified subgroups. Patients who had been assigned to receive hydrocortisone had faster resolution of shock than those assigned to the placebo group (median duration, 3 days [interquartile range, 2 to 5] vs. 4 days [interquartile range, 2 to 9]; hazard ratio, 1.32; 95% CI, 1.23 to 1.41; P<0.001). Patients in the hydrocortisone group had a shorter duration of the initial episode of mechanical ventilation than those in the placebo group (median, 6 days [interquartile range, 3 to 18] vs. 7 days [interquartile range, 3 to 24]; hazard ratio, 1.13; 95% CI, 1.05 to 1.22; P<0.001), but taking into account episodes of recurrence of ventilation, there were no significant differences in the number of days alive and free from mechanical ventilation. Fewer patients in the hydrocortisone group than in the placebo group received a blood transfusion (37.0% vs. 41.7%; odds ratio, 0.82; 95% CI, 0.72 to 0.94; P=0.004). There were no significant between-group differences with respect to mortality at 28 days, the rate of recurrence of shock, the number of days alive and out of the ICU, the number of days alive and out of the hospital, the recurrence of mechanical ventilation, the rate of renal-replacement therapy, and the incidence of new-onset bacteremia or fungemia.

CONCLUSIONS

Among patients with septic shock undergoing mechanical ventilation, a continuous infusion of hydrocortisone did not result in lower 90-day mortality than placebo. (Funded by the National Health and Medical Research Council of Australia and others; ADRENAL ClinicalTrials.gov number, NCT01448109.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Venkatesh at the Department of Intensive Care, Wesley Hospital, 451 Coronation Dr., Auchenflower, Brisbane, QLD 4066, Australia, or at bvenkatesh@georgeinstitute.org.au.

*A full list of investigators in the ADRENAL Trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on January 19, 2018, at NEJM.org.

N Engl J Med 2018;378:797-808.
DOI: 10.1056/NEJMoa1705835

- 72 patients given treatment A are alive, 71 given treatment B are alive
- We decide being alive is the most important thing
- Each alive patient given treatment A wins over every patient given treatment B who is not alive (72 x 29 = 2088 wins)
- Each alive patient given treatment B wins over every patient given treatment A who is not alive (71 x 28 = 1988 wins)
- We decide time in hospital is next most important thing
- So for those alive in group A we compare their time in hospital with time in hospital for each alive patient in group B and the same for group B patients – generates more wins for each group
- Can use an unlimited number of outcomes of decreasing importance to separate patients.

Win ratio comparing 100 patients given treatment A and 100 given treatment B

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

ABSTRACT

BACKGROUND

Whether hydrocortisone reduces mortality among patients with septic shock is unclear.

METHODS

We randomly assigned patients with septic shock who were undergoing mechanical ventilation to receive hydrocortisone (at a dose of 200 mg per day) or placebo for 7 days or until death or discharge from the intensive care unit (ICU), whichever came first. The primary outcome was death from any cause at 90 days.

RESULTS

From March 2013 through April 2017, a total of 3800 patients underwent randomization. Status with respect to the primary outcome was ascertained in 3658 patients (1832 of whom had been assigned to the hydrocortisone group and 1826 to the placebo group). At 90 days, 511 patients (27.9%) in the hydrocortisone group and 526 (28.8%) in the placebo group had died (odds ratio, 0.95; 95% confidence interval [CI], 0.82 to 1.10; P=0.50). The effect of the trial regimen was similar in six prespecified subgroups. Patients who had been assigned to receive hydrocortisone had faster resolution of shock than those assigned to the placebo group (median duration, 3 days [interquartile range, 2 to 5] vs. 4 days [interquartile range, 2 to 9]; hazard ratio, 1.32; 95% CI, 1.23 to 1.41; P<0.001). Patients in the hydrocortisone group had a shorter duration of the initial episode of mechanical ventilation than those in the placebo group (median, 6 days [interquartile range, 3 to 18] vs. 7 days [interquartile range, 3 to 24]; hazard ratio, 1.13; 95% CI, 1.05 to 1.22; P<0.001), but taking into account episodes of recurrence of ventilation, there were no significant differences in the number of days alive and free from mechanical ventilation. Fewer patients in the hydrocortisone group than in the placebo group received a blood transfusion (37.0% vs. 41.7%; odds ratio, 0.82; 95% CI, 0.72 to 0.94; P=0.004). There were no significant between-group differences with respect to mortality at 28 days, the rate of recurrence of shock, the number of days alive and out of the ICU, the number of days alive and out of the hospital, the recurrence of mechanical ventilation, the rate of renal-replacement therapy, and the incidence of new-onset bacteremia or fungemia.

CONCLUSIONS

Among patients with septic shock undergoing mechanical ventilation, a continuous infusion of hydrocortisone did not result in lower 90-day mortality than placebo. (Funded by the National Health and Medical Research Council of Australia and others; ADRENAL ClinicalTrials.gov number, NCT01448109.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Venkatesh at the Department of Intensive Care, Wesley Hospital, 451 Coronation Dr., Auchenflower, Brisbane, QLD 4066, Australia, or at bvenkatesh@georgeinstitute.org.au.

*A full list of investigators in the ADRENAL Trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on January 19, 2018, at NEJM.org.

N Engl J Med 2018;378:797-808.
DOI: 10.1056/NEJMoa1705835

	Patient A	Patient B	Result
Alive	Yes	Yes	Draw
Living at home	Yes	Yes	Draw
Back to work	Yes	No	A Wins
PTSD			
Time in hospital	-	-	
Time on ventilator	-	-	
	Patient A	Patient B	Result
Alive	Yes	Yes	Draw
Living at home	Yes	Yes	Draw
Back to work	Yes	Yes	Draw
PTSD	Yes	No	B Wins
Time in hospital	-	-	
Time on ventilator	-	-	

Reanalysing ADRENAL using a win ratio approach

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

ABSTRACT

BACKGROUND

Whether hydrocortisone reduces mortality among patients with septic shock is unclear.

METHODS

We randomly assigned patients with septic shock who were undergoing mechanical ventilation to receive hydrocortisone (at a dose of 200 mg per day) or placebo for 7 days or until death or discharge from the intensive care unit (ICU), whichever came first. The primary outcome was death from any cause at 90 days.

RESULTS

From March 2013 through April 2017, a total of 3800 patients underwent randomization. Status with respect to the primary outcome was ascertained in 3658 patients (1832 of whom had been assigned to the hydrocortisone group and 1826 to the placebo group). At 90 days, 511 patients (27.9%) in the hydrocortisone group and 526 (28.8%) in the placebo group had died (odds ratio, 0.95; 95% confidence interval [CI], 0.82 to 1.10; P=0.50). The effect of the trial regimen was similar in six prespecified subgroups. Patients who had been assigned to receive hydrocortisone had faster resolution of shock than those assigned to the placebo group (median duration, 3 days [interquartile range, 2 to 5] vs. 4 days [interquartile range, 2 to 9]; hazard ratio, 1.32; 95% CI, 1.23 to 1.41; P<0.001). Patients in the hydrocortisone group had a shorter duration of the initial episode of mechanical ventilation than those in the placebo group (median, 6 days [interquartile range, 3 to 18] vs. 7 days [interquartile range, 3 to 24]; hazard ratio, 1.13; 95% CI, 1.05 to 1.22; P<0.001), but taking into account episodes of recurrence of ventilation, there were no significant differences in the number of days alive and free from mechanical ventilation. Fewer patients in the hydrocortisone group than in the placebo group received a blood transfusion (37.0% vs. 41.7%; odds ratio, 0.82; 95% CI, 0.72 to 0.94; P=0.004). There were no significant between-group differences with respect to mortality at 28 days, the rate of recurrence of shock, the number of days alive and out of the ICU, the number of days alive and out of the hospital, the recurrence of mechanical ventilation, the rate of renal-replacement therapy, and the incidence of new-onset bacteremia or fungemia.

CONCLUSIONS

Among patients with septic shock undergoing mechanical ventilation, a continuous infusion of hydrocortisone did not result in lower 90-day mortality than placebo. (Funded by the National Health and Medical Research Council of Australia and others; ADRENAL ClinicalTrials.gov number, NCT01448109.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Venkatesh at the Department of Intensive Care, Wesley Hospital, 451 Coronation Dr., Auchenflower, Brisbane, QLD 4066, Australia, or at bvenkatesh@georgeinstitute.org.au.

*A full list of investigators in the ADRENAL Trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on January 19, 2018, at NEJM.org.

N Engl J Med 2018;378:797-808.
DOI: 10.1056/NEJMoa1705835

Outcomes collected:

- Number dead at 90 days
- Number dead at 28 days
- Number alive at 6 months
- Health related quality of life at 6 months (EQ-5D-5L)
  - Mobility, self care, usual activities, pain/discomfort, anxiety/depression.
- Time to resolution of shock
- Recurrence of shock
- Time in ICU
- Time in hospital
- Time on mechanical ventilator
- Treatment with dialysis
- New blood stream infection
- Blood transfusion

Reanalysing ADRENAL using a win ratio approach

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MARCH 1, 2018 VOL. 378 NO. 9

Adjunctive Glucocorticoid Therapy in Patients with Septic Shock

B. Venkatesh, S. Finfer, J. Cohen, D. Rajbhandari, Y. Arabi, R. Bellomo, L. Billot, M. Correa, P. Glass, M. Harward, C. Joyce, Q. Li, C. McArthur, A. Perner, A. Rhodes, K. Thompson, S. Webb, and J. Myburgh, for the ADRENAL Trial Investigators and the Australian–New Zealand Intensive Care Society Clinical Trials Group*

ABSTRACT

BACKGROUND

Whether hydrocortisone reduces mortality among patients with septic shock is unclear.

METHODS

We randomly assigned patients with septic shock who were undergoing mechanical ventilation to receive hydrocortisone (at a dose of 200 mg per day) or placebo for 7 days or until death or discharge from the intensive care unit (ICU), whichever came first. The primary outcome was death from any cause at 90 days.

RESULTS

From March 2013 through April 2017, a total of 3800 patients underwent randomization. Status with respect to the primary outcome was ascertained in 3658 patients (1832 of whom had been assigned to the hydrocortisone group and 1826 to the placebo group). At 90 days, 511 patients (27.9%) in the hydrocortisone group and 526 (28.8%) in the placebo group had died (odds ratio, 0.95; 95% confidence interval [CI], 0.82 to 1.10; P=0.50). The effect of the trial regimen was similar in six prespecified subgroups. Patients who had been assigned to receive hydrocortisone had faster resolution of shock than those assigned to the placebo group (median duration, 3 days [interquartile range, 2 to 5] vs. 4 days [interquartile range, 2 to 9]; hazard ratio, 1.32; 95% CI, 1.23 to 1.41; P<0.001). Patients in the hydrocortisone group had a shorter duration of the initial episode of mechanical ventilation than those in the placebo group (median, 6 days [interquartile range, 3 to 18] vs. 7 days [interquartile range, 3 to 24]; hazard ratio, 1.13; 95% CI, 1.05 to 1.22; P<0.001), but taking into account episodes of recurrence of ventilation, there were no significant differences in the number of days alive and free from mechanical ventilation. Fewer patients in the hydrocortisone group than in the placebo group received a blood transfusion (37.0% vs. 41.7%; odds ratio, 0.82; 95% CI, 0.72 to 0.94; P=0.004). There were no significant between-group differences with respect to mortality at 28 days, the rate of recurrence of shock, the number of days alive and out of the ICU, the number of days alive and out of the hospital, the recurrence of mechanical ventilation, the rate of renal-replacement therapy, and the incidence of new-onset bacteremia or fungemia.

CONCLUSIONS

Among patients with septic shock undergoing mechanical ventilation, a continuous infusion of hydrocortisone did not result in lower 90-day mortality than placebo. (Funded by the National Health and Medical Research Council of Australia and others; ADRENAL ClinicalTrials.gov number, NCT01448109.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Venkatesh at the Department of Intensive Care, Wesley Hospital, 451 Coronation Dr., Auchenflower, Brisbane, QLD 4066, Australia, or at bvenkatesh@georgeinstitute.org.au.

*A full list of investigators in the ADRENAL Trial is provided in the Supplementary Appendix, available at NEJM.org.

This article was published on January 19, 2018, at NEJM.org.

N Engl J Med 2018;378:797-808.
DOI: 10.1056/NEJMoa1705835

Where are we at?

- Has been done using researchers' prioritisation
- We would like to do using lived experience priorities

What do we want?

- 10 – 12 people with lived experience to conduct a prioritisation exercise
- Likely to be a video call lasting 2-4 hours to reach consensus
- Pre-reading describing the outcomes in detail
- Contact Brett/Jake if you would like to be a part of this

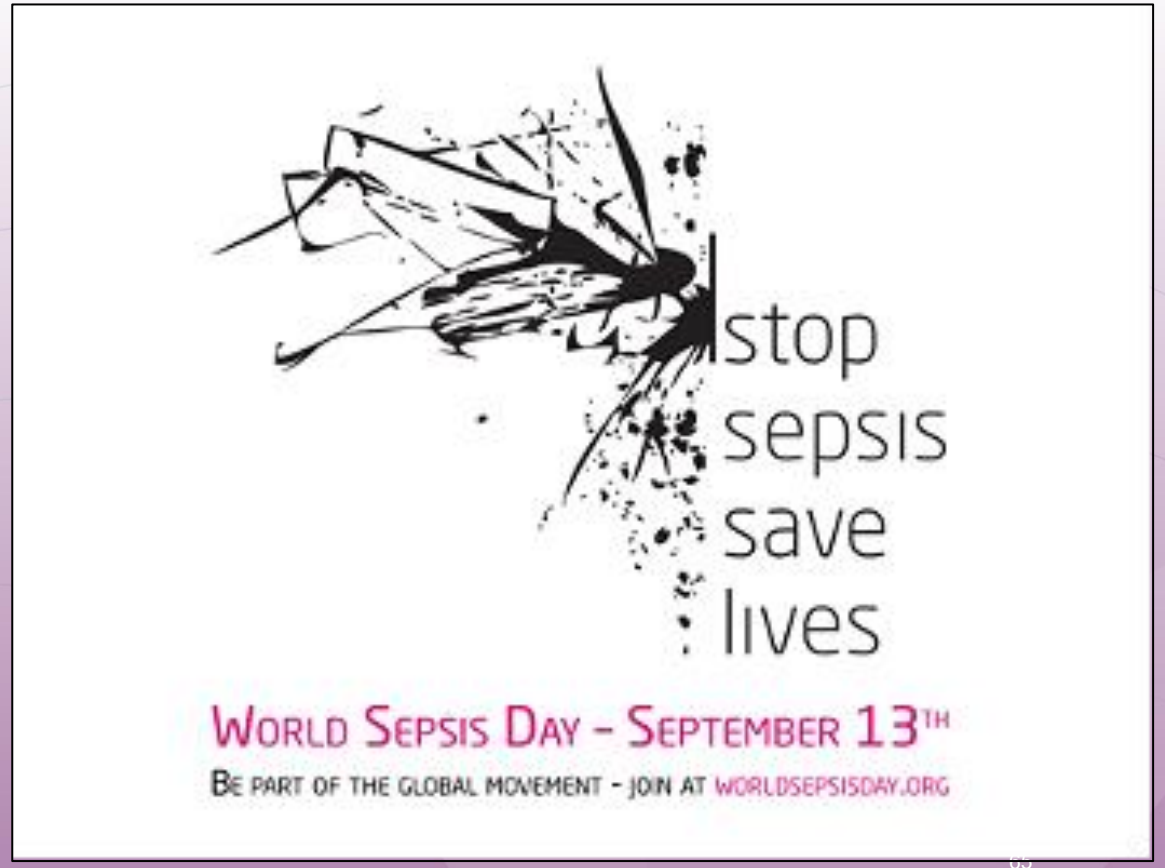
Global Sepsis Alliance

Asia Pacific Sepsis Alliance

Sepsis Australia

The George Institute for Global Health Australia

Thank you



UNSW SYDNEY

Sepsis Australia

National Consumer Symposium 2026

CONSUMER ADVOCACY & STATE PROGRAM INITIATIVES

The George Institute for Global Health

MANDATE SEPSIS PROTOCOLS 2026

Our small Group of lived experience SEPSIS advocates decided that Canberra needed to hear the stories of their constituents
We rallied a team with support of Sepsis Australia and decided to head to Canberra in February 2026

Our following objectives were

1. National Sepsis standards implemented in every hospital
2. National sepsis pathways implemented
3. A national media awareness campaign of the signs and symptoms of sepsis and that Sepsis is a medical emergency and seeking time critical care.
4. Sharing our stories of Bereaved families both infant and adult and lived experience survival stories.
5. As politicians love facts and figures, we showed the economic burden to our economy and the number of deaths and hospital admissions each year.

We secured a Politician, to sponsor our time at Parliament House. thanks to connections in Is It Sepsis and through Jess's Federal member, Luke Gosling MP, in the Northern Territory.

We met with hurdles and time restraints and encountered a few set backs along the way.

It was a consumer led focused campaign with the assistance of Sepsis Australia and The George Institute

CONSUMER LED STORIES

SANDRA AND JOHN TURNER

JOHN"S DAUGHTER LOLA SURVIVED SEPSIS AS A NEWBORN

HOWEVER DEVESATINGLY LOST THEIR HUSBAND AND DAD ANDREW TO SEPSIS

A YEAR LATER

DEBBIE"S STORY

Debbie shared that she was a 4 times Sepsis Survivor. Little did we realise that she actually had Sepsis during her presentation and was admitted to hospital a little later that day!

CAITLIN'S SURVIVAL STORY

CAITLIN TOLD OF HER SEPSIS JOURNEY FROM AN INFECTED WISDOM TOOTH TO A COMA AND NOT FINDING OUT THAT SHE ACTUALLY HAD SEPSIS UNTIL A YEAR LATER.

JESS AND TREVOR

Our little Superhero Trevor's story of surviving Sepsis with Jess sharing their story. Jess emphasised the need for clinicians to listen to parents concerns.

RENEE"S STORY

Renee shared the devesating loss of her baby Cowen at five days old to sepsis.. Again emphasisng the need for parents concerns not to be dismissed.

CONCLUSION

Professor Simon Finfer

Reiterated the importance of Stopping Sepsis National Action Plan (SSNAP) across Australia

Closed
PETITION:

CAN YOU HELP STRENGTHEN NATIONAL ACTION ON SEPSIS?

84,000 REASONS WHY

- 84,000 sepsis hospitalisations annually
- 12,000 *lives lost* per year
- 1 in 3 survivors have lifelong consequences
- Sepsis can be from any infection

Achievements

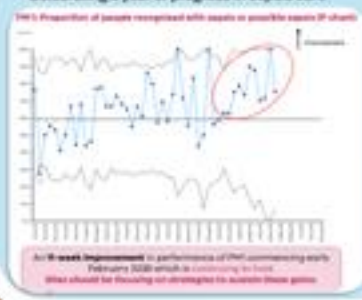
- Working towards a national sepsis awareness campaign with Is it Sepsis
- Social media awareness via Facebook and through political engagement
- Creating a mascot to create a champion of sepsis in a fun way
- Creating trauma teddies and comfort bags for those affected by sepsis
- Continued education sessions from survivors and bereaved families in patient advocacy forums
- A reply from Mark Butler, looking to revisit funding later in the year, after the current resources are utilised

With thanks to
Sepsis Australia
The George Institute
Luke Gosling MP
Sandra and John Turner “Andrews Cause”
Debbie McCarthy
Caitlin Alsop “From Coma to Confidence”
Jess and Trevor Lew Fatt
Renee Cridland vale Cowen
Yvette Clarke “is it sepsis”
all that came to Canberra to help our mission

Safer Care Victoria

Sepsis Research in Victoria
Celebrating a year of progress in sepsis care

Sepsis Research in Victoria
Celebrating a year of progress in sepsis care



From July 2025 to now...

- 9% improvement in first dose antimicrobials within 60 mins of sepsis recognition
- 14% improvement in lactats measurement within 60 mins of sepsis recognition
- 19% improvement in two sets of blood cultures within 60 mins of sepsis recognition

Sepsis Research in Victoria
Celebrating a year of progress in sepsis care

- 50 Health Services came together across Victoria for the Adult Sepsis Collaborative
- Event showcased achievements, shared learning and interactive discussions
- Highlighted impact of collaboration, innovation and shared commitment to improving patient outcomes

Celebrating success

...what does this all mean?

Outcome measures

Celebrating success

...what does this all mean?

Sepsis Research in Victoria

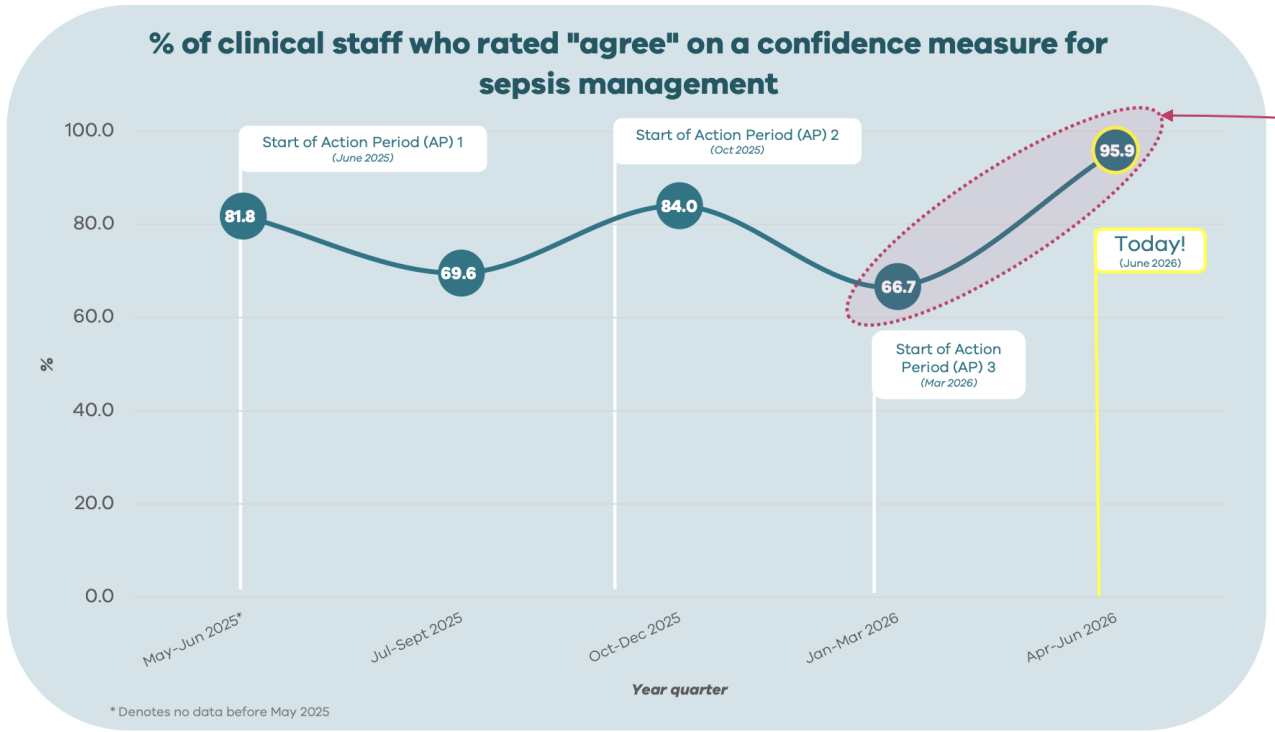
Celebrating a year of progress in sepsis care

- 50 Health Services came together across Victoria for the Adult Sepsis Collaborative
- Event showcased achievements, shared learning and interactive discussions
- Highlighted impact of collaboration, innovation and shared commitment to improving patient outcomes

Dr Jacob Dye, Caitlyn Alsop, Sue Gilbert and Debbie McCarthy sharing the impact of sepsis on their lives to 100+ attendees at the event.

Sepsis Research in Victoria

Celebrating a year of progress in sepsis care



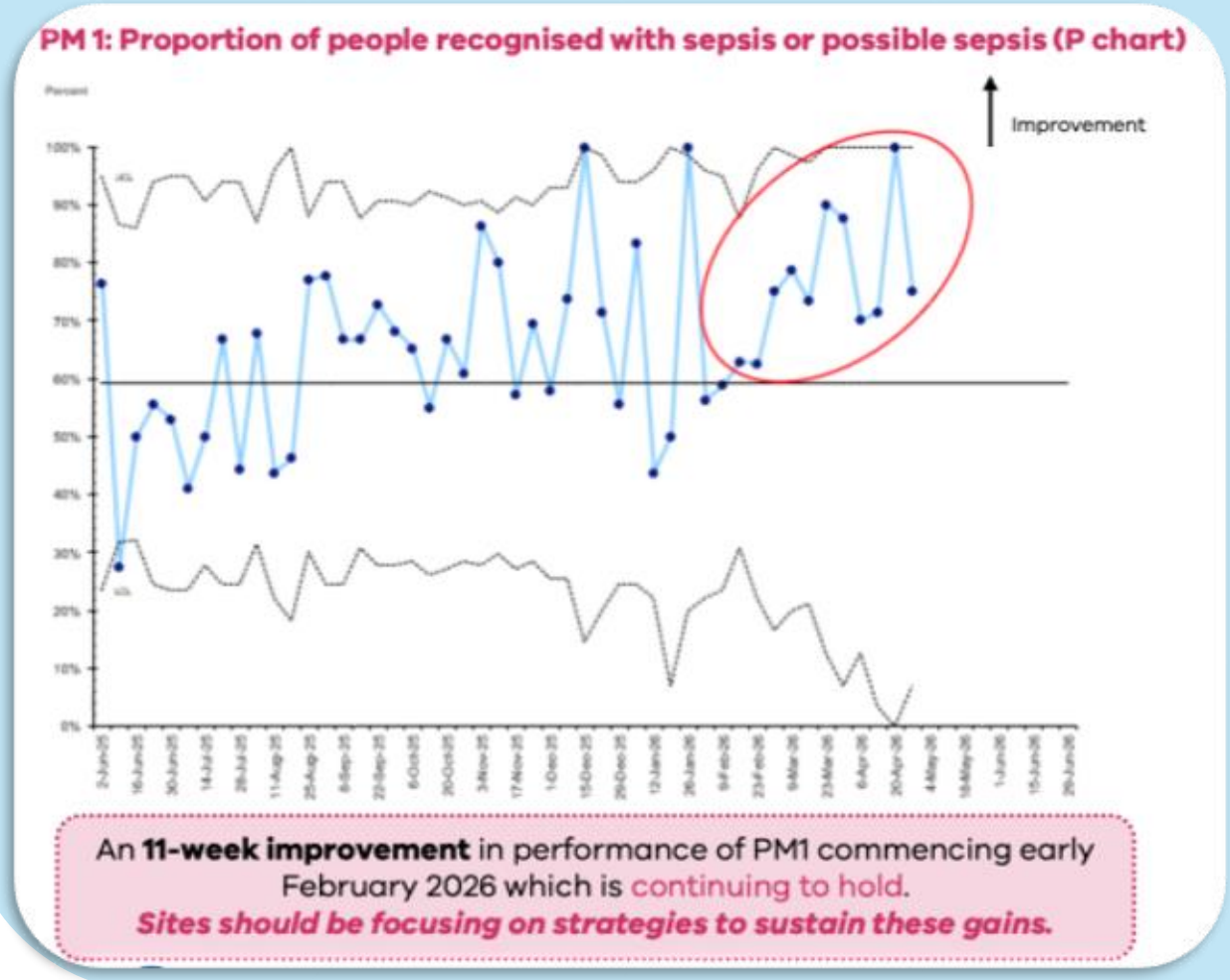
The highest potential signal of improvement happened within action period 3 - **29.3% increase!**

Immediate impact

"The training proved extremely valuable and was applied during a potential cold sepsis presentation this past Saturday."

Sepsis Research in Victoria

Celebrating a year of progress in sepsis care



From July 2025 to now...

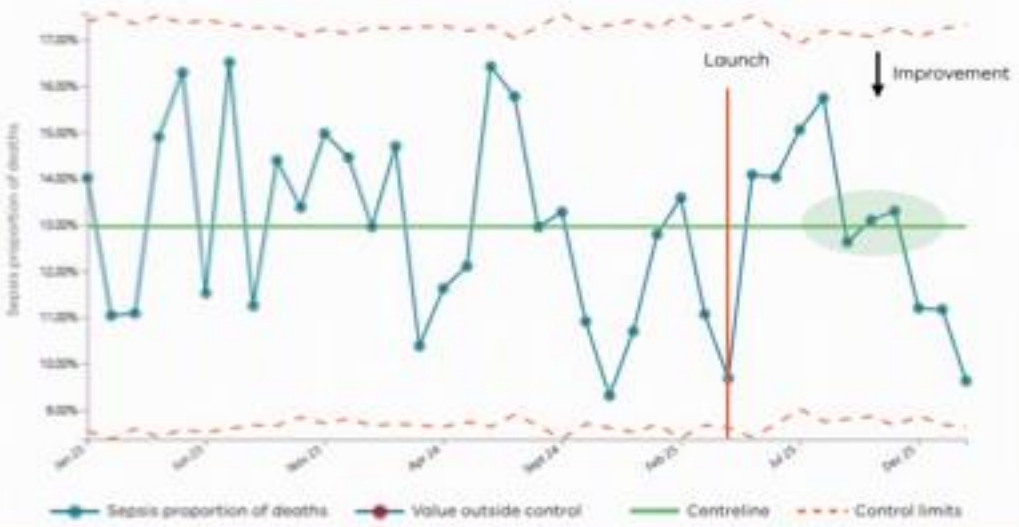
- 9% improvement in first dose antimicrobials within 60 mins of sepsis recognition
- 14% improvement in lactate measurement within 60 mins of sepsis recognition
- 19% improvement in two sets of blood cultures within 60 mins of sepsis recognition

Celebrating success

...what does this all mean?

Outcome measures

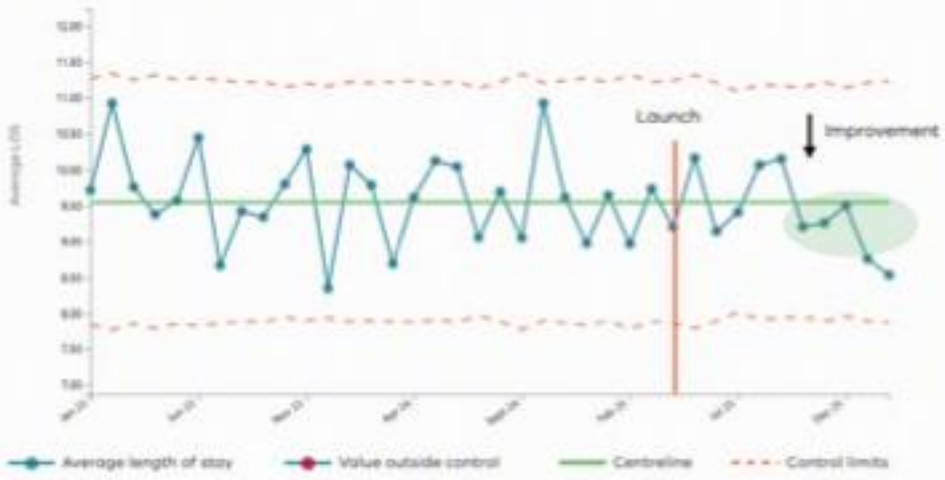
OM 1: Proportion of deaths for patients with Sepsis (P Chart)



Insights

Currently there are no signals of improvement in this measure

OM 2: Average LOS for patients with Sepsis (X bar chart)



Insights

- Currently there are no signals of improvement in this measure
- Continue to closely monitor as the last 5 consecutive data points are below the mean

Institute for Healthcare Improvement

Safer Care Victoria

Celebrating success

...what does this all mean?

Process measures
(graphs on previous slides)

We are seeing system change related to what matters.

- **Improved recognition** of sepsis
- **Improved compliance** to life saving interventions
- **Timely** intervention

Outcome measures

Not shifting yet, but this is expected!

What we do know:
patients are getting home to loved ones quicker.

Aim

By July 2026, we will reduce patient harm within participating Victorian hospitals and reduce length of stay by at least 10%, through the reliable recognition and management of sepsis for every patient, every time.*

Data is trending in the right direction.

Institute for Healthcare Improvement

Safer Care Victoria

Together, we... **FACE SEPSIS**

Anyone. Anytime. Any Infection

FACE SEPSIS

FACE Sepsis early:

FACE Sepsis post-sepsis discharge:

FACE SEPSIS

Let's consider...

- **Would these be helpful?**
- **Does this reflect community needs?**
- **Who could use this?**
- **What else to consider?**

FACE SEPSIS

Find out more...

FACE SEPSIS

www.facesepsis.com/facesepsisresources

Adjunctive FLUDrocortisone with tRanscriptOme evaluation in septic SHOCK

Consumer Engagement Committee

Expressions of Interest Welcome

Chief Investigators
A/Prof Naomi Hammond & Prof Bala Venkatesh

The George Institute for Global Health

Fludro SHOCK

Sepsis Australia

National Consumer Symposium 2026

OPEN DISCUSSION FORUM

The George Institute for Global Health

Sepsis Australia

National Consumer Symposium 2026

THANK YOU

We welcome you to join us for some afternoon refreshments

The George Institute for Global Health