Australian Commission on Safety and Quality in Health Care

Sepsis Australia

NACCHO
National Aboriginal Community Controlled Health Organisation

Keeping Community Strong

Protecting Aboriginal and Torres Strait Islander communities from sepsis

NACCHO is dedicated to supporting culturally informed, community-led healthcare, empowering Aboriginal and Torres Strait Islander people to lead healthier, happier and stronger lives.

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Preface

On 13 September 2019, the Hon Greg Hunt MP announced $1.5 million in funding, to support improved sepsis outcomes. The Commission established the National Sepsis Program in June 2020 under a contract for services with the then Department of Health, Disability and Ageing.

Priorities for coordinated national action on sepsis were identified through consultation with The George Institute for Global Health (TGI), state and territory health departments, sepsis clinical experts and healthcare organisations.

These priority areas formed the basis of the program's key objectives, which included:

- Improving the recognition of sepsis in all healthcare settings
- Providing healthcare professionals with nationally agreed sepsis clinical guidance materials
- Strengthening the comprehensive care planning process for sepsis survivors.

The Commission, in partnership with TGI delivered eight discrete projects including in 2022 the launch of the first National Sepsis Clinical Care Standard.

The 2022-23 Budget provided a further $2.1 million to continue a focus on improving sepsis recognition and response. The Department engaged the Commission in partnership with TGI to deliver the National Sepsis Program Extension between 2023 and 2025.

The Program Extension is made up of five additional projects:

1. Targeted national public awareness campaign
2. Education and training resources for healthcare professionals
3. Coordinated sepsis care and post sepsis support for survivors and families.
4. Data collection tools for improvement
5. Improving recognition of sepsis in First Nation peoples.

AIM

This report is the second component of project five that aimed to understand the impact of sepsis on First Nations peoples; identify the key factors leading to the disproportionate impact of sepsis outcomes; and support the development of targeted strategies to address them. Combined with a scoping literature review completed for the Commission by Indigenous Professional Services (IPS) this report has been released as an addendum to the Program Extension's final report.

Foreword

Sepsis is a life-threatening and time critical condition that arises when the body's response to an infection damages its own tissues and organs. It is a major cause of morbidity and mortality in Australia and globally. Improving early detection, recognition and treatment of sepsis is key to preventing illness and death from this condition.

Sepsis places an enormous burden on the Australian healthcare system and on Australian society. Current estimates suggest there are over 80,000 hospital admissions due to sepsis each year resulting in over 12,000 deaths. The annual cost of acute care of sepsis is over $700 million with indirect costs exceeding $4 billion. Many sepsis survivors are left with lifelong physical, cognitive and psychological disability.

Australia's First Nations peoples are disproportionally affected by sepsis. The age-standardised incidence rate for sepsis is reported to be 1.7 times higher among First Nations people than other Australians across all age group (apart from the youngest patients <1 year old)[1]. In 2022-2023, hospitalisation of First Nations peoples due to sepsis was double the rate of non-indigenous peoples.[2]

In the final report of the national sepsis program the Commission reflected on the challenges of adopting new ways of working when developing quality improvement initiatives to improve health outcomes for First Nations peoples, and affirmed its commitment under the National Partnership Agreement on Closing the Gap by learning from what didn't work and transferring more control over the scope and design of future projects to First Nations led agencies.

In August 2025 the National Aboriginal Community Controlled Health Organisation (NACCHO) agreed to design and deliver a time limited project that could fulfill on the aims of the National Sepsis Program Extension while remaining true to the values of reciprocity, trust, flexibility and community leadership.

The Commission, Sepsis Australia and NACCHO have worked in close collaboration since then, building on our respective strengths to deliver this project. The themes and recommendations in the report reinforce the holistic definition of health and wellbeing and remind us that better healthcare outcomes for First Nations peoples cannot be achieved without also addressing the social and cultural determinants of health.

The next five years are going to be important for health system reform. The National Health Reform Agreement's (NHRA) vision for the Australian Healthcare system is one that is responsive to the needs and aspirations of Aboriginal and Torres Strait Islander people to ensure they enjoy the highest attainable standard of health and wellbeing and experience a health system that is culturally safety and free of racism.

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[1] Australian Institute of Health and Welfare. People with disability in Australia - Chronic conditions and disability web report, last updated 23 April 2024 [cited 2025 August 10]. Available from: https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/health/chronic-conditions-and-disability.

[2] Australian Commission on Safety and Quality in Health Care. National Sepsis Program Extension Epidemiology Report – a national analysis of the sepsis patient journey in Australian public hospital admitted care. Sydney; ACSQHC; 2025 Available from 10 September 2025.

As you read this report, we invite you to consider where the issues, themes and findings about sepsis can improve outcomes for people affected by sepsis; where they apply more broadly across the health system and how the ideas and opportunities suggested for sepsis could be extended to strengthen holistic outcomes in your health service.

Sepsis Australia

NACCHO
National Aboriginal Community Controlled Health Organisation

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NACCHO June 2026

Keeping community strong – protecting Aboriginal and Torres Strait Islander communities from sepsis

Final Report

Acknowledgements

This report respectfully refers to the First Nations Peoples of Australia as Aboriginal and/or Torres Strait Islander peoples.

We acknowledge the Traditional Custodians of Country throughout Australia and their holistic concept of health, including the interconnectedness of Country, Community and culture. We pay our respects to Elders past and present and extend our respect to all Aboriginal and Torres Strait Islander peoples.

We acknowledge the contribution of Aboriginal and Torres Strait Islander peoples, communities, and organisations who shared their perspectives, experiences, and knowledge that informed this report. Their leadership and generosity of spirit continue to shape the path toward equitable and strong sepsis care.

Introduction

This report has been prepared by the National Aboriginal Community Controlled Health Organisation (NACCHO) to support the Australian Commission on Safety and Quality in Health Care's (the Commission) work under the National Sepsis Program. It draws on consultations with Aboriginal Community Controlled Health Organisations (ACCHOs) to contribute sector-informed recommendations to enhance sepsis care with Aboriginal and Torres Strait Islander peoples, families and Communities. The report highlights the influence of social and structural determinants of health on sepsis incidence and outcomes, whilst amplifying the strengths of ACCHOs and community-centred care in supporting sepsis prevention, recognition, response and recovery. In doing so, it complements the Commission's broader sepsis work by elevating priorities identified by

the Aboriginal and Torres Strait Islander health sector to strengthen sepsis care and outcomes.

Method

Consultations

Four consultations with independent ACCHOs were conducted between February and April 2026. The duration of each consultation was within two hours. Three consultations were delivered in a hybrid format with participation both in-person and online, and one was undertaken as in person only. A total of 61 participants represented a range of health professionals and ACCHO staff across metropolitan, regional and remote settings (Table 1).

Consultations were conducted as yarns, a culturally informed approach that respects Aboriginal and Torres Strait Islander ways of knowing, being and doing. The yarning methodology is grounded in developing rapport and building trust. The project lead is not there to control the conversation, but to create a culturally safe space for storytelling, reflection and multiway learning between the project team and the participants. Yarns were guided by pre-defined consultation questions developed by the project team and reviewed by the Commission (Appendix 1).

The George Institute and Sepsis Australia supported the NACCHO project team to develop consultation questions and iteratively refine the consultation questions, contributed to shared data and insights throughout the analysis process, and actively supported delivery by attending and helping facilitate one ACCHO consultation, enabling two-way learning and strengthening the overall approach.

Following each consultation, participants were invited to review the key themes, quotes and case studies identified. Before the report was submitted to the Commission, each participating ACCHO was given the opportunity to review the document. This method honours reciprocity and trust.

Table 1 The Modified Monash Model (MM) classification[2] for consultation sites and diversity of participant roles.

	Regional Centre, Victoria (MM2)	Regional Centre, Queensland (MM2)	Remote Communities, Northern Territory (MM6)	Metropolitan Area, New South Wales (MM1)	Total
Medical officers	7	4	1	3	15
Aboriginal Health Practitioners /Trainees	3	3	0	6	12
Nurses	3	8	0	13	24
Pharmacist	1	1	1	0	3
Practice managers and others	4	0	1	2	7
Total	18	16	3	24	**61**

Analysis

Consultation data were de-identified and analysed using reflexive thematic analysis. The stages of analysis included familiarisation with the data, coding, development of initial themes, review and refinement of themes and final synthesis. Coding and interpretation were led by the researcher. Code validation and initial theme development was supported using digital tools. Final theme refinement and interpretation was completed by the researcher. Themes and recommendations were reviewed by the broader NACCHO project team.

Themes

Throughout the consultations, sepsis was described in the context of broader patterns of chronic illness, continuity across services and social and structural inequities. The framing of sepsis in this way, rather than as a discrete medical episode, is reflective of the Aboriginal and Torres Strait Islander holistic concept of health; health transcends beyond physical wellbeing and encapsulates the social, emotional and cultural wellbeing of person, family, Community and Country[7]. Values of reciprocity, flexibility, multi-way learning, and community leadership in sepsis care also emerged during the consultations. These values predicated the themes identified (Figure 1).

Three broad themes emerged:

1 Build on community strengths.

2 Strengthen health systems.

3 Privilege prevention.

Within these are subthemes of trust, community autonomy, workforce capacity, continuity of care, equitable and culturally safe care (Figure 1).

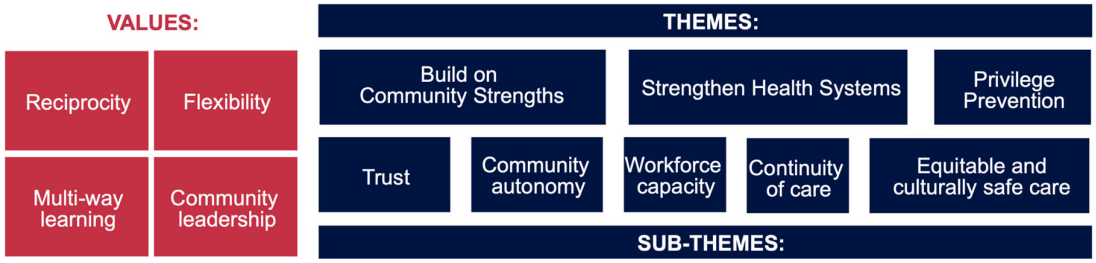

Figure 1 The values, broad themes and sub-themes identified during consultations.

The sub-themes do not sit in isolation. They transcend the entire patient journey, from sepsis prevention to post sepsis care (Figure 2). Together, the themes and subthemes capture key opportunities and enablers for improving sepsis care and outcomes for Aboriginal and Torres Strait Islander peoples.

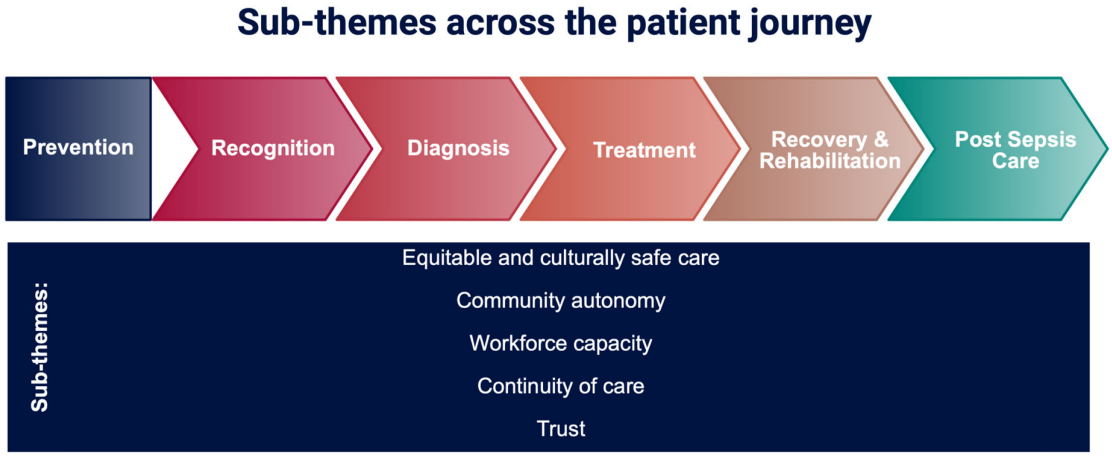

Figure 2 The sub-themes transcend the sepsis care continuum.

Build on Community strengths

Trust

ACCHOs act as trusted, holistic, culturally safe anchors across the sepsis journey.

Across all four consultations, ACCHOs are positioned as the most trusted part of the care system: places where community members are known, feel safe and are more likely to present. The ACCHO service model, as described in NACCHO's Core Services and Outcomes Framework[5], guarantees cultural authority and self-determination.

ACCHOs play an important role in sepsis prevention (case study 1) and in recovery. Recovery after sepsis can be ongoing and resource-intensive, with people often requiring support across clinical, functional, psychosocial and practical domains after discharge.

ACCHOs are well-placed to offer this holistic, wrap-around, multi-disciplinary care. Many ACCHOs currently provide this multi-factorial support through routine practice, without dedicated resourcing. Some ACCHOs have identified mechanisms to strengthen this. For example, through the funding and employment of embedded pharmacists and hospital Aboriginal Liaison Officers. For this wrap-around care to be done proactively and at scale, ACCHOs need to be supported with adequate resourcing.

"ACCHOs are often the ones stitching the system together across silos." — ACCHO clinician

Case study 1: ACCHOs are trusted bridges to urgent care

A 31-year-old woman presented to an ACCHO General Practitioner (GP) with three-day respiratory symptoms: headache, fatigue, fever, runny nose, cough with yellow phlegm. Clinical observations were borderline for sepsis criteria. Given this and her complex history, the GP referred her to the nearest Emergency Department (ED).

The woman was reluctant to attend ED. However, following a conversation with a trusted ACCHO registered nurse with whom she had an established relationship, the woman agreed to present to hospital.

The woman was admitted to hospital and diagnosed with Influenza A infective exacerbation of asthma with mild acute kidney impairment. After 24 hours of treatment, the woman was discharged.

This case demonstrates the capability of ACCHOs to recognise sepsis red-flags and contribute to early intervention, ultimately preventing progression to sepsis.

Community autonomy

Flexible, community-led health promotion can enable effective prevention and early intervention.

Prevention and early intervention are strongest when services have the autonomy to respond to community priorities through co-designed health promotion initiatives. This autonomy can be built-in to flexible funding arrangements. With this, ACCHOs can direct resourcing, design and deliver health promotion activities that privilege community priorities, reflect local languages and culture and optimise workforce availability. This may

include combining initiatives where topics are complementary. For example, sepsis awareness could be linked with antimicrobial stewardship through the NACCHO Antimicrobial Stewardship Program[6]. Alternatively, funding could be directed to specific teams who contribute to sepsis care, for example the social and emotional wellbeing teams or outreach teams.

"What really makes the difference is stable funding over several years, not short-term programs." —ACCHO clinical manager

Co-designed resources are a valued health promotion tool. Community-facing resources are needed to build awareness and help people, families and communities identify when urgent care is needed. Clinician-facing resources are required to support ACCHO staff with sepsis decision-making, triage, escalation and referral pathways. Resources should also support the identification of post-sepsis syndrome, so ongoing physical, cognitive, psychosocial and practical recovery needs are recognised after discharge.

A one-size-fits-all approach is unlikely to be effective. These tools should reflect local workflows, available technology, workforce roles and escalation options. Sepsis Australia and NACCHO could co-develop adaptable core resources that ACCHOs can tailor to reflect local languages, visuals, priorities and delivery channels.

"Health promotion works best when it's led by Aboriginal staff and designed with community." — ACCHO clinician

Strengthen Health Systems

Workforce capacity

There is a strong dependency between workforce capacity and the ability to deliver early intervention.

Adequate workforce capacity is vital to optimal sepsis recognition, treatment and recovery. Sepsis is often not recognised early because people may not know the term, symptoms are vague, illness is normalised and chronic disease makes deterioration hard to distinguish.

"When people live with multiple chronic conditions, feeling unwell becomes normal. It's hard to recognise when something different and dangerous is happening." —ACCHO clinician

Recognition often happens relationally, rather than through formal sepsis language. It occurs through ACCHO staff knowing what is "usual" for a person, familiarity with community members and through family concern. This creates a strong dependency between workforce capacity and the ability to deliver early intervention. In practice,

workforce capacity is challenged by under-resourcing, staff shortages and turnover and fragmented communication systems.

> *"When clinics are well staffed with regular clinicians who know the community, early changes are picked up before things escalate."* — ACCHO clinical manager

Aboriginal Liaison Officers are essential to culturally safe care, yet too few staff are expected to support the needs of an entire Community.

All consultations identified Aboriginal Liaison Officers as critical to supporting culturally safe care within hospitals. However, participants also acknowledged the significant cultural load, workload pressures and limited capacity attached to these roles. As a result, this support is not always available to every Aboriginal and/or Torres Strait Islander person in hospital.

Aboriginal Liaison Officers can also offer critical support within the community setting. In one consultation, an example was shared of an Aboriginal Liaison Officer role funded by a hospital but employed through an ACCHO. The role supported community members to attend outpatient appointments, coordinate post-discharge care and address barriers such as transport or childcare. While this model was seen as valuable, participants noted that current funding and capacity are not sufficient to support every patient, or even all high-risk patients.

Continuity of care

Coding clarity and interoperability enable continuity of care.

Good sepsis care relies on ensuring the patient and all health professionals involved in their care are aware of the sepsis diagnosis. Sepsis and post-sepsis syndrome should be explicitly identified in clinical systems. This may be addressed through changes to International Classification of Diseases (ICD) coding protocols. Ultimately, interventions should be locally determined, with services supported to adopt practical system changes to improve the recording of a sepsis diagnosis.

Accurate coding is important not only for communication, but also for enabling appropriate care pathways during admission and at discharge. When sepsis and related risk factors are clearly identified, this can trigger multidisciplinary action across inpatient care, rehabilitation planning and discharge support. Without accurate identification of high-risk patients, opportunity for additional services and follow-up may be missed.

Importantly, cultural and ethical considerations to data sharing must be respected. Many people may feel discomfort or shame if health-related information is shared indirectly to their primary health provider, for example through an ACCHO receptionist who, outside of work, may be a fellow community member. Clear, culturally informed privacy structures and principles of data sovereignty must therefore be maintained.

Mainstream hospital discharge is the major fracture point in continuity of care.

The transition from hospital back to community is where patients, families and ACCHOs are often left to manage risk with incomplete information. The process was repeatedly described as being worsened by delayed or absent discharge summaries, missing or wrong information, unclear responsibility, poor notification to ACCHOs, weak medication handover and limited proactive follow-up after hospitalisation.

"Discharge summaries are often delayed, poor quality, or don't arrive at all. We usually find out people are back when we wish we'd known earlier." — ACCHO clinician

"The lack of timely discharge summaries completely disrupts continuity of care." — ACCHO clinician

The greatest risk for post sepsis readmission is within the first 30 days after discharge[1]. For this risk to be actively managed, it is imperative that a sepsis diagnosis and associated risks be communicated with both the patient and their primary care provider at the time of discharge, if not earlier.

"Many patients leave hospital thinking they've fully recovered, when in reality their recovery is only just starting."
— ACCHO clinician

"Hospitals should be proactively telling ACCHOs when someone is being discharged back to community." — ACCHO clinician

A coordinated shift to formally recognise, appropriately resource and sustainably fund a transition-of-care function is needed. Without this, the expectation on existing frontline health and ACCHO staff to assume the additional responsibilities required for adequate and timely handover will remain unrealistic and unsustainable.

A minimum action proposed is a risk-based discharge assessment be developed and implemented. The aim is that high-risk discharges, including sepsis, trigger a more thorough handover to the primary health provider. This process should include confirmation of the correct primary care recipient, communication of essential discharge information and direct clinician-to-clinician handover for complex cases. Culturally informed privacy and data sovereignty principles must be upheld.

Consideration should be given to a dedicated transition-of-care workforce that operates between tertiary and primary care. This workforce should have foundational clinical knowledge to support care coordination and escalation requirements, potentially through targeted certification rather than degree-level qualification.

The introduction of a Medicare Benefits Schedule item for post-discharge general practitioner and allied health review should be considered. This would support adequate

appointment time and act as a system-level flag for patients needing follow-up after hospitalisation.

Case Study 2: ACCHOs deliver culturally safe, trauma-informed care

A baby became very unwell at home and an ambulance was called. Ambulance staff assessed the baby and advised that they needed to go to hospital. The mother who was caring for multiple children realised that she could not travel in the ambulance with all children. This meant that the sick baby would be taken without her. She responded, “you are ‘not taking’ my baby”.

For this mother, the situation triggered past and intergenerational trauma. Mum had been removed from her family in childhood. The thought of being separated from her baby caused fear and mistrust.

The mother took the baby to her local ACCHO and asked whether the doctors could help. ACCHO staff confirmed that the baby needed hospital care, took the time to explain why, reassured the mother and supported her through the decision. Because the ACCHO staff knew the mother’s story and provided trauma-informed, culturally safe care, Mum trusted their advice and took baby to hospital.

This case calls out the need for mainstream services to be more accountable for the ongoing impact of current and historical policy decisions and upskill in cultural contexts and trauma-informed care.

It further highlights the important role ACCHOs play as trusted care providers, particularly when past trauma affects how people engage with mainstream services.

Equitable and culturally safe care

System structures can enable care, but cultural unsafety can disrupt it.

Structural racism in hospitals remains a persistent barrier to care. Fear, trauma, shame and culturally unsafe experiences can delay presentation, contribute to early discharge and undermine continuity after discharge. While sepsis policy should reflect the need for culturally safe care, this issue cannot be addressed through sepsis standards alone. Improving organisational and staff capability, and embedding accountability for culturally safe practice, will be critical to better sepsis outcomes. A proactive way forward to achieving this is through establishing Aboriginal and Torres Strait Islander Governance structures within mainstream health services.

The structural and social determinants of health must be addressed.

Throughout the consultations, it was clear that structural and social determinants of health influence the sepsis care continuum. These social, political and economic mechanisms currently drive disparity; however, the manipulation of these determinants has the potential to shift the equity dial. Addressing key barries like travel distance, financial burden and rigid appointment structures will enable timely treatment and optimal recovery.

"People think about distance, cost, leaving family and past hospital experiences before deciding to seek care." — ACCHO clinician

The consultations highlighted the specific influence of social determinants on sepsis recovery. While the term 'post-sepsis syndrome' was not well known, participants clearly described post-sepsis recovery as more than a narrow medical issue. Recovery is enabled by access to clean water, hygiene facilities, stable housing and food security.

"If we don't address food security, wound care, housing and living conditions, we're setting people up for readmission." — ACCHO clinician

Privilege prevention

Addressing cultural safety and systemic inequities are vital in a prevention agenda.

Prevention of sepsis is the ultimate care goal. Optimising clinical tools and addressing the broader conditions that shape health and wellbeing: multi-morbidity, chronic disease and the social and structural determinants of health, will contribute to a prevention agenda.

The consultations highlighted that the implementation of two, ACCHO-level clinical tools would strengthen the prevention of sepsis:

- point of care testing
- vaccination.

Point of care testing would provide insights needed to direct preventative strategies and aid early intervention. A focus on improving vaccination rates, underscored by building trust and cultural safety within the healthcare system, was also highlighted as a community priority.

Sepsis incidence and outcomes are underwritten by structural determinants of health alike governance, racism and health system design. These factors do not uniquely affect Aboriginal and Torres Strait Islander peoples, families and Communities. Rather, they reflect generations of systemic and structural inequities that prevent many Australians from receiving adequate and culturally safe health care. In turn, not all Australians are afforded the opportunity to "stay well". Effective sepsis prevention therefore requires more than clinical intervention alone. It requires coordinated, national action to address underlying determinants through Aboriginal and Torres Strait Islander governance, co-design, policy and sustained investment.

Recommendations

Six recommendations focus on building community strengths, strengthening health systems and privileging prevention, reflecting the key themes identified throughout the consultations. Importantly, the recommendations span the sepsis care continuum, supporting action at each patient touchpoint from prevention through to post-sepsis care (Figure 3).

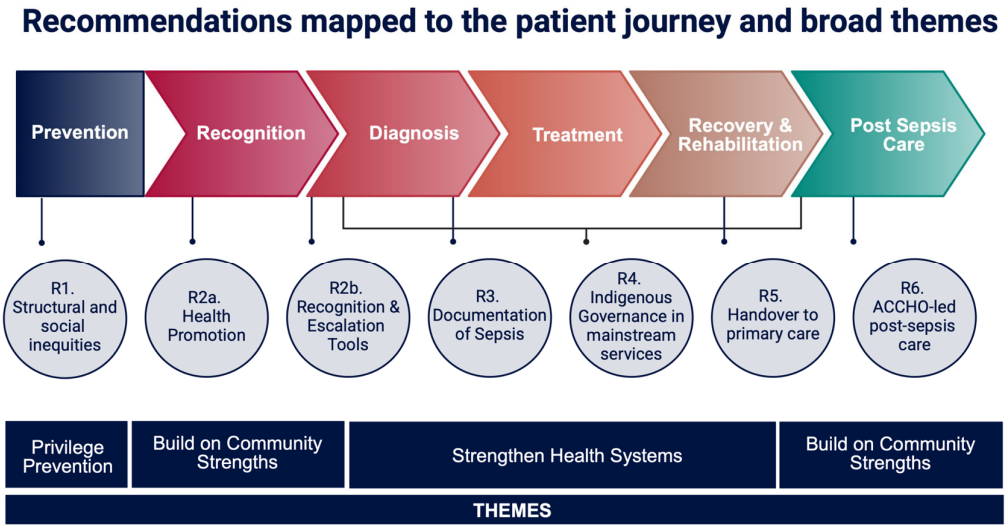

Figure 3 The recommendations for sepsis care with Aboriginal and Torres Strait Islander peoples, mapped across the care journey and against identified themes.

The recommendations also align with The National Aboriginal and Torres Strait Islander Health Plan 2021–2031[3] priorities and the four priority reforms of the National Agreement on Closing the Gap[4].

1 Formal partnerships and shared decision making.

2 Building the community-controlled sector.

3 Transforming government organisations.

4 Shared access to data and information at a regional level.

NACCHO acknowledges the Commission's role both in commissioning this project and in its broader responsibility for improving the cultural safety, quality and continuity of care across hospitals and health services. While this project focused on sepsis, the findings underlying recommendations one, four and five are not specific to sepsis alone. Rather, they reflect broader systemic issues in hospital-to-primary care transitions and culturally safe care for Aboriginal and Torres Strait Islander peoples. We therefore recommend that these findings inform the Commission's wider work in this area, including through seeking leadership and guidance from the Commission's Aboriginal and Torres Strait Islander Health Advisory Group.

1. The Australian government should address the structural and social determinants of health that increase sepsis risk and limit access to timely, culturally safe care.
National agreement on closing the gap priority reform 3
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 priorities 1-7

2. The Australian, state and territory Governments should facilitate the co-design and implementation of culturally relevant, locally adapted:
a) sepsis and post-sepsis syndrome health promotion activities (community facing) and
b) sepsis and post-sepsis syndrome recognition and escalation tools (community and clinician facing).
National agreement on closing the gap priority reform 1
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 priority 1-2, 4 & 6

3. The Australian Government should identify methods to clearly document a sepsis diagnosis in medical records and discharge summaries.
National agreement on closing the gap priority reform 3 & 4
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 priority 12

4. Mainstream health services should embed localised and sustainably resourced Aboriginal and Torres Strait Islander governance structures to guide and support achieving culturally safe services.
National agreement on closing the gap priority reform 1 & 3
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 priorities 1, 8, 11

5. The Australian government should facilitate a dedicated transition-of-care function, including appropriate resourcing and sustainable funding.
National agreement on closing the gap priority reform 2-4
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 priorities 3, 6-7, 9, 11-12

6. The Australian, state and territory Governments should formally recognise and resource ACCHOs to coordinate culturally safe post-sepsis care.
National agreement on closing the gap priority reform 2
The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 priorities 1-2 & 9

Final word

Good sepsis care for Aboriginal and Torres Strait Islander peoples must be grounded in keeping Community strong. This requires approaches that are co-designed, culturally safe and locally adapted. Values of reciprocity, flexibility, multi-way learning, and community leadership must sit at the centre of this work.

These approaches challenge mainstream health care systems, which privilege the “average” patient and population. These systems often overlook the needs, strengths and lived realities of the individual, family and Community seeking care. Realising the National Agreement on Closing the Gap priority reforms[4] requires a paradigm shift. The health system must be reconditioned to provide sepsis care that is truly personalised, culturally safe and responsive to individual and Community context.

References

1. Australian Commission on Safety and Quality in Health Care. (2025). *National Sepsis Program Extension Epidemiology Report: A national analysis of the sepsis patient journey in Australian public hospital admitted care*. https://www.safetyandquality.gov.au/resources/national-sepsis-program-extension-epidemiology-report

2. Australian Government Department of Health, Disability and Ageing. (2025). *Modified Monash Model.* https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

3. Australian Government Department of Health, Disability and Ageing. (2021). *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*. https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031

4. Commonwealth of Australia, Department of the Prime Minister and Cabinet. (2020). *National Agreement on Closing the Gap.* Closing the gap. https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap

5. National Aboriginal Community Controlled Health Organisation. (2021). *Core Services and Outcomes Framework: The Model of Aboriginal and Torres Strait Islander Community-Controlled Comprehensive Primary Health care.* https://www.naccho.org.au/wp-content/uploads/2024/10/Core-Services-Outcomes-Framework-full-document.pdf

6. National Aboriginal Community Controlled Health Organisation. (n.d.). *NACCHO Antimicrobial Stewardship Academy*. https://www.naccho.org.au/medicines-pharmacy/ams-academy/

7. National Aboriginal Health Strategy Working Party. (1989). *A national Aboriginal health strategy*. Australian Government Department of Aboriginal Affairs.

Appendix 1: Consultation questions

Sepsis Awareness
What is your understanding of sepsis?

Hospital admission and inpatient care
In your role, do you work with patients who are admitted to hospital with sepsis or suspected sepsis?
How are you and your ACCHO involved in the admission process?
What are the main issues you see when patients are admitted with sepsis?

Hospital discharge and risk of readmission
How are you and your ACCHO involved in the discharge process?
Do you work with patients after they are discharged following a sepsis admission?
What are the main issues you see when patients are discharged after sepsis?
Prompt if needed: medical, psychological/cognitive, physical and social/economic.
How aware is your ACCHO of the risk of readmission after sepsis?
Why do people end up back in hospital after sepsis?
Prompt if needed: readmission rates after sepsis are high.
How well known is post-sepsis syndrome (PSS) in your setting?
Prompt if needed: ongoing physical, cognitive, or mental health issues after surviving sepsis.

Recognition of Sepsis
What makes sepsis easier—or harder—to recognise and act on?
Prompt if needed: refer to each age group

Role-dependent follow-up
Does having ceftriaxone in the doctor's bag help when sepsis is suspected?

Transition of care and follow-up after discharge
How do you know when your patient:

- presents to the Emergency Department?
- is admitted to hospital?
- has been discharged from hospital?

For patients after discharge:

- How do you prioritise engaging with patients?
- Who in your service contacts patients following discharge?
  Follow-up: Is there dedicated time or a staff member for this?
- How do you contact patients after discharge (method, timing, frequency)?

In your experience, how important is it to formally identify and communicate 'sepsis' as the patient's diagnosis?

What supports do you offer patients post-discharge, particularly those who experienced sepsis?
Who usually carries the load of care after discharge and how can services support those people better?
When transition of care works well, what makes the biggest difference for your service and community?
Where does the system make things harder than they need to be for people after sepsis?

Community role and support after sepsis
What is the community's understanding of sepsis?
What usually happens when sepsis is suspected in the community?
How well known in the community is the risk of readmission after sepsis?

Current practice & strengths
What opportunities exist to build on these community strengths?
What is your service already doing well to support people after a sepsis admission?
Prompt if needed: what support your service offers to patients/families/community
What helps people feel safe and supported to seek care after discharge?
How can we encourage this further? (especially for patients who have disengaged from the health care system)

Follow-up – support and system gaps
What are the biggest gaps, or opportunities to improve, supporting people after sepsis?
Prompt if needed: information handover, workforce, language, distance, funding, training.

Open ended
Are there any stories, teachings or experiences you'd like to share that might help improve outcomes for community members before and after sepsis?
Have any patients provided or shared feedback from their experiences in hospital or primary health care services?

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