The Dudley Group
NHS Foundation Trust

Date: 02/08/2017

FREEDOM OF INFORMATION REQUEST FOI/013552 – sepsis

FOI request for Sepsis CQUIN data for the following years 2015/16 & 2016/17

2015/16 – We have data as reported for this time frame through Unify reporting. This required a retrospective review of trigger identification and treatment initiation. No data was collected on outcome of the patient at this time in terms of mortality.
2016/17

1a) Of all patients recorded in the Sepsis CQUIN figures by the Trust, showing the number presenting with simple sepsis/ severe sepsis, Red Flag Sepsis or septic -shock, (depending on the protocols in place at the time) that received intravenous antibiotics within the hour, please state the number where death was a recorded outcome.
41 of 179 have death as a recorded outcome.

1b) Of all patients recorded in the Sepsis CQUIN figures by the Trust, showing the number presenting with simple sepsis/severe sepsis, Red Flag Sepsis or septic shock, (depending on the protocols in place at the time) that did not receive intravenous antibiotics within the hour, please state the number where death was a recorded outcome.

2016/17	Total No. who received IV antimicrobials <60min	Total who did not receive IV antimicrobials >60min	No. who received IV antimicrobials <60 who died	No of IVAB >60 who died
Totals	179	104	41	28

2a) Of all patients recorded in the Sepsis CQUIN figures by the Trust, showing the number presenting with simple sepsis/severe sepsis, Red Flag Sepsis or septic shock, (depending on the protocols in place at the time) that received intravenous antibiotics within the hour, please give the number of cases that were subsequently investigated as part of the hospital's internal clinical risk reporting process.
This data was not collected within the time frame given.

2b) Of all patients recorded in the Sepsis CQUIN figures by the Trust, showing the number presenting with simple sepsis/ severe sepsis, Red Flag Sepsis or septic shock, (depending on the protocols in place at the time) that did not receive intravenous antibiotics within the hour, please give the number of cases that were subsequently investigated as part of the hospital's internal clinical risk reporting process.

This data was not collected within the time frame given. Delays in care are now put through DATIX. Delays in care are now put through DATIX and have been done so since the Trust had a Sepsis lead practioner (May 2016) and initial DATIX incident reports where again made following
review of coded cases. Seven case requiring investigation for potential delay, recognition were initiated by the sepsis practioner in the time frame.
3) Of questions 2a and 2b, please identify the number of investigations that related to a death outcome and the number that related to a harm outcome.
No data available from the allocated time frame.

4) Please also state whether CQUIN compliance rates for Sepsis Screening and/or Antibiotics compliance has been renegotiated by the Trust. If so, please give details of the change in the agreed rate of compliance and what year this was made.

For the year 2016/17 only; a local agreement was made for the direct admission areas to receive full payment on achieving IVAB administration in >60% of Sepsis & Septic shock patients, in accordance with the CQUINN local agreement was to be arranged and agreed between Trust and CCG. No change to any other aspects of CQUIN.

Trust Sepsis Nurse Practitioner
17/07/17