

Reducing the impact of serious infections CQUIN FAQs, parts 2c and 2d

October 2017

The following information has been updated in response to questions asked of NHS England, NHS Improvement or Public Health England (PHE) in relation to parts 2c and 2d of the [Reducing the impact of serious infections CQUIN](#). This update clarifies Part 2c requirements to facilitate data collection.

If you have any questions not answered below, please contact either:

- CQUIN@phe.gov.uk – for any queries relating to submission, analysis or publication of CQUIN 2c and 2d data
- e.cquin@nhs.net – for all other queries.

Part 2c – Antibiotic review

Does the antibiotic review include all patients?

You should only include patients with sepsis who are still inpatients 72 hours after antibiotics are given in the antibiotic review section of this CQUIN. Review should be completed between 24 and 72 hours (not less than 24 hours) after starting treatment. If a patient's antibiotic treatment is changed sooner than 24 hours after starting it, this decision cannot be used as the 24 to 72-hour review.

Three optional sections have been added to the [PHE data collection tool](#) for Q3. These allow you to record the antibiotic and route on admission, on the ward and during the 24 to 72-hour mark, which helps the data collector determine what decision was made regarding the 24 to 72-hour review.

For the AMR CQUIN for 2016/17, 90% compliance with the empirical review element was required by the end of Q4. Why have step changes from 25% upwards been introduced in this CQUIN? Is this a backward step?

As part of this year's serious infections CQUIN we request greater evidence of review of patients with a diagnosis of sepsis: to include evidence of the local IV to oral switch tool being applied and justification for continuing the same empirical IV antibiotics. As this is not currently routine practice, a stepped approach has been introduced.

Who can review patients and who is classed as a senior clinician?

As per the CQUIN the following staff can clinically review patients:

- infection (infectious diseases/clinical microbiologist) senior doctor
- infection pharmacist
- senior member of the clinical team.

A senior member of the clinical team is one who is at ST3 or above. SAS and CT3 grade doctors are equivalent to ST3.

How many patients should be included in part 2c (antibiotic review)?

A minimum of 30 patients should be included per quarter and we suggest this equates to 10 patients per month. Data should be submitted to PHE using the [submission tool](#). A sample data collection tool is available on the [NHS Improvement AMR webpage](#).

How to submit part 2c data?

We have revised the submission survey for part 2c for Q3 according to feedback from users. [Use this link to access the submission survey](#).

Data for part 2a and 2b no longer needs to be submitted using the above survey. We have replaced this requirement with an additional question to determine if antimicrobial teams are working closely with sepsis teams to collect the data required for the CQUIN.

Why has the data collection tool been amended in Q3?

We have amended the data collection tool so that its content aligns with the submission survey, facilitating the data submission process.

Part 2d – Reduction in antibiotic consumption per 1,000 admissions

Will separate median values be calculated for teaching hospitals?

Following a review of the available data, median values for 2013/14 will be calculated for specialist hospitals, teaching hospitals and non-teaching hospitals.

What is the baseline period for reduction?

The baseline against which reductions are required is calendar year 2016 – that is, January to December. A 1% or 2% reduction is required, depending on antibiotic consumption from January 2016 to December 2016 compared to the specialism median values for England for 2013/14 such that:

- 1% reduction for those trusts with 2016 consumption indicators below the 2013/14 median value

- 2% reduction for those trusts with 2016 consumption indicators above the 2013/14 median value.

Each indicator is independent. For example, if from January 2016 to December 2016 your trust's total antibiotic consumption and piperacillin/tazobactam consumption are below the median for 2013/14, but your carbapenem consumption is above the median value, then the following reductions against the baseline for January 2016 to December 2016 would be required:

- total antibiotic usage – 1%
- piperacillin/tazobactam – 1%
- carbapenem – 2%.

When will the baseline data be available and our required reduction percentages be known?

We will publish a spreadsheet containing baseline data on the NHS Improvement AMR webpage. This will give information on median values and the reductions each organisation is required to make.

Will the antibiotic reduction still run because of the piperacillin/tazobactam shortage?

Yes it will. [Guidance from the Department of Health's Advisory Committee on Antimicrobial Prescribing, Resistance and Healthcare Acquired Infections \(APRHAI\)](#) of alternatives during the shortage highlights the need to minimise automatically switching to carbapenems. Many acute trusts have continued to decrease their carbapenem and total antibacterial usage despite the piperacillin/tazobactam shortage.

Our provider did not take part in the AMR CQUIN for 2016/17. How will baseline data be generated for us?

Providers that did not take part in the 2016/17 AMR CQUIN should submit quarterly data from January 2016 to December 2016 using the antibiotic consumption spreadsheets available on the [NHS England AMR CQUIN webpage](#). Without this data a baseline cannot be calculated for your provider.

The data we submitted for financial year 2015/16 was not given in quarters. How will you calculate our Q1 data for 2016?

Data can be resubmitted for Q1 2016 using the antibiotic consumption spreadsheets available on the [NHS England AMR CQUIN webpage](#). Without this data a baseline cannot be calculated.

How can we monitor progress of part 2c and 2d of this CQUIN?

All data submitted to PHE will be available on the [PHE fingertips data portal](#).

AMR indicators of relevance to the CQUIN can be found in the 'supporting NHS England initiatives' domain under the acute trusts area type. These are:

- defined daily dose (DDD) of antibiotics dispensed by acute trust pharmacies to all inpatients and outpatients per 1,000 admissions
- DDD of piperacillin/tazobactam dispensed by acute trust pharmacies to all inpatients and outpatients per 1,000 admissions
- DDD of carbapenems dispensed by acute trust pharmacies to all inpatients and outpatients per 1,000 admissions
- percentage of antibiotic prescriptions with evidence of review within 72 hours, by quarter
- outcome of antibiotic reviews by quarter.

Data will be released as follows:

- Q1 2017/18 – early October 2017
- Q2 2017/18 – early January 2018
- Q3 2017/18 – early April 2018
- Q4 2017/18 – early July 2018.

When should we submit data?

Data should be submitted as soon as possible after the end of each quarter and no later than the end of the month following the end of the quarter:

- Q1 2017/18 – 31 July 2017
- Q2 2017/18 – 31 October 2017
- Q3 2017/18 – 31 January 2018
- Q4 2017/18 – 30 April 2018.

If you need to submit historical data because you did not take part in the 2016/17 CQUIN or you wish to submit Q1 data for 2016, you should submit this no later than 31 May 2017.

Can we amend the antibiotic consumption spreadsheet if data is missing?

The antibiotic data collection spreadsheet should not be amended. Please e-mail CQUIN@phe.gov.uk if additional antibiotics were dispensed.

How do we view CQUIN data?

Consumption data per 1,000 admissions is available for all years (2013/14 to present). You can view this most easily under the 'trends' tab for each of the three antibiotic consumption indicators. It allows 2016/17 and 2013/14 baseline data for each individual provider to be compared. Provider data should only be compared to the baseline for England or to other

providers with extreme caution as the data is not casemix adjusted. The 'overview' tab only shows data for the most recent reported time period.

How is admissions data calculated?

Indicators are published to support the CQUIN report consumption data as a rate of DDDs per 1,000 admissions. These rates are calculated using admissions data from the same financial year as the antibiotic consumption data. Admissions data is extracted from Hospital Episode Statistics (HES); please refer to the summary HES data webpage (currently being updated) for the most recent openly published data (2015/16).

PHE can access preliminary (non-published) admissions data for 2016/17 to the present from HES in advance of publication of finalised data. This provisional admissions data is subject to change and will be updated on a quarterly basis and as finalised data becomes openly available.

The HES admissions method counts the number of admission episodes that finished within a financial year. Note this includes patients who were admitted in previous years (ie before 1 April of the financial year). So each quarter contains the number of admission episodes that finished in that quarter, regardless of when they started. Records are included if:

- patient classification = ordinary admission, day case admission or mothers and babies using only delivery facilities (ie not included if a patient is a regular day attender, regular night attender or entry was not applicable)
- finished episode
- first episode in spell.

Our data differs from the published data. What should we do?

On investigating potential differences between rates of antibiotic consumption published on fingertips and your own local data, a good first step is to check whether it is the DDD count and/or the value (rate) that differs. This can tell us whether the basis of any difference lies in the DDD count or the admissions figure. If you wish to query any data, please email CQUIN@phe.gov.uk