Sepsis.

an update is the last thing we need.

Dr Ron Daniels
Chief Executive, Global Sepsis Alliance
Fellow: NHS Improvement Faculty
Chief Executive: United Kingdom Sepsis Trust & Chair, UK SSC
Society for Acute Medicine, Coventry, 10th May 2013
A U.K. Perspective
Sepsis is on the up..

Hospitalization rates for septicemia or sepsis more than doubled from 2000 through 2008.

Figure 1. Hospitalizations for and with septicemia or sepsis

NOTE: Significant linear trend from 2000 through 2008 for both categories.

CDC National Center of Hospital Statistics
Why do we need to change?
Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2008
Serum lactate measured

Blood cultures obtained prior to antibiotic administration

From the time of presentation, broad-spectrum antibiotics to be given within 1 hour

Control infective source

In the event of hypotension and/or lactate >4mmol/L (36mg/dl):

- Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent)
- Give vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) ≥ 65 mm Hg.

In the event of persistent arterial hypotension despite volume resuscitation (septic shock) and/or initial lactate >4 mmol/l (36 mg/dl):

- Achieve central venous pressure (CVP) of ≥8 mm Hg
- Achieve central venous oxygen saturation (ScvO₂) ≥70%
Table 3. Change in achievement of bundle targets

<table>
<thead>
<tr>
<th></th>
<th>Initial Quarter Achieved, %</th>
<th>Final Quarter Achieved, %</th>
<th>p Value Compared With Initial</th>
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</thead>
<tbody>
<tr>
<td>Initial care bundle (first 6 hrs of presentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure lactate</td>
<td>61.0</td>
<td>78.7</td>
<td>≤.0001</td>
</tr>
<tr>
<td>Blood cultures before antibiotics</td>
<td>64.5</td>
<td>78.3</td>
<td>≤.0001</td>
</tr>
<tr>
<td>Broad-spectrum antibiotics</td>
<td>60.4</td>
<td>67.9</td>
<td>.0002</td>
</tr>
<tr>
<td>Fluids and vasopressors</td>
<td>59.8</td>
<td>77.0</td>
<td>≤.0001</td>
</tr>
<tr>
<td>CVP &gt;8 mm Hg</td>
<td>26.3</td>
<td>38.0</td>
<td>≤.0001</td>
</tr>
<tr>
<td>Scvo2 &gt;70%</td>
<td>13.3</td>
<td>24.3</td>
<td>≤.0001</td>
</tr>
<tr>
<td>All resuscitative measures</td>
<td>10.9</td>
<td>21.5</td>
<td>≤.0001</td>
</tr>
<tr>
<td>Management bundle (first 24 hrs after presentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroid policy</td>
<td>58.5</td>
<td>73.9</td>
<td>≤.0001</td>
</tr>
<tr>
<td>Administration of drotrecogin</td>
<td>47.4</td>
<td>53.5</td>
<td>.003</td>
</tr>
<tr>
<td>Glucose control</td>
<td>51.4</td>
<td>56.8</td>
<td>.0009</td>
</tr>
<tr>
<td>Plateau pressure control</td>
<td>80.8</td>
<td>83.8</td>
<td>.24</td>
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<tr>
<td>All management measures</td>
<td>18.4</td>
<td>25.5</td>
<td>≤.0001</td>
</tr>
</tbody>
</table>

CVP, central venous pressure; Scvo2, central venous oxygen saturation.

*Represents the last quarter of data submission from each institution during the 2-yr data analysis period and institution participation.

R. Phillip Dellinger, MD\textsuperscript{1}; Mitchell M. Levy, MD\textsuperscript{2}; Andrew Rhodes, MB BS\textsuperscript{3}; Djillali Annane, MD\textsuperscript{4}; Herwig Gerlach, MD, PhD\textsuperscript{5}; Steven M. Opal, MD\textsuperscript{6}; Jonathan E. Sevransky, MD\textsuperscript{7}; Charles L. Sprung, MD\textsuperscript{8}; Ivor S. Douglas, MD\textsuperscript{9}; Roman Jaeschke, MD\textsuperscript{10}; Tiffany M. Osborn, MD, MPH\textsuperscript{11}; Mark E. Nunnally, MD\textsuperscript{12}; Sean R. Townsend, MD\textsuperscript{13}; Konrad Reinhart, MD\textsuperscript{14}; Ruth M. Kleinpell, PhD, RN-CS\textsuperscript{15}; Derek C. Angus, MD, MPH\textsuperscript{16}; Clifford S. Deutschman, MD, MS\textsuperscript{17}; Flavia R. Machado, MD, PhD\textsuperscript{18}; Gordon D. Rubenfeld, MD\textsuperscript{19}; Steven A. Webb, MB BS, PhD\textsuperscript{20}; Richard J. Beale, MB BS\textsuperscript{21}; Jean-Louis Vincent, MD, PhD\textsuperscript{22}; Rui Moreno, MD, PhD\textsuperscript{23}; and the Surviving Sepsis Campaign Guidelines Committee including the Pediatric Subgroup*  

\textbf{Objective:} To provide an update to the “Surviving Sepsis Campaign Guidelines for Management of Severe Sepsis and Septic Shock,” last published in 2008.  
\textbf{Design:} A consensus committee of 68 international experts representing 14 specialty areas assembled in 2011 to 2012 to update the guidelines.  

\textbf{Methods:} The authors were advised to follow the principles of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to guide assessment of quality of evidence from high (A) to very low (D) and to determine the strength of recommendations.
To be completed within 3 hours:
1) Measure lactate level
2) Obtain blood cultures prior to administration of antibiotics
3) Administer broad spectrum antibiotics
4) Administer 30 mL/kg crystalloid for hypotension or lactate 4mmol/L

To be completed within 6 hours:
5) Apply vasopressors for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure [MAP] 65 mm Hg
6) In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate 4 mmol/L (36 mg/dL):
   - Measure central venous pressure (CVP)*
   - Measure central venous oxygen saturation (ScvO2)*
7) Remeasure lactate if initial lactate was elevated*
The Sepsis Six

1. Give high-flow oxygen via non-rebreath bag
2. Take blood cultures and consider source control
3. Give IV antibiotics according to local protocol
4. Start IV fluid resuscitation Hartmann’s or equivalent
5. Check lactate
6. Monitor hourly urine output consider catheterisation

within one hour
..plus Critical Care support to complete EGDT
## Severe Sepsis

<table>
<thead>
<tr>
<th>Treatment</th>
<th>NNT 'basic' care</th>
<th>NNT invasive care</th>
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</thead>
<tbody>
<tr>
<td>Sepsis Six (our data)</td>
<td>4</td>
<td>6</td>
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<tr>
<td>First hour antibiotics</td>
<td>6</td>
<td></td>
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<tr>
<td>EGDT (Rivers)</td>
<td>6</td>
<td></td>
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<tr>
<td>Resusc Bundle (SSC)</td>
<td>18</td>
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</table>

## Acute coronary syndrome

<table>
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<tr>
<th>Treatment</th>
<th>NNT 'basic' care</th>
<th>NNT invasive care</th>
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</thead>
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<tr>
<td>Clopidogrel</td>
<td>48</td>
<td></td>
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<tr>
<td>β-blockade</td>
<td>42</td>
<td></td>
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<tr>
<td>Aspirin</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Thrombolysis</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>PCI over thrombolysis</td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>
The College of Emergency Medicine

Patron: HRH The Princess Royal
Churchill House
35 Red Lion Square
London WC1R 4SG

CLINICAL EFFECTIVENESS COMMITTEE
Standards for Severe Sepsis and Septic Shock Management in Adults
May 2007

Standards

Patients with severe sepsis or septic shock

- In 95% of cases documented evidence in the notes of temperature, pulse rate, respiratory rate, blood pressure, mental status (AVPU or GCS) and capillary blood glucose on arrival.
- In 95% of cases documented evidence in the notes that senior EM / ICU help was summoned.
- In 95% of cases documented evidence in the notes that high flow O₂ via non-rebreath mask was initiated (unless there is a documented reason to the contrary) prior to leaving the Emergency Department (ED).
- In 95% cases documented evidence that serum lactate measurement obtained prior to leaving the ED.
- In 95% of cases documented evidence that blood cultures were obtained prior to leaving the ED.
- Fluids - documented evidence that first intravenous crystalloid fluid bolus (up to 20mls/kg) was given:
  - In 75% of cases within 1 hour of arrival
  - In 90% of cases within 2 hours of arrival
  - In 100% cases prior to leaving the ED
- Antibiotics - documented evidence that antibiotics were administered
  - In 50% of cases within 1 hour of arrival
  - In 90% of cases within 2 hours of arrival
  - In 100% cases prior to leaving the ED
- In 90% of cases documented evidence that urine output measurements were instituted prior to leaving the ED.

Review January 2011
CEM Clinical Audits 2011-12

Severe Sepsis & Septic Shock
First hour antibiotics in 27%...

CEM Clinical Audits 2011-12

Severe Sepsis & Septic Shock
How to achieve better sepsis outcomes?
2 groups with 2 sets of needs.

1. Get community-acquired sepsis patients to hospital quickly
Boy, 17, died when bungling doctors misdiagnosed his blood poisoning FOUR times thinking it was flu

- Greg Bear’s condition was dismissed by three doctors and a paramedic six days before he died
- Mother was told his condition did not warrant a hospital visit, even when he began coughing up blood
- Paramedic told Elizabeth Bear: If I was to take every 17-year-old boy coughing up blood, the system would grind to a halt

By AMY OLIVER
PUBLISHED: 10:29, 12 October 2012 | UPDATED: 16:00, 12 October 2012

A teenager died of blood poisoning after medics dismissed his illness as flu four times, an inquest has heard.

Greg Bear, 17, had been examined by three doctors and a paramedic six days before he died.

After he began coughing up blood - a key symptom of septicaemia - his mother Elizabeth begged one paramedic to rush the teen to hospital.

But she was told his condition was not bad enough and that he should take some paracetamol.

The teenager died half an hour later.
Audit of deaths less than a week after admission through an emergency department: how accurate was the ED diagnosis and were any deaths preventable?

Tabassum Nafsi, Rob Russell, Cilla M Reid, Syed M M Rizvi

Aim: To review the causes of death in patients admitted via the emergency department (ED) who died within 7 days of admission and to identify any ways in which ED care could have been better. The study also aims to compare the diagnosis made in the ED and the mortality diagnosis.

Methods: A retrospective study; subjects were all patients who attended the ED over 4 months and died within 7 days of admission. The paramedics’ notes, ED case cards, inpatient medical notes and details of postmortem findings were examined to identify the time and date of arrival in the ED, presenting complaint, provisional diagnosis made by the ED, treatment plan devised by the ED, diagnosis made in wards, and the cause of death as issued on death certificates or from postmortem findings. Summary sheets of cases where the care provided by the emergency department could have been improved were reviewed, errors were identified and deaths were classified as preventable or unpreventable.

Results: Database revealed 3521 admissions via the ED over 4 months, of which 95 cases (2.69%) died within 7 days of admission. 78 patients (82.1% of cases) were appropriately diagnosed and managed whereas 17 (17.87% of cases) were identified with deficiencies in either the diagnosis or the management provided in the ED. We reviewed the quality of care provided in the ED for these cases and rated deaths according to our preventability criteria: 5 (5.26%) deaths were unpreventable despite the deficiency in care provided in the ED; 3 (3.15%) deaths were definitely preventable; 3 (3.15%) were probably preventable; and 6 (6.31%) were possibly preventable deaths.

Conclusion: The ED is playing a good role in the management of critically ill patients, with appropriate diagnosis and management in 82% of cases. Training of junior doctors is required to prevent occurrence of errors and thus preventable deaths, but all deaths are not preventable. New guidelines for sepsis management need to be developed to ensure accurate diagnosis and management.
Audit of deaths after ED admission

- Respiratory: 26%
- Cardiovascular: 12%
- Septicaemia: 9%
- Carcinoma: 7%
- Renal failure: 3%
- Surgical (other): 2%
- AAA: 7%
- Cerebrovascular: 21%
- Other: 20%
FASTer identification means faster treatment

The Stroke Association recently funded the first clinical study to investigate whether paramedics can accurately identify stroke.

Is FAST a reliable tool?
A stroke may be identified and diagnosed using FAST at an early stage by the ambulance paramedic, however this early diagnosis is of benefit if it is in agreement with the stroke physician’s diagnosis.

The research project
(Published in Stroke, 2004; 35: 1759-1763)

What the research

2001 and July 2002, by the North East Ambulance Service. For each patient, comparisons were made between paramedics and stroke physicians: FAST recordings, across all of the three neurological signs: facial weakness, arm weakness and speech disturbance.

Abstract

Does initiation of an ambulance pre-alarm call reduce the door to needle time in acute myocardial infarct?

S R Learmonth, A Ireland, C J Mckie, and P Burton

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P Burton, Clinical Audit Department, Glasgow Royal Infirmary, Glasgow, Scotland

Correspondence to: Sarah Learmonth
Flat 3/3, 42 Minard Road, Glasgow, G41 2HW, sarah.learmonth@gmail.com

Received November 19, 2004, Revised May 20, 2005, Accepted June 7, 2005.

Objectives
To assess the effect an ambulance pre-alarm call for patients with suspected acute myocardial infarction (AMI) would have on door to needle (DTN) times.

Methods
We carried out back to back audits of DTN times following the initiation of the pre-alarm calls.

Participants
The United Kingdom Sepsis Group
Recommendations for pre-hospital sepsis identification and management

April 2011

Background

The United Kingdom Sepsis Group (UKSG) is comprised of senior clinicians, nurses, paramedics, healthcare managers and patient representatives representing pre-hospital care, emergency medicine, acute medicine, critical care medicine, haematology, paediatrics and women’s services. It incorporates the United Kingdom Surviving Sepsis Campaign Executive Committee and U.K Pre-hospital Sepsis Group.

Table 1 – Time Critical Features/Conditions

- **Adrenal crisis** (including Addisonian crisis) - is a life threatening condition resulting from adrenal insufficiency – refer to hydrocortisone guidelines.

- **Airway impairment.**

- **Anaphylaxis** – is a life threatening condition resulting from an immune response to an allergen refer to allergic reactions including anaphylaxis guideline.

- Any patient with **GCS <15** - check the airway and blood glucose levels in all patients with a decreased GCS.

- **Cardiac chest pain.**

- **Cardiogenic shock.**

- **Sepsis** – is a life threatening condition resulting from infection. Suspect sepsis in patients who have a history of infection, altered body temperature and a systolic blood pressure below 90mmHg - refer to intravascular fluid guidelines.

- **Failing ventilation.**

- **Severe breathlessness** - unable to complete a sentence.

- **Severe haemorrhage** - refer to trauma.
Pre-hospital Sepsis Screening Tool

Use for all adult (>16 years) patients who are not pregnant

If life is clearly immediately threatened, transport urgently with interventions en route

1. Could this be a severe infection?
   - For example:
     - Pneumonia
     - UTI
     - Abdominal pain or distension
     - Meningitis
     - Indwelling medical device
     - Cellulitis/septic arthritis/infected wound
     - Recent chemotherapy
     - Recent organ transplant

   Call details

   - YES
     - Discontinue form. Apply standard protocols

   - NO
     - Suspected Sepsis!
       - Immediate:
         - Oxygen 15 Lpm via NIV
         - Record actions on ambulance chart

     - Transfer using lights and siren to nearest receiving Emergency Department
       - Pre-alert, situation: ‘Suspected Sepsis’

2. Are any 2 of the following present?
   - Temperature: > 38°C or < 36°C
   - Respiratory rate: > 20 per minute
   - Heart rate: > 90 per minute
   - Acutely confused/reduced conscious level

   Sepsis possible!

   - YES
     - Septic shock!
       - Immediate:
         - 250 ml bolus Hartmann’s to maximum 1000 ml, repeated based on response (also in CHD)
         - Oxygen 15 Lpm via NIV
         - Record actions on ambulance chart

   - NO
     - Discontinue form. Apply standard protocols
Sepsis is a rare but serious condition that can look just like self-limiting infections such as flu, gastroenteritis or chest infections.

See your GP immediately if you develop any one of the following:

- Slurred speech
- Extremely painful muscles
- Passing no urine (in a day)
- Severe breathlessness
- “I feel like I might die”
- Skin mottled or discoloured

email info@sepsistrust.org for more information
2 groups with 2 sets of needs.

2. Recognize in-patient deterioration reliably
Media Centre

Trust Admits Failure To Provide ‘Lifesaving Treatment’ To Nursery Nurse

Grandmother Died Weeks After Successful Cancer Surgery

11/06/2012

Lawyers representing the family of a nursery nurse who died after medical staff failed to treat an infection causing blood poisoning just weeks after she underwent successful cancer surgery have called for the trust responsible to show steps have been taken to prevent future tragedies.

After suffering for a month with stomach pain, vomiting and nausea, mum of four and grandmother of five Gerry Hutchinson, 69, from Thorne in Doncaster, was admitted to Doncaster Royal Infirmary on 14th January 2010 where she and her family received the devastating news that she had a bowel cancer.

Despite undergoing a successful operation to remove the cancer, her condition deteriorated and by January 24th blood tests showed something was wrong. Doctors suspected that she was suffering from a bowel leak and ordered a CT scan, but it proved inconclusive and surgery was needed that day to identify the problem.
2 groups with 1 identical need.

3. Respond and escalate appropriately
The sepsis six and the severe sepsis resuscitation bundle: a prospective observational cohort study

Ron Daniels,¹ Tim Nutbeam,² Georgina McNamara,¹ Clare Galvin¹

¹Good Hope Hospital, Heart of England NHS Foundation Trust, Sutton Coldfield, UK
²West Midlands Deanery, Birmingham, UK

ORIGINAL ARTICLE

ABSTRACT

Background Severe sepsis is likely to account for around 37,000 deaths annually in the UK. Five years after the international Surviving Sepsis Campaign (SSC) care bundles were published, care standards in the management of patients with severe sepsis are achieved in fewer than one in seven patients.

Methods This was a prospective observational cohort study across a 500-bed acute general hospital, to assess the delivery and impact of two interventions: the SSC resuscitation bundle and a new intervention designed to facilitate delivery, the sepsis six. Process measures included compliance with the bundle and the sepsis six; the outcome measure was mortality at hospital discharge.

In recognition of poor compliance, we developed an operational solution reflective of NHS practice to improve delivery of the bundle. The ‘sepsis six’ (box 2) is designed to facilitate early intervention with three diagnostic and three therapeutic steps to be delivered by staff within 1 h. The tasks were identified from those poorly performed in our initial gap analysis. The accompanying education programme, survive sepsis, reinforces that failure of a patient to respond to the sepsis six (persistent evidence of hypoperfusion) mandates immediate referral to critical care to complete the remaining elements of the resuscitation bundle (ie, EGDT).

The sepsis six, endorsed by SSC, has been
Compliance at Good Hope Hospital (%)
## Mortality by Sepsis Six

<table>
<thead>
<tr>
<th></th>
<th>Cohort size (%)</th>
<th>Mortality %</th>
<th>RRR % (NNT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>567 (100)</td>
<td>34.7</td>
<td>-</td>
</tr>
<tr>
<td>Sepsis Six</td>
<td>347 (61.2)</td>
<td>44.0</td>
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</tr>
<tr>
<td>Sepsis Six</td>
<td>220 (38.8)</td>
<td>20.0</td>
<td>46.6 (4.16)</td>
</tr>
</tbody>
</table>
2 groups with 1 identical need.

4. Monitor long-term outcomes and rehab needs
Long-term cognitive impairment after sepsis

Incidence of PTSD (%)

- Fire/natural disasters: 4.5%
- Assault leading to injury: 11.5%
- ITU survivors: 22%
- War: 38.8%
- Rape: 55.5%

2 groups with 1 identical need.

5. Get the public message right
If you are admitted to a hospital, you have a 5% chance of contracting an HAI. 1.7 million people per year get an infection during a hospital stay. Your length of stay in the hospital increases by 17.6 days if you get an HAI.

98,987 people in the U.S. die annually from HAIs. HAIs kill more people each year than Breast Cancer and Prostate Cancer combined.

More than 3/4 of HAIs affect people with Medicare or Medicaid.

System: $35 Billion/yr
Patient: $1,100 per admission
Our Vision & Mission

Our vision is that no person is harmed by a preventable infection.

Our mission is to inform, promote and sustain expert infection prevention policy and practice in the pursuit of patient or service user and staff safety, wherever care is delivered.

Become a member

What's On

- 24 April 2013: HIS & IPS Spring Meeting
- 25th April 2013: Infection Prevention Society London Branch Conference
- 9th May 2013: IPS Ambulance Forum and Audit and Surveillance Forum Conference
- 12th June 2013: IPS North East Branch Conference
- 12th June 2013: IPS South West Branch Conference 'Patient Safety is Everyone’s Business'
- 19th June 2013: EWMIC Conference 2013
- 24th June 2013: Champions Challenged

Infection Prevention 2013

Delegate registration is now open for Infection Prevention 2013

Click on the link below and be one of the first to register for the UK's largest infection prevention conference

Infection Prevention 2013

ExCeL London

30th September – 2nd October 2013

CLICK HERE for more information
ANTIBIOTIC ACTION AFFECTS US ALL AND OUR FAMILIES

NO ANTIBIOTICS...NO CURES
MAKE A DIFFERENCE AND SIGN THE PETITION NOW


Infections management is about...

1. Prevention of avoidable infection

2. Antimicrobial stewardship

3. Rapid treatment of sepsis and other severe infection
Infections management is about...

The trinity of infections management - a coalition statement

To achieve sustainable reduction in harm from infection demands an unprecedented heightening of awareness among health workers, government, commissioners and the general public, and for stakeholders to unite with one voice to disseminate a comprehensive and wide-ranging call to action.

In November 2011, the Department of Health published guidance on antimicrobial stewardship in secondary care in the document ‘Start smart- then focus’ (DoH 2011, Gateway ref. 16853). The key messages were:

1. Avoid antibiotic use in the absence of evidence of bacterial infection (unless used for evidence-based procedural prophylaxis).
2. If there is evidence/suspicion of bacterial infection, use local guidelines to initiate prompt, effective antibiotic treatment after sampling cultures and record review date. Review the appropriateness of ongoing therapy within 48 hours and seek opportunity for de-escalation or cessation.

This coalition welcomes this guidance, and seeks to ensure its wider application. Success demands that strategies to reduce unnecessary antimicrobial use and initiate prompt, appropriate treatment where there is evidence of infection be addressed with equal vigour to those employed to reduce the incidence and spread of infections, and be complemented by urgent investment in the development of existing and new classes of...
The World Sepsis Declaration

Sepsis is one of the most common, least-recognized illnesses in both the developed and developing world. Globally, 20 to 30 million patients are estimated to be afflicted every year, with over 6 million cases of neonatal and early childhood sepsis and over 100,000 cases of maternal sepsis. Worldwide, a person dies from sepsis every few seconds.

In the developed world, sepsis is dramatically increasing by an annual rate of between 8-13 % over the last decade, and now claims more lives than bowel cancer and breast combined. Reasons are diverse, but include the aging population, increasing use of high-risk interventions in all age groups, and the development of drug-resistant and more virulent varieties of infections. In the developing world malnutrition, poverty, lack of access to vaccines and timely interventions, and increasing climate change, are leading to an exponential rise in incidence.
World Sepsis Day
We’re supported by:

The Royal College of Surgeons of England

Royal College of Physicians

Royal College of Nursing

The Intensive Care Society

The Patients Association

National Patient Safety Agency

the uk sepsis trust
New topics chosen for NCEPOD to start in 2013! Gastrointestinal bleeding and Sepsis will get going shortly!
What ‘doing sepsis right’ might mean for us
Achieving 80% reliability

For each year, for every 100k in the local population:

- 20 lives saved
- 285 fewer bed days
- 168 fewer CC bed days

*Direct* costs for survivors reduced by £0.25M

*For the UK, that’s 13,400 lives and £170 million. Every year.*
Summary

*Sepsis is a medical emergency- and a big killer*
Awareness and recognition are the key

*Early antibiotics and fluids will save more lives than Critical Care*
We need a whole-systems approach

*The public message around infections management needs to be refined*
To give equal weight to all important aspects