UK Health Security Agency

Minutes

Title of meeting	HCAI DCS Stakeholder Engagement Forum
Date	9th July 2026
Time	11:00 – 12:00
Venue	MS Teams
Attendees	

Hanna Squire	Principal Scientist (Epidemiology), UKHSA
Lucy Findlater	Senior Scientist (Epidemiology), UKHSA
Ahmed Raza	Epidemiology Scientist, UKHSA
Tim Pollington	Senior Scientist (Epidemiology), UKHSA
Russell Hope	Lead Scientist & Head of Gram-Negative Team, UKHSA
Antoine Salzmann	Senior Scientist, UKHSA
Samantha Hogg-Davies	
Janette Gray	NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE
Lorraine Durham	Manchester University NHS
Alex Simmons	NHS CENTRAL EAST ICB - 06N
Amina Deria	
Kevin Marshallsay	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION
Janet Oatley	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Yvette Reece	LEEDS TEACHING HOSPITALS NHS TRUST
Helen Wilcox	WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST
Pietro Coen	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
Lorraine Young	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
Graham Verbrugge	NNUHFT
Danel Meno	WHITTINGTON HEALTH NHS TRUST
Kirran Klein	EAST SUSSEX HEALTHCARE NHS TRUST

Lisa Redmond	EAST SUSSEX HEALTHCARE NHS TRUST
Fiona Hammond	IPC Nurse Consultant, National Infection Prevention and Control Team, NHS ENGLAND
Idil Osman	NHS CENTRAL EAST ICB - 06N
Katherine Summers	NORTH CHESHIRE AND MERSEY NHS FOUNDATION TRUST 1
Jean Legaspi	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
Halina Davidson	LEEDS TEACHING HOSPITALS NHS TRUST
Iona McLaggan-Lane	UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE - RNS
Laura Whitney	NHS ENGLAND - X24
Damien Mack	ROYAL FREE LONDON NHS FOUNDATION TRUST
Jane Searle	

No.	Agenda items

1.	**Welcome**
	
	- Hanna Squire (Principal Scientist (Epidemiology), UKHSA) opened the meeting at 11:00 and welcomed attendees.
	- Attendees were advised that the meeting would be recorded and that minutes would be published in due course.
	- The agenda was outlined as:
	  o Launch of the new CDI Risk Factor Questions.
	  o SGSS-DCS Case Capture Pilot update.
	  o Changes to the Mandatory Surveillance Protocol.
	  o Questions and discussion.

2.	**New CDI risk factor questions: introduction**
	
	- Russell Hope (Lead Scientist & Head of Gram-Negative Team, UKHSA) explained that understanding the risk factors associated with Clostridioides difficile infection (CDI) is an important component of surveillance activity.
	- Following increases in CDI incidence after the COVID-19 pandemic, UKHSA undertook a review of existing risk factor questions to determine whether they remained fit for purpose.
	- Key points:
	  o A multidisciplinary clinical and infection prevention and control (IPC) review group was established.
	  o The review was led by UKHSA Clinical Lead Dakshika Jeyaratnam.
	  o Lessons learned from the CDI review process may subsequently be applied to bloodstream infection (BSI) surveillance.
	  o Stakeholder feedback will inform future developments.

3.	**New CDI risk factor questions: overview of the review process** - Fiona Hammond (IPC Nurse Consultant, National Infection Prevention and Control Team, NHS ENGLAND) presented the history and methodology of the review:

	Background - The review originated from national CDI collaborative work established in 2023 between NHS England and UKHSA. - Behavioural Insights support was used to challenge whether the existing surveillance system was collecting the most useful data, particularly given the age of the existing CDI surveillance questions (case-level surveillance introduced in 2007). Review Activities - The review involved: o Consultation with organisations across all seven NHS regions. o Comparison of local investigation data with current DCS requirements. o Consideration of changes introduced through the Patient Safety Incident Response Framework (PSIRF). o Assessment of which data items should be collected nationally versus locally. Stakeholder Engagement - A working group to review draft questions was convened in July 2025 including IPC specialists, community services representatives, laboratory staff, policy makers, provider organisations - Questions were assessed according to: o Clinical relevance. o Availability of information. o Ease of collection. o Utility at both local and national levels. Key Findings - The consultation highlighted: o Significant variation in local data collection practices. o Variability in digital maturity between organisations. o The importance of avoiding duplication of information already captured elsewhere. o The need for surveillance questions that support behaviour change and intervention development.
4.	**New CDI risk factor questions: question run through** - Hanna Squire presented the revised question set and implementation plans. - Questions have been tested using dummy data by approximately 20 voluntary trusts. - Go-live is planned later in 2026, with questions initially optional - longer-term intention is to make them mandatory while allowing amendments up to 12 months post sign-off. - "Unknown" options will be available wherever information cannot reasonably be obtained. - The existing (old) CDI risk factor questions consist of 5 parent questions and 3 child (triggered) questions. Most of these questions are optional resulting in incomplete and potentially biased data. - The revised question set contains 9 parent questions and 13 triggered questions. Questions are grouped into 6 themes:

	1. Prescribing history - includes questions on use of antibiotics, Proton Pump Inhibitors (PPI), and Systemic Anti-Cancer Therapy (SACT) 2. CDI treatment - questions on number and name of treatments, route of administration, start and end dates, and completion status 3. Transmission - is there evidence of cross-transmission? If so, did cases have same PCR ribotype? 4. Disease severity 5. Testing – how long after onset of diarrhoea was stool sample sent for testing? 6. Infection prevention and control – was there a delay of more than 4 hours in implementing appropriate patient placement following CDI diagnosis?

5.	**SGSS-DCS case capture pilot: update and next steps**
	
	- Antoine Salzmann (Senior Scientist, UKHSA) presented a pilot project on behalf of colleague Olisaeloka Nsonwu (Principal Scientist (Epidemiology), UKHSA).
	- The project examined whether mandatory surveillance case capture could be automated using centrally available datasets rather than relying solely on local trust data entry, thus reducing administrative burden on trusts, reducing manual data-entry errors, and facilitating expansion of surveillance to additional pathogens in future.
	  - The pilot linked SGSS microbiology data, SUS hospital admissions data, and ECDS emergency care attendance data
	- Participating trusts suspended local reporting of Pseudomonas cases for January, reviewed automatically generated cases, and corrected any inaccuracies before sign-off.
	- Key findings included:
	  o 91% of cases in final sign off were captured by the pilot; 72% were uploaded to HCAIDCS because linked hospital records were available.
	  o 100% accuracy in patient details, 87% accuracy in healthcare-association categorisation.
	  o Accuracy was lower for main speciality, treatment specialty, and patient category fields
	- Feedback from participating trusts indicated pilot guidance/support were considered clear. Most users found the process useful and there was broad support for further development.
	- Challenges were identified - some trusts reported time savings, but others reported increased review workload. Data timeliness remains a significant issue because hospital admission information can be delayed.
	- The pilot demonstrated that automated case capture is feasible, but that further development is required before wider implementation.

6.	**Changes to the Mandatory protocol document** - Hanna Squire presented upcoming changes to the mandatory surveillance protocol. The current protocol (Version 4.4) was published in 2020 and has undergone a comprehensive review over the past year. - Cosmetic improvements have been made to document structure/readability, and to attribution and prior trust exposure algorithm flow diagrams.

	References to Clinical Commissioning Groups (CCGs) have been replaced with Sub-Integrated Care Boards (Sub-ICBs).
	- Several clarifications have been introduced:
	  o Improved clarity of QMLR section e.g. to laboratory finding fields and definitions, details on data submission timeframes.
	  o Clearer descriptions of continuing and repeat infections.
	  o Clarification regarding specimen dates for CDI cases without a stool sample (CT scan or pathology dates should be entered as the specimen date where stool specimens are not used for diagnosis)
	- New additions (prior comms to stakeholders has been done for each):
	  o Added sections on virtual wards and intermediate care facilities (these categories already exist within DCS).
	  o In 2024 the CDI hospital-onset threshold was changed from 'Day 4 onwards' to 'Day 3 onwards', and the protocol is now being brought into line with this.
	  o A&E patients: decision-to-admit date should be used as the admission date when available to provide a more accurate measure of healthcare exposure.

7.	**Questions and discussion**
	
	1. Question from Iona McLaggan-Lane, UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE – RNS: "Would it be possible to create CSV templates for data upload for other tabs fields on the dcs to speed up data upload rather than manually adding into each case? (Prior trust exposure, species, risk factors, source etc) I find data upload to be immense time saving and accuracy from ICnet"
	  - Hanna Squire confirmed that the team would investigate whether templates could be developed for use with the Data Upload Wizard and would discuss this with colleagues responsible for that functionality.
	
	2. Question from Pietro Coen, UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
	  - Reported that colleagues involved in CDI investigations had raised concerns about difficulty obtaining retrospective information, particularly information from outside the reporting trust, for example from primary care settings.
	  - Hanna Squire acknowledged some information may be lacking for some cases, which is why 'unknown' option is available for certain fields.
	  - Fiona Hammond acknowledged the challenges and confirmed that:
	  ▪ "Unknown" responses are permitted where data are unavailable.
	  ▪ Recording unknowns helps demonstrate gaps in digital capability and interoperability.
	  ▪ Feedback received throughout the consultation process has informed wider programmes of work.
	  - Russell Hope advised that future developments may allow national data linkage to enrich DCS records through:
	  ▪ Cancer registries.
	  ▪ Primary/secondary care prescribing datasets.

	▪ Additional national data sources as they become available. ▪ He noted that automated surveillance developments could eventually reduce the burden of manual data collection.
8.	**Concluding remarks** Hanna thanked attendees, presenters and organisers for their participation and contributions. Attendees were reminded that further queries by email could be directed to: Mandatory Surveillance Team: mandatory.surveillance@ukhsa.gov.uk HCAI DCS support inbox: support.HCAIDCS@ukhsa.gov.uk