Public Health England

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HCAI Mandatory Surveillance Stakeholder Engagement Forum: 23rd August 2018

Background:

These notes are based upon the eighth meeting of the National Stakeholder group. Invited attendees were national level stakeholders with a key interest in the mandatory surveillance of key HCAIs (MRSA bacteraemia, MSSA bacteraemia, *E. coli* bacteraemia, *Klebsiella* bacteraemia, *Pseudomonas aeruginosa* bacteraemia and *Clostridium difficile* infection).

NHS colleagues are also invited to ensure that local views/opinions are represented. NHS attendees represent those organisations that expressed an interest attending and whose representatives were available to participate.

Invited attendees:

- PHE HCAI Mandatory Surveillance
- PHE Field Epidemiology Services (FES)
- Department of Health (DH)
- NHS Choices
- NHS Digital
- NHS Improvement
- Oxford University Hospitals NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Dudley Metropolitan Borough Council
- Isle of Wight CCG and Southampton CCG
- NHS Kernow CCG
- NHS Southampton CCG
- Barts Health NHS Trust

The overall aims of the group are as follows:

- To canvas opinion of current routine mandatory HCAI surveillance outputs/publications. This forum specifically focusses on PHE national statistics outputs rather than data collection and system development per se.
- Future developments to routine mandatory surveillance outputs/publications.

Change to the Monthly Outputs

PHE have started reporting the C.*difficile* infections by Prior Healthcare Exposure, where patients have previously been admitted to the reporting Trust. We now separate cases into four categories:

- Hospital Onset – Healthcare Associated
- Community Onset – Healthcare Associated
- Community Onset – Undetermined Association
- Community Onset – Community Associated

The Prior Healthcare Exposure algorithm will become the primary way PHE will look at CDI data and it is following the recommendation from ECDC and EDC.
PHE explained that Prior Healthcare Exposure is defined by the being prior admission to the Trust that is reporting the case.

It was argued from Trust stakeholders that by excluding outpatients from the Prior Healthcare Exposure algorithm, the subsequent CDI rates give an inaccurate representation of many hospitals that deal primarily with outpatients. It was suggested to make a different denominator, which instead of looking at overnight occupied beds, would count outpatients as one day and patients staying overnight as two days. This denominator could be separate from the one that PHE is using, as a secondary indicator.

ACTION: PHE to investigate the possibility of having a different/additional denominator that can include outpatients.

Feedback on Annual and Quarterly Epidemiological Commentaries

Trust Stakeholders said that, although the Annual Tables are excellent, it was confusing to grasp that for *Klebsiella* tables, *Klebsiella* Genus included all other *Klebsiella* species. It is suggested that PHE add a footnote to make sure it is clear.

PHE was expecting *Klebsiella* and *Pseudomonas* data to be more Hospital Onset than they were. The amount of urinary source bacteraemia in *Pseudomonas* and *Klebsiella* was also higher than what was anticipated. Finally, the *Pseudomonas* data was higher than what was anticipated by approximately 5%.

ACTION: PHE to add links to newly published reports on the internal homepage of the HCAIDCS.

PHE informed stakeholders that there are some upcoming reports: Quarterly Epidemiology Commentary (QEC) will be published on 13th September 2018, 30-day Mortality Report to be published on 12th October.

PHE informed that looking at proportion of fatalities has the advantage of looking at the trends in time, or improvement of this indicator over time. Some stakeholders suggested that it would be useful to look at this indicator in terms of absolute numbers, or per 100,000 population, and have it filtered, by age, sex, profile. PHE added that the case fatality rates are included in the report by age, gender, bacteraemia, and region already.

Planned improvements for the HCAI DCS

PHE is planning to introduce an integration between the voluntary lab surveillance and the DCS. This would pre-populate the data in the DCS with the automatic report that PHE currently collects via the hospital labs. Users would be able to supplement that data with the other data that we collect. PHE does not have an ETA for this yet. But it is a project most likely achievable in the medium term improvement to the DCS.

PHE is looking to change the name of the apportioning. It will change the way the apportioning is done, but it will no longer be called Trust-Apportioned or Non-Trust Apportioned, but Hospital-Onset and Community Onset instead, which will bring it into line with our publications.

PHE is planning to develop some video user guides. These will supplement our user guides which are currently on a pdf format on the DCS. The video user guides will demonstrate how users can interact with the DCS to create records, run reports, and interact with the different dashboards. When they will be available, we will send them out to all users' email to let people know about that.

CCG Stakeholders suggest that some CCG users, because they are unaware how to manipulate the system effectively, end up often double tasking, or simply not entering Risk Factor data.

Any Other Business

DH expressed concerned about having data available before PHE publishes their reports as official statistics, which could potentially have negative implications with unwanted media exposure, or publishing data before PHE publishes data. PHE responded that they are in very clear terms with Stats Authority and that they are happy with the way this aspect is being managed; hence PHE is not planning to change the current situation.

Trusts would be interested in adding Chemotherapy as a Risk Factor. PHE's concerned lays about how this would be intended to be used. A possibility would be to replace the neutropenic question by chemotherapy, or a radiotherapy question, since not all cancer patients are neutropenic per se. Alternatively, an additional question asking whether the patient was undergoing chemotherapy could be an option as well. This would be useful for both C.*difficile* and Gram negative BSIs.

Next meeting to be scheduled for: TBC