UK Health Security Agency

HCAI Data Capture System Stakeholder Engagement Forum: 23rdth June 2023

Attendees:

Name	Title	Organisation
Zahin Amin-Chowdhury	Principal Scientist (epidemiology) - HCAI Surveillance team	UK Health Security Agency
Dimple Chudasama	Section Lead for AMRP/Lead Epidemiology	UK Health Security Agency
Sobia Wasti	Scientist (Epidemiology) - HCAI Surveillance team	UK Health Security Agency
Edgar Wellington	Senior Information Manager	UK Health Security Agency
Anand Fernandes	Consultant in Health Protection	UK Health Security Agency
Amy Mbuli	Head if Infection Prevention	NHS LANCASHIRE AND SOUTH CUMBRIA ICB - 01K
Andrea Mazzella	Senior Scientist	UK Health Security Agency
Aukarsh Samanthula	Data Officer	NHS England
Amy Boden	Deputy DIPC Operations & Deputy DIPC	WALSALL HEALTHCARE NHS TRUST
Emma Burnell	IPC Matron	Mid Cheshire Tr

Butcher, Lisa	Lead Nurse & Manager for Infection ...	OXFORD UNIVERSITY HOSPITALS TRUST
Christine Pinkard	National Programme Analyst. (Antimicrobial Resistance), Analytical Lead (Prevention)	NHS England and Improvement
Craig Green	Intelligence Analyst	Public Health Intelligence and Knowledge Services
Esther Taborn	HCAI Improvement Lead	NHS England Improvement
Natalie Foley,	Clinical DIPC	NHS NORTH WEST LONDON ICB - W2U3Z
Andy Gardiner	IPC and AMR programme team Lead	Department Health and Social Care
Gaya Wijayaratne (Guest)	Associate Specialist in Microbiology	WYE VALLEY NHS TRUST
Janette Gray	IPC Lead	NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB - 15C
Jeff Featherstone	Head of Antimicrobial Resistance Medical Directorate	NHSE Improvement
Jose, Stenymol		OXFORD UNIVERSITY HOSPITALS TRUST
Julie OMalley	Deputy Director Infection Prevention and Control	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
Larru Beatriz	Director of Infeciton Prevention and Control	Alder Hey Children´s Hospital
Lisa Ritchie	NHSI IPC lead	NHS Improvement
Lesley McKay	Associate Chief Nurse for IPC	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST
Jalal Miah	Senior Infection Prevention &	BARKING, HAVERING AND

	Control Practitioner	REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
Yee Min	Consultant microbiology	BARNSLEY HOSPITAL NHS FOUNDATION TRUST
Motolani Awokoya	Health Protection Practitioner	
Ninan Obasi	Microbiology Cross Site Service Lead	AIREDALE NHS FOUNDATION TRUST
Idil Osman	Infection Prevention	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N
Vicky Pang	Head of IPC Nursing	ROYAL FREE LONDON NHS FOUNDATION TRUST
Louise Popple	Infection Prevention and Control Nurse Specialist	LEEDS COMMUNITY HEALTHCARE NHS TRUST
Amira Ramos	IPC Lead Nurse	MID AND SOUTH ESSEX NHS FOUNDATION TRUST
Barnaby Roberts	Lead on HCAI and AMR	DHSC
Rosemarie Dobson	Lead IPCN	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
Lydia Rylance-Knight		OXFORD UNIVERSITY HOSPITALS TRUST
Samantha Hogg-Davies	IPC nurse specialist	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST
Vanessa Seeboruth	Infection Prevention and Control Practitioner	NHS FRIMLEY ICB - D4U1Y
Alexandra Simmons	HCAI Surveillance and Admin Lead	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N

Claire Sutton	Infection Prevention and Control Nurse	OXFORD UNIVERSITY HOSPITALS TRUST
Tania Misra	Consultant in Health Protection	UK Health Security Agency
Georgina Theobald	IPC Data and Office Manager - West Herts Teaching Hospitals	WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST
Riji Varghese	Infection prevention and control nurse	OXFORD UNIVERSITY HOSPITALS TRUST
Bruce Wake	Infection Surveillance Coordinator	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST
Laura Whitney	Regional Antimicrobial Stewardship Lead	NHS ENGLAND – X24
Ali M Wilson	Senior Analyst	CUMBRIA COUNTY COUNCIL
Jennifer Wright	Specialist Health Protection Nurse	WILTSHIRE COUNCIL
Lorraine Young	Specialist Health Protection Nurse	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

1.1 Welcome and Introduction

- **Zahin Amin- Chowdhury (ZAC) –** The Principal scientist in the HCAI team introduced herself to the forum and explained the objectives of the stakeholder engagement forum:
  - an opportunity to facilitate discussion and collaboration on the mandatory surveillance of bacteraemia and *C. difficile* infection with stake holders.
  - UKHSA will provide feedback on the routine surveillance processes and input from stakeholders on our routine surveillance outputs.
  - sharing updates on upcoming reports and it changes to those reports and changes to the data capture system.

- No updates or amendments made to previous meeting minutes.

1.2 Actions from the previous meeting

- **Ammendment to prior trust exposure document.** Still in progress and has been delayed due to staff changes
- **Short training videos –** in progress as above.
- **Running regular training sessions -** we plan to have a short feedback survey where we can collect information on what would be useful in terms of training.

1 HCAI DCS surveillance update

1.1 HCAI DCS updates and issues

- **ZAC** explained the AEC report is underway for publication in September 2023. ZAC pointed out that there will be two new chapters will be introduced in this edition, IMD and ethnicity and Mortality.
- **DC** confirmed the Mortality report will be retired as a stand-alone report as it has been incorporated into the AEC.
- **ZAC** - QEC will be published 5th July

2 HCAI DCS updates and issues

2.1 Risk factor data

- Adding field for additional notes.
  Natalie Foley (NW London ICB – W2U3Z) questioned whether it would be possible to add additional information on the DCS, to include information confirming delays in testing/prior trust exposure to give the ICB's a clearer picture. **DC** confirmed that there is a section for prior trust exposure, collecting the discharge dates, there is a tab that collects risk factors and that there is an Additional Comments tab. DC explained that previously, free text has caused issues within the system/created issues from a data analysis issues. **DC** confirmed that the dates entered into the actual fields were the ones that would be used by the DCS to apportion the cases, not the dates in the Additional comments section.**NF** stated approximately one case is affected by the delayed testing.
- **Idil Osman (NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N)** Focusing on getting catheter care and UTI workstream. Stated that obtaining data on primary source has proven difficult and asked how to improve data as they do not have this information and the data is not mandatory**. DC** explained the primary source is an important field and that NHS England have been interested in this data. UKHSA have been reluctant to mandate too many fields on the DCS as we appreciate that they can be challenging to complete. UKHSA would be interested in receiving feedback on how we could improve the data collection.
- **Lesley McKay** (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST) – stated that it is difficult to identify the true source of a blood stream infection (BSI) – therefore unknown is entered. Does not think that risk factor data is entered for community cases – which is not consistent. If it were to be made mandatory it would force the work onto Trusts – not all trusts would have manpower. **Russell Hope (RH)** explained that the UKHSA appreciate the difficulty of obtaining the source and risk factors of the BSI's which requires the community teams input. **RH** explained that this is the reason why the risk factors tab remains unlocked for a year after the case is entered. UKHSA also appreciate that it's hard to determine the true burden of the underlying source of infection. **RH** affirmed that the risk factor data is critical for working out what future interventions might be.
- **Alexandra Simmons**, (NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N) explained that she works with Idil and completes the surveillance. Understand the pressure trusts are under. AS specified that the *E.coli* are sky rocketing and need investigating, she stated that the primary source is pivotal to understanding these increases – AS claimed that only one of their trusts enter the primary source and ICB's do not have any other way to obtain the source data.

- **ZAC** asked the group to share any best practises/approaches by those trusts who have higher reporting of the Source data. **LK** stated that they enter the likely sources as much as they can as IPCN and then discuss the cases with the consultant microbiologists to confirm, suggested that the gap in primary source data is the COCA cases which needs to be collated and entered by the community teams. **DC** reiterated that the fields are critical and required to decide on interventions and requested Trusts to enter as much information as possible.
- **Rosmarie Dobson (**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST**)** Electronic patient records has helped with more complete data entry as they are able to interrogate AE and GP information. Also work closely with their community teams by sending the list of COCA cases to them. Data analysts also help. Depends on the model of the IPC team in their trusts.
- **Amy Mbuli** – understands the difficulty in obtaining the primary sources. They know they are coming from UTI/CAUTR or gall bladder. Interrogating at patient level is time consuming and is unsustainable and would be more effective to look at a higher level.

2.1.2 Prior Trust Exposure issues.

- **ZAC** opened the floor to stakeholders regarding prior trust exposure with an overnight stay and COHA definition.
- **Lisa Butcher (OUT)** – explained her trust deal with a lot of ambulance trusts and hotbeds (purchased beds in nursing homes – under the trusts banner. The trust report them as HOHA because they've had a healthcare exposure in the trust. LB asked the HCAI team for a advice and guidance. **DC** asked if those patients would have been discharged? **LB** confirmed that these patients would not be discharged. **LB** suggested discussing this situation offline.
- **LC** responded to **LB's** comments. Stating that the categorisation would depend on if the case was within 28 days of discharge to a community facility, which would then be categorised as a COHA. If the trust has registered that facility with CQC as part of the trust, **LC** suggested that the case would be a HOHA.
- **Amira Ramos (MID AND SOUTH ESSEX NHS FOUNDATION TRUST)** asked whether the DCS has the ability to detect a duplicate entry across trusts. **DC** confirmed that there is a de-duplication functionality for the same case entered within the same trust within the same episode. **DC** advised that the trust may contact UKHSA to check if the case had already been entered onto their DCS by another trust.

2.1.3 Virtual wards and integrated care facilities

- **ZAC** asked the group how virtual wards and integrated care facilities are being managed and whether trusts are finding more patients are being treated this way? **DC** – interested to know how these patients are being managed. Vary across different trusts- would be helpful to understand how trusts are dealing with these.

- **Jeff Featherstone (NHS England)** clarified the difference between the two concepts. Explaining that virtual wards and intermediate care are quite different things. Virtual wards refer to a package of support to seek to either avoid admission or to provide extended support after discharge, whereas intermediate care are more a building's based solution. **JF** stated they will vary as to whether they're directly provided by the NHS Trust or by external organisations, but they are conceptually different.
- **RH** asked colleagues the proportion of patients in these wards. **JF** stated this would vary around the country and to contact Matt Inda-Kim because he was one of the

leads in relation to them so he might be able to advise further. **RH** confirmed that once we receive summary information from him we will circulate it to the group. **ZAC** said we will circulate this via the feedback group also.

2.1.4 Discussion and feedback

- Nothing to report

3.1 Upcoming HCAI DCS projects

3.1.1 Random sampling:

- **ZAC** informed the attendees that this has been delayed due to staff changes, COVID-19 pandemic and mandatory outputs were priority. ZAC explained that the team have been working with our software developers to update the Data Capture System (DCS) so that it would support the random sampling of cases. The functionality will enable us to ask specific questions for a random sample of cases. The rationale for this is that it would enable more focused surveillance of a certain subset. First, because the subsets are smaller and we can gather more information this way, it will be simpler to gather the data. Additionally, because it will be a representative sample, we may at least anticipate that the findings from that subset will be generalisable to the wider population. The updates are still being worked on by the software developers and we anticipate receiving updates by the end of the month. UKHSA will need to do some validation which will take some time but hope will have made some progress on this matter by the end of the year.

3.1.2 Automated data imports: LIMS to HCAI DCS (case capture)/ Automated data imports – Prior admissions (case capture):

- **ZAC** stated the two initiatives are essentially data linkage projects with the common goal of easing the reporting load on NHS trusts. Hoping to move to testing phase.
    - The first one, Automated data imports: LIMS to HCAI DCS (case capture) is to set-up an automated feed between the LIMS Systems and the Data Capture System (DCS). The plan is for this feed to query the LIMS System, turn the isolate test information into episodes and then automatically generate cases on the Data Capture System (DCS). In essence, the trusts will not be required to manually create hundreds of records in a month, according to the notion. The automated feed will complete it automatically. The users will only be required to update the other case-related details that cannot be obtained via the LIMS system such as admission or treatment information.
        - Two trusts have expressed interest to be part of the pilot phase. Hoping this will be rolled out at some point in the future. **DC** explained, once the linkage between SGSS and DCS has been finalised, will reduce the data entry burden, however there will be gaps. Therefore, will still need some clinical input. **DC** asked Trusts to contact the mandatory team if interested in assisting with the trial.

- The second one- **Automated data imports** – Prior admissions (case capture) is about updating existing cases which relates to the prior trust exposure algorithm. **ZAC** indicated that UKHSA are hoping that this will be one of the options that we can use to get this information or at least, that it will be tested as a validation process.

4.1 Questions/ items from the Stakeholders

1. **Alexandra Simmons (**NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N) – Asked for basic training sessions **ZAC** confirmed that this is something that we are working towards and that we have run similar sessions to those for ICU.

6.1 AOB

- **ZAC** Hoping to circulate a feedback survey on the surveillance outputs as well as the Stakeholder forum and the frequency also what stakeholders will be interested in seeing.
- **RH** referred back to the discussion earlier regarding the burden of entering the additional information and explained that UKHSA had tried to encourage a surge of data to be entered for a particular time period. Some new functionalilty on the DCS will allow UKHSA to request users to enter the additional information for a sample of cases. **RH** also understood that the discussion around focusing on themes, once interventions are put in place to UKHSA, would need to conduct some enhanced surveillance for those underlying source of the infection, to see whether there has been a shift in proportion of the cases caused by the sources that we have the focus of the intervention activity on – not necessarily continuous. Suggested gathering the data electronically, using data linkage to identify underlying sources - stressed the only issue would be that the data linkage may incur an up to quarter delay. **RH** reassured the group that there will not be a need to mandate everything.
- **DC** invited the group to contact the team if assistance is required with the data upload wizard and a member of the team would help.
- **ZAC** explained that there will be some drop in sessions to assist users. **DC** confirmed that there will be some webinars and training sessions set up in the near future. **ZAC** confirmed that the content of the sessions will take feedback received from the session into account. **DC** confirmed that videos will also be added to the DCS homepage to assist users.
- **ZAC** and **DC** explained that the Point prevalence Survey 2023 will be going live in September up to October. Hosted by the AMR team.
- **DC** informed the group that there is lots of other work going on around the national action programme and other avenues with our data, team will be working around health inequalities and policies with an example of this as a feature in the annual epidemiological commentary, **DC** stated that any feedback on the new feature would be appreciated.
- **DC** emphasised the importance of the team sharing other work and research and how any updates will be publicised on the DCS.

- **DC** shared that the team will be investigating the rise in community onset rates in MSSA and try to identify where within the communities we're seeing these rising cases. This will also be fed back via the DCS and forums such as this.
- **DC** encouraged the group to provide feedback via the user survey as it will help capture points stakeholders
- **ZAC** that we UKHSA hope to have more frequent forums for sharing and learning.

- **ACTIONS:**
  - UKHSA to work on short training videos covering different topics for the HCAI
  - UKHSA to set up workshops and drop-in sessions for users to receive training on how to utilise the Data Capture System (DCS) in more detail.

7.1 Date for next meeting: 28th March 2024