UK Health Security Agency

Q&A

Intro to the DCS for the mandatory surveillance of MRSA, MSSA, and GNBSIs, and CDI programme webinar

June 2026

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1 Introduction

Thank you for attending the Healthcare-associated infections Data Capture System (HCAI DCS) webinar in April 2026. We have prepared the below responses to the Q&A section, which are organised into themes. Please contact us by email at mandatory.surveillance@ukhsa.gov.uk with any scientific or data queries and unlock requests, or support.HCAIDCS@ukhsa.gov.uk for account set-up, DCS functionality or technical queries.

2 Q&A responses

2.1 Admission details

Where do we record the patient location if the sample is from ‘hospital-at-home’/virtual ward cases, and will this impact prior trust exposure?

If the patient was in a virtual ward (otherwise known as “hospital-at-home") at the time of specimen collection, then there is a "Virtual ward" category to choose from in the Patient Category field. Virtual ward status is currently treated similarly to non-admitted patient categories in that cases are classified as community-onset, with further categorisation of healthcare-associated or community-associated, depending on their prior healthcare exposure in the reporting trust. For CDI only, cases may also be classified as community-onset of indeterminate association, where applicable.

Is A&E counted as an overnight stay, and what do we do if decision-to-admit (DTA) date is not given?

A&E is not counted as an overnight stay when determining the date of hospital admission. However, where a patient attended A&E directly before inpatient admission, the decision-to-admit (DTA) date should be entered. Use hospital admission date as a proxy only when the DTA date is unavailable.

What would I enter in the admission method field for a patient with a positive sample taken during A&E who was then later admitted?

It depends on the specific case, but if their care was unplanned and did not originate with a waiting list procedure, then ‘Emergency’.

2.2 Prior trust exposure (PTE)

Why do we use days rather than hours for calculating PTE apportionment?

The PTE algorithm provides us with a national surveillance metric to determine prior trust exposure trends. We need the algorithm to be applied consistently to all cases. Not all cases may have the time of admission recorded or discharge or this may not be easily accessible information, so we need to use days. Using this system, borderline cases are expected. If you are concerned about the PTE classification applied to a case, then please work with your ICB and IPC staff to investigate locally.

How would we record a case that we had discussed with the ICB and agreed that a potential HOHA is a COCA case?

The DCS classifies PTE according to the national surveillance definitions, which are date based rather than a per case review. As such, a case cannot be assigned a different PTE category unless there is a change in the underlying surveillance data used by the PTE algorithm to determine PTE classification.

While discussions with the ICB and findings from a local root-cause analysis may provide valuable contextual or clinical insight into the likely source of infection, this does not override the algorithm-based PTE calculation used within the DCS. Local conclusions can, of course, be recorded locally and reflected in internal learning and governance processes, but the national surveillance record cannot be changed.

If a baby was born at home by paramedics and brought to our hospital with the mother after birth, then the baby was admitted the next day and tested positive for a BSI, would we classify this a COCA or COHA?

If the baby was admitted during the first hospital visit with their mother, this case would be COHA, however if they were just attending hospital during an appointment for their mother, they would be COCA.

If the patient attends ED but self-discharges prior to being seen, but has been booked in, is this included or excluded as prior attendance?

A&E is not counted as an admission for prior trust exposure categories, unless a decision-to-admit (DTA) was made during the A&E care. In that case, the DTA date would be used as the admission date for the prior admission.

When looking at prior trust exposure is the date of previous discharge counted as Day 0 or Day 1?

As of June 2026, date of discharge is counted as day 0. Prior to June (as per the protocol document version 4.4), date of discharge was counted as day 1. Following a recent audit which identified an issue with how PTE was described in the protocol, we have amended it to

day 0 which aligns with how PTE is calculated in the DCS. This change will be reflected in the new protocol version (4.5) which is due to be published soon.

When do we not consider an attendance as a prior trust exposure? Do we have a duration to determine this?

If referring to hospital admissions, there is no set duration – even if the patient was admitted and then very quickly discharged, this is still counted. However, note that A&E attendance is not counted as an admission.

2.3 DCS access

Can Local Authorities (LA) get access to the DCS?

Yes, LAs can seek access by requesting an account as described in this user guide. The organisation type to select would be “Local authority”.

Once registered for an account on the DCS, your local administrator will be notified for authorisation. Once approved, they will receive an auto-generated link to verify their email address and set up their password and security questions. If you do not have a local administrator, one will need to be set up.

Please note if the local administrator role is selected, the request can only be authorised by us. Please contact support.HCAIDCS@ukhsa.gov.uk for the additional forms to complete.

2.4 Data Upload Wizard (DUW)

When uploading data using the DUW, why do yellow triangle symbols show even though the data is completed correctly?

This is a system bug for the status symbol found in the search table. This is awaiting resolution with our technical team.

Can I upload multiple Klebsiella species in the same patient and infection episode via DUW?

Where you have multiple Klebsiella species in the same patient and in the same infection episode, you cannot enter all the species via the DUW. Using the DUW, you can only enter one species, and you would need to enter the remaining species manually. In this case, it may be simpler to enter the whole case (including all species) manually, but it is up to you. On the other hand, if you are entering multiple Klebsiella species in different patients and/or infection episodes, then these are fine to upload via DUW together.

When you receive the confirmation e-mail after using the DUW, it doesn't include the DCS ID number. Would it be possible to include it?

Thanks for the feedback - we will investigate adding this feature into the DCS.

2.5 Episode category

What would be considered an infection relapse? And how long after the initial sample?

A repeat or relapsing infection is defined as a new positive specimen occurring:

- more than 14 days* after first positive specimen for bacteraemia, or
- more than 28 days* after first positive specimen for C. difficile infection (CDI)

AND

- occurring within three months (84 days*) of the first positive specimen

AND

- with one or more negative tests recorded between the first positive specimen and the most recent positive specimen.

*Note that day 1 is the date the first positive specimen was taken.

2.6 Inclusion criteria

For MSSA, is only S. aureus required?

For both MRSA and MSSA, reporting includes S. aureus-related complex organisms (i.e. S. aureus, S. argenteus & S. schweitzeri).

Why are cases identified post-mortem excluded?

CDI cases identified post-mortem should be reported to us. However, for bloodstream infections (BSIs) they are excluded because post-mortem blood samples are problematic to take without significant contamination from other body sites, and there is a high risk of false positives due to translocation of commensal organisms in the gut.

For post-mortem cases for CDI, should you only report cases where the patient died in your trust, rather than if your trust just performed the post-mortem?

Acute trusts are responsible for ensuring that all specimens tested at their trust and meeting the inclusion criteria are reported to the DCS. However, a trust may like to put in place a local service-level agreement with another trust stating that it’s the responsibility of the trust where the patient died to report the case rather than the trust that tested the specimen as part of the post-mortem.

Why are patients younger than 2 years excluded from CDI surveillance?

As detailed in page 18 of our protocol, CDI cases in patients under 2 years are not required to be reported to the DCS. However, trusts may use the system to record these cases if they so wish. These will be excluded from data for publication.

Exclusion of patients under 2 years of age is consistent with international CDI surveillance recommendations and reflects the common asymptomatic carriage of C. difficile in infants. C. difficile can be part of the normal gut flora in this age group and therefore the interpretation of positive results is difficult. While C. difficile can be a cause of disease in this age group, and may require treatment, such cases are not routinely included in surveillance programs.

Reference: ECDC - European Centre for Disease Prevention and Control. European Surveillance of Clostridium difficile infections. Surveillance protocol version 2.4. European Surveillance of Clostridioides (Clostridium) difficile infections

2.7 Quarterly Mandatory Laboratory Returns (QMLR)

QMLR data submissions require total number of stool specimens examined. Does this only include those processed after triage, hence, excludes those that were received and triaged, but then not processed for whatever reason?

Include any stool sample examined for a pathogen processed in the lab and exclude stool samples that were received by the lab but not examined.

2.8 Report outputs

Does leaving it up to the individual trust to ascertain whether a previous attendance is counted as an inpatient or outpatient encounter, such as MTU treatment, mean the regional tables should be open to interpretation also - not comparing like for like always?

Yes, there is some potential for variation where trusts apply local judgement in classifying attendances, particularly in areas where definitions are less prescriptive. However, this is relatively limited, and overall, the surveillance operates with a consistent national framework to support comparability across trusts.

Where is the mortality data sourced from?

NHS Digital Spine Summary Care Records via Demographics Batch Services (DBS) tracing

Do you work one month in arrears? For example, if you are entering cases with specimen dates in January, when is sign-off required by?

There is a monthly sign-off deadline on the 15th for all cases from the previous month. For example, cases with a specimen date in January must be signed off by 11:59 PM on 15 February.

2.9 Risk factors

When completing antibiotic use in the risk factors tab, what do you enter if there is no end date for antibiotic use i.e. the course is still ongoing? Do you leave the end date blank, as no green tick applies if you do this?

Yes, if there is no end date then it would be appropriate to leave the “date stopped” field blank. Since the green tick tab marking only appears if all fields are completed, including the optional fields (which the “date stopped” field is), it is fine to have the tab with no green tick in this scenario.

2.10 Sign-Off

What happens if you miss the sign-off deadline?

As these are mandatory data collections, if no data is submitted by a Trust for a particular month, we may reach out to that Trust to find out if support is needed. If we do not get a response from the trust or data is not reported for 3 months in a row, we may escalate to the Department of Health and Social Care. Also, where data was not signed-off by the monthly deadline, this is captured in the published monthly data tables Official Statistics report. It may also lead to inaccuracies in case counts for that financial year and new thresholds computed for the following financial year for the NHSE Standard Threshold: this could impact not just the unsigned-off Trust but also the Sub-ICBs who would normally be assigned a case.

2.11 NHSE thresholds

Will the UKHSA be issuing Standard Contract target thresholds for Trusts this financial year? And if so, when?

The thresholds are published by NHS England. We work closely with NHSE to support the calculation of the thresholds. However, as this output is not issued by UKHSA, we do not have a confirmed publication date. Please contact NHSE directly for further information.

2.12 Webinar

Will the recording/slides be available on the HCAI portal, so I can catch up later?

Yes, the recording and transcript is available at the bottom of the DCS help page.

2.13 Other

Is it possible for the manual data collection sheets to be cross-referenced with the relevant tabs and sections in the web-based DCS, as they do not always align?

If you are referring to the print-out sheets for filling in the data collection on paper, we are in the process of updating these.

About the UK Health Security Agency

UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases, and environmental hazards, to keep all our communities safe, save lives and protect livelihoods. We provide scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

UKHSA is an executive agency, sponsored by the Department of Health and Social Care.

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