UK Health Security Agency

HCAI Mandatory Surveillance Stakeholder Engagement Forum

Date	5th February 2025
Time	14:00 – 15:00
Venue	MS Teams

Attendees

Dimple Chudasama	Lead epidemiologist, UKHSA
Tim Pollington	Senior Scientist (Epidemiology), UKHSA
Rimsha Qureshi	Senior Scientist (Epidemiology), UKHSA
Zahin Amin-Chowdhury	Principal Scientist (Epidemiology), UKHSA
Dakshika Jeyaratnam	Consultant Microbiologist & UKHSA CDI Clinical lead, UKHSA & Medical Microbiologist, Guys & St Thomas NHS Foundation Trust
Christopher Bell	Scientist (Epidemiology), UKHSA
Christy Lee	Information officer, UKHSA
Yvonne Truong	Information officer, UKHSA
Sally Nyinza	
Siddharth Mookerjee	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST
Gabriella Woods	
Philippa Turton	LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
KARINA HESS	Unverified
Gill Case	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST
Elizabeth	Unverified
Lesley Mckay	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST
Arlene Beausire	AIREDALE NHS FOUNDATION TRUST
Vicki Shayler	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
Georgiana Wilson	

Melanie Thornton	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Begona Roe	
Hope Osarenoma	SALISBURY NHS FOUNDATION TRUST
Nicola Scott	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST
Kathryn Noble	Infection Prevention Manager/Analyst
Mini Mathew	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
Deborah Esan	MEDWAY NHS FOUNDATION TRUST
Annabel Ridsdale	Epidemiology and Information Analyst, UKHSA
Ines Almeida	
Graham Verbrugge	Norfolk and Norwich University Hospitals NHS Foundation Trust
Vivienne Oconnor	NHS HAMPSHIRE AND ISLE OF WIGHT ICB - D9Y0V
Baljit Boparai	WALSALL HEALTHCARE NHS TRUST
Yasmin Neal	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
Niamh Whittome	NHS ENGLAND - X24
Bruce Wake	
Kate Gorman	NHS SURREY HEARTLANDS ICB - 92A
Roxanne Mohammed-Klein	NHS NORTH WEST LONDON ICB - W2U3Z
Gill Damant	NHS ENGLAND - X24
Beth Robinson	
Shakeel Suleman	Epidemiology and Information Scientist, UKHSA
Damien Mack	ROYAL FREE LONDON NHS FOUNDATION TRUST
Rowan Slowther	NHS NORFOLK AND WAVENEY ICB - 26A
Jane Yeldham	
Natalie Sharma	
Vanessa Seeboruth	NHS FRIMLEY ICB - D4U1Y
Tracey Singleton	External
Julie O'Malley	
Katie Jeffery	Microbiology/Infection
Roger Burnett	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
Janette Gray	NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB - 15C
Nicola Colborne	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Kirran Klein	EAST SUSSEX HEALTHCARE NHS TRUST
Trevor Brooks	
Victoria Gentry	FRIMLEY HEALTH NHS FOUNDATION TRUST
Tracy Cartledge	Data Audit Technician, Infection Prevention & Control Team, Calderdale and Huddersfield NHS Foundation Trust

Fiona Hammond	NHS ENGLAND - X24
Preya Dey	MID YORKSHIRE TEACHING NHS TRUST
Rachel Russell	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
Jennifer Bennett-Britton	NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB - 92G
Lesley Wilson	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
Lara Utsi	Senior Epidemiology Scientist, NEYH Field Service Health Protection Operations, UKHSA
Michael Woodward	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
Selena Luff	
Jennifer Adams	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST
James Leeson	
Sadie Heddon	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Menard-Ryan Ong	WHITTINGTON HEALTH NHS TRUST
Beverley Claughton	External
Stefanie Davies	Epidemiology and Information Analyst, UKHSA
Shabnam Iyer	
Midhun Mikayal	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
Claire Haill	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
Alice Liu	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Matheson Nayara	RJC
Kaylash Juggernauth	NHS ENGLAND - X24
Alastair Harlow	NHS DEVON ICB - 15N
Thomas Inns	Consultant Epidemiologist (North West), UKHSA
Katrina Brooks	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
Aukarsh Samanthula	NHS ENGLAND - X24
Carole Fry	IPC Strategic Lead
John Scott	NHS ENGLAND - X24
Stefano Oggiano	WALSALL HEALTHCARE NHS TRUST
Gemma Bastow	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
Catherine Matthews	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Shamma Mumtaz	Senior Scientist (South East & London), Field Services Division, Health Protection in the Regions
Lisa Redmond	EAST SUSSEX HEALTHCARE NHS TRUST
Mona Dave	Senior Scientist, UKHSA
Kerry Richardson	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
Ami Butler	NHS CORNWALL AND THE ISLES OF SCILLY ICB - 11N

Luca Comisi	NHS NORTH EAST LONDON ICB - A3A8R
Gill Hickman	
Chaamala Klinger	
Kimberley Wynn	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
Catherine Tremlett	Norfolk and Norwich University Hospitals NHS Foundation Trust
Kerrie Howles	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
Kathy Randall	ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST
Lisa White	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
Craig Green	Public Health Intelligence and Knowledge Services
Laura Capewell	NHS GREATER MANCHESTER ICB - 00Y
SMIRTHWAITE Sandra	ULHT
Ma Iglesias	
Hasan Al-Ghusein	Data Analyst, Medical Microbiology, St George's University Hospitals NHS Foundation Trust
Hilary Munube	NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST ICB - 10Q
Andrea Jackson1	External
Maria Gasmin	External
Yvette Reece	LEEDS TEACHING HOSPITALS NHS TRUST
Tiphanie Clarke	RTH
Sally Matravers	External
Matt Edmunds	Consultant Epidemiologist, UKHSA
Joe Alberts	Epidemiology and Information Analyst, UKHSA
Fionnuala Browne	Consultant Nurse , Infection Prevention & Control, Mersey and West Lancashire Teaching Hospitals NHS Trust
Hammed Adeleke	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
Trupti Patel	
Tina Arnold	NHS Dorset
Nicola Sirin	NHS ENGLAND - X24
Charlie Lobley	LEEDS TEACHING HOSPITALS NHS TRUST
Daniel Sanchez	Epidemiology and Information Scientist, UKHSA
Grimshaw John	R0A
Emma Spooner	THE ROYAL WOLVERHAMPTON NHS TRUST
Karina Gazdar	KINGSTON AND RICHMOND NHS FOUNDATION TRUST
Penny Cotterill	
Gaya Wijayaratne	
Kerry Roulston	Consultant in Public Health Infection (Midlands), UKHSA
Tom Jacques	IMPERIAL COLLEGE HEALTHCARE NHS TRUST

Kirsty Morgan	NHS ENGLAND - X24
Emma Batten	NHS SOUTH YORKSHIRE ICB - 03L
Rosie Dixon	NHS ENGLAND - X24
Alison - Brentwood Hospital Williams	
Mel Burden	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Lauren Walker	
Nicola Best	
Claire Sutton	RTH
Dawn Cursons	NNUHFT
Sara Hardman	EAST CHESHIRE NHS TRUST
Eve Spiers	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Elizabeth Perry	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST
Pedro Rodrigues	NHS ENGLAND - X24
Sue Devenish	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06K
Christopher Jeanes	
Louiegi Iglesias	
Alex Simmons	NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N
Jemmy Mumbwatasai	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST
Burnell Emma	RBT
David Tate	Consultant in Public Health Infection (NEYH), UKHSA
Godfrey James	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
Christine Finch	
Sajan Sathyan	AIREDALE NHS FOUNDATION TRUST
Sharon Reed	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST
Rosemarie Dobson	Umail
Mona Keren	MEDWAY NHS FOUNDATION TRUST
Helen Forrest	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST
Matthew Reid	THE ROYAL WOLVERHAMPTON NHS TRUST
Yeeshika Shersing	IMPERIAL COLLEGE HEALTHCARE NHS TRUST
Adele Dyche	LEEDS TEACHING HOSPITALS NHS TRUST
Lisa Hall	THE ROYAL WOLVERHAMPTON NHS TRUST
Jackie Portsmouth	
Zoe Barnes	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
Sarah Barnes	

Paula Mulligan	
Laura Whitney	NHS ENGLAND - X24
Kevin Lawler	
Sharron Lance	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
Jane Searle	External

No.	Agenda Items:
1.	**Introduction** 1.1 Welcome and Introduction • Zahin Amin-Chowdhury (Principal Scientist, UKHSA) opened the meeting at 14:00 and welcomed attendees. • ZAC explained the objectives of the forum are to provide updates on UKHSA's HCAI mandatory surveillance activities, receive feedback from stakeholders on surveillance outputs and processes, and review CDI risk factor question updates. 1.2 To review the minutes from the last meeting • No corrections or updates to the previous meeting minutes were noted.
2.	**HCAI DCS and surveillance updates** 2.1 Key updates • Monthly infection trends summary is now being published to accompany the data tables on the.GOV.uk website, covering the last 13 months. • The quarterly epidemiological commentary (QEC) now includes 12-month rolling percentage change graph for all 6 data collections. • The UKHSA dashboard has been updated to include the monthly data for the last 13 months for the 6 mandatory data collections, with the function to filter by NHS region and prior trust exposure categories. • Plan to remove the pivot table tab from the monthly data tables, as the dashboard provides more automated data access. • Regional *E. coli* and *P. aeruginosa* risk factor completion report have been developed. The report provides information on risk factor completion to support ongoing surveillance activities and help to guide targeted interventions. This report is currently being produced on a quarterly basis and there are plans to disseminate it across all regions via UKHSA Field Services teams. 2.2 QMLR/data quality improvement • Tim Pollington (Senior Scientist, UKHSA) provided an update on the Quarterly Mandatory Laboratory Returns (QMLR) data. • The QMLR contains 8 variables, with 7 being mandatory to submit on a quarterly basis. Two of the QMLR variables are used for the quarterly Fingertips publication, and two others may be used for a new *C. diff* positivity metric.

	• There has been poor completion of the QMLR variables historically, which are important for ongoing surveillance and outbreak response. Discussions are underway with NHS England to introduce a QMLR completion metric for the 2025/26 financial year. • Data quality improvement efforts are focused on retrieving missing QMLR data from 2017 Q2 to 2024 Q3 (30 quarters). Currently, 6 trusts are missing all 30 quarters, and 22 trusts are missing half the quarters. In the last analysis quarter (2024 Q3), a quarter of trusts had missed the submission. • Trusts are encouraged to review their QMLR submission processes, and re-establish links with laboratories, especially if they have delegated to labs, to improve QMLR data completion. • Regional teams to follow up with trusts on QMLR data completion. • UKHSA is happy to provide support on access and training for inputting the QMLR data into the system. • The next QMLR data submission deadline is 15th February 2024 for the Q4 2023 analysis. 2.3 HCAI DCS training day • ZAC updated that the actions from the previous meeting had been progressed. Two in-person training days were held in February 2024 and June 2024. • Several regional DCS webinars were also conducted for the East of England, South West, South East, London, and West Midlands regions. • Feedback on the training sessions was positive. Further in-person and virtual training sessions are in the process of being scheduled for May/June 2025.
3.	**Proposal of changes to CDI risk factor questions** • Dimple Chudasama (Lead Epidemiologist, UKHSA) provided context and rationale for the review of the CDI national surveillance risk factor questions: • CDI has been part of the mandatory national surveillance since 2001/2002, with the introduction of the over 2 years old case definition in 2007/2008. • The CDI dataset includes demographic data, clinical risk factors, and prior trust exposure information. However, these questions have not been reviewed since they were first established in 2007/2008. • Given the feedback from stakeholders and the increases in CDI cases seen post-COVID-19 pandemic, a review was deemed necessary to ensure the data collected remains clinically relevant and fit-for-purpose. • A multidisciplinary team, consisting of epidemiologists, infection prevention control specialists and a clinical microbiologist, from UKHSA and NHSE conducted a review of the existing CDI risk factor

	dataset and drafted proposed updates, and aim to be launched on the online data capture system on 1 April 2025. • The accessibility of the data required to answer the questions would also be part of the evaluation process, as there is variability in what data organisations can access. • Entering the data on the Data Collection System (DCS) would also allow for local data storage and analysis, as well as feeding into national-level surveillance and reporting. • The proposed updated CDI risk factor questions are shared with attendees for review and discussion. • A short poll will be conducted to gather feedback on aspects such as the timeframe for antibiotic use in the proposed updated questions.
4.	**Questions/Discussion** 1. Question from Claire Haill, University Hospitals Plymouth NHS Trust: "We have the data capturing system under our jurisdiction, but not all the patients with the samples that go through our labs are admitted to the hospital. How will the completion of the risk factor report be managed when we don't have access to some of that data, and those patients won't actually be in the acute trust?" Response: • DC explained there are two different datasets being reported to the Data Collection System (DCS0: 1. The QMLR data, which includes aggregate metrics on testing volumes, etc. This was mentioned above and will potentially have a completion metric as part of the standard contracts. 2. The individual patient-level risk factor data that is entered into the DCS. • For the QMLR data that is not for patients admitted to the acute trust, there have been historical issues with trusts not having access to that information. Previously, the Clinical Commissioning Groups (CCGs) have helped by entering some of that community-based data on behalf of the trusts. Now with the changed organisational structures (ICBs, sub-ICBs), DC acknowledged there may be more variability in how this is managed across different areas and UKHSA does not have a definitive answer but recommends that trusts try to work closely with their local ICB/sub-ICB partners to facilitate access to the community-based CDI patient data and enable completion of the risk factor information. • It is recognised there will likely still be gaps, particularly for community samples that do not come through the acute trust. But the goal is to try to capture as much relevant clinical data as possible through this collaborative approach. 2.Question from Karina Hess:

	Karina noted that when entering risk factor information, if 1-5 antibiotics are reported, the system requires the user to provide start/stop dates, indication, and antibiotic name for each. If this detailed information is unavailable, the form cannot be completed, so the user has to enter "zero" or "unknown", which does not accurately reflect the situation. Response: • DC acknowledged this issue had not been previously known and agreed it is important to have an "unknown" option to allow partial data entry where information was not available. • The team has reviewed and updated questions to address this, so users are not forced to enter inaccurate data. 3. Question from Sharon Reed, Deputy Director for Infection Prevention and Control, University Hospital Sussex: Sharon welcomed the proposed changes and provided detailed feedback to the South East lead, Neve. But felt some key risk factors were missing, e.g. clinical environment cleanliness, adherence to national cleaning standards, and hand hygiene. She questioned how these environmental factors could be consistently captured across organisations but suggested using the hospital's "star rating" as a potential measure. She also raised the importance of capturing data on antibiotic therapy, magnesium supplements, and ensuring appropriate infectious diarrhoea sampling. Response: • DC acknowledged the valuable feedback and agreed that environmental factors and hand hygiene are important considerations in CDI prevention and control. • The team had debated including these elements but was concerned about making them mandatory at the individual patient level, as the information may not change frequently. • Instead, environmental factors may be better captured through separate audit-style questions, rather than in the patient-level risk factor data. • The team will review the feedback and consider how to best incorporate these suggestions into the updated CDI surveillance questions. 4. Question from Hilary Munube, NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST ICB - 10Q • She mentioned that she also provided a list of suggestions to Neve regarding risk factors. • She noted that from Claire's perspective, trusts may not have information on patients they have not seen, yet, as the increase in community-onset CDI cases is being investigated by Integrated Care

	Boards (ICBs), she suggested that if the reporting trusts could include the patient's registered GP practice, it would make it easier for the ICBs to generate information from the community. • She also wanted to highlight that trusts have limited capacity to do the paperwork involved in healthcare-associated CDI cases and wondered if there could be a way for the data entered into the data capture system to be transferred into a report that the hospital could use, to avoid duplication of work. • She suggested that if the trusts could add the cleaning and hand hygiene audit results for each CDI case (as part of the root cause analysis or case review), this data could then filter through and provide a meaningful report for the trust. Response: • DC acknowledged Hilary's feedback and suggestions and explained that the GP practice postcode is already available in the data enrichment tab of the system, and the ICBs should be able to access this information. • Will follow up with the database manager to ensure this data is accessible as intended. • Recognised the limitations of the current data capture system but highlighted that users can pull case-level data and create dashboards. • Will explore the possibility of exploring the development of more comprehensive reporting features, either by the system or by supporting trusts in creating their own reports. • Will also work with stakeholders to optimise the use of the system and ensure trusts can maximise the value they get out of the data they input. 5. Question from Alex Simmons, NHS HERTFORDSHIRE AND WEST ESSEX ICB - 06N • She added that from her experience the ICB cannot access the GP practice information in the DCS system for community-onset CDI cases. They have to look up each patient's NHS number individually to obtain the GP practice details. Response: • The team acknowledged the feedback and will investigate the issue further. 6. Question from Shabnam Iyer, Consultant Microbiologist at Royal Berkshire NHS Foundation Trust: • She mentioned that previous CDI episodes are a key risk factor, as patients who have had an initial episode are at high risk of developing recurrent CDI. • The current surveillance system may not capture all previous CDI episodes, as it only logs cases that are toxin-positive.

	• It was pointed out that for every CDI case that is reported, there are likely three additional cases that are not reported, as they may not have a positive toxin test, even though the patients are clinically symptomatic and treated for CDI. This means the true scale of the CDI problem is significantly underestimated at the national level, as the surveillance system is only capturing around a third of the actual cases. • She suggested that capturing information on periods of increased incidence (PII) on the ward where a new CDI case is detected could serve as a surrogate marker for increased C. difficile colonisation pressure and environmental contamination, which could contribute to the risk of healthcare-associated infection for that individual patient. Response: • DC acknowledged her important points about the limitations of the current surveillance system in capturing all CDI episodes, particularly those that are not toxin-positive. The team will take this feedback into consideration as they continue to review and refine the CDI surveillance risk factor questions, to ensure the system is capturing a more comprehensive picture of the problem. 6. Question from Katie Jeffery, Director of Infection Prevention and Control (DPIC) from Oxford University Hospitals • Katie expressed concerns about the onerous nature of the data collection on antibiotic data, stating it can take a whole day for her team to provide the precise dates. • She questioned the value of this data collection, as the link between antibiotics and CDI is already well-established. • As the DIPC, Katie said she would seriously consider telling her team not to fill in the detailed antibiotic data, as this would take staff away from patient-facing activities without gaining additional insight. • She added that while her team does conduct root cause analyses (RCAs) locally, it is now done with a much lighter touch compared to before. • She stated that the true learning is not necessarily in the antibiotic data, as the problem is no longer solely about antibiotics. Instead, the focus should be on other factors, such as the ability to clean properly and the missed linkages between cases. • Katie acknowledged her comments were provocative but felt this was an appropriate forum to have a constructive discussion about the value and burden of the data collection. Response: • Dimple mentioned that Katie's concerns were acknowledged by the team and explained that while the link between antibiotics and CDI is established, the shift in CDI cases is observed and yet to be fully

understood. The granular antibiotic data would help unpack and understand the change, and ultimately reduce the overall burden of CDI cases nationally.

- Dakshika Jeyaratnam (Consultant Microbiologist & UKHSA CDI Clinical lead, UKHSA & Medical Microbiologist, Guys & St Thomas NHS Foundation Trust) mentioned that she also acknowledged Katie's concerns about the burden of manual data entry and agreed that automation would be preferable but is not currently available. She explained that this data collection is intended as a starting point, and the mandatory surveillance team wants to have an inclusive process to determine what is reasonable and feasible for the teams to collect.
- DJ highlighted that the key question is what information the team is trying to obtain from this data set. She noted that while the antibiotic data is included for the locally conducted RCAs or post-infection reviews (PIRs), it is not being collated at the national level, and the national team is limited in its ability to understand the drivers behind the rise in C. difficile rates without access to this basic risk factor data. The importance of this data at the national level to truly understand the factors contributing to the C. difficile trends and She welcomed feedback from Katie and others on what should be included or excluded from the data collection.
- DJ also agreed that if the national team had access to reliable IPC data, such as hand hygiene audit results, it would provide valuable context.
- DJ reiterated her agreement with the points raised by Katie and stated the importance of this open dialogue to refine the data collection approach, and the ultimate goal is to obtain modifiable risk factors, whether related to the hospital environment or other aspects, and share that information nationally to help bring down *C. difficile* rates.

7. Question from Ines Almeida

- Ines expressed similar concerns to Katie, stating that the DCS database can be quite onerous for end-users. She also questioned the value of the extensive investigations into patient notes, as it takes a lot of time that could be better utilised in direct patient care.

Response:

- DC acknowledged Ines' concerns and mentioned the team is exploring automation options to streamline the process and make the data collection as simplistic as possible but recognised that these changes take time to implement.
- The team only knows what it currently knows, and the data collection is an important tool to uncover additional insights that could help reduce the overall burden of *C. difficile*.

	• She expressed appreciation for the open dialogue and stated that the team is willing to explore ways to refine the data collection approach to ensure it is reasonable and feasible for the frontline teams. 8. Question from Siddharth Mookerjee, UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST • Siddharth shared his views the data collection on DCS and suggested to see it as a framework for local action, rather than a standalone reporting requirement. • He suggests using the DCS as an "end goal", where organisations start with similar questions in their local RCA and work towards providing the information required. This approach ensures each *C. difficile* case is thoroughly investigated at the local level, and the required data is already gathered, rather than collected solely for the DCS. • His second point was that even though the general risk factors for C. difficile are well-understood, there are still regional differences that need to be explored and understood to inform local and regional interventions. Therefore, this regional understanding is crucial, and the data collection should not be dismissed, as it can provide valuable insights into the drivers of CDI at the local and regional levels. Response: • DC agreed that the regional differences in CDI are an important factor that the data can help uncover. 9. Question from Damien Mack, ROYAL FREE LONDON NHS FOUNDATION TRUST • Damian provided comments and shared the experience in his organisation where all the required data are uploaded to the DCS by a data analyst, so they do not separately enter any risk factors. • He also mentioned that his team now conducts lighter touch RCA for CDI as most of them did not have any lapse in care. • He added that his organisation cares for many patients with liver and renal conditions, and there may be other important risk factors, such as frailty, inflammatory bowel disease, and gastric surgery, which could be captured from other data sets and linked to the CDI cases. • Finally, he suggested that it would be important to clearly define the risk factors that the team wants to capture, as this may determine whether frontline teams should be expected to manually enter the data or if there are other ways to obtain the information, such as through national data linkage.

5.	**AOB** • DC added that there are ways to automate the data collection process, and the team is working with ICNet to explore automation options, which have some limitations but also positive aspects. • ZAC mentioned that some questions around comorbidities are included in the draft, but the full list of comorbidities is still to be finalised, so it's not currently included. • DC reminded everyone that the risk factor questions have been made available, invited everyone to review and provide feedback as soon as possible. There is a short poll, and participants are encouraged to complete it if they haven't already done so. • DC concluded that the aim is not to add to the workload, but to obtain the right information to understand the drivers behind the increases in *C. difficile* and identify any gaps in the current knowledge. She welcomed any other questions or comments from the participants and encouraged everyone to send their thoughts and feedback on the risk factors through the mandatory inbox. • DC thanked all for attending and closed the meeting at 15:00.

Date for next meeting: TBC