Public Health England

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HCAI Mandatory Surveillance Stakeholder Engagement Forum: 9th June 2017

Background:

These notes are based upon the fifth 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 Improvement (NHSI)
- NHS Digital
- NHS England
- Lancashire County Council
- Calderdale & Huddersfield Foundation Trust.
- Guy's & St Thomas' NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Shrewsbury & Telford Hospital NHS Trust
- NHS Aylesbury Vale Clinical Commissioning Group, NHS Chiltern Clinical Commissioning Group
- Brighton and Hove, Crawley, Horsham and Mid-Sussex Clinical Commissioning Groups
- Coastal West Sussex Clinical Commissioning Group

The major aims of the group are as follows:

- 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.

Actions from the previous meeting (February 2017):

PHE to liaise with NHS improvement colleagues regarding utilising the Provider Bulletin to notify users of forthcoming surveillance changes.

- PHE confirmed that information on the addition of *Klebsiella* spp. and *Pseudomonas aeruginosa* to surveillance had been circulated via the Provider Bulletin. The CDI updates however had not.

- PHE outlined that improved communication remained a high priority and outlined some of the recent methods that had been utilised:-
    - The use of Granicus for various recent announcements. Granicus is a dissemination system, whereby users receive individual emails (mandatory surveillance bulletin).
    - PHE confirmed that they have started adding links for recent publications on to the homepage of the HCAI DCS.

PHE team to look into the re-introduction on a special/feature section in the QEC. This will be included on an ad-hoc basis depending on relevance and associated data completeness.

- PHE conveyed they are keen to introduce the special feature section which is an additional piece of analysis and PHE would be happy for users to suggest content. The group was asked for ideas. PHE put forward a number of suggestions:
    - Looking at age / sex distribution comparing MRSA vs MSSA.
    - Looking across/linked datasets- apportionment of non asceptability *E.coli* post and pre 48 hour cases.
- PHE clarified that the special feature does not necessarily have to be new analysis, could be;
    - Alternative analysis
    - Different visualisation methods for eg. GIS maps
    - PHE proposed that the special feature may be provided by users. For example some trusts have shown reductions in *E.coli* – their successes could be presented as 'best practice'.. The group welcomed this idea and method of sharing good practise.
        - **Action 1 – Users to provide PHE with suggestions for potential special features for QEC.**

PHE to investigate feasibility of presenting mortality data at PHE centre level in future publications.

- PHE explained that this is work in progress and has been discussed with the lead Scientist. Although it is possible to work up the data, PHE are unable to confirm that this would make the final report for this year.

PHE to formally notify users of proposed/forthcoming changes to the CDI algorithm and HCAI DCS as soon as possible.

- PHE reiterated that timely communication remained a priority and that a variety of methodologies are currently being considered. Users were however sent a notification via the mandatory surveillance bulletin (circulated via Granicus).
- PHE enquired how users were adjusting/ finding the new CDI prior healthcare questions. Users expressed positive feedback. Group member asked when the new CDI algorithm document would be available/provided. PHE confirmed that the document had previously

been circulated, is available on the HCAI DCS and will soon be on GOV.UK. PHE confirmed that the new algorithm is not yet officially being used. Discussion at previous stakeholder events indicated that NHS colleagues were not keen for the change to be formally made in April 2017. The intention is that some preliminary analysis be presented to users prior to formal switchover to the new algorithm.

- Annual and QEC publications received well by the group. QEC being the more preferred output.

Feedback on Current Outputs/publications

The most recent mandatory surveillance publications were discussed by the group:

1. Routine monthly outputs
2. The Quarterly Epidemiological Commentary (QEC)- Published June 2017
3. Thirty-day all-cause fatality subsequent to MRSA, MSSA and *E. coli* bacteraemia and *C. difficile* infection– published January 2017

1. Routine Monthly Outputs

- Group agreed that the monthly tables served a purpose and users preferred the bare boned counts by month. The introduction of monthly trends was discussed by the group however it was concluded that not much would be achieved by producing monthly trends and that information was available via other publication routes the QEC and other published reports.

2. Quarterly Epidemiological Commentary (QEC) – June 2017

- The group stated that the QEC represents the most frequently used output as it goes beyond simple counts by organisation. Although analysis is only on regional and national level the report does consider/analyse trends. The group agreed that the QEC is widely used to monitor trends. Users queried whether it was possible to produce/publish the QEC to a tighter timeline. PHE outlined that the current timelines were based upon time constraints for signing off the data and producing the report. Reducing timelines would impact data quality.

3. 30-day all-cause Fatality report- January 2017

- Although users expressed an interest in the report it was not an output they were familiar with.

PHE clarified that this output replaces the earlier report produced by the ONS. Overall it shows a reduction in deaths following CDI infection and MRSA bacteraemia. Although there has been an increase in *E.coli* and MSSA bacteraemia the associated case-fatality rate (CFR) has decreased. This is representative of the improvements in aftercare across all four mandatory surveillance data collections.

Gram-negative reporting outputs

PHE outlined proposed updates/changes to routine surveillance to support the government's ambition to halve healthcare associated Gram-negative bloodstream infections by 2020/21:-

1. **Proposed updates to *E. coli* bacteraemia outputs**

- The intention is to apportion *E.coli* bacteraemia data in the same way as MSSA bacteraemia. Reported cases with specimens taken two or more days following admission to the acute Trust will be classified as 'Trust apportioned' (hospital onset) cases.
- There are also plans to implement a counterpart to the 'Trust apportioned' table. This table will provide details of those cases that do not fulfil the criteria for Trust apportionment. PHE clarified that this would be included as an additional table enabling users to determine the proportion of community onset cases.
- The group agreed that these updates would both be beneficial. A large proportion of Gram-negative bacteraemias are community onset. Given that this information feeds into the Quality Premium CCGs have an obvious stake. Trust users expressed that they would also find it useful to see data categorised in this manner.
- Users expressed some concern about CCG's ability to provide the necessary additional risk factor information required before sign off. PHE reassured the group that the risk factor tab remains unlocked for up to a year after the case has been entered onto the HCAI DCS. This allows relevant risk factor data to be entered as/when it is obtained by CCG users. PHE stated that they are currently reviewing *E. coli* bacteraemia risk factor completion levels with a view to identifying low reporting organisations and any particular questions that are causing issue. The intention is that this information will be fed back to the NHS in the future. This could be a potential special feature for the QEC.

2. ***Klebsiella* spp and *Pseudomonas aeruginosa* bacteraemia data outputs**

PHE provided an overview of intentions for the *Klebsiella* spp and *Pseudomonas aeruginosa* bacteraemia data collections moving forward:

- Monthly data will be published for the first time in October. This will include data from April to August 2017. Data will then be published in line with the routine monthly publication schedule moving forward.
- Data will be published in an identical way to *E. coli* bacteraemia– the intention is that cases will be also be split into Trust apportioned, CCG attributed and all cases.
- *Klebsiella* spp and *Pseudomonas aeruginosa* bacteraemia data will be included in the subsequent QEC and AEC publications.

These proposals were welcomed by the group who felt that it would be beneficial to have this information made available at the earliest opportunity.

PHE encouraged group to contact the mandatory surveillance team with any comments/suggestions/ feedback to contact the team.

Next meeting to be scheduled for September/October 2017.