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HCAI Mandatory Surveillance Stakeholder Engagement Forum: 5th October 2016

Background:

These notes are based upon the second 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 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.

Attendees Included:

- PHE HCAI Mandatory Surveillance
- PHE Field Epidemiology Services (FES)
- Department of Health
- NHS England
- Brighton & Hove, Crawley, Horsham and Mid-Sussex CCG
- West Berkshire & East Berkshire CCG
- North Middlesex University Hospital NHS Trust
- Poole Hospital NHS Foundation Trust

The major aims of the group are as follows:

- Opinion of current routine mandatory surveillance outputs/publications.
- Future developments to routine mandatory surveillance outputs/publications
- Forthcoming changes to the CDI algorithm

Engaging User Groups/General Public

Specialist Groups

Due to the diversity of users and requirements separate meetings are being arranged for specialist groups with an interest in HCAI. The separate meetings will allow PHE to focus on key issues of a specific demographic. As with today's meeting the specialist meetings will be used to canvass opinion on existing outputs and future plans.

This will extend our systematic engagement to the voluntary sector and help to form a view from the expert patient perspective. The intention is that the meeting agenda will follow a similar format to the original Stakeholder Engagement Forum. Unfortunately a suitable time/date could not be found in the final quarter of 2016. Discussion is currently ongoing with interested parties in order to establish a suitable date in early 2017.

- **Action: PHE to organise a meeting with interested specialist groups for early 2017**.

General Public

Following discussion at the previous stakeholder meeting a page of infographics per organism were added to the annual publication (Annual Epidemiological Commentary). This addition has been quite well received by health service colleagues and helps to explain complex issues in lay-terms. Users deemed that the dissemination and notification of PHE publications were not publicised effectively, as not all representatives were aware of the Annual Epidemiological Commentary publication in July.

Current methods available for providing feedback were discussed. The main mechanism for obtaining feedback is via the "Contact us" section included in the caveats of all mandatory surveillance publications.

Current Outputs/publications

There was concern among group members that currently employed methodologies for communicating forthcoming publications/releases (quarterly and annual) to stakeholders needed improvement.

The PHE team clarified that both quarterly and annual outputs were National Statistics outputs and as such were subject to a strict publication protocol with dates being widely known/available throughout the health service. All publications are announced 12 months in advance and the dates are published on our publication page, on the "Statistics at PHE" timetable.

Links to the most recent quarterly and annual publications are also available through both login pages of the HCAI Data Capture System and on the caveats page of the routine monthly outputs.

Despite these existing mechanisms the group felt that it would be useful if PHE were to ensure more extensive notification in the run up/at the time of publication. The following approaches were explored:-

- The group discussed the possibility of adding links to recent publications on the landing page of the HCAI DCS that would be viewable once users log in.

- **Action: PHE to explore the possibility of adding links to the HCAI DCS landing page.**

- Colleagues in PHE Field Epidemiology Services suggested utilising GOVdelivery (www.govdelivery.co.uk). This approach has been used successfully by other departments at PHE.

➢ **Action: PHE to look into the feasibility of using this service for the dissemination of key reports/outputs.**

- The group suggested asking specialists groups to announce/publicise publications via their websites.

➢ **Action: PHE to explore this possibility in forthcoming discussions with specialist user groups (proposed date of early 2017).**

Monthly Data Tables:

The group indicated that the monthly data tables continued to serve a purpose at a local/regional/national level. No suggestions as changes/updates were offered.

Quarterly Epidemiological Commentary (QEC)

The group suggested that they considered the QEC to remain a useful output. NHS colleagues indicated that they found it to be a useful tool for comparing their organisational data against others.

Following the success of the infographics included in the Annual Epidemiological Commentary (AEC) PHE queried whether the group would also find it beneficial if some summary infographics were published alongside the QEC. The group agreed that this would be useful.

➢ **Action: PHE develop infographics for QEC**

Annual Epidemiological Commentary (AEC) and associated data tables

PHE representatives from the Mandatory Surveillance team outlined that the AEC published in July had been updated in light of discussion at the previous stakeholder meeting (May 2016). Notably infographics had been included in order to provide a more visual representation of the data. This has aided interpretation/understanding by non-expert users. Infographics are provided as supplementary documents with a single page per organism.

Future Developments:

Changes to the algorithm used for mandatory surveillance of *C. difficile* infection (CDI)
NB: the slides presented to the group can be found in appendix 1.

1. Overview of the update process

PHE outlined some of the background behind the proposed changes:-

- CDI numbers have been subject to an overall downward trend since mandatory surveillance was introduced in 2007 but have plateaued over recent years.

- Alongside the general downward trend there has been an interesting shift in case breakdown over this time period:-

- Prior to 2010/11 the bulk of cases were Trust apportioned (hospital onset) – this is; however, where the bulk of reductions observed between 2007 and 2010 occurred.

- Post 2010/11 there are more non-Trust apportioned (non-hospital onset) cases reported annually.

- Unlike Trust apportioned cases which are well understood and largely reducible via traditional infection prevention/control measures, less is known about the pool of non-trust apportioned cases. Some may have been subject to prior healthcare interactions whereas others may be true community cases.

- Updates to surveillance will enable the additional categorisation/analysis of cases currently classified as non-Trust apportioned cases.

- Updates will be largely in line with CDI surveillance definitions used by European Centre of disease Control (ECDC) and the US Centre for Disease Control (CDC).

- Essentially CDI surveillance data will be split into four categories:

i. Healthcare Onset – Healthcare Associated:-
    - Detected >two days after an admission to the reporting Trust.
        - Essentially Trust apportioned cases.

ii. Community Onset – Healthcare Associated:-
    - Case is detected within 2 days of an admission to the reporting acute Trust or a case not detected among an inpatient at the reporting acute trust **AND**
    - Patient has been an inpatient in the reporting Trust in the four weeks prior to the specimen date.

iii. Community Onset – Indeterminate Association:-
    - Case detected within two days of an admission to the reporting acute Trust or a case not detected among an inpatient at the reporting acute trust **AND**
    - Patient has been an inpatient in the reporting Trust in the 12 weeks prior to the specimen date, but not in the most recent four.

iv. Community Onset – Community Associated:-
    - Case detected within two days of admission to the reporting acute Trust or a case not detected among an inpatient at the reporting acute trust **AND**
    - Patient has not been an inpatient in the reporting Trust in the previous 12 weeks.
        - Essentially viewed as community cases

- Intention is that data will be reported via acute Trust self-report to the HCAI DCS. Trusts will be expected to report prior admissions to their own Trust only (e.g. 'within Trust' interactions).

- This will be undertaken via a series of new/additional questions on a new tab on the HCAI DCS. Users will always have the option of providing a "don't know" response in order to complete/sign off the record.

- Prior analysis (via linkage of HCAI DCS data with HES data) indicates that 87% of prior admissions are to the same Trust. This suggests that a self-report strategy for 'within Trust' interactions will be effective in identifying a high proportion of prior interactions within an achievable framework using existing resources.

- Mandatory surveillance data is audited against alternate data sources in line with National Statistics requirements. The intention is that CDI data reported via the self-report mechanism will be routinely cross-checked against HES data to ensure that prior interactions are being correctly recorded/reported by acute Trusts.

Although, on the whole, the group welcomed the proposed developments, NHS Trust representatives expressed some concerns with aspects of the process:-

- Some clarity in terms of expression was requested.

- The group felt the use of the term 'healthcare' was potentially misleading as only hospital admissions are being captured. PHE agreed to update the term to better reflect what is being captured.

  - **Action: PHE to update the term 'Healthcare' with 'Hospital' in all uses of the term in the four categories**

  - Representatives also queried the use of the term 'indeterminate' as this term has an alternate meaning for those involved in laboratory testing of CDI. PHE confirmed that the use of this term was consistent with international surveillance definitions (e.g. ECDC).

  - There was some concern among group members that the proportion of prior admissions within Trust may vary by region. Preliminary analysis undertaken by PHE did not indicate such differences.

  - The group indicated that it would be helpful if a document were produced/published detailing the rationale behind the proposed change to CDI surveillance. This would include further details of the extended surveillance categorisations and some comparison with similar international definitions (e.g. ECDC, CDC).

  - **Action: PHE to consider producing/publishing a 'rationale' document**

2. Proposed table format and associated publication timetable

The group were given the opportunity to comment on the proposed table structure for publishing the updated CDI surveillance data (appendix 2).

- PHE outlined that the intention was to begin collecting data in financial year (FY) 2017/18.

- There was concern from the group that the change to surveillance would supersede current reporting/publication options. This is problematic as NHS Improvement (NHSI) performance initiatives are based upon the current two tier 'Trust apportioning' methodology.

- PHE emphasised that the intention is to run the updated surveillance algorithm alongside the existing algorithm for at least 12 months. This will ensure continuity in performance management/assessment and will enable time to establish and quality-assure the updated algorithm.

➢ **Action: PHE to consider frequency of publication of revised algorithm data (perhaps quarterly).**

- PHE also outlined plans to publish HCAI DCS/HES linkage analysis. This will provide NHS stakeholders with an indication of how their historical data will look using the revised surveillance methodology.

- PHE further reassured stakeholders that users would be given ample time to adjust to the updated surveillance methodology before a formal 'switchover' occurred. All routine mandatory surveillance NHS publications are National Statistics and under the associated code of practice PHE are required to notify users of any changes to the algorithm/data approx. 6 months in advance.

- PHE also emphasised that they would be liaising with national and local level stakeholders over coming months to ensure that all surveillance updates were effectively communicated moving forward. CCG representatives advised that the best method to contact all CCG's and gauge their opinions would be to email them using the contact details stored on the HCAI DCS, with a select survey.

➢ **Action: PHE to liaise with NHS Improvement in order to ensure a coordinated approach to surveillance update and associated performance management**

➢ **Action: PHE to compile lines to commissioners confirming that data will not be used for performance monitoring at the current time**

- NHS England representatives outlined that current CDI guidance focusses on local 'Lapse in Care' reviews and that the updated algorithm will help CCGs to focus resources/investigations appropriately. Differences in the number of community cases across/between CCGs will be evident allowing focus on these particular cases

- NHS England will be presenting the new CDI algorithm to the London DIPC forum in the coming weeks.

➢ **Action: NHS England to provide feedback from the London DIPC forum to PHE**

Next meeting to be scheduled for February 2017