Public Health England

Protecting and improving the nation's health

Clarification of prior trust exposure definitions

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From April 2017, the mandatory surveillance of bacteraemia and *Clostridioides difficile* infection (CDI) introduced questions regarding prior exposure (i.e. admission) of the patient to the reporting trust. In April 2019, the wording of these questions was revised for CDI to reduce the burden of data entry and harmonise the questions across data collections. However, there has been some ambiguity over which prior trust exposures meet the definition.

This document clarifies which admission types should be included as part of the prior trust exposure questions and provides further information around the prior exposure questions.

Prior trust exposure

The patient's admisions that should be included must meet all of the following:

- admitted to the acute trust that reported the infection case
- admission either inpatient, day patient, regular attender or emergency assessment admissions

The following patient care episodes are excluded:

- all outpatient episodes should be excluded

Note: Trusts should follow their local processes and procedures to determine the categorisation of the admission as per the NHS data dictionary.

Changes to denominator data

In addition to overnight bed days, we will include day patients data when calculating trust level healthcare-associated rates where both hospital and community-onset cases are included in the numerator. This metric will be used from April 2020 and calculated back to April 2017, when the prior trust exposure questions were introduced.

Frequently asked questions (FAQs)

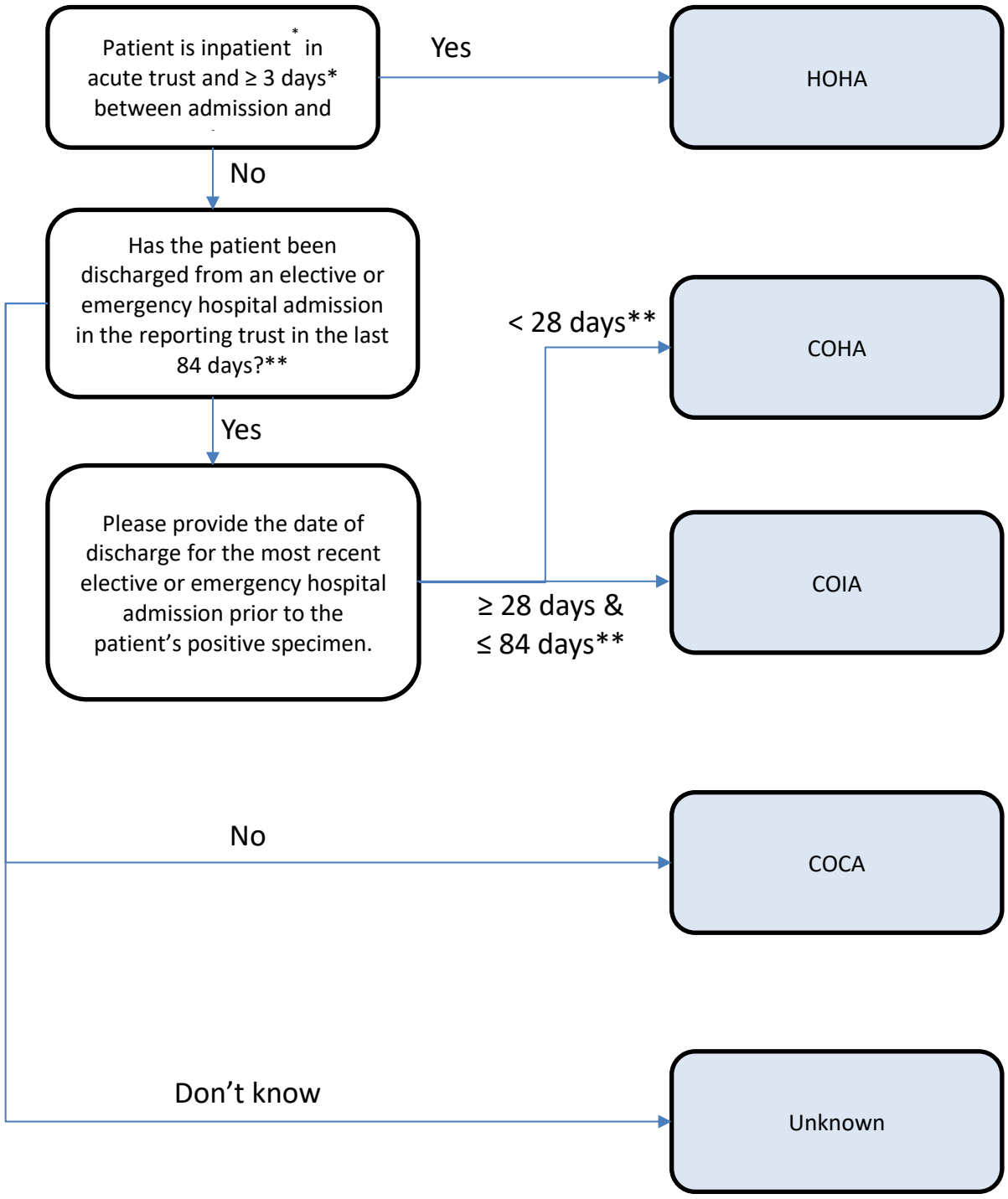
1. How is a case considered healthcare-associated?

From 1 April 2019 the CDI prior trust exposure algorithm and questions were updated to align more closely with ECDC and CDC definitions and use similar language to the bacteraemia data collections. The CDI prior trust exposure algorithm is outlined in the figure below. Healthcare associated infections are the sum of the Hospital-onset healthcare associated cases and the Community-onset healthcare associated cases.

These cases are considered healthcare associated because the patient was either in hospital for over two days before the onset of their infection or they had been admitted to the reporting trust in the previous 28 days. Therefore, in these cases, healthcare association can not be ruled out and further investigation is warranted.

The new algorithm for CDI and bacteraemias is shown in full in the flow diagrams (Figure 1 & Figure 2).

Figure 1: Flow diagram for determining prior trust exposure for CDI

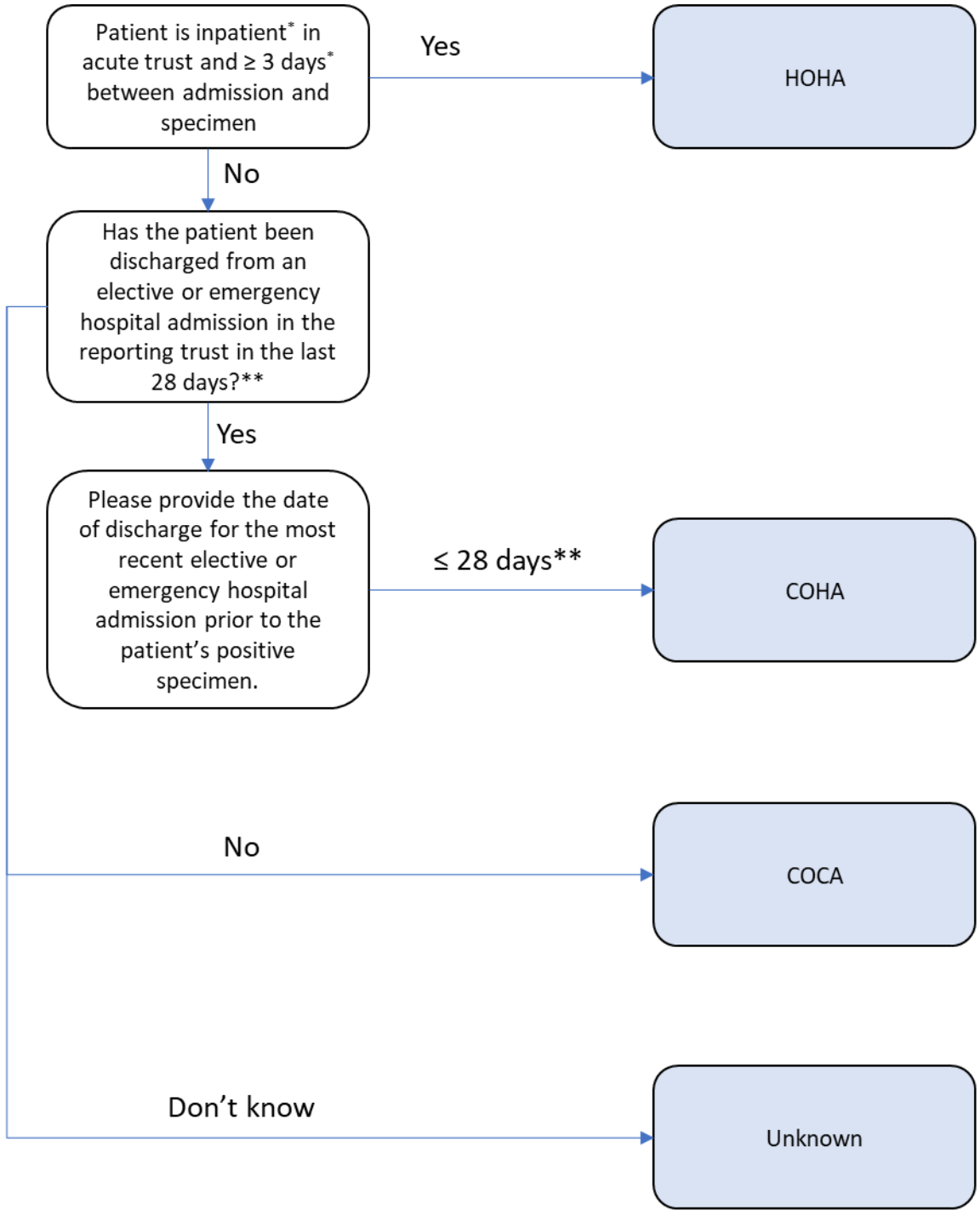


**Referring to days between current hospital admission and specimen date. With day 1 as day of admission. Not applicable to community/non acute trusts*

*** *With date of discharge being counted as Day 1*

NB All prior healthcare exposure questions must still be completed even if a case fits the criteria for a HOHA. Also community/non-acute trust specimens should also complete the prior exposure questions, the same criteria for prior exposure apply.

Figure 2: Flow diagram of for determining prior trust exposure for bacteraemias



**Referring to days between current hospital admission and specimen date. With day 1 as day of admission. Not applicable to community/non acute trusts*
*** *With date of discharge being counted as Day 1*

NB All prior healthcare exposure questions must still be completed even if a case fits the criteria for a HOHA. Also community/non-acute trust specimens should also complete the prior exposure questions, the same criteria for prior exposure apply.

2. What hospital admissions are counted in the prior trust exposure questions?

These should include all admitted patients, and would include the following:

Inpatients – a patient admitted to an acute trust for care and is expected to stay overnight.

Day patients – a patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a Hospital Bed overnight. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an Inpatient.

Regular day attender – a patient admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions.

Regular night admission – a patient admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions.

Emergency assessment – a patient admitted to an Emergency Assessment Unit (EAU).

All outpatient episodes should be excluded

PHE are unable to advise on whether a patient is an admission, and trust should follow their local processes and procedures to determine the categorisation of the patient, see example below.

e.g. Chemotherapy patient – attends a trust 3 times over a period of a week

If the trust would label these as an ‘admission’ (whether as a day-case or regular attender) based on their local procedures this case would be **included**. However if the trust local procedures report these exposure as an outpatient then this exposure would be **excluded** from the prior trust exposure.

Note: only prior admissions to the reporting trust are to be included, as these are the only admissions trusts can be reliably expected to know about. Based on previous analysis of data linked to the Hospital Episodes Statistics dataset, this captures ~80% of all relevant patient admissions.

3. What if I haven't included all the correct information, can I/should I amend and correct these?

Yes, if you are aware of any incorrect data and have not included all the prior trust exposure that apply then we would urge you to correct these.

Data from April 2019 – users will need to request unlock of the relevant periods through the normal processes (please refer to page 25 of the protocol). Cases can then be manually amended by users.

Note: Data from April 2019 will be used in the production of objectives around December 2019. It is therefore essential that trusts ensure the data in the DCS is accurate as this will affect 2020/21 targets.

Users will also have the opportunity to amend any incorrect data for cases with specimen dates from April 2017 to April 2019. We will facilitate any changes/corrections to historic data through the normal unlock request process (please refer to page 25 of the protocol).

4. How do we report a case tested in our trust but where the sample was taken elsewhere?

Acute trusts are responsible for ensuring that all specimens tested at their trust and meeting the inclusion criteria are reported to the DCS. If your trust's laboratory processes samples for a different trust or if your trust uses private laboratory services local arangments should be inplace to ensure those cases are reported

The prior trust exposure questions refer to whether the patient had been admitted to the reporting trust (note the reporting trust is dictated by the "Reporting Organiation" field in the Episode details tab). If the patient was admitted elsewhere or not at all, then you

Where one acute trust or associated pathology laboratory tests specimens for another acute trust, local service level agreements should be in place to ensure that the case is reported on the HCAI DCS, under the acute trust where the specimen was taken

In the case of specimens taken outside of acute trusts, cases should be reported by the trust associated with the testing laboratory, except where local service level agreements exist, to report them under a different trust. The trust associated with a laboratory is

determined by the Parent Organisation Code for the testing laboratory in the NHS Digital Organisation Data Service (ODS) file eplab.csv[1]

5. When should I use ‘Don’t know’ when answering the prior exposure question?

The option “Don’t know” should be used to answer the prior exposure question when the information is unavailable. This may be due to the case notes not being available, incomplete information in the patient case notes, missing identifiers preventing you from identifying the patient and/or their records.

[1] https://digital.nhs.uk/services/organisation-data-service/data-downloads/miscellaneous