MINUTES OF MEETING

HSE Health Protection Surveillance Centre

Title of Meeting:	CPE Expert Group		
Purpose of Meeting:	Refer to Agenda		
Location of Meeting:	HPSC		
Attendees:	**In person:** Cathy Barrett Boyce (CBB), Infection Prevention & Control Nurse, IPCI representative Professor Martin Cormican (MC), HSE HCAI/AMR Clinical Lead & Director of the CPE Reference Lab (CPERL) Clodagh Cruise (CC), Surveillance Scientist, Naas General Hospital, SSAI representative Dr. Rob Cunney (RC), Consultant Microbiologist, HSE-HPSC Representative Dr. Jerome Fennell (JF), Consultant Microbiologist, ISCM Representative Prof. Hilary Humphreys (HH), Prof. of Clinical Microbiology & Consultant Microbiologist, Chairperson of CPE Expert Group Shane Keane (SHK), Principal Environmental Health Officer, Environmental Health Dr. Kevin Kelleher (KK), Director HPSC & Assistant National Director, Health & Wellbeing: Public Health & Childcare Anita Kelly (AK), Surveillance Assistant, HSE-HPSC, Administrative Support to the CPE Expert Group Dr. Siobhan Kenneally (SK), Consultant Geriatrician, National Clinical Advisory Group Lead, Social Care Division & Clinical Lead Integrated Care Programme for Older People Dr. Sarah O'Brien (SOB), Specialist Registrar in Public Health Medicine, HSE-HPSC Elaine Phelan (EP), Specialist Medical Scientist, Academy of Clinical Science and Laboratory Medicine Medical Scientist (ACSLM) Representative **By telephone:** Dr. Catherine Fleming (CF), Consultant in Infectious Disease, ISDI Representative Dr. Margaret O'Sullivan (MOS), Consultant in Public Health Medicine, Faculty of Public Health Medicine RCPI Representative		
Apologies:	Dr. Karen Burns (KB), Consultant Clinical Microbiologist & Honorary Clinical Senior Lecturer, RCSI. HSE-HPSC Representative Dr. David O'Hanlon (DH), General Practitioner Representative		
Date/Time of Meeting:	Monday, 4th December 2017, 10am, HPSC offices	Date/Time of Next Meeting:	Wednesday, 10th January 2018, 10.30am, HPSC offices
Prepared by:	Anita Kelly	Date Circulated:	2nd January 2018
Circulation:	**Full Group**		

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1	**Introductions** The group members were introduced to each other. All were welcomed to the group by the Chair (HH). **Apologies** Dr. Karen Burns (HPSC). KK advised that he is also seeking international experts (possibly from Public Health UK or ECDC), and a senior operations manager, to become members of the group. The group were advised of a letter received from the Irish Antibiotic Pharmacists' Group stating that they were unable to provide a representative due to ongoing negotiations with the HSE on career structures. HH asked the group if anyone else should be part of the group. RC proposed a patient representative. SK proposed a GP from primary care. This has already been requested. CBB proposed a community infection control nurse.	**KK to seek international experts and a senior operations manager** **RC to revert to AK with person to contact ref patient representative** **CBB to propose a community infection control nurse.**
2	**Chairman's statement** HH advised that this group was convened as part of the CPE PHE declaration, and he was pleased to chair the group. He thanked the members for their time. HH is conscious of the responsibilities the group must fulfil. The group must respond to instruction, provide a sounding board and a steer on decisions, and must facilitate and lead in improvements on the current situation. The group should be comfortable and free to express their views. He is conscious that people are busy and that time is a constraint, so the group must use time effectively and efficiently. KK advised that the group will be reviewing documentation, most of which will be written outside the group. The group would be involved in editing and commenting on the documentation. The group should also generate ideas. The group confirmed that they were happy with the above.	
3	**Review of Terms of Reference** HH advised that the terms of reference (TOR) were generic, and included being a sounding board and providing oversight. KK advised that a letter with revised TOR had come from Dr. Tony Holohan (Chief Medical Officer) shortly before the meeting. The main points were to prioritise CPE screening documentation, and then review other documentation and other priorities, as determined by the group. The updated/amended TOR will be disseminated to the group.	**Updated TOR to be disseminated to the group (AK)** **Recently published**

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	HH will also disseminate a recently published guidance document from the ECDC on infection prevention and control measures with regard to CPE. **Membership** Already discussed at the introduction.	**guidance document on infection prevention and control measures to be disseminated to the group (AK)**
4	**Updates from Prof. Cormican & Dr. Kelleher** MC discussed the current assessment that he had disseminated to the group as a short document, prior to the meeting. He advised that the numbers colonised/infected with CPE so far in 2017 is understated (380), with over 9 outbreaks during the year to date. Acute hospital transmission is currently the main mode of transmission. He has met with all the CEOs of the hospitals personally to raise awareness of the issue. His team have worked closely with the Business Information Unit (BIU) to put in place a process for monthly reporting. This is working well. He advised that there is a substantial risk of failure to control CPE, as root and branch change throughout the HSE is required, and the scale of the problem and change required is not yet fully accepted throughout the organisation. His opinion is that it is important to get the screening process right as this will identify the true extent of the problem and raise awareness of the issue. He also advised that this needs to be urgently addressed, as time is a constraint. KK led on from MC's update by stating that it was important to try and get the system to recognise the problem of antimicrobial resistance (AMR). CPE is the most recent manifestation of AMR. Countries in Europe who reacted more quickly and efficiently have better systems in place to deal with these problems, including most recently, CPE. A massive mind/culture shift in the organisation is required. A letter issued seven weeks ago from the Director General to the Minister for Health articulates a lot of what is required. CPE will have a major impact on the organisation and on resources, as serious financial resources are required. A HIQA report out today has highlighted that Limerick University Hospital is not screening or cohorting patients properly. There is a lack of single rooms and the wards are inappropriate to carry out screening effectively. The situation in Limerick is not unique. Tallaght Hospital is slightly better, but is losing income on rooms. It is important that we turn things around. **Discussion** HH stated that it was important to optimise the short-term issues, and to highlight and subsequently put long term strategies in place, e.g. improved hospital infra-structure. MC acknowledged the work that had been done to contain CPE, but noted that it wasn't sufficient. KK added that the number of CPE infections (as opposed to carriage/colonisation) is low to date, but it is spreading with 80-90% spread in the hospital setting. MC	

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	responded to a question by SK in relation to discussions with the acute hospital divisions by stating that monthly meetings were held with BIU to guide hospital management. CF advised that antibiotic stewardship and active management of CPE cases (invasive and colonised) are also very important. There is currently no support for GPs in the community. MC confirmed that that is a problem as support and case management is required at community level. RC commented on the high use of antibiotics in Ireland, which is driving CPE. He agreed that it was important to address AMR stewardship. MC summarised that the emphasis should be on 1. Governance, 2. Proper screening, and 3. National policy on antibiotic stewardship. CF asked who follows antibiotic use for patients with CPE discharged (either invasive or colonised) over the following years. MC stated there was no process in place to follow patients. The first priority is to ensure proper screening to understand the extent of the problem. Screening also forces people to face and acknowledge the problem.	
5	**Questions from NPHET & Review of extant guidance** The first question posed by NPHET is to review HPSC advice and guidance in the light of current international best practice, and then to prioritise other guidance. KK referred to the A3 document handed out to the group at the meeting. The group needs to review and comment on the first document (screening) on this list. The group must then prioritise and review the other documentation on the sheet, and then consider if other guidance is required or needs to be addressed. HH advised that the documentation would be forwarded to the group after the meeting, with a two-week turnaround for review and commentary. MC suggested that it was important to review measures in acute hospitals as that area has huge resource implications. The group must make a case for the resources that are required. KK will disseminate the two documents after the meeting. MC suggested that community guidance in infection control was important, and that there was a deficit of guidance on the management of patients with CPE. CBB asked whether contact tracing should be covered in the requirements of screening? She has concerns about patients being discharged without being told of their CPE colonisation and with no follow up as the long-term effects of that process were a concern. MOB pointed out that there was a balance between allaying public fear and providing information. It was agreed that a clear communication package was required. MC added that a document on this was currently under review, and CPE cards were being issued to patients (in GUH and Mayo), which prompted a conversation with that patient. It was acknowledged that if a patient with CPE presents at another hospital, there is no process to identify that patient as a CPE carrier: There is no joined up national system.	**Policy documents on screening and control of transmission to be disseminated to the group after the meeting (AK)** **Group members would review and preferably feedback comments to AK for collation. AK will prepare a response document to MC in advance of the next meeting.**

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	CBB added that the public were told up front about MRSA and there was public appreciation of that. SK also pointed out that a different communication package would be needed for long-term care facilities. HH stated that communications were important and that it would be discussed at the next meeting. With regard to extant guidance, simple coherent guidance is required. This must also cover niche areas such as long-term care facilities, health care workers, and primary care.	
6	**Surveillance datasets** MC advised the group that there are currently three sources of data: 1. CPE Reference Laboratory (CPERL) 2. BIU 3. HPSC He advised that the CPERL data was based on the submission of isolates. It was passive data, but was timely and de-duplicated, and includes private hospital data. Whole genome sequencing is carried out on isolates. They have noted that with OXA48, there are two closely related plasmids appearing. Because the workload has increased substantially (a fivefold increase in the volume of samples since inception), there is a need to review what can be done and what resources are required. MC advised of a strong relationship with BIU. Formal reporting comes from the general manager in the hospital. They must sign-off and thus accept responsibility for the data submitted. KPIs include the number of screenings carried out, the number of positives, the number of patients not isolated overnight, and the number of grams of meropenem used. In response to a question from MOB, monthly outbreaks will also be included on the BIU return. A monthly meeting is held with BIU to review data and feed comments back. Weekly data was initially requested, but this was too much of an administrative burden, so monthly data has been submitted since October last. A reconciliation piece between the number of CPEs reported by hospital and the number of CPEs in the reference lab still has to be thought out and resolved. RC advised on the datasets available in HPSC. EARSnet data is captured for invasive bloodstream infections only, and is limited to only *Klebsiella* spp. and *E. coli*. It provides background data on the level of AMR. There is enhanced surveillance for CPE, which is voluntary, with all hospitals participating (in principle). However, some do not submit data. The data captured includes patient age, clinical or screening sample, in-hospital transmission, infection developed/treated. Further to that, all outbreaks and infections caused by unusual pathogens are notifiable; CPE fits into this. However, many hospitals don't notify their outbreaks. Is the answer to make CPE notifiable? This would ensure better	

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	information and the sharing of data. However, there have been issues in sharing of data because of new EU data protection regulations. Data is available on community AMR at county level, antimicrobial consumption (AMC) in hospitals (data submitted quarterly, but currently reported bi-annually due to resource issues). Monthly AMC data is required, with hand hygiene data providing a context. HH asked if the CPE data could be rationalised to have quick, useful, easily collected data. KK advised that NPHET are requesting that all CPE is notifiable. BIU is important in terms of hospital data, with data from the CPERL supporting that. MC added that BUI is performance management data that the General Managers should be reviewing and proactively addressing anyway. Currently they await feedback that they have exceeded targets prior to addressing. RC added that as the group work through the guidance and find the non-negotiables, these will inform the data for improvement and the data for performance, which differ from each other. All agreed that data should be timely, suitably formatted and should be "one touch" data. KK asked how to get data on antibiotic prescribing as only meropenem data is currently available. MC advised that it was important that people providing the data knew what it was being used for. SK advised that there is no surveillance in some areas, and asked how this could be addressed. MC added that there could be financial implications to providing the data (or not), where funding would be removed from hospitals not carrying out screening and funnelled to hospitals carrying out screening. MOB asked if the right people were being screened. MC said no, that this would follow on.	
7.	**Administration and Workings of the Expert Group** HH advised that this had been covered. The work would take place between meetings. Official sign-off would take place at meetings. It was asked of the group that they comment on every document they are asked to review, even if there are no edits required. Input is required from everyone in the group. It is also important that all documentation include a version and date on each document. KK confirmed that NPHET currently meet monthly. It is envisaged that this group would eventually meet 4-6 times per year. HH said he would like to stick to 1.5/2 hour meetings if agreeable, and of course if possible given the issues to discuss. HH advised that a declaration of conflict of interest was important and would be addressed at the next meeting. CC noted that there was no national definition of CPE. KK advised that a formal definition would be available when it became notifiable. Definitions for hospital acquired and community acquired CPE were also required. JF commented that the move from the use of CRE to CPE should	**Feedback table to be drafted by KK and disseminated to the group by AK**

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	be reflected in HPSC documentation. RC commented that the WHO and ECDC use CRO (carbapenem resistant organism), and asked which do we use and where do we draw the line. KK advised that there were four actions from the meeting: 1. Extra members to be recruited 2. Circulate papers for review 3. Circulate papers for comment/information (separately) 4. Circulate a feedback table for completion	
8.	**Next Meeting** It was agreed that the next meeting would be held at 10.30am on 10th January 2018 in HPSC offices.	**Reminder to the group (AK)**