31 July 2008

Gateway ref: 10324

To: SHA Chief Executives
SHA Directors of Finance
SHA Directors of Nursing
SHA Directors of Performance

cc PCT Chief Executives (via weekly bulletin)
NHS Trust Chief Executives
NHS Trust Directors of Infection and Prevention Control
NHS Trust Directors of Nursing
NHS Foundation Trust Chief Executives
NHS Foundation Trust Directors of Infection and Prevention Control
NHS Foundation Trust Directors of Nursing

Dear Colleague

MRSA SCREENING – OPERATIONAL GUIDANCE

This guidance is aimed primarily at Chief Executives, Finance Directors, Directors of Nursing and Medicine, Directors of Infection Prevention and Control and their teams, medical microbiologists, laboratory managers, bed managers, and those running pre-admission clinics and admission units.

Aim

This guidance is to support NHS trusts in introducing MRSA screening for all elective patients by the end of March 2009.

It builds on previous guidance “Screening for MRSA colonisation – a strategy for NHS Trusts: a summary of best practice” which is available on the Department of Health website at
This guidance document clarifies:

- what is meant by screening;
- which patient groups should be screened;
- how the NHS should assure itself that performance data are robust in reporting achievement of the commitment; and
- what data DH will collect from each trust to provide assurance at a national level.

This guidance updates the existing guidance but does not replace it. It does not prescribe how the NHS should deliver the commitment. This is a matter for local determination.

**2008/09 Operating Framework Requirement**

There is a commitment in the 2008/09 Operating Framework to introduce MRSA screening.

“Meeting the challenge of HCAI will require additional actions across the system for 2008/9, including: introducing MRSA screening for all elective admissions from 2008/9 and for all emergency admissions as soon as practicable within the next three years.”

**Context**

Following the previous guidance, *Screening for MRSA colonisation*, all trusts should have reviewed their screening policies, identified patient groups for screening, and implemented a decolonisation regimen for people identified as carrying MRSA, both to reduce their risk of infection occurring in themselves and the spread of MRSA to other vulnerable patients.

Further guidance will be issued as necessary, including guidance on screening emergency admissions.

**What is screening?**

MRSA screening is the microbiological testing of a sample taken from the potential carriage sites of a patient on or before admission. It is the process by which patients who are colonised with MRSA is identified. They must then be actively de-colonised. It is not about deciding which groups should be considered for testing: all relevant elective admissions should be actively screened.

**Which patient groups should be screened by March 2009?**
All elective admissions should be routinely screened. We have identified within elective admissions and attendances, the following patient groups who should not be routinely screened:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures, eg, warts or other liquid nitrogen applications
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics except for elective caesareans and any high risk cases, i.e. high risk of complications in the mother and/or potential complications in the baby, (e.g. likely to need SCBU, NICU because of size or known complications or risk factors.)

In addition, it is important that trusts continue locally to assess all their patient admission groups for screening according to risk – as advised in the existing guidance.

**How should patients be tested?**

There are four types of suitable screening methods; which one is used should be decided locally. They are:

a) PCR test (rapid testing)
b) Rapid enrichment and immunomagnetic/bioluminescent detection
b) (Chromogenic) Agar plating (direct culture)
c) Broth enrichment culture followed by agar subculture

**How should performance be measured?**

From 1 April 2009, each NHS or other organisation that admits and treats NHS elective patients will have to assure itself, its patients, commissioners and the Department of Health that it is delivering the MRSA screening commitment. Providers, commissioners, SHAs and DH will also want to understand progress on delivery of this commitment in the period up to April 2009.

As a minimum, providers should ensure that robust local processes are in place to count the overall number of these MRSA screening tests completed as part of preparation for elective admission, and the number of positive tests and compare these numbers against the actual total number of relevant admissions or attendances in the same period.

This “matched census” approach, which looks at overall numbers of screening tests and the numbers of relevant patients admitted or attending rather than patient level data, is to balance the need for assurance against avoiding unreasonable additional data requirements. There is no reason, however, that patient level data should not be collected if that is what is decided locally.
Information on matching should be shared routinely between provider and commissioner and there should be local assurance that the match is of at least 1:1 ratio. Ideally, there should be more tests than relevant admissions and attendances to account for re-testing following de-colonisation, and other reasons for patients requiring multiple tests. This will be locally determined.

**DH Monthly Return**

To support this process, DH will put in place a routine monthly return to allow trusts to record:

- the aggregate numbers of tests undertaken on patients who should be screened; and
- the numbers of admissions and attendances of elective patients who should be screened using the broad definition in this guidance.

We recommend that trusts and commissioners agree locally the cohort of patients that should be screened and report these each month.

Subject to ROCR approval, this information will be collected from October 2008 i.e. the first data collection will be on activity in September 2008, reported in October 2008, to allow high-level assurance that progress is being made to ensure screening is in place in every trust in line with the commitment in the Operating Framework. It is for trusts to agree with commissioners any local mechanisms to allow assurance of the make up of the reported aggregate figures. Further details including the template for completion will be published on Unify on 11 August 2008.

**18 Weeks**

The requirement to screen elective admissions is not expected to nor should it have an impact on the delivery of the 18 weeks target.

Yours sincerely

Dame Christine Beasley CBE
Chief Nursing Officer

David Flory
Director General
NHS Finance, Performance and Operations