Minutes of the 31st meeting of the Strategic Infection Prevention and Control Advisory Group (SIPCAG) on 10 November 2021, 9am–12pm, via zoom

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Present:	Arthur Morris, Claire Underwood, Gillian Bohm, Greg Simmons (Chair), Janine Ryland, Jocelyn Peach, Jo Stodart, Lynne Downing, Max Bloomfield, Sally Roberts, Ngāpei Ngatai, Susan Barnes, Sue Wood
In attendance:	Amanda Wood, Jeanette Bell, Marie Talbot (minute taker), Nikki Grae, Ruth Barratt
Apologies:	Andi Shirtcliffe, Anne Hutley, Claire Doyle
Did not attend:	Josh Freeman

1. The meeting began at 9am. Greg Simmons opened the meeting with a Karakia, announced apologies, and requested members to introduce themselves. There was one change to the declaration of interests register for Arthur Morris.

2. Minutes of the previous meeting held 30 July 2021

The minutes were accepted as a true and correct record.

Matters arising:

- Follow up on timeframe for engagement of consumer representatives on the National Infection Prevention and Control Expert Group (NIPCEG). Complete – Nikki Grae has contacted the organiser of NIPCEG. While the group is looking to ensure that there are consumer representatives, they are currently in transition and reviewing their terms of reference and membership.

Papers for noting:

- The DHB chief executives' (CE's) August 2021 report was tabled and noted.

3. Clinical Lead update

Sally Roberts provided the group with a written report.
A specific item mentioned:

- A paper, 'Using a randomized control trial to test the effectiveness of social norms feedback to reduce antibiotic prescribing without increasing inequities', has been published. This piece of work was set up by Catherine Gerard in 2019. Further work planned for 2020 was put on hold due to the COVID-19 pandemic and it's hoped to continue with this when possible.
  This work was led by the Behavioral Insights Team, who started as The Nudge Group, in the UK Ministry of Health. They now have an office in Wellington. They are currently contracted to the Ministry of Health (MoH) looking at Infection Prevention and Control (IPC) practices within Managed Isolation and Quarantine (MIQ) spaces and support IPC guidance for people isolating at home.

This is a great group to be aligned with and Sally will update SIPCAG on the COVID-19 work once completed early next year.

4. Surgical Site Infection Improvement (SSII) programme update

Arthur Morris and Emily Mountier gave an update on the SSII programme which covered the following points:

- Fourteen District Health Boards (DHBs) are now doing light surveillance, which means they send in denominator data via a CSV extract and do an investigation of each SSI that includes the completion of a full data set. The remaining six DHBs have opted to continue with full surveillance.
  As part of the move to light surveillance a deep dive tool[1] has been developed that provides a structured checklist DHBs can apply to deep or organ space infections, going through pre-operative, perioperative, and post-operative factors that could contribute to an SSI. This will provide local teams with areas of focus for quality improvement.
  The IPC team is working to present real time changes in trends to DHBs using monthly data collection. This feedback will be in the form of CUSUM charts, a form of control chart designed to show small changes in process over time and will be presented to SIPCAG at the next meeting.
- A brief update was given on changes made to the orthopaedic SSI dashboard, to accommodate the change to light surveillance and national rates for risk factor reporting. Due to light surveillance DHBs not being required to submit full process measures data, their risk factor data and analysis will be reported as counts on a separate tab. Where the DHBs are supplying full data, rates are shown.
  An equity view, previously included in the Quality and Safety Marker reports, has been added to the orthopaedic SSI dashboard. This allows DHBs to view 12 months rolling data by broad ethnic groups and is done by matching with the National Minimum Data Set (NMDS) data. A time lag getting the NMDS data means ethnicity reporting is several months behind the other data on the dashboard.
  The cardiac SSI dashboard has not been changed but a recent drop has been observed in the rate of procedures achieving timing and post-operative antibiotics quality and safety markers, over the last few quarters. This is being followed up with DHBs to check if this is due to data collection issues or changes to process.
- The impact of the anti-staph bundle, designed to reduce staphylococcal SSI cases, is being assessed. This bundle was implemented in 2 cohorts and included several DHBs and private surgical hospitals (PSHs). A before and after comparison will be presented at the next SIPCAG meeting.
- The adherence to two-gram doses of antibiotics for adults is complicated by the fact that Pharmac NZ only funds one-gram vials. A submission to Pharmac NZ to fund two-gram vials has been accepted and this will be included in the next tender round for supply.
- Notification from six DHBs have been received regarding difficulties submitting SSI data, for the current quarter, due to COVID-19 impacts. Some DHBs data will be delayed while others will need a postponement of one quarter's data. In some cases, the DHB will catch this up later but for others there will be a gap in their data.

[1] Orthopaedic Light Surveillance Deep Dive Tool name changed to SSI Investigation tool following this meeting and prior to launch of the final tool

- Jeanette Bell gave an overview of the SSII programme champions survey (26 July – 18 Oct 2021) results. The purpose of the survey was to seek feedback from SSI champions on light surveillance and to inform future programme training and support requirements. The survey was emailed to 45 SSI champions and 19 responses were received from 16 DHBs. 84 percent of respondents had more than 2 years' experience with the programme and 67 percent were using light surveillance.
  Key findings included:
    - 50 percent had no cover for the champion
    - Light surveillance is easier and saves time (33 hours saved per quarter on average)
    - The deep dive tool could be made easier to use
    - Required data collections timelines are OK
    - SSI dashboards are used and shared with other teams for quality improvement
    - The national SSII programme team respond and assist quickly
    - Finding information on the HQSC website could be improved
    - More training requested on using the national monitor and dashboards, the deep dive tool and supporting new champions

  Next steps will include three training webinars, a national monitor guide and a review of the deep dive tool. The HQSC website is currently being updated.
- Nikki Grae gave an overview of a set of examples of healthcare associated infections (HAI) for the adverse event Severity Assessment Codes (SAC). Currently the national Adverse Events programme, which is managed by the Commission, does not have/highlight any kind of HAI infection examples for these codes. Reporting by DHBs is inconsistent, the level of reporting of HAIs as SAC events by DHBs is unclear, and there is significant variability in the types of infections that are reported. The national Adverse Events Policy and SAC example lists are being reviewed over the next eight months, so the IPC team is working with the Adverse Events team and Quality and Risk Managers to ensure that there are HAI examples included in the updated list, for example, types of orthopaedic SSIs. This will provide clarity for DHBs regarding the types of HAIs that constitute a SAC one or two event. The deep dive tool has a table of the parameters in which the SSI should be reported as an adverse event and completed forms can be uploaded to the national Adverse Events programme thus providing a mechanism for their collection.

Comments:
Sally Roberts highlighted the discussions about national data collection as we move to the new health structure. The IPC Programme needs to make sure this is a focus so that IPC are included.
Nikki Grae agreed this is an important focus and mentioned that the IPC team is in communication with the MoH to understand their national strategy and ensure alignment. Currently the national monitor is a separate system for SSI data collection/warehousing and is inflexible regarding adding future HAI surveillance. Nikki suggested that discussion around this would be a good agenda item for the next SIPCAG meeting.
Sue Wood commented that current SSI data collection, outside of the Commission's programmes, isn't validated and not necessarily meeting definitions. Bringing more clinical information, so that data is validated, is important. Nikki Grae agreed with this

and mentioned that members of the Public Health team, at the MoH, understand the need for clinical input and decision making in HAI surveillance.

5. Hand hygiene (HH) programme

Sally Roberts introduced Amanda Wood, the new IPC specialist at the Commission with responsibilities for HH. Amanda then gave an overview of upcoming activities:

- Amanda will touch base with HH leads, over the next few weeks, to introduce herself
- A national HH meeting is planned for February 2022
- A celebration of 10 years of HHNZ data collection will be organised and promoted
- Analysis of HH moments by ward type will be completed

Sally Roberts gave a preview of the latest HH results:

- The high HH compliance rate, for DHBs, has been sustained and is now 87.5 percent. This is a great result as most of the auditing is completed by IPC teams who have been under a lot of pressure with the COVID-19 workload. The number of moments collected is down for several DHBs.
- The rate of healthcare-associated *Staphylococcus aureus* bacteraemia (HA-SAB) has been the outcome measure from the start of this programme. Overseas countries use HA-Methicillin-resistant *S. aureus* (MRSA) bacteraemia rates if it is endemic in hospitals in that country. As MRSA has never been endemic in New Zealand hospitals it was decided to use both MRSA and methicillin-susceptible *S. aureus* (MSSA). Despite sustained improvement in hand hygiene compliance the HA-SAB rate has continued to increase.
- The IPC team has been working with 21 private surgical hospitals (PSHs) that have registered with the programme. For the first time aggregated data for the PSHs is included in the national compliance report. The overall compliance rate was 82.4 percent. 17 PSHs achieved a compliance rate of 80 percent or above and met or were within 100 moments of the required number of moments.

Ruth Barratt gave an overview of the recent data collected reviewing the HA-SAB source. The points covered included:

- The Commission doesn’t currently collect data relating to the source of HA-SAB so DHBs were invited to submit data from 2017 to June 2021.
- All 20 DHBs submitted data but some was partial or incomplete, as a result we don’t have a complete data set.
- The total MRSA isolates decreased from 12 percent to 8.4 percent, during that time and three quarters of MRSA events were from the metro Auckland DHBs and Northland DHB.
- Most DHBs collect some level of source information but categorize the data in different ways. Work is ongoing to re-categorise the data in a standardised way. A few principal statistics were shared with the group related to the HA-SAB percentage in each category:
  - Devices - more than 50%
  - SSI – 10.9%
  - Non-surgical organ sites – 7% (for example burns and pressure sores)
  - Other procedures 6.2% (for example insertion of pacing wires and epidurals)
  - Neutropaenic sepsis – 3.2%
  - Pneumonia – 2.5%
  - Unknown / not provided – 14%

For devices the breakdown was:

- Central venous catheters (CVC) – 50.6%
- Peripheral intravenous catheters (PIVC) – 45.1%
- Indwelling urinary catheters (IDC) – 3.2%
- Arterial vascular catheters – 0.6%
- Ventilator associated pneumonia (VAP) – 0.3%
- Suprapubic urinary catheters (SPC) – 0.1%

The main finding was that rates of PIVC associated SAB have increased. 453 events were attributed to CVC and of these the type of CVC was reported for 222 events:

- 60 peripherally inserted central catheter (PICC)
- 37 implanted Portacath
- 109 tunnelled CVC – including Hickman and tunnelled dialysis CVC
- 16 other

The Commission is developing a tool to support collecting of SAB source data in a more systematic way and standardizing categorization nationally.

- Sally Roberts commented that the 14 percent of unknown sources is higher than what is reported in other countries such as Scotland. ADHB has reviewed all their unknown sources and been able to identify a source for about 60%. SR will provide the poster on this work presented at the ASID (NZ) Sepsis meeting in Nov 2021. The Target CLAB ZERO programme collected data at a national level but when it was complete this role was transferred back to DHBs. Since this programme ended it is unclear if all DHB ICUs still have an active CLAB ZERO programme. It may well still be collected by ANZSIC. SR to find out and report at next meeting.
- Max Bloomfield commented that one of the issues is denominator data in terms of interpretation of this type of data over time. While this is difficult to collect, both within ICUs and outside, it's still very important.
- Sally Roberts commented that ADHB have the rates reported per thousand inpatient bed days, capture line days for renal for people who have tunnelled lines and have started to capture line days for adult haematology. This has identified there are some issues, but the small numbers and large swings make it difficult to interpret the data but over time it may be clearer.
- Sue Wood commented that a SAB source data collection tool needs to be integrated with Adverse Event processes. Sue also invited the IPC team to be involved with the development of an electronic fluid balance chart at CDHB so the labelling of lines and catheters will be the future information that would go into ICNet. Sally Roberts endorsed Sue Wood's comment and mentioned that ADHB is using ICNet to capture line days in their adult haematology unit and intend to roll this out in other units. Sue Wood mentioned that line days can be captured in their fluid balance chart. There is the potential for this chart to be part of a national programme.
- Gillian Bohm asked if any of the ANZICS data, held by the Commission, is being utilized with this work? Sally Roberts responded that she was unaware of this and the team would look at it.

6. Health antimicrobial resistance coordination committee (HARC) update and National antibiotic prescribing survey (NAPS)

Claire Possenniskie joined the meeting to update the group about HARC and NAPS. Claire's role at the MoH changed six months ago and now includes antimicrobial resistance (AMR). The Ministry launched the AMR action plan in 2017 but progress with

implementing this has been challenging, so Claire is reviewing the status of the plan, the implementation of actions and the priorities, which are mainly driven by the Minister and Associate Minister of Health. At a HARC meeting recently there was an opportunity for Claire to check in with the group and discuss these issues. There have also been meetings with the AMR governance group, who are joint leads for the AMR action plan and sit across the MoH and the Ministry for Primary Industries, focusing on the same issues. Minister Verrall has asked for advice on what the priorities will be over the next 2-3 years. IPC is one of the five main objectives of the AMR action plan, so Claire is working closely with the IPC team at the MoH, particularly around the development of the National IPC Strategy to ensure there is a forward plan for AMR.
Another piece of work Claire has picked up is NAPS. Notification has been received that New Zealand's access to NAPS is going to be discontinued even though it has a lot of value and support for it to continue. Contact has been made with the Australian team who run NAPS and an interim arrangement has been set up through to March 2022 to keep current access. Work is underway to define, longer term, what a sustainable connection with NAPS should be and the possibility of having a national programme to support NAPS. It is recognised that there is a need, that it will require resource and that funding will need to be resolved.
Comments and questions:

- Sally Roberts commented that it's an excellent programme and to have a long-term relationship with the Australian team as well as a New Zealand version of NAPS would be fantastic.
- Nikki Grae commented that NAPS is a point prevalence survey, so it's completed annually. If it is set up nationally then it would be a great multi-agency programme and would enable some quality improvement structure and support. Something that hasn't been explored are the various modules within NAPS, which would provide an opportunity to explore prescribing behaviours in a number of settings, for example, residential care.
- Ngāpei Ngatai asked how NAPS fits with addressing inequalities? Claire Possenniskie responded that having transparency and more data will give visibility of prescribing and opportunities to see where variations in practice and inequalities are. It will then allow the sharing of different approaches and learnings.
- Sally Roberts commented that it's also important to share the capability to deliver NAPS nationally.
- Arthur Morris commented that if 'you don't measure it then you can't manage it'. One of the biggest things that IPC has suffered from is lack of IT/database integration and data access which would allow connectivity with ethnicity and poverty. It's essential that there is an integrated health data sharing process to enable identification of problems and quality improvements to correct them.
- Ngāpei Ngatai acknowledged the previous comment and remarked that at the end of the day it comes down to the patient being at the centre.
- Sue Wood commented that there is significant implicit bias in the system and work is needed to understand this. IPC is seen as the responsibility of IPC departments but in actual practice it is organisation/region wide.
- Janine Ryland asked about the timing for advising Minister Verrall? Claire Possenniskie responded that this is ongoing and went on to mention that the Office of the Prime Minister's Chief Science Advisor has had a key project this

year around infectious diseases, including AMR. A report on this will go to the Prime Minister by the end of 2021.
- Sally Roberts commented that IPC is seen as something done on wards by nursing staff and maybe a change of name would ensure that IPC has medical engagement and that multi-disciplinary teams deliver IPC within DHBs. Very little medical FTE for IPC nationally which reduces the medical voice and inclusion in discussions. Many countries now use the term 'Healthcare associated infections and antimicrobial resistance' to define their national groups.

Claire Possenniskie left the meeting.

7. Point prevalence survey (PPS) update

Arthur Morris and Emily Mountier gave an update on the PPS which included the following points:

- A recap of the survey purpose, objectives, and approach
- The smooth running of the survey was a result of the preparation by the IPC team and the high level of support in DHBs
- The PPS sample included 5,469 patients and 423 active HAIs identified in 361 patients. The estimated point prevalence per 100 patients was 6.6% with an estimated rate per 100 patients of 7.7%
- Patient demographics included a median age of 70 years, an almost even split between females (52.8%) and males (47.2%), ethnic group representation was similar to the general population (Māori – 14%, Pacific peoples – 7.5%, Asian – 7.4%, European – 69.4%), Other ethnic groups – 1.6%)
- Most admissions were for acute cases, 70%, and the remaining 30% for arranged (elective) admissions
- The number of patients by service type: Medical – 40%, Surgical – 36.8%, Rehabilitation/Older persons' care – 13.8%, Obstetrics & Gynaecology – 7.8%, and ICU 1.6%
- Rates of HAIs by service type did differ: Medical – 4%, Surgical – 8%, Rehabilitation/Older persons' health (OPH) – 3%, and ICU – 23%. These risk factors will be explored further during analysis
- For targets of intervention, two thirds of patients had some sort of device – 65.6% (PVC - 53.4%, CVC - 10%, IDC – 17.7%, and ventilator - 1%). There are bundles of care for all these devices, so the IPC team will be looking to see if widening the spread of the bundles, supporting/auditing their use could have benefits for patient outcomes
- 308 patients (85.3%) had one HAI, 45 (12.5%) had two, 7 (1.9%) had three and 1 patient (0.3%) had four infections
- The four infection types with the highest numbers were Surgical site – 104 (24.6%), Urinary tract – 80 (18.9%), Pneumonia – 75 (17.7%), and Bloodstream – 55 (13%). These four make up between two-thirds and three-quarters of all HAIs
- For device-associated infections, of the 39 urinary tract infections, 48.8% related to urinary catheters, of the 14 bloodstream infections 25.4% related to IV catheters, of the 13 pneumonia events 17.3% were associated with invasive ventilation and of the 3 local infections, 18% related to IV catheters. Again, there are bundles of care around all of these and the IPC team will be investigating which is most important

- About 70% of SSIs are either deep (26.9%) or organ space (40.4%) and the health costs for these are an additional $40,000, while from the patient perspective, more than 40 additional days in hospital.
- In relation to demographics, for ethnicity alone, differences between ethnic groups and HAI rates were not found. By age group the breakdown was 18-40 (11%), 41-64 (30%) and 65+ (60%). By sex there was no statistical difference between male and female. Some next steps for analysis include:
    - A complete review of univariate analysis of possible risk factors
    - Multiple logistic regression model of risk factors
    - Regional variations
- PPS next steps include:
    - HQSC Board paper with findings – 26 November
    - Review most common HAIs
    - Review published bundles to reduce HAIs
    - Prioritise possible interventions
    - Publication and presentations of findings
    - Develop a plan for reducing HAIs that will be presented to SIPCAG and the HQSC Board and other key stakeholders and finally signed off by the HQSC Board

Comments and questions:

- Gillian Bohm asked if there was any impact over the time of the survey and COVID levels in relation to acute versus planned care? Arthur Morris responded that all the DHBs were at the same COVID level over the course of the survey. Gillian also commented that the HQSC Board will want to know what, from this data, is new for New Zealand, and/or shows why the project was worthwhile?
- Janine Ryland asked how costing to the system is going to be determined and if ACC costs and clients claim entitlements will be included within scope as these are significant costs for ACC in relation to treatment injury? Arthur Morris responded that this would mean linking the PPS and ACC data which would include getting additional consents. The costs may not include this which would need to be acknowledged but if there is ACC data that is available it may be possible. The overall structure of how the costs will be calculated is yet to be finalised.
- Sue Wood commented that she is interested in which groups are notified and which ones are not and if this creates a bias.
- Sally Roberts commented that the impact on patients and their whānau/family is another aspect that would be great to better define, for example lost income. Also, the impact on primary care, for patients that don't require readmission to hospital, isn't captured. How an individual experiences an event will be a focus and patient stories are a great way to engage people.
- Nikki Grae asked for any data analysis recommendations from the group. Sue Wood responded that comparisons with the national coding data would be good and would help with CDHB's ongoing monitoring. Nikki Grae asked if CDHB has a code set they use and if this could be shared and Sue Wood agreed to do this. Arthur Morris commented that the surveillance definitions going to be used will be quite specific, which needs to be kept in mind. It would be more important for the PPS to pick up a significant HAI that isn't coded. Sally Roberts commented that as the PPS was completed on a single day, not all HAIs would have been

captured because they might have been identified while a patient was still in hospital but after the survey was completed, so there would be some variation. Max Bloomfield commented that CCDHB completed an analysis for accuracy, on postoperative coding, and it was found to be extremely inaccurate because coders take key words from the patient notes which are often entered by junior members of the medical team. Arthur Morris asked what the main question Sue Wood would want answered if this matching was done? Sue Wood responded that for improvement projects, around bundles, it would be good to have an easy way to monitor changes. Sally Roberts commented that for any improvement projects, particularly around devices, the documentation will be a crucial part of the programme.

Action: Sue Wood to share the code set that CDHB uses for ongoing monitoring of HAIs with the IPC team.

8. Strategic IPC initiatives in community care settings discussion

At the last SIPCAG meeting Andi Shirtcliffe asked the group if they had considered the merit of IPC initiatives in community care settings considering the importance of antimicrobial resistance and the fact that most antibiotics are prescribed and consumed in the community and that DHBs' responsibilities are wider than just hospitals. It was agreed at the time to add this to the agenda for the next SIPCAG meeting for discussion. Greg Simmons asked for the group's views on what this might look like and then possibly a way forward.

Comments:

- Sue Wood – The timing is a problem with the move away from DHBs and some underpinning principles are needed to be able to have the discussion.
- Sally Roberts – This sits in a way with NIPCEG. To date there has been very little IPC support in the community and multiple different organisations are writing their own IPC guidance without any IPC input. This reflects how little investment there has been in New Zealand across the IPC workforce and the lack of capacity. Sally asked if there might be capacity for secondment within larger ARC facilities that have IPC expertise. Until there is a national strategy that builds up a workforce across the whole sector it's hard to see how any initiatives, in a community setting, could be undertaken.
- Sue Wood – There isn't any community data, other than lab data which doesn't mean a diagnosis, so there is no information about infections in general practice.
- Sally Roberts - any data that is collected stays within the sector, it's not shared widely. NIPCEG does have wide representation across the health sector but people don't always come with the expertise or capacity required to ensure delivery that meets their needs. Hopefully through NIPCEG and the new health structure, a strategic plan will be put in place.
- Arthur Morris – Some people think ARC is just the larger organisations that are profitable and therefore able to fund their own resources, but there is a disconnect with providers of hospital level aged care which are mostly charities that can't fund IPC resources.
- Greg Simmons – Agreed that this issue sits with NIPCEG. Having recently been involved with management of COVID-19 in elderly care and disability facilities, has seen how variable IPC practices can be in those settings.

- Jocelyn Peach – Dr Frances Hughes and Cheyne Chalmers, two nurse leaders of large national groups in aged care, have put together a group to try and address some of these issues by creating structures and systems that clearly address the standards, that can then be shared. Jocelyn recommended contacting/consulting this group.
  Waitemata DHB has had several aged care facilities that have been impacted by COVID-19 so have had their IPC nurses go in to complete audits, remedial work and provide resources and training. The DHB tried very hard to connect using electronic learning opportunities.
- Sue Wood – Highlighted that aging in place, and people who visit general practices routinely, need IPC as well and are part of the strategy so also need to be considered. Sally Roberts agreed that ways to engage and work with this group needs to happen.
- Jo Stodart – SDHB has appointed three fixed term, part-time IPC roles for ARC that will finish in July 2022. This has enabled SDHB to complete readiness audits around COVID-19 with the approximately 70 ARC facilities in the region. Discrepancies have been identified between IPC nurses audits and HealthCERT findings.
  Even when extra resources are funded there is then the issue of recruitment and retention of staff. IPC needs to be more attractive to staff, which includes pay rates and better systems.
- Ruth Barratt – There has never been a national model for DHB IPC teams to provide resource(s) to the community. There is a responsibility for larger providers to invest in IPC resources and some of them do. As a result of the COVID-19 outbreaks Australia now mandates that every individual ARC facility needs to have a named IPC lead who has completed certified education. In primary care, the delivery of IPC education is very focused on the Cornerstone quality programme, but this has a very limited scope in terms of IPC. Expanding this might be one way to improve IPC education in the primary care sector.
- Nikki Grae – has been in contact with Ruihua Gu from the MoH and HealthCERT, who is a member of the Commission's ARC leadership team, who indicated that they are appointing an IPC specialist in the HealthCERT team.

9. Group representative updates

- **The Australasian Society of Infectious Diseases (ASID)** – As Max Bloomfield had to leave the meeting early Sally Roberts updated the group. The Australasian Society of Infectious Diseases New Zealand Branch virtual conference, in conjunction with the Sepsis Trust is being held in mid-November and there will be Commission representation.
- **National IPC Expert Group (NIPCEG)** – Nikki Grae gave a brief overview of this group who, despite delays due to COVID-19, has been meeting when possible. The group has been working on the National IPC Strategy over the past few months. The purpose of this strategy is to enable leaders in planning and coordination roles to make informed decisions that will support the reformed health system to reduce HAIs and antimicrobial resistance over the next five years and onwards. The strategy is intended to strengthen whole system integration and collaboration and to be relevant to any setting where healthcare is delivered, so there is a wide range in membership. There are five workstreams: leadership and governance, IPC workforce capacity and capability, surveillance risk and monitoring, environment equipment and

infrastructure and outbreak management. Each workstream has a high-level goal which are currently being finalised as well as a review of the stakeholder list. The strategy is a high-level document and underneath this will be a national work programme which also needs to be developed. Further discussion regarding how to connect and align the antimicrobial resistance and stewardship groups with the IPC groups is needed. There is an opportunity to ensure that pharmacies, IPC, labs and infectious disease physicians are linked. Once the strategy and work programme are completed, they will go out for widespread feedback across the sector. The plan is for the MoH to oversee the implementation of the strategy however the resourcing commitment to do this has yet to be defined. The terms of reference for the group are also being reviewed to ensure the name and membership are fit for purpose. Not all NIPCEG members are experts in IPC which may mean that a separate expert group, that sits alongside NIPCEG or within certain workstreams, is required.

- **The IPC Nurses College** – Jo Stodart gave this update. The College has just launched their new website. Their education programme has been well received and resources/funding are being sought to develop more modules. The annual conference was cancelled and has been rescheduled for June 2022. A zoom meeting, that included education, has been held and was well received by members. Another meeting in early December is planned. Jo commented that the IPC workforce is exhausted, and the college have asked the Commission to offer support to the IPC workforce, and to minimise the requirements for data collection as much as possible.
- **ACC** – Janine Ryland gave this update**.** Development of national antibiotic guidance is still planned, and Synergia has developed a scoping report. Currently ACC is waiting for direction from the MoH on how this will progress. A report by Synergia on HAI guiding principles, with a recommended approach for rollout, is due shortly. Support for the rollout of ICNet, Northland, Southern and Waikato have started implementation. In the midlands region, Tairawhiti will be the only DHB without ICNet so contact will be made to offer them support with this and Counties Manukau have expressed an interest in joining the Northern region. The development of co-designed resources for a New Zealand aseptic technique education package is planned with a pilot to start early next year. Know Your IV Lines has been implemented in 6 DHBs with others planned in the new year. Strategically, infections remain a priority in the treatment injury area but next steps over the coming one to two years, will be impacted by COVID-19. While not wanting to put pressure on the frontline due to COVID-19, would it be better to put more focus on enablers? Any feedback on this to be emailed to Janine.

10. General Business

- Nikki Grae gave a quick update on a sepsis stocktake that is planned by the IPC team. The team has worked with ACC to provide assistance to Taranaki DHB to implement the Sepsis Ready programme, originally designed by Waikato DHB. The programme has been very successful with focus on equity and working with the Māori health outcomes team throughout. In mid-November the National Sepsis Action Plan will be launched by the Sepsis Trust and the Commission has been asked, what could the Commission do to support this plan. To understand how we could provide quality improvement support, the team has decided initially to do a stocktake of the current management of sepsis in New Zealand. Specific providers

will be targeted: DHBs, a representative sample of PSHs, private 24-hour emergency care services and national ambulance services. The stocktake will look at current practices/protocols, data collection in place and opportunities for improvements. The work will be contracted out and will take approximately six months to complete.

- The Commission is also asking for feedback on what work Commission staff could undertake during a COVID-19 outbreak to support the IPC sector. Feedback to be emailed to Nikki Grae.

The meeting was closed at 12pm with a Karakia.

Action list following SIPCAG meeting 10 November 2021

Action No.	Meeting date	Topic	Action required	By whom	Status
1.	10 Nov 21	PPS	Share the code set that CDHB uses for ongoing monitoring of HAIs with the IPC team	Sue Wood	
2.		CUSUM reporting	Add to agenda for next SIPCAG	IPC Team	
3.		IPC standards in ARC	Jocelyn Peach mentioned that Dr Frances Hughes and Cheyne Chalmers, two nurse leaders of large national groups in aged care, have put together a group to try and address some of these issues by creating structures and systems that clearly address the standards, that can then be shared. Jocelyn recommended contacting/consulting this group.	Nikki Grae	
4.		IPC Team response to COVID-19	The Commission is also asking for feedback on what work Commission staff could undertake during a COVID-19 outbreak to support the IPC sector. Feedback to be emailed to Nikki Grae	All	
5.		ACC	Janine Ryland is seeking feedback on what enablers ACC can focus on during COVID-19.	All	