Minutes of the 24th meeting of the Strategic Infection Prevention & Control Advisory Group on 30 January 2019
1–3pm

Present:	Julie Patterson (chair), Sally Roberts, Mo Neville, Linda Shepherd, Sheldon Ngatai (from 1-2pm), Sue Wood, Jo Stodart, Josh Freeman, Tanya Jackways, Arthur Morris, Karen Orsborn and Gillian Bohm
In attendance:	Gary Tonkin, Andrea Flynn & Nikki Grae
Apologies:	Lorraine Rees
Absent:	Richard Everts

The meeting commenced at 1pm via Zoom.

1. Declaration of interest
There were no updates the declaration of interest register.

2. Minutes of the previous meeting held 3 October 2018
Correction to item 4 para 6. The minutes were accepted as a true and correct record. The action log was updated.

Matters arising:

Item 3, Accident Compensation Corporation (ACC) update – an update was requested on the status of the draft definitions document.

Action 1: ACC to provide a more formal update on the progress and next steps for the draft definitions document at the next face-to-face meeting (4 April).

Item 5, Surgical Site Infection Improvement Programme (SSIIP) less counting more preventing – Julie reaffirmed the national chief executive (CE) group's commitment to publishing district health board (DHB) identifiable data. In principal the DHB CEs are committed to open and transparent publishing of DHB level data by the Commission. Out of courtesy the national CE group would appreciate the opportunity to preview their data prior to publication.

Item 7, healthcare associated infection (HAI)/infection prevention control (IPC) matrix – there is still an opportunity for members to provide feedback on the draft HAI/IPC matrix. Only one response has been received.

Action 2: IPC programme team to resend the HAI matrix to members for feedback.

3. SSIIP options paper - future data collection associated with the orthopaedic programme

This item follows consideration in October last year of feedback from the sector and other information on data collection associated with the SSIIP. Nikki gave an overview of the options outlined in the paper and the benefits and disadvantages for each option.

Members were asked to request clarification on any of the points and make suggestions or offer alternative options.

Arthur signalled some potential refinements to the recommendations for prophylaxis timing and dosing based on more detailed analysis of the data. Multivariate analysis will be undertaken on the data to determine the significance of the findings.

The outcome of the multivariate analysis may alter current recommendations.

Possible refinements:

- an increase in dose (3g cefazolin) for those over 120kg
- recommending preoperative antibiotics are given 20 mins prior to knife-to-skin
- single dose of pre-operative antibiotics with additional perioperative antibiotics for long procedures, and no post-operative doses.

It was noted that there is not an international quality standard.

Any change to the recommendations must have a strong evidence base or the programme runs the risk of losing reputation with the sector.

Option 4 – abandon surveillance

All members agreed that option four should be discarded. No further discussion needed.

Option 1 – standard/full surveillance (status quo)

While Auckland DHB can capture a lot of their fields electronically making it is easier to carry out full surveillance this isn't the case for other hospitals. Southern DHB find the data collection very resource intense but they really value the data.

Option 2 – light surveillance

This option suggested full data collection for surgical site infection (SSI) cases would continue but reduced denominator data. A sub-option (b) suggested a threshold based on the SSI rate for the reduced denominator data to apply.

There was discussion about modifying sub-option b) based on adherence to process measures rather than the outcome measure. Practical implications were discussed.

It was agreed that sub-option b) should be discarded because it would be too difficult to implement in practice.

It was noted that light surveillance would ensure more time is available for IPC and surgical staff to review SSI cases in more detail which may lead to the identification of further opportunities for improvement. If the time freed from full data collection was used to expand SSI surveillance to other procedures, this could compete with the opportunity for further quality improvement activities.

Approximately 50 percent of DHBs don't do any other surveillance and SIPCAG should consider whether the programme should recommend another procedure or offer a suite of procedures to choose for surveillance, if reducing the level of surveillance for orthopaedic surgery. Having a choice would allow a DHB to choose a procedure that presents the most opportunity to reduce harm. Alternatively, instead of doing certain procedures DHBs could for example audit prophylaxis ie, dose, timing, or alcohol skin prep use and feedback using the quality improvement model.

It was suggested that a better use of time would be to require certain SSIs to be reported as an adverse event. It is important to recognise when there are diminishing returns and when the resources are better directed elsewhere.

Following up with Public Health Scotland may be useful, to better understand their experience of light surveillance.

Action 3: Follow up with the Public Health Scotland to better understand their experience of light surveillance.

Option 3 – intermittent surveillance

This option limits the ability to look at seasonality and surveillance would produce prevalence (proportion or rate of patients with an SSI for a given period) rates rather than incidence rates (new cases over time) for orthopaedic SSIs.

General comments

There is an opportunity to learn from those DHBs who have minimal manual data collection and those who have other healthcare workers or administrators entering data which frees up time for the IPC team. There is also opportunity to raise the profile within DHB leadership teams as they can assist with removing barriers and raising the priority. Any new surveillance programmes need to be owned by the clinical service, with medical leadership shown and IPC providing advice on how to prevent infections.

The paper could be stronger on the strategic opportunity a national electronic surveillance method brings and the opportunity to reduce duplication through taking advantage of existing datasets.

Follow up would be useful with the Wales HAI programme to see how they are progressing with their SSI programme and ICNet as well as continuing to work with ACC to see what support ACC can offer (e.g. looking at other systems that can be integrated).

Action 4: Follow up with the Wales HAI programme to see how they are progressing with their SSI programme and ICNet.

The chair asked all members their preferred option at this stage in the process noting that further consultation is needed. Light surveillance was the preferred option to consult on however Sally and Tanya did not support a move to light surveillance. DHBs could still choose to undertake full surveillance. There was agreement that time will be needed to effectively transition to light surveillance, including seeking further feedback, planning for change and assessing the impact of the anti-staph bundle on the SSI rate.

DHBs who do not undertake other surveillance following a transition to light reporting should undertake other quality improvement activities, such as audits for process measures across all surgical procedures or undertake a point prevalence study to highlight opportunities to reduce harm. The national IPC programme should explore potential options to be offered to DHBs for further consideration by SIPCAG.

Tackling the priority given to infection prevention by DHB leadership should be a separate area of focus. The chair suggested initiating a discussion with DHB CEs, prompting them to formally review their commitment to IPC.

Decision

SIPCAG resolved to recommend:

a) seeking further feedback on a move to light surveillance. Timing for this needs to be more fully investigated but should be no earlier than January 2020.
b) the national programme suggests quality improvement options as an alternative activity for further consideration by SPICAG.
c) the national DHB CEs be prompted via the chair of SIPCAG to formally review their DHB's commitment to IPC specifically their surveillance tools, capacity and capability, and medical leadership.

Note: light surveillance would be the minimum requirement and DHBs may wish to continue with full surveillance.

The programme will proceed to engage with the Royal Australasian College of Surgeons (RACS) and the New Zealand Orthopaedic Association (NZOA) as well as other key stakeholder groups. An update will be provided at the April meeting.

Action 5: Continue to seek feedback from stakeholders on the preferred option and report back to SIPCAG.

Action 6: Work up what other quality improvement activities could be offered to DHBs.

Action 7: Further discussion with the chair of SIPCAG offline re: the messaging for the DHB CE group.

4. Any other business

SIPCAGs involvement in the consultation on the Antimicrobial Testing Leadership and Surveillance (ATLAS) domain exploring variation in antibiotic dispensing in the community was raised. The ATLAS work is led by the Commission's Health Quality Intelligence team. Sally Roberts chairs the group and will provide an update to SIPCAG once the ATLAS is complete. Sally explained the aim is to provoke questions rather than answer questions.

Action 8: Invite Catherine Gerard to the next SIPCAG meeting on 4 April to provide an update on the ATLAS exploring variation in antibiotic dispensing in the community.

The meeting closed at 2.55pm.

Action list following SIPCAG meeting 30 January 2019

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	30 January 2019	Matters arising	ACC to provide a more formal update on the progress and next steps for the draft definitions document at the next meeting.	Linda	4 April 2019	
2.	30 January 2019	Matters arising	Nikki to resend the HAI matrix to members for feedback.	IPC team	15 March 2019	
3.	30 January 2019	SSIIP options paper	Follow up with the Public Health Scotland to better understand their experience of light surveillance.	Sally	April 2019	
4.	30 January 2019	SSIIP options paper	Follow up with the Wales HAI programme to see how they are progressing with their SSI programme and ICNet.	IPC team	April 2019	
5.	30 January 2019	SSIIP options paper	Continue to seek feedback from stakeholders on the preferred option and report back to SIPCAG.	IPC team	April 2019	
6.	30 January 2019	SSIIP options paper	Work up what other quality improvement activities could be offered to DHBs for further consideration by SIPCAG.	IPC team	April 2019	
7.	30 January 2019	SSIIP options paper	Further discussion with the chair of SIPCAG offline re: the messaging for the DHB CE group.	Gary/Julie	April 2019	
8.	30 January 2019	Any other business	Invite Catherine Gerard to the next SIPCAG meeting (4 April) to provide an update on the Atlas of variation in antibiotic dispensing in the community.	IPC team	April 2019	Complete
9.	3 October 2018	HH moments	Investigate the moments required in Australia and the rationale for setting that level	HHNZ team	December 2018	In progress
10.	9 November 2017	IPC programme plan	Continue to develop 5-year vision and emphasis on capability, as part of ongoing development of the Commission's Improvement Hub and HAI programme planning	IPC team	March 2018	Planning day 31 January

No	Meeting date	Topic	Action required	By whom	By when	Status
11.	3 August 2017	HHNZ - GAT	HHNZ programme to identify and prioritise actions relating to each theme from the survey feedback.	IPC team	9 November	Workshop scheduled 27-29 March