Minutes of the 25th meeting of the Strategic Infection Prevention & Control Advisory Group on 4 April 2019
9:30am–3:00pm

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

The meeting began at 9.30am.

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

2. Minutes of the previous meeting held 30 January 2019
The minutes were accepted as a true and correct record. The action log was reviewed.

Matters arising:
The district health board (DHB) chief executive group are meeting next week. Julie will raise the importance of investing in infection prevention and control (IPC) and also appropriately resourcing IPC at the meeting.

3. ACC update
Linda provided an update on the ACC infections work programme and ICNet expansion programme.

ACC have asked the Health Information Standards Organisation (HISO) to lead the work on the infection definitions. This is one of the ICNet expansion programme workstreams. No further work has taken place. Linda suggested inviting Rosemary Jarmey to present at the next meeting on the ICNet expansion project.

There has been a review of the terms of reference for the ACC infections expert group. As a result, the membership has been extended to include the Commission. This group is chaired by Dr Gary Duncan.

ACC are planning to hold two national workshops, one on peripheral intravenous catheters (PIVC) and one on aseptic non-touch technique (ANTT). Linda offered to give an in-depth presentation on these two areas of work at the next meeting in August 2019.

ACC have reviewed and revised their publication 'How to treat – wound infection prevention and treatment'. This work is targeted at primary care. Linda offered to share a copy of the

resource with members along with the most recent treatment injury publication (expected May 2019).

The group questioned whether the ACC expert group and strategic infection prevention and control advisory group (SIPCAG) are joined up enough. There was agreement that there needs to be collaboration to avoid duplication in an area where resources are constrained. The Commission is experienced in quality improvement methodology and measurement and there is scope for both parties to work together utilising each other's strengths. Involving DHB directors of nursing and leadership should not be overlooked.

Actions:

1. Provide an in-depth presentation on the PIVC and ANTT projects at the next meeting.
2. Share the most recent treatment injury publication (once available) and 'How to treat – wound infection prevention and treatment' publication.
3. Invite Rosemary Jarmey to provide an update on the ICNet expansion programme at the next meeting.

4. National healthcare associated infection programme funding

Gary provided an update on funding for the national healthcare associated infection (HAI) programme. DHB chief executives have agreed to increase their Population Based Funding Formula (PBFF) funding contribution to the Commission. The funding will enable the Commission to expand the current scope which focused on surgical site infection improvement and hand hygiene, to a broader healthcare associated infections (HAI) programme. The increase in funding takes effect 1 July 2019.

5. Draft HAI work programme 2019/20

On 31 January 2019 the IPC programme team along with the national clinical leads and CDHB SSI contract lead came together to discuss the potential work programme for an expanded Commission HAI programme.

Andrea presented on the key priority areas and asked members to provide feedback on any missed opportunities as well as comment on whether the areas identified are the 'right' areas to focus on.

There was consistent feedback on the need for there to be a strong focus on governance and leadership, particularly utilising infection control committees. The review of the IPC Standard provides an opportunity to strengthen IPC governance and have some consistency across New Zealand.

Quality improvement capability was discussed. There was a specific IPC quality improvement facilitators course in 2016/17 along with a consumer co-design course. In 2017/18 the commission ran a collaborative to roll out an anti-staph bundle. It is important to continue to build quality improvement capability into new work. The work around PIVC presented an opportunity for following quality improvement methodologies and the intention is to hold another anti-staph collaborative in 2019/20; potentially widening the scope. Being confident with data has been identified as a further area of opportunity. Other Commission programmes have delivered a series of webinars to build capability in this area. This may be something that can be replicated for IPC.

Preventing inadvertent hypothermia, which can be a contributing factor to SSI, has recently been raised with the Commission by the Australia and New Zealand College of Anaesthetists (ANZCA). Arthur will look at the literature to see the there is consensus on maintaining temperature during the perioperative period.

Consumer engagement and improving equity are both important areas that need to be considered at the beginning of any new work.

Josh offered to share the terms of reference for a model for effective Infection Control governance he is involved in trailing at Canterbury DHB.

Actions:

4. Reflect the feedback from SIPCAG into the 2019/20 HAI programme plan
5. Josh to provide a copy of the terms of reference for the Canterbury DHB Infection Control Committee (ICC) executive group for circulation to the group.

6. SSIIP – Reducing the burden of future data collection

Since the last SIPCAG meeting 30 January 2019 the Commission has undertaken further engagement in relation to a possible move to light surveillance for orthopaedic surgery. The senior portfolio manager and IPC national clinical lead attended the Royal Australasian College of Surgeon's executive meeting to provide an update on the SSIIP. The update included an overview of the programme, quality and safety markers (QSMs), results, reporting and the four options relating to future data collection for orthopaedic surgery. There were some suggestions from the different surgical specialities about other process measures the programme could consider.

The IPC team met with Health Protection Scotland to further understand their drivers for moving to light surveillance. SSI light surveillance was introduced within Scotland for all mandatory and non-mandatory procedures in July 2011 to support the national Point Prevalence Survey (PPS), and was extended after the PPS was completed. A case note validation of the light surveillance methodology was conducted by Health Protection Scotland (HPS) during 2013/14 for caesarean section procedures. Validation of caesarean section SSI surveillance data from Scotland for the period January to December 2012 demonstrated that data definitions for SSI were being applied correctly and the data were therefore valid and robust.

Nikki discussed possible options for quality improvement if light surveillance is implemented which included detailed review of orthopaedic SSI cases, additional process measures, other procedures or non-SSI surveillance. The proposed measures and procedures discussed are below:

Process measures:

- glycaemic control
- anti-coagulant behaviour
- normothermia
- pre-operative interventions for obese patients
- anti-staph bundle
- antibiotic prophylaxis and skin prep QSMs across all clean procedures
- perioperative oxygenation.

Surgical procedures:

- caesarean sections
- colorectal surgery
- spine surgery.

Non-SSI surveillance:

- peripheral intravenous catheter infections
- catheter-associated urinary tract infection (CAUTI)
- *Clostridium difficile* infections.

Feedback was sought on the different options and on the next steps.

When considering other surgical procedures, it is important to see what data/registries already exist. The programme could look to data sources such as safe surgery, Enhanced Recovery After Surgery (ERAS), Health Round Table and registries. An alternative way to monitor uptake of process measures in a new surgical speciality was suggested which would involve recommending an ideal patient pathway and then auditing against it.

Without a point prevalence study we can't know the true burden of infection in New Zealand so rely on international literature and seeking out bundles with strong evidence.

The chair sought to reconfirm the group's preference for further engagement on future surveillance. While most of the members support continuing to engage on the possible introduction of light surveillance two members still have reservations about moving to light surveillance. There was support for introducing further quality improvement activity providing the burden doesn't sit with IPC teams. IPC is a partner in any change but a multidisciplinary approach is needed with leadership from the relevant clinical area. Identification of current level of evidence, existing data sources, service or group engagement and level of leadership support will be included as background information for potential quality improvement activities.

The next steps for engagement include discussion with the New Zealand Orthopaedic Association (NZOA) and the IPC Nurses College (IPCNC) along with the orthopaedic expert faculty group.

Follow up with the Australian and New Zealand College of Anaesthetists (ANZCA) is required to discuss including a hypothermia bundle and their letter addressed to the clinical lead.

A wider sector discussion paper will be sent out to stakeholders for feedback after the next stage of engagement is complete.

Actions:

6. Arthur look at evidence for temperature
7. Engagement with NZOA, IPCNC
8. Respond to letter from ANZCA
9. Discuss with orthopaedic expert faculty group

7. SSIIP – anti-staph bundle update

Nikki provided an update on the anti-staph collaborative. An update article was published on the Commission website in February and featured in the Commission's e-digest. The perioperative nurse's college want to feature the article in their quarterly college publication *The Dissector*. An updated version of the article with the latest available data has been provided to the college and this data was presented to SIPCAG. The group was impressed with the improvement to date and recommend circulating the results through the relevant colleges and targeting hospital leadership. It was suggested the programme describes improvement in the number of people rather than rate as this is more relatable.

New Zealand has an opportunity to contribute to the national evidence on use of alcohol and povidone-iodine for nasal decolonisation. A published article is planned. This should be co-authored by participants.

A further collaborative is planned for 2019/20 and there is an opportunity to widen the scope.

Actions:

10. Further promote the success of the anti-staph bundle to date.

8. HAI matrix

A HAI matrix has been developed as a method of prioritising areas of opportunity for reducing HAIs to support decision making. A first draft was discussed at a previous SIPCAG meeting and since then there have been opportunities for members to provide feedback. Feedback was sought from members and Nikki discussed opportunities to simplify the matrix further. A simplified version will be sent to members following the meeting to trial and provide feedback on.

Actions:

11. Send a simplified version of the HAI matrix to members for trialling and feedback.

9. Atlas of healthcare variation – prescribing of antibiotics in the community

Catherine Gerard, evaluation manager in the health quality intelligence team joined the meeting to present the new Atlas of healthcare variation – prescribing of antibiotics in the community, which will be published on the Commission website soon. Sally Roberts is the chair of the Atlas working group and Sheldon is the consumer representative on this group. Catherine also discussed the 'nudge' work undertaken in the UK and Australia by the behavioural insights team, which was included in the meeting papers, and the plans to replicate this work in New Zealand.

The feedback on the Atlas was very positive. The group queried how frequently the data in the Atlas would be refreshed. It could be as frequent as annually but it hasn't been determined. The group was interested in improvements in prescribing in Australia as a result of similar work, particularly for indigenous communities.

This work presents tangible opportunities to reduce antibiotic resistance with the added benefits of cost savings.

10. Clinical lead update – Sally Roberts

Sally provided a clinical lead update which included an update from the recent health antimicrobial resistance meeting which was a joint meeting of human and animal health and agricultural representatives. The review of the IPC standard is expected to be completed late 2020. This review is of significant importance to IPC. It was noted that DHB annual plans ask what antimicrobial resistance (AMR) stewardship activities are taking place.

SIPCAG reflected on what they can be doing to support the plan.

11. HHNZ

Nikki discussed the paper proposing amendments for hand hygiene auditing requirements that would address sector feedback while sustaining improvements in the hand hygiene compliance rate.

The current Hand Hygiene New Zealand (HHNZ) requirements allow organisations with more than 400 beds to either audit all standard risk areas for a minimum number of 100 moments every audit period or rotate standard risk areas and audit each of these areas for a minimum of 300 moments over the year. The majority of DHBs, regardless of the number of hospitals within the DHB, continually audit every standard risk area each audit period so it is recommended option A is removed so this auditing requirement is standardised across all organisations regardless of bed number.

Currently the total minimum number of moments required for each DHB (organisation) and the high risk and standard risk wards during each audit period are determined by DHB bed size. Since many DHBs have more than one hospital that are different size, it is recommended that the minimum number of moments required each audit period is based on hospital bed size, not DHB bed size.

The current minimum moments for high risk and standard risk areas required per audit period are standardised across NZ based on DHB bed numbers. For organisations to sustain the auditing requirements long term, it is important to adjust these requirements. Also, since the 3 audit periods are not equal time periods (three-, four- and five-month periods), it is burdensome for some hospitals to meet the auditing requirements for the shorter audit periods.

Fig. 1 proposed future auditing requirements for high risk and standard risk areas.

Number of high risk and standard risk inpatient beds in organisation	Minimum number of HH moments per high risk area per audit period		Minimum number of HH moments per standard risk area per audit period	
"organisation" would be changed to "hospital"	Current	Future	Current	Future
>400	250	100	option A	100
301-400	250	100	100	100
201-300	200	100	100	100
101-200	200	75	100	75
51-100	50	50	50	50
25-50	50	50	50	50
<25	not existent	50	not existent	50

Given the requirements would be the same for high risk and standard risk areas the guidance to the sector would be to audit all wards (high risk and standard risk) every audit period collecting the specified number of moments based on hospital (not DHB) size. The guidance should also clarify wards that are in scope eg, emergency department which is not counted when determining hospital size as not inpatient but is a requirement for auditing.

Feedback from the sector indicates that there are some small high risk and standard risk wards that are difficult to reach the minimum auditing requirements. Changing the minimum auditing requirements to be based on hospital size rather than organisation (DHB) size, will mitigate these concerns in many DHBs. However, there are some high risk and standard risk departments that are either unusually small or the work flow doesn't easily lend itself to collecting hand hygiene moments (eg, NICU and maternity). While the auditing requirements will continue to be standardised based on hospital bed size, the programme proposes to include some further clarification in the HHNZ auditing manual regarding the expectations for difficult areas to audit.

SIPCAG was asked whether there should be a total minimum number of moments required for each hospital given the aim is to audit all areas each period collecting a minimum number of moments based on hospital size.

SIPCAG was also asked if there are any amendments not included in the paper that the programme should consider. There was discussion about the number of audit periods and the duration of the audit periods. The programme is open to looking at the duration of the audit periods. This should be brought back to a future meeting.

Decision:
SIPCAG resolved to recommend the HHNZ programme amend the requirements outlined in the HHNZ Auditing Manual. The following changes would take effect from 1 July 2019.

a) Removal of option A for DHBs with greater than 400 beds. All hospitals should audit all clinical areas every audit period.
b) The total minimum number of moments for standard and high-risk areas will be determined based on bed numbers for each hospital.

c) The total minimum number of moments for standard and high risk areas will be amended as per Fig. 1 and given the requirements are the same for high risk and standard risk there is new numbers will apply to all eligible clinical areas. Clarification will be provided on eligible clinical areas.
d) The total minimum number of moments per organisation will be removed as the focus is on auditing across the whole hospital and meeting the revised minimum number of moments.
e) There will be further guidence on difficult to audit areas in the auditing HHNZ manual.

Actions:

12. Develop comms to the sector notifying them of the impending changes to the guidance in the HHNZ auditing manual.
13. Update the HHNZ auditing manual to include the updated guidance.
14. Discuss the duration of the HHNZ audit periods at a future meeting.

The meeting closed at 3:00pm.

Action list following SIPCAG meeting 4 April 2019

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	4 April 2019	ACC update	Provide an in-depth presentation on the PIVC and ANTT projects at the next meeting	Linda		
2.	4 April 2019	ACC update	Share the most recent treatment injury publication (once available) and 'How to treat - wound infection prevention and treatment' publication.	Linda		
3.	4 April 2019	ACC update	Invite Rosemary Jarmey to provide an update on the ICNet expansion programme at the next meeting.	Linda		
4.	4 April 2019	Draft HAI work programme	Reflect the feedback from SIPCAG into the 2019/20 HAI programme plan.	IPC team		
5.	4 April 2019	Draft HAI work programme	Provide a copy of the ToR for the CDHB ICC executive group for circulation to the group.	Josh		Complete
6.	4 April 2019	SSIIP – reducing the burden of orthopaedic data collection	Review evidence for preventing inadvertent hypothermia as a contributing factor to SSI	Arthur		
7.	4 April 2019	SSIIP – reducing the burden of orthopaedic data collection	Engagement with NZOA, IPCNC	Gary/Nikki		
8.	4 April 2019	SSIIP – reducing the burden of orthopaedic data collection	Respond to letter from ANZCA	Sally		

No	Meeting date	Topic	Action required	By whom	By when	Status
9.	4 April 2019	SSIIP – reducing the burden of orthopaedic data collection	Discuss options with the orthopaedic expert faculty group	Arthur		
10.	4 April 2019	SSIIP – anti-staph bundle update	Further promote the success of the anti-staph bundle to date.	IPC team		
11.	4 April 2019	HAI matrix	Send a simplified version of the HAI matrix to members for trialling and feedback.	IPC team		Complete
12.	4 April 2019	HHNZ guidance	Develop comms to the sector notifying them of the impending changes to the guidance in the HHNZ auditing manual.	IPC team		
13.	4 April 2019	HHNZ guidance	Update the HHNZ auditing manual to include the updated guidance.	IPC team	1 July 2019	
14.	4 April 2019	HHNZ guidance	Discuss the duration of the HHNZ audit periods at a future meeting.	IPC team		
15.	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	In progress
16.	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	Complete