Minutes of the 16th meeting of the
Strategic Infection Prevention & Control
Advisory Group on 30 August 2016
9.30am – 3.05pm

Present:	Ashley Bloomfield (Chair), Sally Roberts, Arthur Morris, Lorraine Rees, Jo Stodart, Nick Kendall, Richard Everts, Trevor English, Sheldon Ngatai, Bridget Goggin, Adrienne Morgan, Jenny Parr, Karen Orsborn, Gillian Bohm, Josh Freeman and Theresa Dyer.
In attendance:	Gary Tonkin, Andrea Flynn, Nikki Grae, Olivia Jones (minutes) and Debbie Jowitt.
Apologies:	Sue Wood, Jane Pryer and Mo Neville.

The meeting commenced at 9.30am.

Members were asked to introduce themselves and encouraged to complete their declarations of interest.

Richard Everts joined the meeting at 9.45am and Adrienne Morgan at 9.50am.

Lynette Drew joined the meeting for the hand hygiene section of the discussion.

1.1 Minutes of the previous meeting held 4 May 2016

A correction was noted on Page 1, para 4 - This will be Gabrielle's last SIPCAG meeting.

A correction was noted on Page 3, para 1, NZ Microbiology Network should read NZMN.

The minutes will be corrected to reflect the changes.

The minutes were confirmed as a true and correct record with changes noted above.

1.2 Actions update

Action 1 – *Share IPC programme plan on website*
To ensure consistency across the Health Quality & Safety Commission (the Commission), all quality improvement programmes will develop a project charter and programme plan. The project charter will be a public document published on the Commission's website.

Action 7 - *Share ESR CDI report once finalised*
The report is still not finalised by ESR so not released.

Action 9 - *seek further information about review of NZ Standards Health and Disability Standard for IPC 8134.3:2008 within Ministry and feedback*
The standards were deemed suitable back in 2012 and therefore will not be changed anytime soon.

Action 12 – *ACC data matching*
ACC are completing the data matching exercise with seven DHBs. Canterbury DHB are yet to complete the exercise.

2.1 HHNZ Outcome from the July board meeting

The board met on 21 July and agreed that the Commission should increase the range of wards audited for hand hygiene compliance and introduce an organisational measure to report the number of clinical areas audited. The board agreed that the Commission should consider stronger auditing of the outcome marker and process marker for hand hygiene.

Sally Roberts led the discussion on the most recent hand hygiene compliance report which showed a national aggregated average of 82.5 percent. Many DHBs are achieving the 80 percent compliance target however some are struggling to reach the minimum number of moments required. It was noted that South Canterbury DHB was granted a dispensation and are completing the number of moments they negotiated.

There was discussion about the compliance rate by health care worker and if there are resources available that might help improve compliance amongst doctors. There was a comment that the WHO five moments video does not appear to have an impact. Nurses are asked to encourage doctors to undertake good hand hygiene. There was discussion around why the health care worker type is relevant with regard to good hand hygiene practice. The group noted the different motivating factors for doctors compared with nurses.

2.2 Hand hygiene organisational measure and options for validation of observational audits

Nikki Grae presented preliminary results from a hand hygiene audit survey undertaken to inform work on the organisational measure and to help determine the current level of spread. Fifteen DHBs had participated in the survey.

The survey found five DHBs audit continuously throughout the audit period while five DHBs stop auditing when the required minimum number of moments are achieved. The remaining five DHBs audit until the close of the period.

The survey found that 11 of the 15 DHBs had changed their approach to auditing in the last 12 months. Eight of the 11 DHBs had increased the number of clinical areas audited. Six out of eight had increased the number of clinical areas audited but not increased the number of moments. Six of 11 DHBs reported auditing across all wards however approximately 50 percent of those moments are submitted to a local audit and therefore not captured in the national rate. Four of 15 DHBs audit the same clinical areas every period and 3 DHBs audit the same areas most of the time. Seven DHBs regularly rotate audit areas.

There was discussion about the definition of a ward (the denominator for an organisational measure) and the need to ensure all DHBs are using the same definition. For example, agreement about the range of clinical areas that are included e.g. haemodialysis units.

Nikki Grae presented the paper on the organisational measure and options for validating observational audits, as requested by the board on 21 July. There are two components proposed for the organisational measure. The first is the proportion of wards audited and the second is the number of observations collected.

The group discussed increasing the spread of moments and the potential for an unintended consequence of moments being spread thinly across areas and less moments observed in a high risk ward where patients are very vulnerable to infection e.g. ICU. The group suggested that a minimum of 100 moments per area would address this. The programme needs to ensure the spread does not impact on auditing key areas. The programme needs to show that it is sustaining the improvement in compliance rates and spreading it.

It was suggested that a working group be established to inform options for consideration by the board for an organisational measure. Members were asked to volunteer; Lynette Drew, Gillian Bohm, Josh Freeman, Sheldon Ngatai, and Jenny Parr agreed to participate.

Action: Programme team to establish organisational measure working group.

The group discussed cross DHB auditing as another option for validation and noted the implication for isolated DHBs where it would be a time intensive exercise due to travel.

It was suggested the programme make video clips available as a way to validate auditing.

The group noted that local auditors are often tougher when undertaking internal validation and that many DHBs already undertake some form of validation.

It was noted that there are a number of existing elements of accreditation of auditors. It was suggested that the board may be interested in knowing the number of auditors who have completed the annual validation process including the online module and undertaking a minimum no of moments each period.

Educational DVDs are used in the private sector to maintain auditing standards.

Action: Programme team to check if annual validation online modules are available to the private sector.

2.3 SAB reporting - next steps

The board agreed on 21 July that *Staphylococcus aureus* bloodstream (SAB) rates should not be decoupled from the hand hygiene programme at this time, but should continue to be reported as an important indicator of the quality of IPC practice generally.

Nikki Grae presented the paper on the next steps for SAB reporting and commented that SAB was chosen as the outcome marker at the start of the hand hygiene programme in 2011. Despite increased hand hygiene compliance, the SAB rate has not changed significantly overtime. The SAB data has never been validated. The programme receives a few enquiries each year asking if a SAB case should be included. There is a standard definition of SAB but there is uncertainty around if it is being applied correctly. There is a need to validate SAB cases and ensure the correct numerator and denominator is used.

The group discussed how SAB is used as an outcome marker in other jurisdictions. There appears to be little research showing a change in SAB as there are so many contributing factors. The UK uses SAB as an outcome marker but it is not related to hand hygiene.

The group commented that it would be useful to gain insight into the attributable causes of SAB as there is currently limited visibility of the causes of SAB. DHBs already hold this information however they would need to spend time submitting the information. A pilot with a small number of DHBs was suggested.

Action: Debbie, Sally, and Nikki to test approaches to validating sources of SAB with a small group of DHBs.

3.1 SSIIP clinical lead update: National orthopaedic and cardiac work stream update

The clinical lead report included in the papers was taken as read.

Arthur Morris provided an update on the national report for orthopaedic surgery and commented that there have been requests to separate hip and knee, and superficial and deep SSIs. There is an opportunity to include analysis by deprivation and ethnicity in future reports.

In July the board agreed to retire the current surgical skin antisepsis preparation process QSM for orthopaedic surgery from 30 June 2016 as compliance with the marker has been high and stable.

3.3 SSII hub – sustainability model

A paper was presented on the development of the national surgical site infection improvement (SSII) programme 'hub' and sustainable funding approach. The programme is exploring options for long term funding to ensure an appropriately funded sustainability model is in place by the beginning of 2018. The key components of what would be required including a quality improvement focus were discussed. The Commission is ensuring that a whole of sector approach is taken.

The group discussed potential funding options, including the Commission, ACC, DHBs and a bid for new Vote Health funding. It was suggested that anyone with an interest in the hub could be a contributor. The DHBs are already contributing to support the SSI National Monitor so that the Commission isn't funding the infrastructure on an ongoing basis.

The Commission would need to propose to ACC a hub that would provide a return on investment through having a likely impact on reducing SSIs. As treatment injuries are a huge area of expenditure for ACC, a project could be to consider preventative measures and options for expanding the programme to incorporate these.

The group discussed expanding the hub to include a number of specialities e.g. hernias, spinal operations, caesarean sections. For example, every DHB could decide to have a different procedure of interest. Public Health England believe they have reduced the rate of infection for hips/knees down to an irreducible point and are now looking to reduce infections in other surgical specialities.

The Royal Australasian College of Surgeons could be a stakeholder as they are relatively well funded compared to other groups. They could be approached to gauge their level of interest.

Private surgical providers have their own systems and SSI rates are understood to be comparable with public providers but there is interest to be part of a bigger programme. A flexibility model might achieve more buy in from private surgical providers as not all facilities perform hip and knee procedures.

It was noted that New Zealand has wanted a system such as this for decades. The Commission has invested more than a million dollars over the last few years. The question is how we achieve sustainable funding for the hub. The ambitions and benefits of the programme need to be strongly outlined in the next version of the paper.

Gillian Bohm and Karen Orsborn left the meeting at 12.25pm.

3.2 Meta-analysis on interventions to reduce Gram-positive SSIs

Arthur presented the meta-analysis report prepared by the Royal Australasian College of Surgeons (RACS). The purpose of the report was to conduct a systematic literature review and meta-analysis related to interventions to reduce Gram-positive surgical site infections in orthopaedic and cardiac surgery. The focus of this work was to identify the effectiveness of pre-operative bundle components that have been utilised to reduce SSIs caused by *Staphylococcus aureus*. The findings from the meta-analysis will be used to develop a consultation paper on potential implementation of a national anti-staphylococcal bundle.

The group was asked to consider the following questions:

1. Is the evidence good enough to support implementation of a new extended pre-operative bundle for clean elective surgery procedures across NZ DHBs?
2. Should we pre-screen for MSSA/MRSA carriage?
    - If no, then universal decolonisation of all elective orthopaedic and cardiac patients
3. Should nasal or skin decolonisation or both be part of the bundle?
4. Does your DHB do any pre-screening or decolonisation for patients?

When considering the evidence for a new extended pre-operative bundle, many agreed that the evidence was sufficient to proceed. The questions have also been discussed at the expert faculty meetings. Other discussion questions will be explored through the consultation process with public sector stakeholders. There is great potential for consumer co-design/engagement.

4.1 ACC

Nick Kendall provided an update on treatment injury and ACC's involvement in the SSII programme. Twelve thousand and five hundred claims are lodged every year and 8,500 accepted. The claim rate is increasing over time. ACC is particularly interested in hip and knee procedures and coronary artery bypass grafting. The number of accepted claims for the categories specified has doubled over the last 5 years. A treatment injury is always attributed to the facility even if a DHB funds the surgery that takes place in a private hospital. This illustrates the importance of expanding the programme into private surgical hospitals.

The data shows that there is no stable baseline to make comparisons. The cost of hip surgery has more than doubled since 2011. It was noted that the joint registry could provide the denominator as it contains about 98% of procedures.

There was general discussion about the discrepancy between the programme's data and ACC's data as illustrated by the data matching exercise. ACC is clearly capturing more SSI cases. The data matching exercise will help to understand the reasons for the mismatch. The SSII programme's definition of an infection means that some infections are excluded because of the rigorous surveillance definition e.g. there will be some superficial infections that occur more than 30 days after procedure and therefore do not meet the criteria however they are genuine superficial SSIs. This is also the case for deep infections where the cut off is 90 days. ACC can accept an SSI as a treatment injury regardless of the time lag between procedure and infection.

ACC spends approximately 6.3 million per annum on infections after a traumatic injury. A literature search identified that between two to 17 percent of traumatic injuries will get infected. The likelihood of infection depends on the site of injury and the circumstances including whether soil is introduced to the wound. The literature search found 30 or 40 papers where there was a comparison of treating a wound with antiseptic versus not. The research showed that overall the antiseptic reduced the infections by around half. To provide insight as to how injuries are treated in New Zealand schools, approximately 100 were contacted and a response was received from 20. The work found that there is a wide spectrum of how injuries are treated. This presents an opportunity for the creation of a set of guidelines on how to deal with traumatic injuries that would improve the rate of infections.

5.1 National IPC workshop 9 August 2016

Gary Tonkin presented a summary of the evaluation results from the national IPC workshop on reducing harm from healthcare associated infections on 9 August in Wellington. It was pleasing to see the workshop met or exceeded expectations for most. The lightening talks

and regional workshops were well received. Many participants highlighted the importance of multi-disciplinary teams and the need for data to be collected operationally for quality improvement initiatives. The workshop was a multi-disciplinary event with a great mix including representatives from the private sector, surgeons, doctors and quality leads.

There was discussion at the workshop about the possibility of forming a collective group of different professions that have an interest in IPC. There was also discussion about forming a national group (Director IPC level) to develop a national IPC strategy.

The Commission will hold another national IPC event in the next financial year. The group discussed options for the next event and whether it could be part of an existing conference. It was suggested that it depends on the audience and that attaching it to a conference may not attract a multi-disciplinary group.

6.1 Regional IPC networks

Nikki Grae provided an update on the outcome from the regional meetings. Region specific hand hygiene and SSI data was presented at the meetings and was well received. The importance that smaller DHBs advertise when they are doing gold auditor training and to share resources was discussed.

DHBs are using a range of options to validate their audit data. Some DHBs are using SAB as a KPI however there is not a lot of follow up regarding individual cases. The regions discussed general quality improvement initiatives relating to hand hygiene.

The regions are interested in looking at BMI trends, gram positive, gram negative, elective or acute procedures and splitting out hip from knee and superficial. The IPC committees expressed an interest in extracting their own data from the national monitor.

The Midland region IPC meeting is scheduled 2 September.

7.1 HAIGG update

Sally Roberts provided an update from the meeting 6 June. The group discussed the *Clostridium difficile* infection report. They had anticipated feedback from WHO about antimicrobial resistance however there was no discussion. The group discussed ESR activities.

The next meeting is 14 September 2016.

7.2 NZMN update

Josh Freeman provided an update from the NZMN meeting 18 July.

The meeting included a discussion on anti-microbial resistance. ESR presented on the review undertaken on different antibiotic resistance surveillance programmes. It is uncertain if the report will be sent out for consultation. Most of the points in the report were supported by the group.

Action: Josh Freeman to send review of antibiotic resistance surveillance programmes report to SIPCAG members.

Action: Josh Freeman to send minutes to SIPCAG members.

7.3 National clinical lead update

The clinical report update was taken as read.

Sally Roberts discussed the Atlas of Healthcare Variation work that looked at the number of antibiotics prescribed after a major surgery (i.e. were in hospital for two or more days). Thirty-three percent had an antibiotic prescribed either when in hospital or in the community within 30 days of the procedure. Fifty percent of the prescriptions were given one day after the day of discharge. Augmentin is the most commonly prescribed antibiotic. It is retrospective so there is no documentation about the reason for the antibiotic prescription. This will be presented to SIPCAG when the work is complete.

7.4 IPC Quality Improvement Programme/SSI co-design programme update

Nikki Grae is attending the quality improvement programme delivered by Ko Awatea. Eighteen people are enrolled in the course. The purpose of the course is to build capability in IPC teams and is specifically for infection prevention practitioners involved in the SSII programme. Sally Roberts presented at one of the sessions and Arthur Morris and Debbie Jowitt are scheduled to present at the September workshop.

Participants will undertake a two to three month project over the course of the year. A wide range of projects have been chosen including a few related to caesarean sections. Nikki Grae's project relates to improving the utilisation of the orthopaedic SSIIP report.

The co-design course has been postponed by a few months and will now commence 27 September. The course is in a different format to the QI programme with 2 one-day sessions at Ko Awatea and seven 1 hour web-ex sessions. It was originally intended to be a six month course however it will now run for eight months until start of May 2017. Eleven pairs of delegates and consumers are confirmed participants. Nominations are still being accepted.

Action: Programme team to circulate the list of DHBs participating in the co-design course.

7.5 AMR action planning group update

Debbie Jowitt provided an update on the Antimicrobial Resistance Action Planning Group. The group consists of about 20 people. A document based on the Australian antimicrobial resistance (AMR) action plan was distributed for feedback in late July. The feedback received related to ensuring consumer representation is achieved, recognising prescriber groups are wider than pharmacists (e.g. nurse practitioners and midwives), the role of the IPC nurse in preventing AMR. The group is waiting for the revised version which will be close to the final action plan and will be released for consultation.

Action: Programme team to send information about AMR webinar to SIPCAG members.

World antibiotic awareness day is 18 November 2016. The Commission will be promoting this including links on the website to relevant articles.

The group discussed the national guidelines and the leverage it gives the IPC workforce. The standard needs to be updated because it lacks relevant references and content to help drive change in behaviour. It doesn't address the SSII programme's efforts to reduce waste by discontinuing antibiotics after 24 hours post-surgery. There is a lack of visibility of the policy discussions about IPC.

The group agreed to have this as a standing agenda item.

Arthur Morris left the meeting at 2.40pm.

8.1 IPC programme plan

Andrea Flynn presented the IPC programme status report for July. This report is provided to the Commission's General Manager each month and is aligned to the IPC programme plan.

One work stream is coloured amber because not all five DHBs performing cardiac surgery are participating in the programme. Capital & Coast DHB have informed the programme they are collecting data from 1 August however Waikato DHB are in a testing phase.

The request for proposal for the SSIIP evaluation is now complete. Sapere has been selected as the preferred provider. An evaluation steering group has been established and are due to meet 13 September 2016. The group includes the programme's clinical leads, Commission staff and ACC representatives. The evaluation plan will be presented at the next SIPCAG meeting. The purpose of the evaluation is to review the programme's achievements and consider opportunities for improvement. An evaluation has been completed for hand hygiene and CLAB.

Any other business

The group noted that this was Adrienne Morgan's last SIPCAG meeting and thanked her for her contribution. Adrienne requested that the IPC programme's connection with the private sector is maintained.

The meeting closed at 3.05pm.

The next SIPCAG meeting will be held 25 October via teleconference.

Action list following SIPCAG meeting 30 August 2016

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	30 August 2016	AMR	Circulate information about AMR webinar to SIPCAG members.	Olivia	October 2016	Complete
2.	30 August 2016	Co-design	Circulate the list of DHBs participating in the co-design course.	Olivia	October 2016	Complete
3.	30 August 2016	NZMN	Circulate NZMN minutes to SIPCAG members.	Josh	October 2016	Complete
4.	30 August 2016	NZMN	Send report on review of antibiotic resistance surveillance programmes to SIPCAG members.	Josh	October 2016	Complete
5.	30 August 2016	Hand hygiene	Check if annual validation online modules are available to the private sector.	Andrea/Olivia	October 2016	Complete
6.	30 August 2016	Hand hygiene	Establish organisational measure working group.	Lynette	October 2016	Complete
7.	4 May 2016	HAIGG Update	Jane to share ESR CDI report once finalised.	Jane Pryer	August 2016	The report is still not finalised by ESR so not released.

No	Meeting date	Topic	Action required	By whom	By when	Status
8.	4 May 2016	IPC Programme Planning and Reporting	Jane to seek further information about review of NZ Standards Health and Disability Standard for IPC 8134.3:2008 within Ministry and feedback to the group Update from Jane: No new progress on the standards as yet other than myself and Carolyn Clissold will be meeting with HealthCert in September to look at current auditing against the NZS 8134.3.1 2008 NZ Standards and whether the audits are the tool to ask for better evidence against each standard (the standards themselves were deemed suitable back in 2012 and therefore will not be changed anytime soon).	Jane Pryer	August 2016	In progress.
9.	4 May 2016	HHNZ Update	Highlight in the audit report DHBs that are auditing more areas, e.g. options B or C in the HH auditing manual.	Sally Roberts	August 2016	Superseded by the work to develop an organisational measure
10.	10 February 2016	IPC Programme Plan	Seek permission to share an edited version of the final IPC Programme Plan on the website. Update: A project charter will be available on the Commission website early 2017.	Gabrielle	August 2016	In progress.