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| Letterhead logo**Minutes** of the 14th meeting of the Strategic Infection Prevention & Control Advisory Group (SIPCAG) held on 10 February 2016 |

Present: Gabrielle Nicholson (Chair), Gillian Bohm, Geoff Cardwell, Richard Everts, Trevor English, Andrea Flynn, Joshua Freeman, Bridget Goggin, Nick Kendall, Adrienne Morgan, Arthur Morris, Sheldon Ngatai, Mo Neville, Jenny Parr, Jane Pryer, Sally Roberts, Lorraine Rees, Jo Stodart, Deborah Jowitt

Apologies: Sue Wood

The meeting was held in the Sunderland Room, Wellington Airport Conference Centre, and it commenced at 9.30am.

Gabrielle Nicholson welcomed Sheldon Ngatai, the new consumer representative. Sheldon is a consumer representative on a number of groups within the health sector including the Ministry of Health’s (MoH) Healthcare Associated Infections Governance Group (HAIGG).

* 1. **Minutes of the previous meeting held 4 November 2015**

The minutes were approved.

* 1. **Actions update**

The action list was reviewed and updated.

Mo Neville provided an update on Waikato District Health Board’s (DHB) staff vaccination policy. The Waikato DHB influenza vaccination rate for 2015 was 83 percent, significantly higher than achieved before the current vaccination policy. The implementation of the policy is under review with a focus on its implementation. Waikato DHB staff must be vaccinated against influenza annually or wear a mask when caring for patients.

Mo also noted that it would be useful to share the learnings from the Waikato DHB Carbapenem-resistant Enterobacteriacea*e* (CRE) outbreak with the group.

There was general discussion about the Lippincott Infection Prevention and Control (IPC) guidelines introduced from the US and adapted for local use by Waikato DHB. South Island DHBs are implementing the adapted guidelines, which focus on clinical procedures, and which have the advantage of being regularly updated by Lippincott. Jenny Parr questioned whether SIPCAG was the appropriate forum for discussing the guidelines as the decision to implement them is organisation and/or region dependent. Not all DHBs have chosen to do so. She suggested it would be useful to bring the issue to the attention of the Chief Nurse Jane O’Malley, as the national Directors of Nursing (DON) group has been central to driving this initiative.

Action: Jane Pryer to bring the implementation of the Lippincott guidelines to the attention of Jane O’Malley (Chief Nurse).

Action: Gabrielle will follow up with Helen Pocknall, lead of the DONs group, and provide an out-of-meeting update to the group.

Consumer engagement – Gabrielle explained that she and Geoff Cardwell had discussed the proposal for a separate agenda item for consumer engagement at each SIPCAG meeting but had agreed that it would be preferable to integrate consumer concerns into the discussion on each agenda item. Sheldon confirmed her support for this approach.

**Item 2.1 Healthcare Associated Infections Governance Group (HAIGG) Update**

The last HAIGG meeting took place on 16 December 2015. Gabrielle provided an update on the main topics discussed:

1. IPC IT Business Case

Catherine Torrance (General Manager and Program Director MoH) has been asked to do work around the IPC IT Business Case to understand the current state, and what is feasible and desirable, by the end of June 2016.

Action: Meeting required with Catherine Torrance, MoH, and National Health IT Board at the earliest convenience (HQSC IPC team).

1. Staff influenza immunisation coverage

A follow up teleconference was held on the day following the HAIGG meeting to find out what each DHB is doing to promote staff vaccinations and to share ways of strengthening programmes within hospitals and overcoming logistical problems.

Action: Jane to share minutes of the MoH teleconference on DHB staff influenza coverage with SIPCAG.

1. Antimicrobial stewardship

Shirley Crawshaw, Deputy Director of Public Health, presented to HAIGG 16 December on the approach being taken to meet the requirements of the World Health Organization (WHO) global action plan to reduce antimicrobial resistance (AMR). NZ is committed to having a strategy in place by May 2017 (aligned to WHO guidelines). An AMR Action Group has been established with Debbie Jowitt as the HQSC representative. The AMR Action Group will feed back to governance structures within the Ministry of Health via HAIGG, and Ministry for Primary Industries (MPI). This work is being undertaken jointly between MPI and the MoH.

A joint statement by MPI and the MoH will be communicated soon. The first meeting of the Action Group is planned for 2 March 2016. The initial focus will be on completing a stocktake of current activities. Gillian Bohm suggested the group seek out the previous work done in this space by the MoH’s AMR Advisory Group.

Action: Debbie to provide regular updates of action group meetings to SIPCAG.

1. Antimicrobial stewardship questionnaire

This questionnaire will inform the activities of the AMR Action Group. Sharon Gardiner (CDHB Antimicrobial Stewardship Pharmacist) has developed this for the hospital sector, but further work needed to be done to expand the survey to Age Related Residential Care and the community. Sally Roberts suggested that it could go out for consultation to DHB Chief Executives and Chief Medical Officers as it is focused on prescribers rather than pharmacists. HAIGG are aiming for the survey to be sent out early March and SIPCAG will be kept up to date regarding this.

5 HAIGG Strategic Plan

Jane advised that the feedback on the revised plan was that it needed to be more specific about deliverables to be able to measure achievement over time. The group will continue the discussion at the next meeting.

6 *Clostridium difficile* infection (CDI)

Environmental Science & Research (ESR) is still analysing the results from the six pilot site DHBs involved in the CDI study. Jane will share the CDI report with SIPCAG once it has been received by the MoH. A paper outlining the pros and cons on making CDI a notifiable disease is to be drafted.

Action: Jane to share the report on CDI with SIPCAG when received.

In addition, Jane noted that Dr Kevin Snee (Hawke’s Bay DHB) is the DHB Chief Executive representative on HAIGG. The next HAIGG meeting is planned for 16 March.

**Item 2.2 National Microbiology Laboratory Network (NMLN) update**

Minutes from the previous meeting 14 December were tabled at the meeting.

Josh Freeman provided a brief update on the recent meeting. He described the network as very effective for information sharing but still working to establish influence on policy at the national level. Michelle Balm (Capital & Coast DHB) is representing the network on the MoH AMS Action Group.

**Item 2.3 National Clinical Lead update**

The report provided in the papers circulated was taken as read. Sally informed the group of the lead story in the latest edition of the New Zealand Listener, ‘Cutting Edge’ which focuses on the Commission’s role in improving surgical outcomes for patients. The article features Commission Board Chair Alan Merry, Ian Civil, Safe Surgery clinical lead, and Sally as the national IPC clinical lead.

<http://www.listener.co.nz/current-affairs/health-current-affairs/cutting-edge-2/>

**Item 3 and 4 Review of the IPC Programme Plan and partnership with ACC**

Item 3 and 4 were discussed together as they directly relate to each other.

Gabrielle and Bridget Goggin provided a progress update on the partnership between the Commission and ACC, specifically in relation to the expansion of the Surgical Site Infection Improvement Programme (SSIIP). ACC goals and objectives align with what the current SSIIP is trying to achieve. Surgical site infections are the biggest area of treatment injury claims for ACC.

The work to expand SSIIP will span 2.5 years. Key activities will include:

* Funding for an IT specialist (for 12 months) to work with DHBs and their local SSII team to ensure they can get appropriate support from their Business Support Units. Further engagement with senior DHB management will be required to explain the purpose and benefit of this work, and to leverage support and appropriate resource.
* Support for one person from each DHB to participate in the IPC quality improvement course. This will be a tailored course to provide quality improvement training for IPC teams. The aim is to start in this financial year.
* Consumer co-design/partners in care project.
* Focus on long term sustainability - what do we need now and what do we need in the future to sustain the benefits.
* Hand hygiene will become core to all IPC programmes as fundamental to infection prevention.

Gabrielle confirmed that reducing SSIs for caesarean sections will be subject to the same prioritisation process undertaken for all new Commission initiatives. There is no budget or capacity within the IPC Programme to deliver this initiative currently.

**IPC Programme Plan 2016/19**

Gabrielle led the group through the draft three-year IPC programme plan. Suggested changes to the plan were made directly in the document with tracked changes. The main areas of focus/discussion were:

Driver diagram

Some time was spent discussing the driver diagram in the IPC Programme Plan. The actions summary needs to align to the programme objectives. Consideration needs to be given to how the actions can be measured.

Measures of success

There was discussion and feedback on the measures of success, particularly the other more strategic measures. Feedback will be incorporated into the programme plan.

Assumptions/Constraints

There was discussion about the assumptions and what was meant by ‘support’ when referring to the IPC Nurses College(IPCNC) and Australasian Society for Infection Diseases (ASID).

Action: Further exploration re ensuring active engagement with IPCNC and ASID and their membership (HQSC IPC team).

Workstreams

The group had the opportunity to provide feedback on each of the five workstreams.

Josh emphasised the need for a focus on frontline ownership. Jenny agreed that this is key to sustainability and succession planning.

Workstream 3: SSIIP for orthopaedic and cardiac surgery

There was discussion about the timeframe for quarterly and national reporting being fully operational for cardiac surgery and whether this included all five DHBs undertaking cardiac surgery or the three currently participating in surveillance. There was agreement that it should include all five DHBs and those not entering data will show as red in the QSM report. The group agreed that if Cardiac QSM reporting should occur from December 2016 then this would need to be communicated well in advance.

Workstream 4 - Network, leadership, capability and consumer engagement development

There was discussion about serious adverse event (SAE) reporting. Nick Kendall finds the learning that comes out of the SAE/open book useful. Geoff questioned whether consumers have visibility of SAE reports.

Action: Discuss reporting infections as serious adverse events at a future SIPCAG meeting.

Sheldon commented that consumer participation is not always well recognised / enabled by local DHBs.

Workstream 5 - Measurement and evaluation

Discussion regarding DHB’s use of own data and how the level of expertise offered by DHB business support teams makes a difference. Often DHB business support units do not know how to present data for improvement.

General discussion

Clarification was sought on the audience of the programme plan. Gabrielle explained it is for internal use. There was a desire by the group for the plan or excerpt (particularly the driver diagram and the measures of success) to be shared more widely or posted on the Commission’s website.

Action: Gabrielle to seek permission to share an edited version of the final IPC Programme Plan on the website.

This led to discussion about sharing SIPCAG minutes more widely and the timing for when minutes can be published on the Commission’s website. Currently the minutes are draft until they are approved at the meeting following (3 months).

Action: Provide a timeframe for correcting factual accuracy of the draft minutes (2 weeks max). Once the deadline has passed the minutes will be taken as approved and can be published on the Commission’s website.

Action: ASID and the IPCNC to be advised that going forward the SIPCAG minutes will be uploaded to the Commission website (Commission IPC team).

**Item 5 - Surgical Site Infection Improvement Programme (SSIIP) update**

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

Arthur Morris led the discussion on items 5.1, 5.2 and 5.3 which were covered by a presentation on the progress of the SSII programme. This included an update on:

* the most recent national orthopaedics report (April to June 2015) published December and the draft national orthopaedics report (July to September 2015) to be published March 2016.
* the orthopaedic expert faculty group meetings
* the preliminary cardiac data which has been sent to the clinical directors of the five DHBs doing cardiac surgery, and
* the establishment of a cardiac expert faculty for the cardiac workstream.

Arthur noted that for cardiac surgery most superficial infections occur at the donor site (data is not collected on the location of the donor site).

Preliminary data shows that approximately 17 percent of patients going for cardiac surgery are either insulin-dependent (1 percent) or noninsulin-dependent diabetics (16 percent).

For cardiac surgery there is potential to replace the QSM for skin prep with a QSM around post-operative glucose control for diabetics. Lorraine Rees suggested that the programme utilises diabetes expertise and that ‘Type 1’ or ‘Type 2’ diabetes is used rather than Insulin-Dependent Diabetes Mellitus (IDDM) and Non-Insulin-Dependent Diabetes Mellitus (NIDDM) to differentiate the types of diabetes.

Jo Stodart commented that in case reviews undertaken at SDHB post-operative wound management was identified as a possible contributing factor of infection. A member of the SDHB IPC team with expertise in wound care undertook a review of wound management in cardiac surgery patients with identified infections. Arthur suggested these learnings would be good to share nationally and could be included as a story in the SSIIP newsletter.

Action: Link up Jo and Margo White re the work being done at SDHB to standardise and improve post-cardiac surgery wound care by May 2016 (HQSC IPC team).

Arthur explained that the national data to date shows that almost half of SSIs are caused by Staph*ylococcus aureus* and other staphylococcal species. The orthopaedic expert faculty discussed the possibility of replacing the skin prep intervention with a bundled approach to reduce staphylococcal colonisation prior to surgery. The first step in investigating this approach would be to put together a proposal for a provider to undertake a meta-analysis of the available evidence up to the end of 2015.

Richard Everts outlined the steps already being taken at Nelson Marlborough DHB where all orthopaedic patients are given intranasal Betadine ointment and chlorhexidine washes rather than only those who are *S.aureus* positive on screening. There was general discussion about the limitations and logistics of implementing a new intervention.

Action: Develop a budget and proposal for the SSI meta-analysis (Arthur and the Commission IPC team).

**Item 5.4 SSIIP Perception survey**

A summary of the responses to the survey was provided in the papers as well as the full results. A formal report will be provided to SIPCAG at the next meeting.

Action: Include the SSIIP perception survey report for SSII champions and clinical directors in the papers for the SIPCAG meeting 4 May (Commission IPC team).

**Item 5.5 Update on SSIIP sustainability model**

Gabrielle provided an update on the SSIIP sustainability paper that went to the Board in November. After considering the options the Board’s preference was for the Commission to drive this work forward as the SSII ‘hub’. The next steps are to identify funding and hosting options and look at what staffing would be required. Funding would not be able to come out of the Commission’s baseline funding therefore further work will be needed involving the Ministry of Health, ACC, and ESR to achieve a stable long term funding platform.

**Item 6.1 Hand hygiene**

Gabrielle briefly outlined the progress made to date with transitioning the hand hygiene programme to the Commission. The March 2016 national hand hygiene compliance report will be developed by the Commission with input from Sally incorporating hand hygiene into her role as national clinical lead.

Josh discussed the sustained national improvement to date, and the improvements throughout the different clinical services. The new functionality in the Hand Hygiene Australia database allows the progress in specific clinical areas (for example emergency departments and ICUs) to be compared nationally and at local level over time. Auckland DHB is now submitting moments from all areas audited instead of only its high risk areas and selected wards. Other DHBs are starting to do this, and Mo suggested that Waikato DHB could also start to submit moments from all areas.

Debbie noted that Michael Gardam, who led the national frontline ownership workshop in September 2015, had emailed to congratulate the team on the on-going progress and to thank them for acknowledging the frontline ownership approach in engaging staff in improvement at the local level.

**Items 6.2 Healthcare associated *Staphylococcus aureus* bloodstream infection (HASABSI) report January 2016 and discussion re hand hygiene outcome measure**

Sally tabled the HASABSI report with both nationally aggregated and stratified DHB data. The national rate has been unchanged since the programme began in 2012, even with stratification into three different groupings (using bed numbers as a surrogate for complexity of patients). In reference to the discussion at SIPCAG in November 2015 re the unchanged HA-SAB rate despite improved hand hygiene and the difficulties of choosing an appropriate outcome measure for the hand hygiene programme, Sally also referenced international studies that used infection markers such as HA-SAB as an outcome measure.

The reduction in rates in several of these studies reflected a major problem with endemic MRSA, which is not present in NZ hospitals. A recent systematic review and network meta-analysis confirmed that the World Health Organization ‘5 moments for hand hygiene’ is effective at increasing compliance with hand hygiene in health care workers. The article also reported on clinical and microbiological outcome measures. Of the 41 studies that meet the requirements for inclusion, however, only 19 reported on outcome measures and of these the authors considered only three studies to have been analysed and reported appropriately.

Josh explained that in looking for other more appropriate measures for the DHB sector he had considered a composite of pathogens mainly affecting ICU and haematology patients. However, on further consideration, he wondered if the unchanged national HASABSI rate reflected the improvement had already begun to occur before the programme was reinvigorated and gained momentum in 2012–13. Sally added that the earlier development of the programme in 2009 had brought hand hygiene compliance up from its earlier very low levels (35 percent) to about 62 percent, within the range proposed by Didier Pittet and other experts as impacting on HAI rates. It is impossible to know whether rates would have been much higher had the programme not existed or whether we may have had higher rates prior to 2012 without reliable national data.

As hand hygiene is a key component of a number of infection prevention interventions, the rollout of the national ‘Target CLAB Zero’ central line associated bacteraemia initiative in January 2012 and the national Surgical Site Infection Improvement programme which started in late 2013 may also have contributed to a reduction in HA-SAB. Aggregated national reporting does not show improvements that may have occurred at individual DHB level. Auckland DHB have been able to demonstrate a reduction in their hospital onset SA-BSI rates from 2.9 to 1.3 per 1000 inpatient days since 2009.

Action: Provide further information on reduction in the SAB rate at Auckland DHB since 2009 (Sally and HQSC IPC team).

The group endorsed Sally and Josh’s view that hand hygiene has a cumulative effect on reducing HAIs and sustaining good hand hygiene is vital to the resilience of the health system. This is increasingly important as multi-resistant bugs increase. Sally suggested that it may be better to either replace the current measure with a reducing target, or to develop an outcome measure that is an across the board marker for IPC rather than specifically for the hand hygiene programme.

Action: Explore HASABSI marker as a marker for IPC rather than a programme specific marker for hand hygiene improvement (Sally & Commission IPC team).

Lorraine described the difficulties for frontline workers in sustaining improvement and emphasised how important it is to have the backing of the Commission. Geoff added that patient participation and infection prevention need to go hand-in-hand to improve practice.

**Item 6.3 Hand hygiene monitoring**

Debbie spoke to the paper discussing the strengths and weaknesses of the WHO-5 monitoring method (direct observation auditing) vs other monitoring methods (automated and electronic technologies). The consensus in the literature is that studies on these alternative monitoring methods are limited, and further studies are required to assess the accuracy, effectiveness and cost-effectiveness of these systems. Direct observation auditing for local and national reporting purposes, with auditor training sustained by regional networks, appears to be assisting to embed good hand hygiene practice in DHBs.

The Board want the programme to consider increasing the Quality and Safety Marker (QSM) for Hand Hygiene compliance. The advisory group were in agreement that 80 percent was an appropriate level of compliance and the programme should focus on embedding compliance over the next 12 months. One option is to encourage DHBs to submit all of the data and monitor the rates.

**Item 6.4 Hand hygiene perception survey**

Sally discussed the key points raised by the survey which has been done annually for the past three years. Regional collaboration appears to be increasing with 17 of 21 respondents actively linked to a regional network. Most coordinators are using smartphones and other technology to collect and submit data, and most indicated that the QSM reports have been effective in raising the profile of hand hygiene and gaining support for the programme at senior management level.

Action: The survey report was endorsed by SIPCAG and can now be distributed (Commission IPC team).

**Item 6.5 Regional meeting update**

Gabrielle spoke to the report on the South Island regional IPC network meeting held on 14 December at Princess Margaret Hospital, Christchurch. There was a high level of attendance with multidisciplinary representation. Draft terms of reference for the group are being developed by a working group led by the South Island Alliance Project Office.

**Item 6.6 Feedback from Michael Gardam workshop**

Debbie spoke to the feedback following the workshop. Twenty-two people responded with the majority stating that they have already used one or more of the techniques shared at the workshop, and that the frontline ownership approach is very effective at engaging staff in hand hygiene improvement.

**Item 6.7 – National IPC multidisciplinary workshop – Wellington 9 August 2016**

Dr John Ferguson, Infectious Diseases Physician Hunter New England Health NSW, has accepted an invitation to be keynote speaker at the national workshop. He is keen to bring Kris Farrar, IPC nurse, who has been closely involved in the rollout of ICNet at Hunter Valley Health since 2013. Kris has been invited to lead a session on IPC IT. An invitation is also being extended to Dr Rhonda Stuart, Monash Health Melbourne. Local speakers and facilitators will also be invited, and the programme circulated to IPC nurses, SSIIP and hand hygiene champions, ASID members, and quality & risk managers.

**Item 7 - SIPCAG ToR**

An amendment was made to terms of reference to include ‘executive with interest in and responsibility for IPC’ in place of Director of Nursing in the membership list.

**General business**

World Health Organization World Hand Hygiene Day 5 May 2016 will focus on ‘hand hygiene as part of infection prevention and control programmes in all settings that support surgery, prevent patient infection and reduce an avoidable burden on health systems’. This will provide an opportunity to bring the two IPC programmes together: <http://www.who.int/gpsc/5may/en/>.

**The next SIPCAG meeting will be held on Wednesday 4 May 2016 in Wellington**.