Minutes of the 15th meeting of the Strategic Infection Prevention & Control Advisory Group (SIPCAG) on 4 May 2016 9am – 3.30pm

Present:	Richard Everts, Trevor English, Joshua Freeman, Nick Kendall, Sean Bridge (for Bridget Goggin), Arthur Morris, Sheldon Ngatai, Mo Neville, Jane Pryer, Sally Roberts, Lorraine Rees, Jo Stodart, Sue Wood.
In attendance:	Gabrielle Nicholson (Chair), Deborah Jowitt, Andrea Flynn, Nikki Grae.
Guests:	Helen Heffernan, The Institute of Environmental Science and Research (ESR).
Apologies:	Bridget Goggin (Accident Compensation Corporation [ACC]), Adrienne Morgan, Jenny Parr, Karen Orsborn, Gillian Bohm, Shirley Crawshaw (Ministry of Health [MoH]).

The meeting was held in Conference Room 3, Wellington Conference Centre, Level 7, 50 Customhouse Quay, Wellington.

Gabrielle opened the meeting at 9.40am due to delayed flights. Noted that Jane will join at 10am; Sue and Trevor were still en-route in taxis.

Gabrielle introduced Nikki Grae, the Commission's new Infection Prevention and Control (IPC) Specialist and invited members to introduce themselves.

Debbie informed members she has reduced her hours to two days a week and will be continuing to support the IPC team working with Nikki. This will be Debbie's last SIPCAG meeting.

1. Minutes of the previous meeting held 10 February 2016

Item 2.1 Healthcare Associated Infections Governance Group (HAIGG) Update – Gabrielle noted that the national business case for ICNet had not been developed. She committed to keep the Group updated on progress.

Jane Pryer joined the meeting at 9.45am.

Item 4 Antimicrobial stewardship questionnaire – Sally asked for progress update. Jane is waiting for feedback and the questionnaire has yet to be sent out. This will be followed up at next HAIGG meeting.

Gabrielle noted that Shirley Crawshaw is sick and the team are trying to get someone else to present in her place. As another solution, Jane has Shirley's slides from a previous presentation and can share them with the group.

Joshua Freeman joined the meeting at 9.55am.

Arthur noted a correction on pg 6 – Item 5, para 3, data IS collected on the location of the donor site. Minutes will be corrected to reflect this change.

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

2. Actions update

Action 3 – *Share ESR CDI*
Jane noted the initial report did not meet requirements. MoH is currently awaiting a revised version. Action carried over.

Helen Heffernan arrived and Gabrielle welcomed her to the meeting, group re-did quick round-table introductions.

3. Presentation from ESR – Surveillance of multi-resistant organisms

Helen Heffernan, Environmental Science and Research (ESR), introduced a presentation on national surveillance of antimicrobial resistance, which ESR is funded by MoH to manage.

Reporting is annual and Helen expressed the view that they need an alerts system. ESR is currently in discussions with MoH regarding real-time reporting. She noted that the data is available if anyone wants updates during the year.

Helen noted that vancomycin-resistant enterococci (VRE) is emerging in NZ.

Helen noted that annual surveillance of Methicillin-resistant Staphylococcus aureus (MRSA) shows that the epidemiology has changed a lot in NZ; in the past 10 years there has been an emergence of AK3 strain.

She introduced a one-off survey of antimicrobial susceptibility in relation to gonorrhoeae in NZ 14-15 with the caveat that two thirds of those surveyed were from the Auckland area so it wasn't a nationwide representation. There was no ceftriaxone resistance, but some resistance to azithromycin – Helen noted there is a high level of resistance to azithromycin in the UK.

Gabrielle asked for clarification about how this information was obtained. Helen confirmed that ESR asks labs to manually send these results and that once 5% resistance is reached the drug is not used empirically.

Helen explained that there are anomalies regarding annual data collection as ESR ask for the number of isolates tested and the number resistant but some labs group together resistant and immediate resistance in one data set. ESR ideally needs to collect separate data for resistance, intermediate resistance and susceptibility. The output from data collection is provided as data back to the labs and also as national data comparison. Data is published on ESR website and also annually reported. ESR supply information from data collection for the World Health Organisation (WHO) report.

SIPCAG had asked Helen to address some specific questions:

- What/who determines which multi-resistant organisms are surveyed?
- How often is the list reviewed?
- What actions come out of the MRO surveillance reports?

Helen noted that MoH's Antimicrobial Resistance Advisory Group (ARAG) had met at least annually and reviewed ESR surveillance activities, but this was now defunct. In future – NZ Microbiology Network would look at this – but this is a big group; MoH are putting together an Antimicrobial Resistance Action Plan – and will have an implementation document to accompany this.

Helen didn't know whether the MRO surveillance reports informed policy recommendations or whether it is used to evaluate effects of intervention.

Richard commented that as a user he thought ESR's work was fantastic. Nelson Marlborough DHB use their website and look at what they do. He commented that if Carbapenem-resistant Enterobacteriaceaes (CREs) were reported more often it would assist in determining which patients to isolate (i.e. inter-hospital transfers), otherwise this information is disseminated via the media. Helen reiterated the real need for an alerts system and advised that she does now have a mandate to develop this.

Lorraine commented that from a DHB/nursing operation perspective, timely reporting was required to ensure timely interventions (e.g. isolation). Another issue is with national alerts on patient files - a lack of standardised alerts is resulting in confused information on patient files. Helen commented that they used to identify the ward in MRSA reporting and there is a web-based system to report transmission of any outbreaks of resistant organisms. The weekly MRSA report is currently not reliably used but this could potentially form the basis of an alerts system.

Josh commented that timely sharing of information was very worthwhile for him but information not cascading to others within the DHB is an issue.

Richard commented that surveillance reports should inform policy recommendations and Pharmac committees should get ESR results. He suggested that SIPCAG reps should raise this at the next HAIGG meeting.

Gabrielle thanked Helen for attending and advised that the slides will be shared with the group for them to pass onto their networks.

Action: SIPCAG reps to speak in support of ESR surveillance reports informing policy recommendations at the next HAIGG meeting.

Action: Commission to share Helen's slides with SIPCAG members

4. HAIGG update

Jane talked through the draft minutes. Kevin Snee is CEO rep on HAIGG. Grant Pidgeon is stepping down as CMO rep.

IPC IT (ICNet) work – contract has not been agreed.

CDI as a notifiable disease – Don is leading this; he has gone back to the communicable diseases team who will work on the reasoning. Arthur noted that more information would be needed from ESR and a focus on whether it is a public health issue not vaccine preventable disease needs work and consideration.

Jane commented re influenza vaccine requirements for healthcare workers that there had been good ideas for increasing vaccination rates within hospitals. Richard asked if it is going to be disseminated. Jane confirmed they publish on website and attendees are supposed to disseminate information to DHBs.

Next HAIGG meeting is 8 June.

Action: Jane to share minutes from the influenza teleconference 16 April once finalised.

Action: Jane to share ESR CDI report once finalised.

5. NMLN update

Minutes from the previous meeting (14 March) were tabled.

Josh provided a brief update on the March meeting. He noted that the ESR CRE report was discussed in relation to the utility of the report and it would be useful to have this on a monthly basis. The round the country update was the most useful part of these meetings. The agenda included the new WHO action plan and there was a suggestion the group look at organisms and surveillance.

6. National IPC Clinical Lead update

The report included in the papers was taken as read. Sally had presented at the annual cardiac surgeons meeting recently and aims to become a permanent presenter at their meeting. She had presented on the value of investment in IPC at the National DHBs CE meeting in April along with Debbie, Janice and Gabrielle and this had gone well.

Action: Share the presentation to the National DHB CE Group.

Sally drew the Group's attention to World Hand Hygiene Day – 5 May – and that posters had been distributed through the hand hygiene coordinator network. The focus for the day was "clean hands in surgery".

There was discussion about the Australian Society for Infectious Diseases (ASID) meeting in Tasmania. It was noted that there was not much infection prevention material, and an absence of NZ representation at the meeting, which Sally intends to follow up.

Sally commented on the work undertaken to match data from the National Surgical Site Infection (SSI) Monitor on surgical site infections at Auckland DHB over a set period with data from ACC on claims.

7. IPC Programme update

The most recent monthly programme status report for the IPC programme has been shared with this group for the first time. This report is provided to the Commission GM each month and is aligned to the IPC programme plan. It is confidential to SIPCAG members and not for sharing wider.

Gabrielle walked the group through the March report, paying particular attention to amber and red ratings. She commented that if there was anything that members were particularly interested in further details could be provided.

8. ACC Treatment Injury update

Nick commented that ACC really admires SIPCAG and the work being done which is very helpful to ACC.

Nick explained "treatment injury" (TI) eligibility requires physical injury directly causally related to treatment by a registered health professional. If nothing changes by 2023 treatment injury will be the largest ACC account. There is a current outstanding liability of over $4 billion. An ACC minister and Board decision has invoked the injury prevention portion of ACC's Act to provide resource to TI.

SSI is an area of significant interest to ACC, but a relatively small volume, with the vast majority coming from primary care. He stressed the importance of clinicians getting

feedback on cases coming into treatment injury as more reporting and more injury gives ACC the imperative to act.

There was discussion about whether the treatment site is reported to DHBs. Nick explained that ACC process is very rigorous – the claim needs to be causally related to a treatment so the treatment site is recorded on the claim form. Concerns were expressed about resources to investigate treatment injury. Nick commented that ACC has asked DHBs what resource they require but has not received any response.

Nick confirmed that he is happy to keep the Treatment Injury update as a standing item on the agenda.

Action: Gabrielle to connect Nick with Gillian Bohm re the national Quality and Risk Managers meeting.

Gabrielle and Sally gave the group a quick update regarding the ACC data match project that Sally is working on at ADHB. She's been comparing ADHB's SSI data from the national SSI monitor for a particular period with ADHB's ACC claims for SSIs during the same period and not finding much of a match – e.g. only three of eleven patients with an orthopaedic SSI had correct forms lodged (ACC2152) and only one of the three had the claim lodged against the original surgical procedure, the 'treatment' from which the injury resulted. Approximately 10 of the 11 SSIs were deep/organ space. None of the seven cardiac SSI patients had an ACC claim for treatment injury lodged. ACC staff are looking into their data to see what they can find from their end.

The group agreed that repeating this at other DHBs is a good idea so a broader understanding can be reached. This has implications for the SSIIP's ability to reduce ACC claim volumes; in fact the likely outcome is that claims will increase, and it's important to know this asap. Sue Wood and Mo Neville agreed to work with Sally to repeat the work at Canterbury and Waikato DHBs. Sally is writing up the methodology and will share this asap.

Action: Sally and programme team to follow up with Sue and Mo to get the ACC data match work repeated at Canterbury and Waikato DHBs.

Action: Sally and programme team to follow up with Jenny Parr and see if she's willing to repeat the ACC data match work at Waitemata.

9. National IPC Workshop 9 August 2016

Gabrielle asked for input on the programme from the group, particularly regarding speakers/facilitators and chairs.

The Group thought the agenda was interesting and asked who expected attendees would be. It was confirmed that it was expected to be multi-disciplinary and was not associated with the IPC Nurses Conference. The group suggested the use of storyboarding, including consumer experience and calling for posters as a way to share local quality improvement initiatives.

Trevor commented that Chris Auld, Regional Director for Health and Services for Microsoft had recently returned to New Zealand. Gabrielle felt this was worthy of an event in itself and asked Trevor to get in touch with Gillian Bohm who had facilitated the workshops with Drs Atal Gawande and Michael Gardam.

10. MoH Antimicrobial Resistance Action (AMR) Group

In Shirley's absence, and with no one else available to take her place, Jane walked the group through Shirley's presentation from One Health Symposium – Summer School. The presentation provided an update of where NZ are in the AMR resistance space and what's happened following the WHO global challenge taken up by the World Health Meeting in May. New Zealand, as a member state, has committed to develop an action plan by May 2017.

An AMS group has been established with representation from MPI, MoH, NZ microbiology network, IPC and the Commission. The group's remit is to carry out a stocktake on AMR in NZ against the WHO's five strategic objectives, describe existing initiatives and identify gaps. Gap analysis needs to be complete by July 2016 and solutions identified by September 2016. The report will then go out for consultation. By December the Group's chairs will prioritise work to address gaps, and a strategic plan and implementation plan will be completed by May 2017.

Jane commented that she is working on a comms plan raising the profile of AMR; both Ministers are aware of this as the Ministry would like endorsement and support from them for this. She confirmed that there had been some media interest with some very specific questions from Martin Johnston (NZ Herald).

The AMS group will meet next on 27 June.

Gabrielle confirmed that this would be a standing agenda item.

11. SSIIP report

Gabrielle confirmed that the Commission has identified funding to allow Canterbury DHB to recruit a full time Business Analyst to manage the national SSI monitor work for the national SSI programme, particularly the relationship with Baxter, change requests, user acceptance testing and outward facing work with DHBs who are finding data collection and reporting a burden. A draft JD for the role has been drawn up and HQSC are varying the contract with CCDHB.

Gabrielle talked to the QI Scholarship Programme. Richard Evert commented that NMDHB was reluctant to send someone. This had come to the attention of the Commission and they are looking at following up with the Director of Nursing. Richard is happy to follow up if we can provide the correspondence previously sent out to DHB CEs.

Action: Andrea to send Richard Everts the correspondence previously sent out to DHB CEs about the QI programme.

The Consumer Co-Design Partners in Care course had generated less interest and Gabrielle felt it would be more difficult to get full participation in the set timeframe. Mo commented that teams were keen but they wanted to be sure they had a consumer. This was a big commitment from a consumer especially if they are working.

Action: Seek permission to share MidCentral Co-Design newsletter with the group.

The SSIIP Steering Group met in April. It is supporting the removal of Quality and Safety Marker (QSM) for skin preparation for Orthopaedics. National compliance is now at 99 percent and has been high for the life of the programme. SIPCAG is being asked to consider supporting the recommendation from the SSIIP Steering Group to remove the QSM for skin preparation for Orthopaedics. A paper seeking approval will need to go to the Board.

Decision: The group agreed to the proposal to remove the QSM for skin preparation for Orthopaedics.

Sue commented that the terminology of "retiring" a QSM had proved confusing for some practitioners (she referenced the 'retirement' of the Safe Surgery NZ process QSM) and asked if this could be changed to "no longer centrally reported", so that DHBs could make the decision whether or not to continue collecting and reviewing the data internally.

Gabrielle commented that the RFP for systematic literature review and meta-analysis on interventions to reduce Gram-positive surgical site infections in orthopaedic and cardiac surgery 2011-2015 closed at 6pm on 3 May with at least six proposals received. SIPCAG will be kept up to date regarding the outcome.

Action: Commission programme team to update SIPCAG following the conclusion of the Meta-Analysis RFP review process.

12. Comparing SSIIP outcomes with other comparable surveillance programmes

Debbie introduced the paper, commenting that the work was prompted by queries from Nick Kendall regarding the lack of change in the outcome measure.

Action: Commission programme team to send SIPCAG the papers that Nick has provided regarding outcomes from other jurisdictions.

The team has looked at other English-speaking countries that have a comparable SSII programme; she is particularly interested in Scotland and WA because of similarities in scale. The programmes looked at are all well established. The complexities found in reporting and data collection pose some issues for meaningful comparison and the group discussed other factors such as financial incentives in the US, lack of improvement component in Scotland, lack of standardisations for improvement interventions and the National Quality Strategy in the US.

There was further discussion around behavioural change interventions, looking at outliers and what they have been doing and sharing this.

Gabrielle commented that discussions would be continuing and there would be further research/papers to come in this area.

13. National SSIIP Clinical Lead report

The clinical leadership report was taken as read.

14. National SSIIP orthopaedic workstream

Arthur presented the SSII Perception Survey reports for endorsement for circulation back to programme stakeholders.

Decision: SIPCAG endorsed the two reports summarising the results from the perception survey for distribution to stakeholders.

Arthur talked through the orthopaedic national quarterly report Jun-Sep 2015. He noted that steady progress over time could be seen for most of the QSMs and initial feedback was that people appreciated this format of data presentation.

Stats show obesity contributing to an increase in SSIs.

Arthur noted that the Orthopaedic Expert Faculty Group is working well.

Action: Arthur and the programme team to separate hip and knee data and bring to next SIPCAG.

15. National SSIIP cardiac workstream

Arthur informed the meeting that the first expert faculty group for cardiac was held on 3 May with three cardiac surgeons and perioperative nurse representation. The group discussed public reporting – it looks like Waikato is further ahead than anticipated and will have data for the next quarter i.e. Jul-Sep, CCDHB will also try to provide this.

The group was asked whether public reporting for QSMs could be delayed by one quarter and it was decided that this was acceptable as it would allow time for Waikato and Capital & Coast DHBs to enter data for that period and give the DHB adequate notice.

Decision: Commence public QSM reporting from March 2017.

Arthur presented a first draft cardiac report.

The expert faculty discussed the skin prep QSM for cardiac and it was decided to wait for higher compliance from other DHBs before recommending dropping this QSM. They also discussed post and pre op glucose control as a possible QSM. There was also discussion about increased risk of SSI for morbidly obese patients and whether increased dosage could mitigate risk but there was no data to confirm this.

16. Hand Hygiene NZ (HHNZ) update

Sally talked to the HHNZ audit report April 2016.

There were discussions about sharing ideas nationally and highlighting DHBs who are doing well to drive others to achieve better results. Sally commented that Auckland has 120 gold auditors doing 50 audits a month. She confirmed that gold auditors were able to train others. It was suggested that neighbouring DHBs could work together and that there might be a move to regional support for training – this is occurring between some DHBs already, e.g. Hutt Valley and Capital and Coast.

Sally drew the meeting's attention to figure two which presented an easier way to look at information. This is interactive on the Commission website.

Action: highlight in the audit report DHBs that are auditing more areas, e.g. options B or C in the HH auditing manual.

Action: QSM table needs to comment on the change in QSM target over time.

17. HHNZ and *Staphylococcus aureus* bacteraemia (SAB) outcome measure

Gabrielle informed the meeting that at the most recent Board meeting there was some discussion about the HH programme and the Board expressed concern that the outcome measure (SAB) hasn't changed and whether the right methodology is being used.

Mo advised that as far as Waikato is concern the HHNZ programme has had a very positive impact – they've had zero norovirus for 24 months and attribute this to hand hygiene.

Action: Commission programme team to follow up with Mo to see if this could be a case study for the HHNZ newsletter / website.

Some discussion about the WHO five moments ensued and whether SAB is the right outcome measure and whether or not HHNZ should have an outcome measure. It was agreed that: 1) the methodology should not be changed now that the programme is well

established and good progress has been made, and that international reviews of the methodology have arrived at the conclusion that the WHO five moments is an appropriate approach (jurisdictions that have changed have only done so at the fringes, e.g. Canada, which collects four moments by combining moments four and five into one); and 2) SAB is a good measure for IPC more generally and the information should continue to be collected and reported, but decoupled from the HHNZ programme because of the wide contributing factors to reduction and / or hospital hand hygiene practice's inability to affect SAB on its own – especially community acquired SAB (the group agreed that there is international precedent for this).

Gabrielle noted that a more detailed paper would be put to the Board meeting in July, and in the interim members of SIPCAG group might be called upon for expertise.

Decision: SIPCAG agreed that their advice would be not to change the 5 moments and instead decouple the outcome measure (SAB) from HH, but continue to report this as an IPC-wide outcome measure.

18. Frontline ownership

Debbie explained to the group that she had followed up with Dr Michael Gardam after the survey monkey to gauge how participants had benefitted from the workshop with him last September. There was an enthusiastic response and Michael asked whether individuals would be interested in a call so he could get some direct feedback on how the tools were being used. Debbie organised a half-hour session for participants to talk to Michael about ways they had used the techniques learned from the workshop. It was a very positive experience for all involved and Debbie made a commitment with Michael to arrange another session in 3-4 months to review progress. She has also been in touch with comms to do a case study.

19. Regional IPC network meetings

Northern and Central IPC network meetings have been held since last SIPCAG meeting.

Debbie reported that the Central meeting had been well attended. Arthur had updated the Group on the SSII programme. She felt the meeting augured well for a strong regional network. The meeting also had support from the Director of Nursing. The next meeting is scheduled for 24 August in Wanganui.

The first Northern meeting of the year was shared between three DHBs. The meeting was hosted by Counties Manukau Health with Northland joining by VC. Arthur presented an update on the SSII Programme and Debbie on the IPC Programme. Local issues were discussed and Debbie Rouse-Hailstone, charge nurse of ED followed up on previous presentation on HH in ED.

There is no confirmed date for next South Island meeting.

Midland has committed to holding a meeting before end of the financial year.

Action: Mo Neville to advise what support is needed for the Midland region IPC network meeting.

20. SIPCAG Terms of Reference

Gabrielle presented the Terms of Reference with tracked changes and asked for any comments.

Item 2.2 on second page bullet point 4, measurable improvement – it was agreed that there shouldn't be a time limit on it.

It was also agreed to rename clinical leaders list to DHBs and put Quality & Risk Managers under DHBs and also reword: members are expected to convey, with caveat, where feasible, or where a consensus view exists.

Action: Make the above changes.

21. Any Other Business

Gabrielle commented that this was her last SIPCAG meeting, as she would be moving into a new 0.6 FTE role as Senior Project Manager in the QI team from mid-July. The Commission is currently recruiting a new Senior Portfolio Manager hopefully starting mid-June. Gabrielle thanked the group for their efforts over the past two years. The group thanked Gabrielle for doing such an excellent job of chairing the Group.

The next SIPCAG meeting will be held on 3 August in Wellington.

Action list following SIPCAG meeting 4 May 2016

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	10 February 2016	IPC Programme Plan	Seek permission to share an edited version of the final IPC Programme Plan on the website.	Gabrielle	August 2016	In progress
2.	10 February 2016	HASABSI report	Provide SIPCAG with further information on reduction in the SAB rate at ADHB since 2009.	Sally Roberts & Commission IPC team	August 2016	In progress
3.	10 February 2016	HASABSI report	Explore HASABSI maker as a marker for IPC rather than a programme specific maker for HH improvement. Added to with further discussion at May 2016 meeting: Draft Board paper regarding this to be shared with SIPCAG out of cycle (prior to going to the Board)	Sally Roberts & Commission IPC team	August 2016	In progress
4.	4 May 2016	Surveillance of multi-resistant organisms	SIPCAG reps to speak in support of ESR surveillance reports informing policy recommendations at the next HAIGG meeting	Sally Roberts and Gabrielle Nicholson	August 2016	In progress
5.	4 May 2016	Surveillance of multi-resistant organisms	Commission to share Helen's slides with SIPCAG members	Andrea Flynn	August 2016	In progress
6.	4 May 2016	HAIGG Update	Jane to share minutes from the influenza teleconference 16 April once finalised.	Jane Pryer	August 2016	In progress
7.	4 May 2016	HAIGG Update	Jane to share ESR CDI report once finalised.	Jane Pryer	August 2016	In progress
8.	4 May 2016	National Clinical Lead Update	Share the presentation to the National DHB CE Group.	Andrea Flynn	August 2016	In progress
9.	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	Jane Pryer	August 2016	In progress

No	Meeting date	Topic	Action required	By whom	By when	Status
10.	4 May 2016	IPC Programme Planning and Reporting	Change the wording in the report to reflect feedback from Arthur (ref pg 24 programme report paediatric procedures are included.)	Andrea Flynn	August 2016	Complete
11.	4 May 2016	ACC Treatment Injury Update	Gabrielle to connect Nick with Gillian Bohm re the national Quality and Risk Managers meeting.	Gabrielle Nicholson	August 2016	Complete
12.	4 May 2016	ACC Treatment Injury Update	Sally and programme team to follow up with Sue and Mo to get the ACC data match work repeated at Canterbury and Waikato DHBs.	Sally Roberts and Nikki Grae	August 2016	In progress
13.	4 May 2016	ACC Treatment Injury Update	Sally and programme team to follow up with Jenny Parr and see if she's willing to repeat the ACC data match work at Waitemata.	Sally Roberts and Nikki Grae	August 2016	In progress
14.	4 May 2016	SSIIP	Andrea to send Richard Everts the correspondence previously sent out to DHB CEs about the QI programme.	Andrea Flynn	August 2016	Complete
15.	4 May 2016	SSIIP	Seek permission to share MidCentral Co-Design newsletter with the group.	Andrea Flynn	August 2016	In progress
16.	4 May 2016	SSIIP	Commission programme team to update SIPCAG following the conclusion of the Meta-Analysis RFP review process.	Andrea Flynn	August 2016	In progress
17.	4 May 2016	SSIIP Outcomes Comparison	Commission programme team to send SIPCAG the papers that Nick has provided regarding outcomes from other jurisdictions.	Andrea Flynn	August 2016	In progress
18.	4 May 2016	National SSIIP Orthopaedic Workstream	Arthur and the programme team to separate hip and knee data and bring to next SIPCAG.	Arthur Morris	August 2016	In progress
19.	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	In progress
20.	4 May 2016	HHNZ Update	QSM table needs to comment on the change in QSM target over time.	Sally Roberts	August 2016	In progress

No	Meeting date	Topic	Action required	By whom	By when	Status
21.	4 May 2016	HHNZ and *Staphylococcus aureus* bacteraemia (SAB) outcome measure	Commission programme team to follow up with Mo to see if this could be a case study for the HHNZ newsletter / website.	Andrea Flynn	August 2016	In progress
22.	4 May 2016	Regional IPC network meetings	Mo Neville to advise what support is needed for the Midland region IPC network meeting.	Mo Neville	August 2016	In progress
23.	4 May 2016	SIPCAG ToR	Rename clinical leaders list to DHBs and put Q&R Managers under DHBs. Reword – members are expected to convey, with caveat, where feasible, or where a consensus view exists.	Andrea Flynn	August 2016	In progress