Minutes of the 21st meeting of the Strategic Infection Prevention & Control Advisory Group on 9 November 2017
9.35am – 3pm

Present: Ashley Bloomfield (Chair) arrived 11.45am, Lorraine Rees, Josh Freeman, Mo Neville, Sheldon Ngatai, Sue Wood, Trevor English, Sally Roberts, Jo Stodart, Gillian Bohm, Nick Kendall left at 11am, returned at 1.30pm, Richard Everts, Bridget Goggin, Jane Pryer and Jane Barnett

In attendance: Gary Tonkin (Chair from 9.35am – 11.45am), Andrea Flynn, Nikki Grae and Lynette Drew

Guest presenter: Natasha Murray, Ministry of Health

Apologies: Arthur Morris

The meeting commenced at 9.35am.

Gary Tonkin announced he would be chairing the meeting until Ashley arrived.

Membership
The Chair welcomed Jane Barnett, as the new NZ Private Surgical Hospital Association representative. Jane is sharing the role of communicating back to the PSH sector with Tanya Jackways and Tanya will attend when Jane isn't available.

The Chair noted Trevor English's term has ended and thanked Trevor for his contribution over the last three years. Trevor encouraged ongoing engagement with the Pathology Roundtable.

1. Declaration of interest
Members were given an opportunity to update the declaration of interest register. No updates were made.

2. Minutes of the previous meeting held 11 May 2017
The minutes were accepted as a true and correct record. The actions were updated.

There was discussion about sharing the minutes from this meeting with wider stakeholders. The Health Quality & Safety Commission (the Commission) encourages members to share the minutes of the meeting with their respective groups and networks. The approved draft minutes are published on the IPC section of the Commission's website approx. 6 weeks after the meeting, then finalised following the next SIPCAG meeting. Members are welcome to share what was discussed at the meeting but should state clearly when they are expressing their own view.

3. IPC Clinical Governance in DHBs
Jo Stodart gave a presentation on her thesis, IPC clinical governance in New Zealand DHBs, as part of her Masters in Public Health at the University of Otago. Jo explained she had limited understanding of the topic (prior to starting her research project), however she believed it was important to the IPC role. Her research included a series of semi-structured interviews with IPC nurses (10 DHBs) and a review of all 20 DHB's Infection Control Committee terms of reference. It also referenced the Commission's *Clinical Governance: Guidance for health and disability providers*.

Findings from interview thematic analysis:

- The IPC Standard (NZS 8134.3:2008) was viewed as positive
- Implementation of the IPC standard depends on clinical governance structure
- Inconsistent implementation of the IPC standards between and within DHBs
- Continual change impacts on effective clinical governance
- The importance of IPC opinion leaders and positive relationships.

Recommendations:

- Update the IPC standards to reflect changes in clinical governance
- Education and training to be provided on the meaning and application of clinical governance
- A multidisciplinary team approach to IPC
- The responsibility for the operationalisation of clinical governance should sit with individual DHBs
- Each DHB should include consumer engagement in the IPC programme
- IPC programmes and frameworks should reflect the importance of Te Tiriti o Waitangi to the New Zealand health system and reference this
- Constant change in health management impacts the implementation of IPC; this impact should be considered during any proposals for change in New Zealand DHBs.

Conclusions:

- IPC and clinical governance are critical components for patient safety.
- IPC provides a unique insight into the functioning of an organisation.
- The role of IPC is often invisible especially if it is functioning well.

Members thanked Jo for sharing the findings from her research and had an opportunity to ask questions. In response to the questions Jo made the following points:

- In small DHBs the number of layers between IPC and the CE was often less.
- Change management can have a positive impact on IPC but allowing sufficient time to fully embed the changes is essential.
- Linking the IC committee ToR to the DHB strategic plan enables it to be effective.

4. IPC Clinical lead update

Sally Roberts gave a quarterly update on clinical leadership in relation to IPC.

Sally has presented on the Commission's work at a number of meetings throughout October including the Hand Hygiene NZ workshop, IPC Nurses College Conference and the New Zealand Orthopaedic Association annual meeting, where there was interest from the paediatric surgeons in relation to the orthopaedic surgery SSIIP.

Sally has been supporting the local implementation of ICNet and has been doing work on benefits realisation in relation to ICNet which she intends to share more widely to assist other DHBs considering purchasing ICNet.

5. ACC update on ICNet roll out

Trevor provided an update on the ICNet rollout. The goal for this project is to reduce the incidence and severity of healthcare associated infections, taking account of growing antimicrobial resistance. The initial focus is on hospitals while building capability in primary care.

His presentation was given at the recent Health Information New Zealand conference.

The work has been divided up into a number of workstreams and a project leadership group is being established.

The key workstreams include:
- User group/national support
- Standardised definitions
- Data use/stewardship
- Product architecture
- Commercial
- Business case and implementation products
- Interoperability
- Joint plans with other agencies.

The project team has engaged with all of the DHBs to determine their readiness/appetite to procure. There is a lot of interest and engagement.

Trevor expressed a need for the sector to be more agile, however our systems are not designed to support rapid change.

There is no requirement for DHBs to undertake an RFP (request for proposal) process regarding ICNet.

Projects in excess of $500k require Ministry sign off. The project team is working with MoH to arrange prior approval to support the process.

Trevor supports the use of consistent language in relation to ICNet with DHBs and other stakeholder groups. This will ensure a level of familiarity across the sector.

The involvement of NZ private surgical hospitals was discussed and further discussion about how this could be progressed will occur outside of this meeting.

Within the current contract arrangements there are no financial incentives for adopting a regional or national approach to implementing ICNet.

The programme has developed an economic model using a health economist. This will support business case development. The model is based on a large DHB but should also be able to be applied to a regional hospital. The question was asked about why the Ministry won't fund this project given the predicted savings from the economic model.

6. ACC update

Nick provided an update on the ACC infections programme. The second report on *supporting patient safety: treatment injury information* is expected to be released in two weeks. The latest report will include national level private surgical hospital data. ACC is looking to include equipment failures, surgical mesh and omissions (missed diagnosis) in this report.

The process of reviewing treatment injury claims data highlighted an increase in peripheral line infections for Hutt Valley DHB. ACC has since funded a programme at Hutt Valley DHB to reduce peripheral IV line infections. There has also been interest from another DHB.

The ACC infections reference group met yesterday. ACC needs to reflect on the ideas discussed before it can provide an update to SIPCAG.

Nick left the meeting at 11am.

7. Antimicrobial resistance (AMR)

Natasha Murray provided an update on progress since SIPCAG last met. The AMR action plan was released early August. Since then, the Health Antimicrobial Resistance Coordination Group (HARC) group has been established. The first meeting of HARC occurs on 14 November in Wellington.

The AMR section of the Ministry of Health's website has been refreshed to reflect recent updates and there are plans to develop the website further to report the status of activities under the 5 objectives of the plan. This will be updated three times each year.

http://www.health.govt.nz/our-work/diseases-and-conditions/antimicrobial-resistance/new-zealand-antimicrobial-resistance-action-plan

World Antibiotic Awareness Week (WAAW) runs from 13-19 November. The Ministry engaged with a range of stakeholders and partners to develop key messages for communities and health professionals which are now published on their website, and encourage people to share this information wider. They are also participating in a live twitter campaign alongside HQSC on 6 November. The Ministry acknowledged the Commission's support for WAAW.

Objective 3 - Infection prevention & control - has the most relevance to SIPCAG and Jane Pryer provided an update on activities specifically relating to this objective.

- There are plans to develop and update national guidance for Carbapenemase-producing Enterobacteriaceae (and other multi-drug resistant organisms), review the IPC components of the NZ Health and Disability standards (2008) to achieve a nationally consistent approach, and enhance accreditation and quality assurance programmesacross human health, animal health and agriculture.
- A literature search is underway for updating national guidance.
- There were 393 responses to a HealthCERT survey about the NZ Health and Disability standards (2008) and 297 were in support of either amend or replace. HealthCERT are responsible for the review of the standards. A report is expected before the end of the year on the status of the standards.
- There is interest in reviewing the process for accreditation.
- Jane found Jo's earlier presentation on IPC clinical governance informative and will take back the findings related to the IPC standard.

The group discussed membership of the HARC and suggested inviting a senior DHB representative on to the group e.g. a CMO.

Feedback and questions relating to the implementation of the AMR action plan should be directed to AMR@moh.govt.nz

Ashley joined the meeting at 11.45am.

8. Progress in HAI national governance and SIPCAG's role in supporting/advising

Ashley gave a brief update on the interim national HAI governance group. This group had its first meeting last week. Membership includes representatives from MoH, the Commission, PHARMAC, ACC and DHBs. Stewart Jessamine is the Chair and the Commission is providing secretariat support for the group.

6. Peripheral intravenous (PIV) line management

At the last SIPCAG meeting the IPC programme team was asked to further define the problem relating to PIV infections and identify opportunities for national involvement.

Nikki presented more comprehensive SAB source data from 18 of the 20 DHBs.

Based on the information provided by the IPC champions, twenty-one percent of SAB infections were from PIVs. Twenty-three percent were unknown or 'other'.

Members asked whether it looked like there was under-reporting in some areas. Those who work at DHBs felt there may be more infections than what is reported.

DHBs had been asked whether they collect data on PIVs either through reportable events, IV Clinical Nurse Specialist (CNS) or HAI surveillance. The response to this question was discussed. It was noted that not all DHBs would have an IV CNS.

Nikki outlined options for what could potentially be done within our current resourcing and opened up the discussion.

Suggestions included reviewing available information and best practice and developing an infographic (e.g. Here is the problem and this is what it is costing the health system) and developing guidance similar to the falls projects' top 10 topics for falls.

There was discussion about what could be used as a denominator. A proxy was suggested such as cannula days.

Aseptic non-touch technique (ANTT) can be applied to multiple interventions and procedures presenting an opportunity for wider improvement based on principles.

Emergency departments, St Johns Ambulance, IV Nurses and ward nurses all insert PIV lines. It was thought some staff will be unaware of the risk of infection.

Monitoring PIV lines presents a further opportunity to support reducing antimicrobial resistance as a review of lines presents an opportunity to assess whether IV antibiotics can be stopped.

There was a collective view that PIV management is a priority area.

Dr Vineet Chopra MMBS is the keynote speaker for the IVNNZ 2018 meeting. The IVNNZ have approached the Commission about engaging with Dr Chopra while he is in NZ.

Action: Commission IPC team to determine opportunities for raising awareness of PIV infections at a national level and report back to SIPCAG. Continue discussions with IVNNZ and IPCNC.

7. Hand Hygiene

HHNZ workshop
Nikki presented a summary of the recent HHNZ national workshop. The workshop was well attended by public and private sector participants. The presentations were circulated with the meeting papers. These will be made available to participants and HH coordinators.

Spread was an area of focus for the workshop and it was clear from the presentations and the discussions that hospitals are already spreading or planning to increase the wards audited in their organisation. There was a workshop activity specifically focused on spread and another on validation of auditing.

Reporting on spread of HH improvement
Since the last SIPCAG meeting the HHNZ team has made contact with each DHB to confirm their HH ward information, high risk areas and bed numbers. The database has been updated accordingly. The latest audit data has been used to populate a table showing where each DHB is on their journey to spreading across all acute clinical areas.

There was discussion about how this information can most usefully be communicated to DHBs to support spread. SIPCAG's view is that DHBs would already know where they need to focus to achieve spread and the information in the report is available to the HH coordinator via the HH database. DHBs would be less inclined to look at the progress of other DHBs and would be focused on their own improvement.

SIPCAG suggested that over time, accountability for hand hygiene should more explicitly be assumed by DHB clinical governance structures. and asked that the Commission writes to senior leaders highlighting their responsibility for ensuring good hand hygiene practice is embedded across the whole organisation and including up-to-date spread information. Further guidance could be given to IC committees with expectations or questions for consideration.

The IPC programme team was asked by SIPCAG to consider an end point for the Commission's investment and discuss with the Ministry of Health options for embedding hand hygiene within the existing accountability frameworks. It was asked whether hand hygiene compliance could form part of the IPC standard or could be part of regional service plans.

Action: HHNZ team to track progress of spread by DHBs, discuss with specific hand hygiene coordinators as needed and include in letter to senior leaders during 2018.

Action: consider an end point for the Commission's investment and discuss with the Ministry of Health options for embedding hand hygiene within the existing accountability frameworks.

Nikki proposed an approach to seeking expert advice from our hand hygiene coordinators. This involved pulling together a group of self-nominated HH coordinators along with representation from the IPC Nurses College and private surgical hospitals to inform the HH programme on key areas of work e.g. around spread, HA-SAB and gold auditor training. The group could help us in prioritising work and provide valuable feedback on the operationalisation of the new guidance. SIPCAG was in favour of a topic-based approach, seeking participation based on the nature of the topic to be discussed as required.

8. SSIIP – update

Andrea talked to the SSIIP quarterly update report included in the meeting papers. The last quarter has been very productive in terms of engagement with DHB users and using more of the functionality available in the national monitor. A suite of reports to easily identify common data entry errors has been developed and demonstrated to users. Feedback on the usefulness of these reports has been positive. There has been a strong focus on data cleaning and validation. The programme team has reconciled all of the procedures and SSIs in the national reports with the data in the national monitor and followed up with DHBs on any differences. The team is now focused on encouraging users to review their data after it is submitted to the national monitor and are working towards moving away from producing a full draft report.

The SSII evaluation report has been finalised and a copy was included with the papers. This report will be published soon. The Commission's comms team are helping to develop a media release and key messages to coincide with publication of the report.

SIPCAG was pleased with the final report and the findings.

Lynette provided an update on the reducing staphylococcal SSI collaborative. Two face-to-face learning sessions and two webinars have occurred since the previous SIPCAG meeting. Each hospital team shared their progress and current plans for developing and implementing their preoperative anti-staph bundle including any tests of change. All projects include a strong patient focus on the development of patient literature, and suitable products. Discussion related to nasal decolonisation products and compliance audits to measure adherence were among the topics discussed by the participants.

Nick returned at 1.30pm.

Programme plan 2018/19

An outline programme plan for 2018/19 was included with the meeting papers. The paper summarised the areas of focus for Hand Hygiene NZ, SSII and IPC throughout 2017/18 and noted the activity which is likely to continue through to 2018/19. The Commission is committed to reducing HAIs over the long term and has committed funds to maintain the current improvement programmes. The IPC programme sought feedback from SIPCAG on opportunities to improve patient outcomes by reducing the incidence and impact of HAIs and how to determine where there is the greatest need. Feedback was also sought on what the programme could do at a national level to support the sector.

Feedback from SIPCAG suggested a need for further cross-organisation capability building, particularly around engaging consumers, improving governance and quality improvement methodologies. This would enable DHBs to look at their own data, identify opportunities to reduce harm and use the QI methodologies to test solutions. A consumer engagement how to guide was suggested and revision of the IPC Standard was again noted as being a useful way of embedding the foundations required for capability in DHBs. There was an interest in looking at opportunities to improve equity, particularly around sepsis data.

In relation to identifying what HAIs/procedures to focus on there was a suggestion to develop a matrix for HAI considering the frequency and burden. It could also consider availability of data and evidence based bundles. PIV is a particular area of interest and there are a lot of evidence based guidelines available already. Guidance could be provided for IPC clinical governance structures – looking at key questions for different roles within the organisation. CAUTI was suggested as an opportunity as in some areas/countries it is used as a proxy measure for IPC.

SIPCAG suggested the team defines the vision for the next 5 years and also looks at opportunities from implementing ICNet.

Action: Continue to develop 5-year vision and emphasis on capability, as part of ongoing development of the Commission's Improvement Hub and HAI programme planning.

Action: Develop a matrix to help assess potential areas of focus.

Action: Scope up PIV as a QI programme.

9. National multidisciplinary workshop on reducing HAIs

Following the success of the 2016 national multidisciplinary workshop the Commission is planning an event in the first half of 2018. The Commission sought feedback from SIPCAG on themes for the workshop and preferred location and month. Suggestions included:

- discussion on what we should be collecting locally and nationally - what data is useful to collect and how should we use it

- communicating data - tailoring information for different audiences, pitching to the right group e.g. Hans Rosling
- talks from participants on the QI facilitators programme
- consumer story
- AMR
- leadership capability
- session on PIV
- unconferencing format for part of day.

It was suggested the event is held in Wellington in May.

Action: Secure a venue in Wellington and send out a 'save the date' flyer for a date in May.

12 Any other business

The meeting closed at 3.00 pm.

The next SIPCAG meeting will be on 20 March 2018.

Action list following SIPCAG meeting 9 November 2017

No	Meeting date	Topic	Action required	By whom	By when	Status
1.	9 November 2017	PIV	Commission IPC team to determine opportunities for raising awareness of PIV infections at a national level and report back to SIPCAG	IPC team	March 2018	
2.	9 November 2017	HHNZ spread	HHNZ team to track progress of spread by DHBs, discuss with specific hand hygiene coordinators as needed and include in letter to senior leaders during 2018.	HHNZ team	February 2018	
3.	9 November 2017	HHNZ transition	Consider an end point for the Commission's investment and discuss with the Ministry of Health options for embedding hand hygiene within the existing accountability frameworks.	IPC team	March 2018	
4.	9 November 2017	IPC programme plan	Continue to develop 5 year vision and emphasis on capability, as part of ongoing development of the Commission's Improvement Hub and HAI programme planning	IPC team	March 2018	
5.	9 November 2017	IPC programme plan	Develop a matrix to help assess potential areas of focus	IPC team	End June 2018	
6.	9 November 2017	IPC programme plan	Scope up PIV as a QI programme	IPC team	Update at the next meeting	
7.	9 November 2017	National MDT workshop on reducing HAIs	Secure a venue in Wellington and send out a save the date flyer for a date in May.	IPC team	December 2017	In progress
8.	3 August 2017	AMR	Ashley to raise CPE in relation to the AMR action plan at the next interim governance group meeting.	Ashley	At next meeting	
9.	3 August 2017	HHNZ - GAT	HHNZ programme to identify and prioritise actions relating to each theme from the survey feedback.	IPC team	9 November	In progress

No	Meeting date	Topic	Action required	By whom	By when	Status
10.	3 August 2017	ICNet roll out	Ashley and ACC to raise ICNet as an opportunity for AMR surveillance through interfacing e-meds at the interim governance meeting noted earlier.	Ashley	At next meeting	