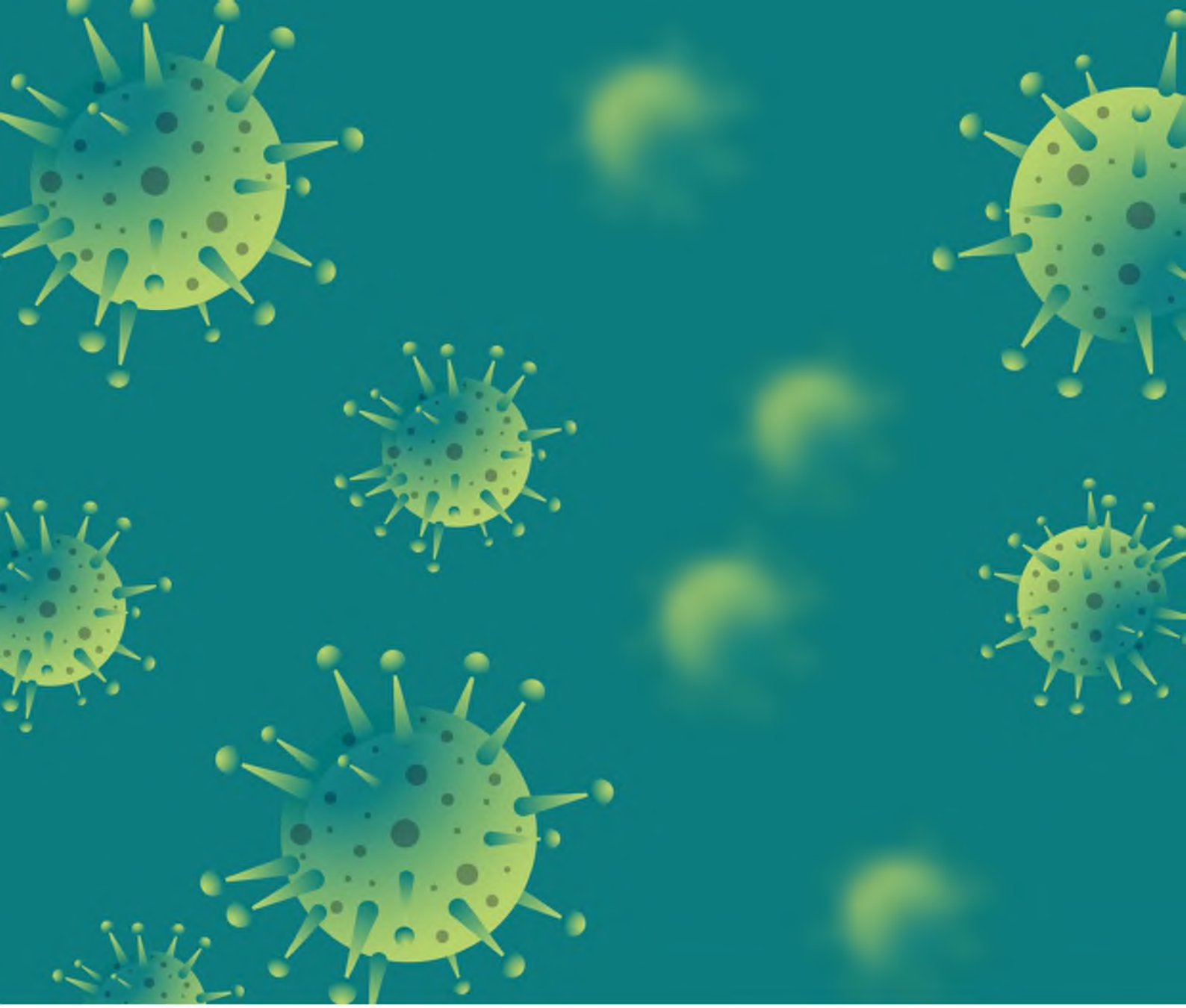

ACIPC

Australasian College
for Infection Prevention and Control

ACIPC COVID-19 Response Inquiry

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Introduction

The Australasian College for Infection Prevention and Control (ACIPC) is the peak body for infection prevention and control in the region, providing leadership, education, and evidence-based practice for a healthy community. The College supports members and Infection Prevention and Control (IPC) in the broader community through activities including education, IPC advocacy, collaboration with health associations and international IPC organisations, and communication with members and stakeholders.

Response to the COVID-19 Response Inquiry terms of reference

1. *Governance including the role of the Commonwealth Government, responsibilities of state and territory governments, national governance mechanisms and advisory bodies supporting responses to COVID-19.*

It became evident during the COVID-19 pandemic, that there was a lack of coordination in the response from the Federal and State governments, with communications being inconsistent and disjointed, creating chaos across the health system and community.

The Infection Prevention and Control Expert Group (ICEG) was established as a sub-committee of the Australian Health Protection Principal Committee (AHPPC), to provide expert advice and support IPC best practices within the community, hospitals and institutional settings. The need to rapidly establish ICEG highlighted the fact that national pandemic preparedness was deficient and emphasised the need for an Australian Centre for Disease Control (CDC) with a permanent ICEG-like group, to lead and drive policy independently of politicians.

The AHPPC did not formalize ICEG within the committee structure. Doing so would have positioned the ICEG to establish authority and provide advice across jurisdictions. Due to the lack of ongoing formal arrangements, including; committee structure within AHPPC, membership, and approach to stand-up the ICEG, the current position remains the same as at the beginning of COVID, with no IPC advisory body in Australia.

ACIPC were well represented at ICEG and the COVID-19 Evidence taskforce. This allowed IPC input on evidence-based guidelines developed by the task force. Once established, these groups functioned reasonably well, however, the recognition and use of the ICEG as an IPC advisory body during the pandemic was inconsistent and lacked uniformity with the State and National pandemic approach.

It became clear during the pandemic, that IPC is an under-resourced and under-recognised specialty. COVID-19 is an infectious disease, and the response was not led by Infectious Diseases or IPC. There were incorrect perceptions that the IPC response was able to be provided by Public Health and Safety and Quality Commission. However, these are very different modalities and while there needs to be clear and strong lines between each section, the expertise and advice relating to IPC needs to come from that branch.

Recommendation: Establish and embed IPC within the CDC

- Implement a Chief IPC role within the CDC (similar to the Chief Medical Officer and Chief Nurse) to provide one source of authority & leadership across the health and public sectors.
- Ensure the CDC has IPC and ID expertise with experienced and credible membership.
- Provide a formalized and embedded committee structure to the ICEG, including an escalation plan to stand up the ICEG when governance is required for outbreak and disaster management.

2. Key health response measures

The challenges with COVID-19 response measures were evident due to the lack of recognition of IPC as a specialist field, and a lack of IPC input into guideline development.

It was noted that the national stockpile of PPE posed significant issues including; the extent of the stockpile, variability to stock access, and a lack of consideration to the guidelines for PPE use that did not consider availability and accessibility of PPE stock.

There was significant variability in the engagement with IPC expertise in community programs, e.g., establishing vaccination and quarantine programs, which required IPC expertise.

Recommendation:

- Recognize and endorse IPC as a specialized field, and the practitioners as experienced and qualified experts within this field.

5. Support for industry and businesses

The aged care sector was particularly vulnerable during the pandemic resulting in multiple and significant outbreaks, due to the at-risk population and a fragmented and underfunded sector.

The implementation of an aged care Infection Prevention response to strengthen the industry was required. Including the development and implementation of an Aged Care Infection Prevention Strategy that integrates the IPC and AMS standards for accreditation, including practice requirements to meet risk; such as training and education pathways, resource development, and established community of practice.

During the pandemic, it was mandated for Aged Care facilities to have one trained IPC lead, however, there was no consideration for other health sectors, e.g., public and private health, community, and disability.

There is considerable variability within the design, structure and resources allocated to the implementation and management of IPC programs around the country. A national benchmark needs to be established, to reduce variability within the States, and bring consistency to the programs.

Recommendation:

- The Aged care approach is translated across all health sectors, including public and private health, community, and disability.
- The CDC develops resources to guide IPC program design, resource allocation, structure and implementation.

7. Community support.

IPC has historically related largely to hospital care, however, during COVID-19 it became evident that there is a requirement for IPC resources within the community, that are underdeveloped and under-resourced. IPC is translatable within community environments and an embedded structure to build upon is a necessity during a pandemic. Supporting the public to manage IPC within the community with IPC supports will enhance the response, provide consistency in the response, and improve outcomes when used in conjunction with public health.

Recommendation:

- Increase the profile of IPC and its role within the non-hospital setting, e.g. Aged Care, community, and disability.
- Enhance the provision of IPC resources when managing a pandemic response to facilitate strategic practices and consistency across States.

8. Mechanisms to better target future responses to the needs of particular populations.

While ICEG's advice was well intended and based on the best available evidence, it was up to each state and territory to implement IPC guidelines, and on many occasions, they did not follow ICEG's advice. This highlights the need for a national approach to pandemics with a CDC.

Considering the Federal Government's announcement that all aged care providers must have one or more trained infection control officers, to improve infection control management within their facilities, ACIPC was able to pivot their education program structure to facilitate the large intake of students from the aged care sector into the Foundations of Infection Prevention course (FIPC).

Recommendations: IPC is structured within the CDC to;

- Provide strategic oversight in the coordination and development of health programs, pandemic preparedness, and protection.
- Include a national surveillance program with; standardized case definitions, clinical guidelines and best practice advice for the health, aged care, and community settings.
- The CDC functions primarily as an advisory body for public health, with the scope to provide a bridge between government agencies and the healthcare and aged care sectors.
- Implement a Chief IPC role within the CDC (similar to the Chief Medical Officer and Chief Nurse) to provide one source of authority & leadership across the health and public sectors.
- Ensure the CDC has IPC and ID expertise with experienced and credible membership.