



Tasmania's Response to the Human Swine Flu (H1N1) Pandemic

ISSUES AND RECOMMENDATIONS FROM A GENERAL PRACTICE PERSPECTIVE

An outbreak of pandemic influenza poses a significant threat to the health and wellbeing of the Australian population. A well organised and integrated health care response including a prepared and protected general practice workforce is essential to protect the Australian community in such an environment.

The General Practice Tasmania (GPT) Network has been an active participant in planning and preparing for a pandemic outbreak. The Network's existing systems and infrastructure including information databases, effective communication protocols and consultative mechanisms are of particular relevance to assist in planning the service response to pandemic influenza.

This document was developed by the GPT Network in collaboration with the Tasmanian faculty of the Royal Australian College of General Practitioners (RACGP) and the State branch of the Australian Medical Association (AMA). The GPT Network, and related general practice stakeholder organisations, value the opportunity to provide input to the Department of Health and Human Services' (DHHS) review of the State response to the 2009 pandemic. Furthermore the Network encourages the Department to provide opportunities for organisations, GPs and practices to participate in future debriefing and review activities.

The following information outlines a number of issues that emerged from a general practice perspective in the 2009 response to the outbreak of human swine flu in Tasmania. The document also makes a number of recommendations for improvements in pandemic preparation, process and response.

1. Planning and preparation

A variety of plans and protocols exist to support the coordination of the Tasmanian pandemic response. The GPT Network has been actively engaged in planning activities and values ongoing participation. Through the recent outbreak of human swine flu several issues have been identified that may require future plans to be modified.

ISSUES

There is a continued lack of familiarity with pandemic response plans at the State level across the various parts of the health sector. This is believed to be partly due to the government style framework of these documents and partly as a result of human nature whereby plans of this type are not meaningful until such time as they are needed. While efforts have been made to address this issue within general practice through the development of a reference resource and training undertaken through the General Practice South project, regular and ongoing familiarisation and training is necessary across all parts of the health sector. This may be achieved through a mixture of regular pandemic response exercises, clearly documented and simple plans and ensuring that every person that

may be required to be involved in responding to a pandemic is aware of the response plans and has access to resources to be able to familiarise themselves with the role that they may be expected to play.

There were also frustrations experienced within the GPT network as a result of DHHS staff being deployed to the Public Health Emergency Operations Centre (PHEOC) or Emergency Coordination Centre (ECC) that had no knowledge of work that had already been undertaken between DHHS and GPT and arrangements that had been discussed or agreed.

GPT and its members have established through its annual General Practice Census a means of assessing practice preparedness and monitoring the willingness of GPs and other practice staff to provide support to a pandemic response.

RECOMMENDATIONS:

- 1.1 *The Tasmanian Pandemic Influenza Plan (TPIP) must be demystified to the point where all parties that are involved in the response are aware of the TPIP, are clear about the roles, responsibilities and accountabilities of various parties. This may entail the development of a short "plain English" guide or checklist that can be used as a "ready reckoner" for all roles from ECC reception to GP or practice nurse working in a flu clinic.*
- 1.2 *An annual audit of practices in relation to their pandemic preparedness and infection control procedures may be effective and should be considered by the Commonwealth Government in the context of funding ongoing pandemic responsibilities through Divisions of General Practice.*
- 1.3 *That GPT ensures that an assessment of pandemic preparedness and willingness to volunteer features annually in the Tasmanian General Practice Census that is run in May each year and reports these results to the DHHS.*
- 1.4 *That GPT develops a companion document to the TPIP for use in the GPT network that clarifies the roles, responsibilities and accountabilities of parties such as GP Divisions in supporting the State response.*

2. Culture and Context

The GPT network interacted with numerous members of the PHEOC and the ECC that were stood up by DHHS during the H1N1 pandemic. This included regular telephone conversations, meetings and participation in numerous working groups both face to face and via teleconference.

ISSUES:

While staff were clearly highly motivated, were under pressure and had the best intentions during this time, many of them had little knowledge of how general practice works and there was little or no continuity of knowledge and information between "shift changes". This resulted in GPT staff briefing many new DHHS staff members about the events that had occurred to date, about the role of general practice, issues that had emerged and strategies that had been developed. There were also occasions where DHHS staff were overly directive towards GPT staff and appeared to be working from a paradigm that general practices could be instructed to behave in a certain way.

RECOMMENDATIONS:

- 2.1 *That a system is established to ensure adequate briefing of all staff as they join the pandemic response teams.*
- 2.2 *That adequate orientation be built into relevant DHHS staff induction processes to ensure that when staff are actively involved in the PHEOC or ECC they can be assumed to have basic knowledge and understanding of general practice and its role in a pandemic response.*

3. Communication and Information Exchange

Effective communication and information exchange is critical to a successful and effective pandemic response. Communication arrangements and protocols need to be planned, tested and refined to ensure their adequacy and ongoing relevance. In Tasmania, the Director of Public Health (Tasmanian State Department of Health and Human Services) is recognised as the authoritative source of information for general practice about the status of the disease, the pandemic alert level, the case definition, procedures for specimen collection and testing, infection control including the use of personal protective equipment (PPE) and anti-viral medication. In the event of a pandemic the Director of Public Health is also responsible for coordinating the statewide response including the deployment of the general practice workforce and related resources to support the establishment of flu services and flu clinics.

Communications must at all times ensure that general practices are kept informed of any role they may be asked or expected to play in the State's pandemic response.

During the recent H1N1 outbreak in Tasmania, the DHHS invested much effort and energy to keep general practices well informed through a fax stream process, establishing a professional support line through the 1800 FluDoc line to answer queries, and to work with members of the GPT network to refine the response and key messages distributed. GPT and DHHS were sometimes in daily contact and had regular scheduled meetings to problem solve any issues as they arose on at least a twice weekly basis.

ISSUES:

In Tasmania, prior to the H1N1 pandemic, protocols had already been agreed with the General Practice Tasmania Network that the State Government through the Director of Public Health would be considered as the single authoritative source of information provided to general practice. This was a deliberate strategy agreed in an attempt to avoid duplication, contradiction and confusion.

Unfortunately this strategy did not work. What was experienced was a phenomenon of every organisation and level of government wanting "to be seen to be doing something" and others that were on the periphery were often critical of actions taken.

Communications received by general practices in Tasmania during the H1N1 outbreak included the following:

- Daily Fax Streams from the Director of Public Health
- Faxes from the Office of the Chief Health Officer
- Faxes and letters from the Commonwealth Chief Medical Officer
- Faxes and resources distributed by the Royal Australian College of General Practitioners (RACGP)
- A variety of other communications depending on their associations and subscriptions (eg AMA member bulletins and medical press)
- Ad hoc information from Area Health Services and Local Governments regarding flu clinics

The problem was that some of the advice in these communications was conflicting, a lot was duplicative and much of it was written (particularly early on in the pandemic) from a perspective that did not focus on the issues that would be of greatest interest and concern to general practice. This issue was addressed during the pandemic through the agreement of a protocol that the DHHS would use its own GP advisers as the initial drafters of material, that the material would then be reviewed and cleared through the GPT Network prior to being finally cleared through DHHS communications staff and the PHEOC or EOC. While a welcome protocol in theory, in practice it meant that there were often 8-10 people involved in the drafting of materials. Additional complications were experienced when there was a political overlay from time to time on the communications and when it was unclear whether command and control rested with the PHEOC or the ECC. This was further complicated by varying and sometimes inconsistent communications at a regional versus statewide level.

RECOMMENDATIONS:

- 3.1 *That agreed communication channels be developed between the State and Commonwealth Governments to avoid duplication between State and Commonwealth communications.*
- 3.2 *That DHHS and GP Groups (GPT, RACGP and the AMA) reach an agreement about the responsibilities for communication and ensure this is understood and adhered to by all relevant players.*
- 3.3 *That DHHS, in consultation with stakeholders, develop a clear communication flowchart or checklist that all relevant parties agree to.*
- 3.4 *That as far as possible, pandemic communications be declared as a “politics free zone” and that this be agreed by each of the Commonwealth and State political parties and also discussed with other groups such as the AMA.*
- 3.5 *That pandemic communications avoid repetition and (if necessary) refer to previous numbered communications if messages require reinforcement.*

4. Protection and remuneration of the general practice workforce

Adequate training and resourcing of general practitioners, nurses and practice staff is fundamental to a successful response to pandemic influenza. Training has been delivered by the GPT Network through funding from DHHS to cover infection control procedures including the appropriate use of PPE and practice protocols for assessment and separation of patients presenting with influenza-like illness.

If general practice staff are deployed to support the State's coordinated flu response (either through flu clinics, flu services or within practices) then personal protective equipment and prophylactic anti-virals must be provided to those staff. It is also essential that simple employment arrangements are established that cover remuneration, professional indemnity and workers compensation arrangements for GPs, practice nurses and other practice staff agreeing to work at the direction of the State as part of the pandemic response.

ISSUES:

The experience during the H1N1 pandemic was that establishing employment arrangements, particularly to engage GPs to work in flu clinics, was quite complex and time consuming. It essentially involved signing up GPs, practice nurses and practice staff as Government employees and, while not used extensively because of the rapid standing down of flu-clinics, could prove to be a significant bottle-neck to rapid response in the event of the need to stand up flu clinics in future pandemic outbreaks. The recruitment of GPs to work in flu clinics proved difficult in some regions because the clinics were being established at the same time that general practice was experiencing an escalation in demand as patients wished to see their usual practice or GP.

The lack of allocation of PPE and anti-virals from the National Medical Stockpile to general practice was a significant issue when much of the burden of diagnosis and management was felt within general practices. While this was partly addressed by an allocation of replacement PPE to practices that were actively involved in specimen collection it must be recognised as a non-negotiable allocation in future outbreaks. Infection control in general practice is an essential part of containing any pandemic outbreak.

RECOMMENDATIONS:

- 4.1 *That simple employment arrangements are established prior to any future pandemic outbreak that cover remuneration, professional indemnity and workers compensation arrangements for GPs, practice nurses and other practice staff agreeing to work at the direction of the State as part of the pandemic response.*

4.2 *That strong advocacy be made to the Commonwealth to ensure that allocations of PPE and anti-virals are made for general practice in any future pandemic outbreaks.*

5. Clinical Service Delivery

The burden of assessment, screening and management of H1N1 cases was borne primarily by the primary care system in Tasmania.

ISSUES:

There remains a need to encourage general practices to stay vigilant for signs of a second wave or a further mutation of the currently circulating virus.

There was a potential for inadequate infection control procedures because the virulence of the pandemic was not as great as was originally anticipated.

The increased demand for sick certification by members of the community placed an increased pressure on general practices and diverted scarce resources away from greater areas of need. During the outbreak, GPT encouraged employers to consider accepting alternative forms of certification to a doctors certificate (such as a statutory declaration from the employee, a statement of attendance from one of the State's flu clinics or a certificate from another health professional). GPT also encouraged employers to establish and communicate to employees a policy regarding sick leave that will apply during the period of pandemic flu outbreak.

The necessity for flu clinics to be staffed by medical practitioners including general practitioners (GPs) was called into question when GPs that were deployed to the clinics were called upon to undertake duties that could have been adequately handled by nursing staff.

Had the pandemic escalated further, the ability for GPs to provide consultations for their patients over the phone would have been an effective strategy to support containing the spread of the disease and containing demand on general practice services.

The pathology service was not sufficiently resourced to allow rapid testing of suspected cases and this then hampered the containment and contact tracing activities.

There was confusion during the H1N1 pandemic in Tasmania about the distinction between influenza-like-illness (ILI) safe practices and ILI friendly practices and this resulted in a perception of lack of preparedness among general practice and even a mistaken perception that some general practices were unwilling to support the pandemic response.

ILI Safe practices have the capacity to safely carry out screening tests on patients with ILI because of their ability to isolate the patient, eg spare consulting room and their ability to ensure the safe entrance and exit of all patients and to maintain infection control (a separate entrance and exit are desirable but not essential).

ILI Friendly practices are those that have the capacity to provide medical attention to patients that meet the current ILI case definition. That is, they are ILI safe and ALSO have the capacity to manage comorbidities normally dealt with in General Practice. To do this the practice should have separate exit and entrance for people with ILI.

Further work is required to discuss the distinction between ILI safe and ILI friendly and to maintain a database of which category practices are likely to fall into to better support pandemic response planning. There is also a need to investigate whether there is a capacity for general practice to support and treat patients with ILI who have other primary health care needs such as chronic conditions or co-morbidities.

RECOMMENDATIONS:

- 5.1 *Practices to be encouraged to continue to use appropriate infection control techniques especially during winter flu months.*
- 5.2 *Discussions should occur between the RACGP, the AGPN and relevant public health authorities to plan a consistent nationwide awareness of best practice infection control and the need to maintain this standard during a pandemic.*
- 5.3 *That the decision to stand up a flu clinic needs to be based on clear criteria that are consistently applied across the three Area Health Services.*
- 5.4 *That the flu clinic model and the necessity for flu clinics to be staffed by medical practitioners be reviewed.*
- 5.5 *That the State Government works with peak employment bodies to encourage Tasmanian employers to adopt a pragmatic and flexible approach to their requirements for sick certificates and quarantine during a pandemic.*
- 5.6 *That the Commonwealth Government give due consideration to the establishment of time-limited MBS Item to fund GP telephone consultations during a pandemic.*
- 5.7 *That an adequately resourced pathology service be established within the State to ensure the testing service is more rapid.*
- 5.8 *That GPT works with DHHS to review whether the distinction between ILI safe and ILI friendly is necessary to support the pandemic response and, if so, integrates this distinction into pandemic response plans.*