

Inquiry into the Victorian Government's COVID-19 Contact Tracing System and Testing Regime

Dr Ines Rio

Organisation Name:
Your position or role:

YOUR SUBMISSION

Submission:
See attached pdf

FILE ATTACHMENTS

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Ines Rio

Parliament of Victoria Inquiry into contact tracing and testing
Online submission: <https://www.parliament.vic.gov.au/lsc-lc/article/4572>

Dr Ines Rio
21 November 2020

Dear Legislative Council Legal and Social Issues Committee at the Parliament of Victoria

Re: Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime

Thank you for taking the time to consider my submission.

I commend the Parliament of Victoria for undertaking this Inquiry, which signals its commitment to learn and improve its testing and contact tracing to best control COVID-19 and its effects.

Thank you for inviting me to provide a verbal submission at the inquiry. However, unfortunately due to illness, I was unable to attend and have kindly been provided with an opportunity to provide a written submission.

I am an experienced General Practitioner (GP) who has several clinical and non-clinical roles. I work as a general practitioner at North Richmond Community Health, a multidisciplinary service, located within social housing. Although a universal service, we particularly address the health and wider care needs of vulnerable groups, including refugees, the homeless, those with mental health problems, Aboriginal and Torres Strait Islander peoples and those with drug and alcohol issues. Additionally, I work as a GP obstetrician at The Royal Women's Hospital.

My relevant non-clinical roles include as the Chair of North Western Melbourne Primary Health Network (NWMPHN), Chair of the Australian Medical Association (AMA) Victoria Section of General Practice and Medical Advisor for the City of Melbourne,

This submission is my personal submission and is not made on or behalf of any organisation or role.

In this submission, I will address areas of COVID-19 testing and contact tracing that is relevant to general practice. My submission will focus on recommendations to improve our responses in areas relevant to general practice.

All my observations and experiences are based on the real life experiences of me or my colleagues and can be expanded on as required.

At the outset I would like to acknowledge there have been substantial improvements in testing and contact tracing since February 2020 and that individuals at the Victorian Department of Health and Human Services (DHHS) have been under enormous pressure and worked tirelessly.

Nevertheless, there continue to be areas that need to be, and can be, addressed by DHHS in the short term in order to ensure that if Victoria is subjected to another wave of COVID-19 that the loss of life and disruption to the community are minimised.

Testing

The testing regime necessarily evolved through the pandemic.

Positively, testing sites and capacity was quickly escalated at both GP settings and State and Commonwealth dedicated testing sites.

Problems related to the testing varied at different times and included:

- **Communication: Consistency**

Issue that arose included:

- Multiple sources of testing advice that were not consistent (e.g. Commonwealth and State advice often varied and multiple sources of testing information was presented in different ways by governments and other peak bodies such as the Royal Australian College of General Practitioners (RACGP))
- Poor clarity for a busy GP (advice was poorly written and formatted for easy digestibility and application)
- Issues not being addressed, inconsistent or unclear (e.g. continued confusion on release from isolation, use of personal protective equipment (PPE) and access to PPE)

- **Communication: Poor information**

Issue that arose included:

- Lack of addressing in a proactive way a shortage of swabs (e.g. when swabs were in extremely short supply, DHHS was still suggesting the use of three swabs – one for throat, one for the nose and a separate one for non-SARS-CoV-2; whereas other sources were suggesting one could be used. DHHS later moved to a recommendation of one)
- Requirements that increased GP workload with no clear risk/benefit assessment (e.g. earlier on “requirement” to notify Department of at risk cases that are not yet confirmed)
- Incorrect information (e.g. DHHS published that Primary Health Networks (PHNs) responsible for providing all PPE to GP. When informed by PHNs that only masks were available and only limited numbers, DHHS declined to rectify the information)

Problems with communication to GPs is now better understood by DHHS.

I am aware there is currently work being undertaken to develop a collaborative single information sources by multiple bodies (e.g. both Department of Health, PHNs, GP Colleges (RACGP and ACRRM), AMA). This is to be applauded.

Recommendations:

To ensure information targeted to GPs is fit for purpose, clear, consistent, evidence based, responsive and timely

- **DHHS continues to work with other peak bodies to develop a single credible, readily accessible single “source of truth” (of note this is done in Western Australia)**
- **This is led by a high level GP within DHHS (a new role is required for this – see later)**

- **Lack of results to person’s usual GP**

When tested at a Commonwealth funded screening clinic, a person’s GP was captured, and results were sent to a person’s GP (this also occurred in NSW and SA at their state funded centres).

Despite repeated requests, this did not occur at DHHS funded screening clinics until about September 2020, and rates still remain extremely low at about 20% of all tests sent to a GP.

This compares to more than 80% at Commonwealth sites and is clearly suboptimal given that approximately 90% of Victoria's have a regular general practice.

- ***Notification to DHHS of positive cases***

This was an enormous issue that continued from February until at least August 2020.

There was only one mechanism for GPs to notify DHHS of their patients who were COVID-positive, which was through the 1300 651 160 telephone number.

It took three minutes simply to select the correct option on the switchboard. GPs/their staff then needed to hold on the line for up to **several hours** on the telephone. Once someone answered the phone, information was sought and then another DHHS person would call back several hours or days later for more information on the patient, which was or could have been provided to the first person.

At the best of times, the bureaucracy subjecting health professionals to such wait times would be concerning; during a global health pandemic, it was astounding.

DHHS was well aware of the problem, but put quite simply, did not seem to care, or have any understanding to the effect of this on both GP and the ability to provide timely information for contact tracing. At one point, a call back option was developed, but worked poorly. Finally, in about August 2020 the online mechanism that GPs, AMA and RACGP had been calling for months for was developed, so GPs could input the information directly.

This simple operational issue should have been addressed in a matter of a day. It seemed symptomatic of an entrenched counterproductive cultural attitude to general practice and a complete lack of understanding of the pursuant problems.

Contact tracing

Lack of involvement of General practice

As noted above, at DHHS funded sites (including hospitals), GPs were never copied into the results, and now are uncommonly copied into results. This lack of simple communication to GPs is emblematic of a lack of understanding in the Department of the capability of GP, their reach, their responsiveness, and their role.

Moreover, the Department has extremely limited ability understanding of how they might be able to leverage the knowledge, connections and understanding of GPs to their patients and community and leverage off their existing systems and care models.

During the pandemic, there were frequent and recurrent calls by GPs to be more involved. GP practices were quiet, with many GPs on *Jobkeeper* due to little work. They knew their patients and community, were trusted, often spoke the language of their communities, and are highly specialised in communication and in providing individualised infection control education, health care and organising social care.

When a patient at the screening site collocated at my practice was found to be positive by a GP, they were contacted within hours along with a translator and multicultural workers as needed and an array of assessment, services and care initiated.

This included:

- Testing all household contacts **that day**
- Providing education and information on infection control and isolation (that was individualised to their language, knowledge, cultural, family, and physical environment)
- Assessing for COVID symptoms and providing or arranging handover or referral as required (e.g. to their usual GP or if more severe problems to the hospital)
- Assessing and addressing other health conditions (e.g. mental health, maximising lung and cardiac health, medication management)
- Addressing social care and support (e.g. food, childcare, pet walking)

This occurred for all people at the screening clinic, whether they were our patients or not. This care assessment and provision was supported by the development of *HealthPathways* by PHNs:

melbourne.healthpathways.org.au

This was enabled completely outside the DHHS system of care, as we as individual GPs allowed our provider numbers to be utilised by the collocated screening clinic, and we therefore obtained all the results and reviewed them within hours.

Driven by PHNs, and building on the response and system of care of North Western Melbourne PHN to the locked down towers in North Melbourne and Kensington (in collaboration with cohealth and Melbourne Health), similar "[COVID positive pathways](#)" have now been developed across the state. However, significant problems exist. These include:

- Each of these *COVID positive pathways* varies according to the local health network (LHN), with great variability of the GP in this development. It is understandable and appropriate that within the hospital walls this varies.
- The entire state is not covered
- The results go through the DHHS and then to the relevant COVID positive pathway (if one exists). This results in delays.

There is a patchwork of *COVID positive pathways* throughout Victoria.

There are gaps in areas, they lack consistency, some lack GP and PHN codesign and results do not go directly to the commissioned service, but rather through DHHS first, creating time delays.

Recommendations:

There here should be:

- A single consistent *COVID positive pathway* across Victoria
- Each LHN hub should have a PHN representative on its governance team and high level GP in a position of authority to assist with the development and operation of the *COVID positive pathway*
- A publicly available and transparent map of Victoria delineating where each person's postcode maps to each COVID pathway

- **All positive results should go directly to both the patients usual GP and a GP service commissioned by the relevant COVID positive pathway, rather through DHHS first (which creates significant time delays)**

Advice and support for GP

Disturbingly, individualised, timely and appropriate clinical advice and support for GP has been woefully lacking.

I am aware of several instances where, but for the extreme dedication from one or two GPs, Victoria would have had more outbreaks and deaths.

Early on in the first wave, a colleague caring for residents at a residential aged care facility (RACF) where there were two confirmed cases of COVID needed help from DHHS. She wished to screen all the other residents, obtain infection control advice, and help with communication to residents distressed families (several of whom were wanting to move their loved ones). Other than the general phone line, there was no point of contact for urgent clinical advice. It took repeated calls and hours to get through to someone. Once she did it was an inexperienced person who advised here to follow the written guideline (which she explained she had read and felt was not appropriate) and was informed DHHS would not support her to test the other residents (telling her that she *was not allowed to*) or assist in any way. Despite this, the GP tested all 80 residents and received a further three positive cases. She and her colleagues also wrote information for the RACF staff and families (as the DHHS provided written information was not fit for the resident's families in language, tone or in the questions that they wanted answered) and arranged webinars for the families and staff. Despite repeated requests, this was done with no help from DHHS.

Another case I am personally aware of is a GP colleague who received several positive cases from international a student accommodation site, and was unable to alert and receive advice from the relevant people in DHHS. Eventually he contacted his local member of Parliament, who contacted a Commonwealth Department person, who contacted me, and as I had the personal contact of people in DHHS, I contacted them.

There are several not dissimilar episodes I could recount.

Additionally, the issue for infection control advice for GP and RACF needs to be better addressed. GP and RACF are very individualised places. You may have a "mainstream" GP where the written guidelines are fit for purpose. But you may have one where you see many homeless adolescents, where you see refugees with tuberculosis, where you see many elderly patients you need to assist to undress to examine. Likewise, you may have mainstream RACF, or you may have one with shared bathrooms, or where there has been no infection and the patients will not eat unless they eat together. I am aware of one PHN that has employed an infection control nurses to provide such advice to GPs and RACF in their region.

Recommendations:

- **DHHS funds an infection control nurse for each of the six Victorian PHNs to provide individualised infection control advice and the application of infection control guidelines to GP, community primary care and RACF**
- **There is a dedicated high level GP contact at DHHS to provide timely and comprehensive clinical advice to GPs. (This DHHS GP needs to be supported by public health, infectious diseases, and**

infection control clinical advice. However, in order to understand the issues and context it is crucial it is an experienced GP)

Underlying issues

Many of the issues above stem from a lack of understanding in DHHS of the capacity, capability and role of general practice, a siloed approach in planning across health care sectors and a lack of genuine partnership and co-design with general practice and primary care.

This compares to the South Australian experience where there are many experienced GPs in authoritative positions within their department in order to guide and inform responses and harness general practice and community care. Of note, approximately 20 years ago the equivalent DHHS at the time had GP positions of influence and authority within it – this has not been the case over more than the past decade.

Recommendation:

DHHS develops a role for an experienced, well connected and systems experienced GP that reports directly to DHHS Secretary.

This role should oversee the development of structures, systems, practices, and the development of a culture that works collaboratively with and harnesses the capacity of GP. This role is likely to require other DHHS GP support.

Once again, I thank you for your taking the time to consider my submission.

Please feel free to contact me if you have any queries or would like me to expand on any areas.

Yours sincerely


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