Government of **Western Australia**
Department of **Health**

ClinicalSenate

COVID – Vaccines and Variation in Care

Clinical Senate of Western Australia

18 and 19 March 2021

Acknowledgement of Country and People

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Using the term – Aboriginal

Aboriginal and Torres Strait Islander may be referred to in the national context and 'Indigenous' may be referred to in the international context. Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

Contents

Message from the Chair and Executive Sponsor

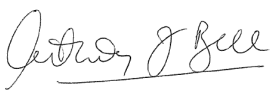
The recent meeting of the Western Australian Clinical Senate provided a timely opportunity to further explore the 'new COVID' future for Western Australian's. The meeting was divided over two days to ensure the large volume of information that needed to be covered was adequately addressed. Our welcome dinner was facilitated by Dr Norman Swan. Senators heard from the Director General, the Clinical Senate Chair, the Chief Health Officer and a consumer with lived experience. The intention of the evening was designed to be thought provoking and set the scene for a productive following day.

The day session consisted of leading experts presenting from a variety of perspectives; as Senators were taken on a journey across the viral and vaccine elements of the pandemic, heard about Federal and State policy approaches and were appraised of the impact COVID had had from a 'Child and Youth' and broader community mental health impact, to humanitarian considerations, including the effect of lockdowns on remote Aboriginal communities.

Following these presentations, the senators and invited guests divided into three workshops. These workshops were themed around the vaccination rollout plan, new patients presenting to the health system with psychological distress, and post-COVID learnings. The outcome of the workshops for each group was to identify recommendations that would be of practical and tangible benefit to the broader COVID vaccination and health sector response.

The complexity of the senate topic is reflected in the recommendations. They have been further refined by the Senate Chair and Executive Sponsor based on the workshop discussions. The recommendations presented in this report will assist the System Manager and Health Service Provider's to translate Senator's ideas and feedback into action.

The senators and expert witnesses are thanked for their contributions in creating an open and honest discussion to create the platform from which to enhance the system response to the ongoing COVID pandemic.



Clinical Associate Professor Anthony Bell
Chair
Clinical Senate of WA

Dr Andrew Robertson CSC PSM
Chief Health Officer
Department of Health

Vaccination Plan

Recommendation 1:

To ensure people in vulnerable populations have good access to and uptake of vaccinations.

1. Utilise different healthcare settings for opportunistic vaccination by taking the vaccine into the community (e.g. hostels, shelters, in patient settings).
2. Utilise non-traditional immunisation personal (e.g. Allied health care professionals and clinical students) when additional capacity is required to roll-out vaccine.
3. Immunise adult families of patients at risk at the same time with Pfizer vaccine.

Recommendation 2:

To address vaccine hesitancy and improve uptake in our health care workers and the wider population.

1. Develop a communication package to increase engagement and uptake of vaccination in healthcare and aged care settings, including approaching senior leadership group of the health care sector and community leaders.
2. Provide Hospital Executive with clear data on those individuals and professional groups that have/haven't completed vaccination in all hospitals to assist in targeted communications.

New psychological distress

Recommendation 3:

To meet the needs of people with new psychological distress because of future lock downs we must;

1. Identify the demand using data driven approaches and anticipate the need for resource reallocation that addresses the needs of those with psychological distress in our community.
2. Clearly define the physical health needs, including the need for vaccination, of clients with severe mental health illness. Assist in WA employed/ contracted mental health team in understanding what options are open to them.
3. Make hospital-based staff aware of their local community resources for referral and support.

Post-COVID learnings

Recommendation 4:

Telehealth enhancement;

1. Progress improvements in digital technology and infrastructure to enhance healthcare and support innovation.
2. Ensure that Telehealth delivery is supported by training that promotes compassionate care delivery of high value to patients.
3. Listen to the patient voice and action feedback to strengthen the "COVID normal" models of virtual care;

Recommendation 5:

Continue public messaging for physical distancing, hand hygiene, masks and stay at home if sick for the foreseeable future, even once target of 70% of eligible population are vaccinated.

Vision

The Executive Sponsor Dr Andrew Robertson together with the Chair of the Clinical Senate designed a semi-structured meeting that provided a strong element of clinical staff engagement on the planning for the next six to twelve months of the COVID response in Western Australia. Mindful of the knowledge that Western Australia has not had a significant number of cases, however the impact has been widely felt across the system resulting in a focus on the challenges WA Health will face with an unprecedented number of new presentations to the health system presenting with psychological distress.

Approach

Dr Norman Swan challenged and led Senators to bring their thoughts, ideas and contributions over the evening and following day. We were reminded that pandemics are fundamentally the result of the way in which humankind reacts to and interacts with the pathogen and provided a historical context to highlight this key message.

The Director General, the Clinical Senate Chair, the Chief Health Officer and the powerful recounting of lived experience from a returning Australian Expatriate, all identified issues to learn from our historical response, to hear the voices of those impacted the most by COVID and to acknowledge the international experience from countries with high infection rates and mortality.

The following day was highly engaging and educational. Dr Andrew Robertson lead the first session, specifically looking at where the health system was currently placed, followed by A/Professor Chris Blyth looking at things through an Infectious Diseases lens, COVID microbiology and his clinical recommendations on who, when and how to vaccinate, including those at highest risk before population-based strategies were rolled out. This was followed by Professor Ian Hickie who looked at relevant and applicable interstate data, including from modelling techniques, that was being used to guide and optimise collaborative working to bridge the public and private systems and how this information can be used more effectively.

The personal experience of Aboriginal Communities during the lockdown was described by Mr Dwayne Mallard and allowed Senators an insight into the personal experiences of these communities. It was hoped that this experience coupled with the consumer experience on the first evening would create a collective understanding and appreciation that Senators could take into consideration when developing their recommendations.

Dr Kamalini Lokuge provided senators with her experience in leading teams as part of infectious disease outbreaks in the developing world. She acknowledged that from her experience of pandemic responses, she identified and impressed upon Senators the pivotal importance of the community response with respect to effective disease control, without which the health care response was doomed to fail no matter how elegant or well resourced. Key to our success now, she said would depend on how effectively we could build and maintain the trust of our community, and to share with them to benefit from their reciprocal effort.

Professor Helen Milroy explained that early intervention is important to get kids back on track but currently that is not what is occurring. Professor Milroy believes that the service model is not necessarily targeted at the right age group, highlighting the example that services are currently only really dealing with youth/adolescents that are acute or high risk. Her belief is that the service model, if it is to be referred to ‘early intervention’, needs to target children earlier in their life. Professor Milroy advocated strongly that any model aimed at addressing under-resourced groups could use a trauma-based response approach. The foundational principals for dealing with psychological distress should include; understanding trauma and its impact, promoting

individual safety, sharing power and governance with consumers, and ensuring choice, autonomy, and cultural competence remain embedded in the healing process.

Dr Swan facilitated a question and answer style panel, allowing for attendees to hear from the combined experiences and expertise of the presenters. With an emphasis on creating discussion to stimulate tangible outcomes for addressing COVID impacts, the role of mental health terminology, use of big data, adapting models of care in the context of what is already available in a community were all discussed. The panellists were able to provide their own advice for what some of the next steps could look like

Dr Amanda Stafford presented the group with a summary of the WA COVID journey so far and asked the group to project forward to a WA Health System of the future. Specifically asking Senators to consider the type of health system they want to work in as a clinician, what changes that have now been made in response to COVID are we proud of or what is it we want to do more of to support healthy work practices?

Dr Andrew Robertson provided the senate with an update on the vaccination plan. He provided expert advice on what the vaccine rollout would look like, the ability to provide vaccine choice, or not, and addressed the topic of vaccine hesitancy and system capacity.

The final session was expertly led by Dr Sophie Davison, reiterating that the COVID pandemic has had a huge effect on mental health and 'Pandemic waves' were still being experienced by the system. Some of the key contributors include, loneliness and isolation, including separation from usual supports, loss and grief and fear and uncertainty. She explained that while the pandemic has had less of an impact in Australia than globally, it has still significantly affected people with pre-existing vulnerabilities. She affirmed the need prepare for the effects of the pandemic waves and new presentations of psychological distress, the worsening pre-existing conditions, whilst also thinking about carers.

During the workshops the following questions were proposed to the group, each were themed around the vaccination rollout plan, new patients presenting to the health system with psychological distress, and post-COVID learnings.

1. Should we reach 70% coverage of the population, how do we transition out from where we are now, to 'COVID normal' and what are the points along the way that we need to achieve?
2. If the Commonwealth is unable vaccinate to deliver on a mass scale, what practical things can the state do to meet this gap?
3. How do we address vaccine hesitancy and improve uptake in our health care workers and the wider population?
4. What are the first steps over the next 6 months that ensures community-based engagement for the co-design and/or adaptation for regionally relevant and community-based models of holistic mental health care for those people who are newly experiencing psychological distress?
5. How do we meet the needs people with psychological distress because of future lock downs or outbreaks especially in vulnerable groups?
6. What do we need to implement to ensure that the patients voices are heard and that their feedback is actioned to strengthen our models of care?

7. How can we ensure that people with severe mental illness have good access to and uptake of vaccination?
8. What post-COVID changes do we keep?
9. What things have we not yet thought about?
10. What do we get rid of?

Each table provided the senate group with a summary of their discussions and their agreed recommendation. These recommendations have been further refined based on the discussions held and in consultation with the Executive Sponsor, Dr Andrew Robertson and Clinical Associate Professor Anthony Bell (Chair).

Presentations from the day can be found on the Clinical Senate website: http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia

Next steps

Following the meeting, the recommendations will be submitted to the Health Executive Council and Director General of Health, for endorsement and implementation. These recommendations will then be disseminated to the senate membership, the relevant departments in the Department of Health and the Health Service Providers for implementation.

Reporting on the recommendations will occur within 12-18 months and be available on the Clinical Senate of Western Australia website.

Collaboration

Presenters

- Dr Norman Swan, Host of RN's Health Report and co-host of Coronacast
- Dr D J Russell-Weisz, Director General, Department of Health, Western Australia
- Mr Matthew Morgan, Consumer representative
- Dr Andrew Robertson, Executive Sponsor, Chief Health Officer and Assistant Director General, Public and Aboriginal Health Division, Department of Health, Western Australia
- Dr Robyn Lawrence, Deputy Chief Health Officer and State Health Incident Controller, Department of Health, Western Australia
- Mr Barry Maguire, Balladong, Wadjuk, Noongar, Welcome to Country
- Associate Professor Chris Blyth, Consultant Infectious Diseases and Microbiology, Perth Children Hospital
- Professor Ian Hickie AM, Co-Director Health and Policy at Brain and Mind Centre, University of Sydney
- Mr Dwayne Mallard Chairperson, Meenangu Wajarri Aboriginal Corporation
- Associate Professor Kamalini Lokuge Senior Fellow, Australian National University
- Professor Helen Milroy, Psychiatrist, University of WA
- Dr Amanda Stafford, Clinical Senate Executive Committee Member, Clinical Senate of WA
- Dr Sophie Davison, Chief Medical Officer, Mental Health Commission

Invited guests

- Dr Clare Huppatz, Strategy Coordinator, Public Health Emergency Operations Centre
- Dr Paul Effler, Senior Medical Advisor, Communicable Disease Control, department of Health WA
- Clinical Associate Professor Paul Mark, Area Lead COVID-19, South Metropolitan Health Service
- Dr Ajitha Nair, Area Lead COVID-19, North Metropolitan Health Service
- Dr Helen Van Gessel, Area Lead COVID-19, WA Country Health Service
- Ms Melissa Vernon, Executive Director, Strategy and Change, WA Country Health Service
- Dr James Williamson, Assistant Director General, Clinical Excellence Division, Department of Health WA
- Mr Paul Forden, Chief Executive, South Metropolitan Health Service
- Ms Liz MacLeod, Chief Executive, East Metropolitan Health Service
- Dr Simon Wood, A/Chief Executive, Child and Adolescent Health Service
- Mr Rob Anderson, A/Assistant Director General, Purchasing and System Performance
- Professor David Forbes AM, Board Chair, North Metropolitan Health Service Board
- Ms Margaret Pyrchla, Board Deputy Chair, Health Support Services Board
- Ms Zinab Al Hilaly, Consumer
- Ms Amelie Farrell, Youth Consumer

Organising Committee

Senate Executive Committee

- Clinical Associate Professor Anthony Bell, Chair and Director of Clinical Services, Rockingham Peel Health Group
- Ms Kate Reynolds, Coordinator of Midwifery, WA Country Health Service
- Dr Tony Mylius AM, Cardiologist and Consultant Physician, Wheatbelt Medical Specialists
- Mr Daniel Mahony, A/Operations Manager – Inland, WA Country Health Service
- Dr Amanda Stafford, Emergency Consultant, Royal Perth Hospital
- Ms Tanya Basile, Immediate Past Chair and Nurse Co-Director, Sir Charles Gairdner Hospital
- Ms Pip Brennan, Executive Director, Health Consumers Council

Additional members

- Ms Laura Snowball, A/Coordinator Clinical Senate of Western Australia
- Ms Kimberly Olson, Program Support Officer, Clinical Senate of Western Australia
- Ms Jennifer Watchorn, Development Officer, Clinical Excellence Division, Department of Health

Appendices

Appendix 1: Abstracts

Child Protection Medical Education pre and post Covid-19

The Child Protection Unit (CPU) at Perth Children's Hospital has run an annual 4day training course for doctors since 2013. The course is accredited by the Royal Australasian College of Physicians and counts towards training in General Paediatrics and Community Child Health. The course is usually conducted face-to-face, but in 2020, due to Covid-19 restrictions, it was conducted entirely via MS Teams.
Aim: To audit the feedback from the course to compare the online format with the usual face-to-face format.

Methods: Daily feedback from the courses in 2014, 2015, 2017, 2019 and 2020 was analysed.
Results: Overall feedback was excellent with between 93% (2014) and 96% (2019) of presentations receiving a score of 4 or 5 (good or very good). Evaluations from the online format (2020) were as good as those from the face-to-face format in previous years. 100% of participants in 2020 said they would recommend the course to colleagues.
Conclusions: Child protection education can be delivered successfully via an online format. The online format provided increased accessibility for people to attend including those from regional WA and internationally.

Active vaccine safety surveillance via a scalable, integrated system in Australian pharmacies

Background: Vaccination programs for COVID-19 are imminent in Australia, with sequenced deployment of vaccines via a broad workforce, including pharmacists. Only limited data exists for safety of pharmacist-delivered immunisations, and no active surveillance systems have been described for pharmacies globally. We integrated a participant-centred active vaccine safety surveillance system (SmartVax) with a cloud-based pharmacy immunisation-recording program (MedAdvisor PlusOne) to create an automated, scalable, pharmacy-based surveillance system linked to national infrastructure including AusVaxSafety. We successfully piloted the system in 2020 to investigate adverse events following immunisation (AEFI) in Western Australian community pharmacies, and to explore pharmacist perceptions of and experiences with SmartVax.

Method: Active surveillance of AEFI (using SMS and smartphone technology) for individuals>10 years receiving influenza immunisations from 22 pharmacies and 90 non-pharmacy (general practice and clinic) sites, was conducted between March-October 2020. Multivariable-logistic regression was used to assess AEFI between pharmacy/non-pharmacy participants, adjusting for age, sex, and vaccine brand. A subgroup analysis of participants over 65 years was also performed. Fifteen semi-structured interviews were conducted with pharmacists in August 2020. Thematic analysis of interview transcripts was performed in using the Framework Method.

Results: Of 101,440 surveillance participants (6,992 pharmacy; 94,448 non-pharmacy), 77,498 (76.4%) responded; 96.1% (n=74,448) within 24 hours. Fewer pharmacy participants reported any AEFI compared to non-pharmacy (4.8% vs. 6.0%; odds ratio: 0.87; 95%CI: 0.76-0.99). For over 65's, AEFIs were similar between pharmacy and non-pharmacy (5.8% vs. 6.0%; odds ratio: 0.94, 95%CI: 0.65-1.35). The most common AEFIs in pharmacy were pain (2.0%), tiredness (1.9%), and headache (1.7%). Perceived benefits of SmartVax included usability, ease of follow-up, and enhancement to the pharmacist-patient relationship. Pharmacists desired more granularity in reports and were concerned about cost to implement the system.

Comments: We observed strong engagement with active surveillance, and found pharmacists are safe immunisers. The integrated system is rapidly scalable across Australia with global potential.

Geriatric Assessment Team in Sir Charles Gairdner Hospital Emergency Department

In 2020, the COVID19 pandemic provided an opportunity for Sir Charles Gairdner Hospital to trial a "Geriatric Assessment Team (GAT)", in the Emergency Department (ED). GAT ran for 3 months from July to October 2020, Monday to Friday. GAT involved a geriatrician based in ED to review frail, older patients over the age of 65 years, to either expedite discharge home from the ED, or direct admission to the relevant ward or hospital. The goals were rapid assessment of older patients, targeted investigations and direct therapy for better quality care, reduced length of stay for older people in ED, decreased number of ward transfers and thus reduced potential COVID19 exposure and other hospital-acquired complications.

We found that early senior consultant decision making and admission under the definitive treating team reduced length of stay in ED and overall inpatient length of stay. For this pilot period GAT demonstrated a saving of 546 bed days compared to the same cohort in 2019. 170 admissions to the Medical Assessment Unit (MAU) were avoided. Of the 236 patients reviewed, 130 were seen and discharged home (including to nursing home) from the ED. 65% of these patients were referred onwards to subsequent geriatric specialty outpatient clinics for follow up including the Frailty Rapid Access Clinic (FRAC) service that was also piloted during the COVID19 pandemic.

Patients who were seen by GAT and required admission had a reduced hospital length of stay by an average of 2.6 days, and a reduced length of stay in ED by an average of 410 minutes for patients admitted directly under Geriatric Medicine and 93 minutes for those admitted to the Medical Assessment Unit.

A geriatrician based in the ED was feasible and led to reductions in ED and hospital length of stay for older, frail patients.

Authors:

Dr Sook Lee, Consultant Geriatrician, Dr Elissa Campbell, Consultant Geriatrician/Head of Department. Department of Rehabilitation and Aged Care, SCGH, Acknowledgement to Russi Travlos, Program Manager Innovation and Improvement Unit, SCGH

Covid Research Response

Professor Toby Richards, University of Western Australis & Professor Jeremy Nicholson, Australian National Phenome Unit

Introduction: 100 million people have contracted COVID-19 with over 2.1 million deaths worldwide. However, the clinical trial data on treatment represents data from less than 50,000 patients (< 0.05%). In Western Australia we set up the COVID Research Response trial building the largest database and biorepository for COVID-19 research in Australia.

Methods: The WHO International Severe Acute Respiratory and emerging Infection Consortium (ISARIC) platform was utilised to build a state-wide harmonised process of data collection, translational research, and clinical trial coordination. Clinical trial leadership, supported by trial managers from UWA in collaboration with the Australian National Phenome Centre set up unified Ethics and governance covering all metropolitan healthcare hospitals, including community follow up. Efficient data capture was achieved by integration of hospital data to the Department of Health REDCap system, including electronic consent. Serum samples were incorporated to clinical pathways at Path West, identified by laser-etched 2D code and stored on an open access platform.

Results: The CRR framework for clinical trials was copied by WAHTN to form the backbone for clinical research into COVID in WA. The CRR trial has enabled sequential cohorts of patients to contribute data to clinical research including ISASRIC (early patients), PANDA (Children), RECOVERY (follow up), SMELL (sensory loss), Passengers (incoming travellers) and WACIC (immunological evaluation). In total over 118 patient data sets with > 90% ascertainment and > 1500 bio samples have been collected and, in part, distributed under the guidance of the Steering Committee. Collaborations of the joint UWA & ANPC initiative cover Australia, UK, America and Europe. Output has included collaboration on; 2 Lancet series manuscripts and 9 translational science articles to date and submission of a patent for new technology.

Conclusion: State-wide platforms for clinical and translational research are feasible with high fidelity and can produce significant results with great benefit to WA and WA researchers.

Funding was via UWA bequest

Active vaccine safety surveillance via a scalable, integrated system in Australian pharmacies

Sandra M Salter1, Gurkamal Singh1, Lisa Nissen2, Kevin Trentino3, Kevin Murray3, Kenneth Lee1, Benjamin Kop1, Ian Peters4, Dani Li5, Alan Leeb4.

[1] School of Allied Health, The University of Western Australia, Perth, Australia

[2] School of Clinical Sciences, Queensland University of Technology, Brisbane, Australia

[3] School of Population and Global Health, The University of Western Australia, Perth, Australia

[4] Illawarra Medical Centre, Perth, Australia.
[5] MedAdvisor International, Melbourne, Australia.

Background: Vaccination programs for COVID-19 are imminent in Australia, with sequenced deployment of vaccines via a broad workforce, including pharmacists. Only limited data exists for safety of pharmacist-delivered immunisations, and no active surveillance systems have been described for pharmacies globally. We integrated a participant-centred active vaccine safety surveillance system (SmartVax) with a cloud-based pharmacy immunisation-recording program (MedAdvisor PlusOne) to create an automated, scalable, pharmacy-based surveillance system linked to national infrastructure including AusVaxSafety. We successfully piloted the system in 2020 to investigate adverse events following immunisation (AEFI) in Western Australian community pharmacies, and to explore pharmacist perceptions of and experiences with SmartVax.

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COVID-19 in Residential Aged Care Facilities Modelling Project

George Milne, David Whyatt, Matthew Yap, Belinda Edmunds. 3rd Feb 2021

Background: Since the COVID-19 pandemic outbreak, no country has avoided outbreaks in residential aged care (RAC) during widespread community transmission. Of 215 Australian RAC Facilities (RACFs) reporting cases, 95 (44%) had a single case1. RACFs are particularly vulnerable to COVID-19 outbreaks2. Infection rates in RACFs are estimated as >10x higher than observed in the community3. Symptom-based screening alone is not sufficient for control, and infection control measures (social distancing, personal protective equipment, hygiene interventions) and rigorous testing regimes have been suggested. While vaccination may prevent serious disease in people infected by SARS-CoV-2, the impact of vaccines on transmission is unclear4.

Aims: This project will apply infectious disease models[5,6] to evaluate COVID-19 outbreak response measures in RACFs, and determine how procedures may be improved to lessen risk. This research is in partnership with the Department of Health, Queensland.

Methods: Our models capture all potential SARS-CoV-2 transmission mechanisms, including fomites and person-to-person contact. To model potential outbreaks in RACFs, networks of person-to-person contacts will be directly represented, as will current hygiene practices, and additional social distancing measures activated if an outbreak occurs.

Data used in model development includes:

1) Documentation from RACFs: staffing, floor plans, staff movement, services, protocols for COVID-19 outbreaks.
2) RACF staff interviews to elicit additional information and insights on individual behaviour.
3) Published information regarding transmission risk.

These models create a “virtual world” and will simulate infectious disease outbreaks in RACFs by capturing person-to-person transmission, with and without social distancing and/or other control measures. Models can evaluate current and alternative infection control measures, and guide responses to future outbreaks.

Ethics approval has been obtained. Staff interviews are underway. We are evaluating novel control strategies including repeated, pre-emptive staff and resident testing. This is significant as recent reports suggest that symptomatic screening alone is insufficient to control outbreaks.

The Bright Side of COVID

Helen McLean and Jessica Sharp, Development Facilitators TRACS WA

Dr Noel Collins, Consultant Psychiatrist, Older Adult Mental Lead, TRACS WA

Background

Health care environments are complex and demanding places to work. The COVID 19 pandemic has resulted in an increased focus on compassionate care, including self care in health care, acknowledging that many health care workers are experiencing considerable stress in their personal and professional lives, and that ongoing uncertainty and concern about infection has adversely affected many users of health services over the past 12 months.

During this time TRACS WA has added a range of resources to our website on 'emotional wellbeing'. In addition, as face to face training was not able to be provided for a period in 2020, we ran a five-part VC series called: 'Tune in with TRACS'. These short conversational style presentations covered a range of topics including: 'Self-care in health care', 'Developing a resilient mindset', 'Communicating effectively from a distance', 'Goals of Patient Care' and 'Courageous Conversations'. They were accessed by staff from a range of clinical backgrounds in metropolitan and country health services and provided a sense of connection and support at a time when many were feeling quite isolated.

Conclusion

The COVID-19 pandemic is a disruptive event that has shaken our understanding of the world and how things should work. Simultaneously, it has enabled us to be innovative in the ways we deliver health care. The renewed understanding that we all need to look after our own emotional and mental health and support each other to cope with ongoing stress and uncertainty, is a welcome focus in health care systems.

Bunbury Hospital Breaths New Life into Birth Education

Antenatal classes play an important role in a woman's preparation for her labour and birth, particularly women experiencing their first pregnancy. Women and their partners are normally provided with the opportunity to attend face to face antenatal education through their local WACHS Hospital.

The advent of COVID saw WA Health direct that all face to face antenatal classes were to be suspended. Pregnancy and birth can be a very anxious time for many families, and the uncertainly around COVID created further apprehension. Providing comprehensive evidenced based information to pregnant women and their supports was even more important during a COVID environment.

Bunbury Hospital had introduced a Comprehensive Antenatal Education program in 2019 which had demonstrated a reduction in birth interventions and improved consumer satisfaction.

A proposal was put forward to WACHS NMO to roll out the existing Bunbury program to all women across the state using video conferencing. Bunbury Midwife Kasey Biggar is a certified facilitator of the course, experienced in telehealth education delivery and currently coordinates /delivers the classes at Bunbury Hospital, and she was extremely excited to be involved in the proposal.

Communication was undertaken with each of the WACHS maternity sites, the program promoted and commenced within 3 weeks of ceasing face to face classes – ensuring seamless provision of information and support to pregnant woman across WACHS. Kasey provided 12 hours of education in 3-hour modules to all women and their partners booked for birth at a WACHS maternity site via VC.

Additional benefits were seen with a single educator enabling to free up midwives from all WACHS sites to provide clinical care

Many stories have been posted on Care Opinion by woman praising the availability of the classes, the evidenced based information and the positive impact it has had upon their preparation for their pending births.

Prepared by: Katrina Jones (Midwifery Manager Bunbury) and Kasey Biggar (Clinical Midwife)

Using every-day video technology to protect our staff and reduce anxiety for our patients.

Problem

- Early in WA's first wave of COVID, we could not predict how many COVID-positive patients were likely to present and we were planning for the worst-case scenario.
- Our nursing teams needed to perform hourly checks on patients, 24 hours a day and Respiratory consultants, pathologists and other clinicians frequented the patient rooms.
- Our patients were anxious, frequently calling the nurses with the 'nurse call button' being the only method available. Some patients were international visitors and English proficiency was poor, adding to their distress with clinical examination and invasive tests.
- Every person and visit to the patient's room required our teams to don/doff PPE every time which presented risk of infection/transmission for our staff and added significant time to the process.
- The PPE supply chain was broken, and our local stores were being rapidly consumed.

Purpose

- Using simple and common technology, substantially reduce PPE consumption on inpatient wards, reduce risk of staff infection, maintain safe, reliable communication with patients and reduce their anxiety and distress.

Methods

- We established two-way video communication hubs at each nursing station and placed self-answering tablets in each patient room.
- The tablets are equipped with google translate allowing simple digital translation into any language.
- Clinical teams would video-call patients for hourly observations.
- Patients could call the nurses station with questions/concerns.
- Other clinical teams could use the technology from any PC on site.

Outcome

- Reduced risk of staff infection/transmission as 3 in 4 visits to patients' room were now virtual.
- Respiratory clinicians could virtually visit from ED/Clinic which soon established 'virtual ward rounds'.
- Time saving/efficiency was greatly improved.
- Heavily reduced PPE consumption (~75% reduction)
- Reduced anxiety for patients (not seeing clinical teams in PPE) and language barrier overcome.

A Frailty Rapid Access Clinic (FRAC) to facilitate early, supported discharge of older patients from hospital during the COVID-19 Crisis.

Objective: To assess the feasibility of a rapid-review Geriatrician outpatient clinic as an alternative to admission from the Emergency Department, or to support early discharge, for older patients at Sir Charles Gairdner Hospital (SCGH) during the COVID crisis. The project aimed to divert older patients from hospital during a period when they were expected to be most vulnerable to the risks of COVID infection in the inpatient setting.

Methods: The COVID crisis led to a reduction in outpatient clinic activity in March-May 2020. We redeployed underutilised outpatient clinic resources during this period to provide a rapid review Geriatrician-led outpatient clinic at SCGH. Inclusion criteria were: SCGH patients over the age of 65 years, residing within the SCGH catchment, who were COVID negative and would benefit from rapid Geriatrician assessment. 50 patients were assessed in FRAC.

Results: Data were available for all 50 patients. The mean age of patients attending FRAC was 80.9 years, and 40% were referred from the Emergency Department. The mean clinic waiting period was 4.66 days from referral. Dementia (22%) and Falls (20%) represented the greatest proportion of primary diagnoses. All patients received Multidisciplinary meeting review, and 80% were identified and referred for subsequent Allied Health intervention from Physiotherapy, Occupational Therapy, Social Worker or Clinical Psychologist. 26% of patients were readmitted to hospital within 3 months of referral to FRAC.

Conclusions: A rapid review Geriatrician-led outpatient clinic for older patients with complex needs was feasible during the COVID-19 crisis. This clinic addressed a previously unmet need for rapid, Geriatrician-led outpatient management of older patients, particularly those presenting to the Emergency Department. An expanded pilot of FRAC to assess its effectiveness during a non-COVID environment is currently underway.

Authors: Dr Nishanthi Pannila, Department of Rehabilitation and Aged Care, Sir Charles Gairdner Hospital, Perth, Western Australia. Dr Sarah Bernard, Department of Rehabilitation and Aged Care, Sir Charles Gairdner Hospital, Perth, Western Australia. Dr Elissa Campbell, Department of Rehabilitation and Aged Care, Sir Charles Gairdner Hospital, Perth, Western Australia

ENT waitlist management for Laryngology referrals during COVID

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One of the fastest changes implemented at Sir Charles Gairdner Hospital in response to the COVID-19 pandemic was the move to telehealth for outpatient services. ENT is a vulnerable speciality due to the exposure of high viral loads during nasendoscopy, which is an essential laryngology assessment tool. There was a substantial challenge to review the waitlist to determine which patients could be safely seen via telehealth. Utilising Speech Pathology to telephone triage laryngology referrals aimed to assist in the urgent waitlist management required by the COVID-19 service delivery changes. This released ENT specialist resources to assess high risk patients; as well as a faster point of contact for laryngology referrals compared to usual category 2 and category 3 wait times. The results support the use of advance practice speech pathologists as a first contact for low risk ENT laryngology patients.

Agile collaboration: State-wide Physiotherapy Responses to the WA COVID19 Pandemic

Submission by Physiotherapy Heads of Department of PCH, FSFHG, RPHG & SCOPHG

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As the enormity of the COVID19 pandemic on society dawned on the world, WA Physiotherapists networked rapidly to address the anticipated challenges. This poster describes the collaborative actions of the Physiotherapy Departments of WA and their impact. Physiotherapist reached far beyond the individual hospital walls and across Area Health Services, as well as assisting colleagues in the private and non-government sectors.

As early reports of uncontrolled community transmission of COVID19 exposed overwhelmed health services, the need for increased numbers of intensive care and complex respiratory competent staff to respond to the predicted upsurge in patient admissions was needed. Also, to plan for reports of 25-50% staff infection rates being possible.

In March 2020, all WA public hospital Physiotherapy Departments instigated broad scaled programs of critical care and respiratory physiotherapy training for example. Significant numbers of Physiotherapist were upskilled rapidly across the state. This included training for the new models of ventilators. Additional recruitment was centrally coordinated together as well as site-specific recruitment.

Physiotherapy protocols were shared, and remote education developed for WACHS. An online Community of Practice (Cop) was initiated to address the emerging recognition internationally of post-acute care needs associated with very early hospital discharge and clinical sequelae of the disease. These efforts were supported by collaborative discussions regarding physiotherapy specific practice in response to rapidly evolving infection control guidelines. Physiotherapists collaborated with colleagues state-wide to troubleshoot local ICU, respiratory, and rehabilitation challenges for example.

Research confirmed persistent physical and psychological impairments, regardless of disease severity. This highlighted the need for Physiotherapy rehabilitation and investment in long follow-up. Physiotherapists aim to identify cutting edge rehabilitation interventions through the WAHTN funded LATER19 trial. Through multi-site collaboration, by May 2020, LATER19 was one of the largest initiatives in the world with 350 participants (150 COVID19 positive; 200 symptomatic controls).

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