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

Terms of Reference
That this House requires the Legal and Social Issues Committee to inquire into, consider and monitor the capacity and fitness for purpose of the Victorian Government's COVID-19 contact tracing system and testing regime, and in doing so consult with businesses, including small business representatives, the community sector and Victoria's multicultural communities, and provide a report to the House no later than 14 December 2020.

Presenter: Dr Mukesh Haikerwal AC; General Medical Practitioner, Altona North.

1. I would like to thank this chamber initiating this enquiry and grateful for the opportunity to speak to you today.
2. My name is Dr Mukesh Haikerwal and I am general medical practitioner in Altona North in Melbourne's west. I'm just completing my 30th year in practice in this area.
3. In the appendix is a background of my career and advocacy.
4. I'm presenting this as a front-line general practitioner who has been involved in providing care the community locally across the State nationally and internationally.
5. The issues relating to Covid 19 need to be put into context regarding the whole response to this pandemic within our community and our state.
6. We first started to be concerned about Covid 19 with horror pictures from China in particular but also Southeast Asia in general with people were dropping dead in the streets.
7. The Australian government initiated significant interventions including closing international borders in the first instance with China.
8. In our own practice we had to prepare for the GPs role in looking after people who potentially would be infected with Covid 19, how to exclude people from the clinic with respiratory disease so that this would not spread within our own workplace whilst providing care for them from testing, diagnosing, treating, providing supportive care, escalated hospital services, post hospital care.
9. Our first test of the system was a gentleman that had come back from travel in China and needed to be tested within our premises.
10. He had been triaged as a potential risk and therefore was asked to come to a different door into a special room and was tested with the available personal protective equipment (PPE). We at this point did have Naso pharyngeal swabs (swabs), a small amount of PPE namely masks goggles and disposable plastic gowns.
11. It was necessary at that stage in February to call the Department of Health and Human Services (DHHS) to obtain permission to do that test. The test had to be labelled and put into 1 plastic bag, then into another bag and then put into a 3rd protective "pink:" bag and then sent off by a special courier to our pathology lab. Our lab would then send it on to the reference lab.
12. This left us with a problem in our building that the doctor would then have to take the PPE of and sanitise. The room was then left closed and sprayed. It was then left

closed for quite some time before we would consider it reasonable to reopen. The question of deep cleansing didn't come in as the person did not test positive.

13. The chain of getting the results from the reference lab was a problem because unlike other labs that lab only use the fax system for getting results back to us. Further the number of tests the lab had to start to handle was significant for it.
14. Early in the piece that DHHS allowed private labs to be involved in the situation which made it much easier to get results electronically in a more timely manner.
15. Later the requirement to get permission to get the test was lifted which also enormously improve the situation.
16. We started testing people in their cars in our car park to obviate the need to clean each room. In our practice of 18 consulting rooms it would have taken just over three days to close down the whole practice whilst also being cleaned.
17. If someone had tested positive we would be shut down for 14 days.
18. By testing in the car park it meant that people were in their own environment and safe and couldn't get contaminated from within our building and we too would be safe as we would not be been contaminated. The need to cleanse premises was diminished.
19. We stopped testing in early March as we ran out of masks ran out of gloves ran out of swabs and so we had to exclude anybody with respiratory illness from a premise ease and send to hospital.
20. To their credit the Federal Minister for Health and the Federal Department of Health set up GP respiratory clinic's. We were fortunate to be chosen as being one such clinic within our area.
21. We proceeded to industrialise the process of testing people in a clinically led way with GPs attesting to the process the whole way through. Each patient would be triaged by a nurse and swabs performed by nurse or a doctor with the whole process was reviewed by a GP. (see evaluations and presentation in Appendix).
22. By having a robust process such as that evaluated noted below, we gathered significant information and data about our patients on site.
23. We also had to work to the guidance of the Federal Department of Health as well as the State DHHS.
24. Guidance and direction is changed regularly. This was expected and understandable and the situation. However the problem was multiple disjointed disconnected messages from different people within the Department of Health and human services not understanding the outcome of their decisions.
25. For instance a scheme was devised to label specimens that were deemed urgent for various reasons into three categories not only were they had labelled there had to be colour-coded. That is a process we managed to use technology to overcome.
26. There was an expectation that only people with symptoms were tested in the respiratory clinic. This was the logical as contacts of people who were diagnosed positive Covid were not symptomatic necessarily. They have to be tested early to ensure that if they are positive they can be isolated and quarantined for the appropriate time.
27. We were also told that everybody need to have elective surgery would have to have a swab. However these people were not covered by the scheme. So on the one hand the Department was suggesting quite rightly that people should be tested for Covid

19 before surgery. Availability was not of around for that and people were not able to be tested on our site.

28. We started work testing in anger on 3 April and had no positive tests in 7500 tests until July 2, 2020.
29. We have now seen over 100 positive patients come through our facility over 40 of whom are patients of the practice.
30. Once the testing start showing positive results our database allowed us to identify a significant cluster in the area. In one day we had nine cases and by the end of five days this had risen to 22. A subsequent cluster was of 9.
31. These were all notified to the DHHS in the normal way. Until more recently this was all done by phone. I used to ring the phone line after 8 o'clock at night as ring during normal business hours was impossible waiting 40 minutes each time as a minimum. Now there is an online form for reporting these cases.
32. Once you reported case to DHHS there is no further interaction whatsoever with the referring GP about the outcome of that case.
33. There is no understanding about what care has been provided what guidance has been given or indeed what the outcome is in terms of been released from quarantine.
34. With direct contact with our patients after being reported to the DHHS, there are multiple reports of patients from families been contacted many times. In one family patient A) will have four or five contacts from the contact tracing agents, each with a different message often. The next person B) in the same family would have a different set of guidance by different set of people. Contact was usually by phone or by text.
35. The Australian defence Force has also been deployed to help with some of this contact tracing. Comments include a military truck being outside on the first day to see one member of the family and then coming in on the second day to see another family member and he asked will be back on the following day to see another family member also diagnosed as positive.
36. Also of note was the case of a refugee been contacted with the significant concern about a military truck pulling up outside the house having a different meaning in his country of origin on the African continent.
37. To this day I have not had any actual guidance as a GP from within the Department as to the correct processes to follow.
38. Ultimately, we have to ensure that sign off from quarantine is done by the DHHS which is only right.
39. It would be so much more sensible to work with the GPs working in the space knowing the patients and knowing family groups, and geography to help join up the dots of care and to give clear understandable concise guidance for patients.
40. This is even more important in track and trace events.
41. Turning to pathology tests and their management first before going on to more details about track and trace this too has been significant upheaval in the sector.
42. When someone has a test is very reasonable to expect that test to be reported to them whether it was negative or positive. When contacted by testing centres it's very difficult to actually understand where the test was done who did the test where the test was stored and how to get access to that test. In our centre we only used one lab. Many of our patients to attend our medical practice will get tested on

multiple sites. This includes local hospitals as well as of the pathology providers. Some of the labs sent their samples interstate and therefore could not use normal electronic reporting mechanisms for in-state results. Information I have suggest that there are at least 18 labs involved in reporting tests for Covid 19 in this period. It is impossible for a single GP to ring through each of those labs ascertain what the result was on a particular patient. There is no repository of these results accessible easily.

43. The manner in which the labs provide the results in commercial labs is by a secure email type of report to the general practitioner into the general practitioners inbox. Unfortunately some of these labs in fact all but five use a fax machine. If you consider the current reported number of tests to date from the Department of Health and human services (17/11/2020: 3,422,760 test results have been received. This is an increase of 17,412 since yesterday) we absolutely have to work with this system electronically.
44. In our practice we had far too many phone calls from people far too often chasing their results. If the results were not done within our own system it was impossible to provide those results. I understand a call centre had been set up to get some of these results.
45. With testing blitzes the number of tests increased remarkably quickly blowing out the days to get a result from around three days to over seven days. Often test that when interstate were very difficult to follow up.
46. It is unreasonable to stand up and say that you are guaranteed to get a test within 24 hours even today. Unfortunately, this Napoleonic manner of communicating with the presence and the clinicians was a trait throughout this whole process. Just because someone stands up and says that it is so, does not mean in the real world it is so. The process of performing tests, sending test of, putting tests into a pathology system by receiving it, annotating it, setting it up for the lab, going through the testing process, reporting it, reporting those results to the DHHS, reporting this to the general practitioners if possible is extraordinarily difficult.
47. One major dramatic change was to see test results being reported back to patients directly by text message if the patient had a mobile phone. This was not encouraging full positive results are very obvious reasons. This made a massive difference with a number of phone calls dropping off as patients got their results.
48. It was still important to follow-up with patients whether they had received a text message or not so that they were not isolating for long periods of time as in fact some people ended up having to do.
49. As people been tested were encouraged to self isolate for a period beyond the negative result being passed on to them, it was often a difficult conversation to encourage them not to go back to work or into the workplace or into shops without a negative result and being symptom-free for three days.
50. Turning now to positive cases. An initial glitch in the system was that we as GPs and respiratory clinic's testing people were initially not given positive results!
51. When we got notification of positive results we were able to tabulate these and see trends in areas where people are coming from where there was positive results.
52. We note that this major outbreaks such as the Al-Taqwa College in Truganina, this the 3 plus abattoirs in our area and multiple distribution centres and shops were never notified to us in any shape or form. We relied on the media. There are media

reports of my colleagues giving advice that was not made aware of the massive cases numbers of cases in those areas.

53. This when we detected positive cases we actively encouraged patients who had attended our facility to get their next of kin to be tested immediately. Some did-unfortunately others did not.
54. The messaging around the need for testing was not good in some communities. The uptake therefore was put in some communities and also in the teenage and post-retirement age groups.
55. When we peaked with 725 cases in a day the number of cases active in the state was significant and it was next to impossible for any system to cope with these alone. There was still no attempt to reach out to general practice.
56. In our own experience it was important to get to patients who were tested positive early, to inform them of the diagnosis, to report this to the Department of health and human services, to write a letter to the GP who the normally saw and to provide support until they were in a system that was functional.
57. We also developed a Covid care at the University of Melbourne and Two bulls which help people understand needing to get a test, getting a test, monitoring the symptoms, monitoring their symptoms if they were positive, noting the escalation pathway if there were not getting better and looking at the mental health.
58. This when patients were being followed up after diagnosis it was important to have a scheme with which to care for them and to ensure that the GPs had received letters informing them of the positive diagnosis.
59. Patients turned to the GPs for ongoing support and care and seeking “wrap this around services” such that they could isolate safely and be properties provided for.
60. In our area we had two spikes that we detected. In the first noted above with 22 cases in five days we reached out to the local council. Hobson’s Bay City Council were magnificent and organised for a mail out to affected suburbs within the municipality. Further significant online resources were developed and made available with content from DHHS. A mobile set of billboards were displayed in prominent sites throughout the municipality. All GPs in the Miss party were written to and asked to provide support to patients should they have a positive diagnosis.
61. Council provided support-material support-to patients with a positive diagnosis.
62. The Community Engagement and Testing within DHHS were exemplary in also supporting activities of the local action. We met regularly every two or three days for two weeks and troubleshot multiple issues including increasing communication with the CALD community, increasing messaging in the area and using collateral developed elsewhere. On-site testing was also increased over the weekends at our respiratory clinic.
63. Whilst the significant action across the community with the local council, DHHS, local GPs and other providers was beneficial, there is a need to cement this sort of working locally within communities and across communities in a systematic manner and sharing his knowledge across principalities.
64. I note that there was an outbreak in Chadstone and am well aware of the fact that the GPs who were working in that facility were not informed of the outbreak.
65. Similarly in Colaroo where there is another respiratory clinic there was no attempt to engage with our practice in the first instance. The GP there has also been working in

the area for many years. Local colleges that had infection were less than a kilometre from this practice.

66. There is now a impetus to established local public health units. There are three established currently within hospitals. The initiative is one I would support. It is a fallacy to assume that because you said there would exist that they do exist and that they are up to par unable to work with all cylinders pumping. There is a very rare real need for these to be working across unities and in many ways should be based within the community.
67. There is a very good task force within DHHS called COVID-19 Primary Care Advisory Group. This includes peak bodies including the AMA (Victoria), the Royal Australian College of GPs, community health centres and representatives of Victorian Aboriginal Community Controlled Health Organisations and Primary care Networks.
68. It is very important to point out the role of the general practitioner on the ground needs to be invested in these processes through whatever mechanism possible.
69. This effort of combining all providers of healthcare in the primary-care sector in particular general practitioners from private general practice-not from funded organisations alone-is of vital support for the community in any time fulfil health and absolutely at the time of pandemic.
70. As our minds turned towards immunisation there is no place more capable and set up and credentialled and accredited with a proper cold chain to provide immunisations. The methodology will be found should the immunisation agent needs to be stored at a very low temperature as has been indicated for one particular vaccine.
71. The GP notes the community in which they work. Then other people within the community including family groups and linkages. Many have linguistic skills and certainly have communication skill from many years of training and deployment on the ground.
72. The DHHS has to work collaboratively meaningfully respectfully with the general practice and other primary healthcare sector.

Conclusions:

There are many shortcomings in the system currently.
The system has started to be improved but needs to be done more collaboratively and proactively
the manner in which the DHHS is governed needs to be improved to allow for clearer decision-making.
I am cognisant of the submission by AMA Victoria president Dr Julian Rait OAM and I concur fully with those points.
Victoria has always led the way in innovation and service delivery and was a standout jurisdiction when I was part of the National health and hospitals reform commission reported 2009. I would like to see Victoria reach those heights again.

APPENDIX:

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Mukesh Haikerwal is a General Medical Practitioner in Altona North in the West of Melbourne, Victoria Australia. He is in a group teaching and training practice where he has worked since 1991 with his wife Karyn Alexander.

They worked with a partnership of 9 to build the "Integrated" North Altona Health Hub – Circle Health (www.circlehealth.com.au) and merged two local practices under the new Altona North Medical Group (www.anmg.com.au).
Part of their vision is CIRQIT Health (Community Innovation Research Quality and Information Technology – www.cirqithealth.com.au) built on the upper floor.
The General practice includes a significant role in supporting patients needing psychiatric and mental health care in the area coordinating care with members of the Mental Health professionals' network and beyond.

The 2020 COVID-19 Pandemic was a catalyst for change in Health and Health care delivery and as part of Mukesh's highly public interventions including "Car-Park" testing, use of Video-consultations, deployment of lay "clinical Health Assistants" and "scribes" CIRQIT was the innovator, integrator and adoption agent for the "North Altona Respiratory Clinic"- a Federal initiative.

On 26 January 2018 he was made a Companion (AC) in the General Division of the Order of Australia for "eminent service to medical governance, administration, and technology, and to medicine, through leadership roles with a range of organisations, to education and the not-for-profit sector, and to the community of Western Melbourne."

Of note, Mukesh has held high offices in Victoria, Nationally and internationally.

- Principal in General Medical Practice
- Board of the Actuator: Australia's Medtech incubator programme (Chair)
- Board Cancer Victoria (deputy Chair)
- Board Beyond Blue
- Chair Beyond Blue Drs' Mental Health Programme
- Board Brain Injury Australia
- Board Australian GP Alliance
- Board of Melbourne Academic Centre for Health (MACH): an MRFF initiative
- Honorary Enterprise Professor, University of Melbourne
- HealthDirect Clinical Governance Committee
- AMA Gold Medalist
- Life Fellow, Royal Australian College of General Practitioners
- 2014-2016 Ex Chair Australian Institute of Health and Welfare
- 2011-2015 Past Chair of Council, World Medical Association
- 13-14/11/2014: Convenor: first #H20Melb in Australia in November 2014.
- 2013: Rotary Melbourne Community Award
- 2003-2005 19th President, Australian Medical Association
- 2001-2003 AMA Victoria President
- 2007-2013 Head of Clinical Leadership, Safety & Stakeholder Management: National E-Health Transition Authority
- 2008-2009 Commissioner, National Health & Hospitals Reform Commission

Mukesh is a passionate advocate for the use of technology in the health sector and stepped down as the National Clinical Lead and Head of the Clinical Leadership & Stakeholder Management Unit at Australia's the National e-Health Transition Authority (NEHTA) after 6 years in August 2013. His roles there were in apprising the Australian community of the benefits of the vital role of IT in health care an enabler of progressive improvements and sustainability.

He worked for the Prime Minister of Australia on the National Health and Hospital Reform Commission formulating a future vision for Australia's health including using eHealth as an enabler. He was previously assigned to the National Minister for Health's eHealth Ministerial Advisory Group and had roles with the Victorian State government.

He was awarded the Order of Australia in 2011 for distinguished service to medical administration, to the promotion of public health through leadership roles with professional organisations, particularly the Australian Medical Association, to the reform of the Australian health system through the optimisation of information technology, and as a general practitioner.

He was the 19th Federal President of the Australian Medical Association, its Federal Vice President and, prior to that AMA Victorian State President. This saw him responsible for national policy development, lobbying with federal parliamentarians, co-ordinating activity across the AMA State entities and representing the AMA and its members nationally and internationally. He is a Life fellow of the RACGP and in May 2014, he was awarded the Gold Medal.

Evaluation of a general practice COVID-19 'Respiratory Clinic': Oct 2020
https://www.dropbox.com/s/cutlm2i0i6nef28/2020.10.5%20Evaluation%20of%20Altona%20North%20respiratory%20clinic.pdf?dl=0

Evaluation of a general practice COVID-19 'Drive Through Clinic': Oct 2020
https://www.dropbox.com/s/oxityx7nxgs5uho/2020.5.24%20Drive%20through%20clinic%20evaluation%20FINAL%20UoM.pdf?dl=0

Presentation of the running of the Altona North COVID-19 'Respiratory Clinic': Oct 2020
https://www.dropbox.com/s/9zlfg5eidwsvi2a/20200818%20GENERAL%20Data%20snapshot.pdf?dl=0

Canute was 40 when he died in 1035. He was also known as **Cnut** the Great, **King** of England, Denmark, Norway and parts of Sweden. By the time of the Norman Conquest in 1066 his story was quickly becoming lost to time but his relationship with the tide lingers on.

http://www.sealevelrise.info/Story%20of%20Canute.php

Find following data as requested from the Royal Australian College of General practitioners.:

Practices (2019)

NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2 800	1 985	1 629	751	542	170	109	161	8 147

Source: Report on Government Services 2020 https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health

GPs (includes VR, non-VR, trainees) (2019)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Headcount	11,482	9,227	8,116	3,881	2,763	936	586	481	37,472
FTE	9,764.9	7,612.0	6,390.3	2,839.1	2,053.9	566.4	396.2	231.1	29,853.8

Source: Department of Health General Practice Workforce providing Primary Care services in Australia - Statistics by calendar year https://hwd.health.gov.au/CalendarYear.html

Community Health Centres:
https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-services

Victorian CHSs operate under two distinct legal and governance arrangements: 56 CHSs operate as part of public health services and 32 are independent registered CHCs.
The independent registered services are companies limited by guarantee, and registered under the *Health Services Act 1988*.

Primary Health Networks (PHNs).
https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background
https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

6 Primary Health Networks in Victoria:

- North Western Melbourne
- Eastern Melbourne
- South Eastern Melbourne
- Gippsland
- Murray
- Western Victoria

The Covidcare APP
https://www.covidcare.io/
https://medicine.unimelb.edu.au/research-groups/general-practice-research/mental-healthprogram/covid-care