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20-3-2020
Hon Brad Hazzard
Minister for Health and Medical Research
NSW Parliament
Macquarie St
Sydney

Dear Minister

Re NSW COVID 19 Pandemic preparations

As the representative body of all NSW Medical Staff Councils, we are writing to you to express our concern that preparations for the NSW hospital reception of patients with COVID 19 are not occurring in a uniform manner. There is inadequate standardisation of how LHDs are preparing for the predicted influx of COVID-19 patients. There is substantial variation between LHDs in the extent of communication from LHD management to their hospitals in preparing plans, with some LHDs providing little input or co-ordination to overall plans. Under the Bio-securities Act, is there no ability for NSW Health to provide more uniform resources and planning capacity across all of NSW, rather than leaving the management of a serious global pandemic in NSW to the fragmented LHD model?

This situation is particularly worrying given the predicted influx of COVID 19 patients that we will start to see over the next days to weeks with the infection rate i**n NSW doubling every 2-3 days** and NSW currently has the most cases of any state or territory in Australia.

As you are also aware international evidence about the current pandemic informs us that 80% of patients have mild illness, 15 % have moderate illness requiring hospitalisation and 5% have serious pneumonia or shock and require Intensive Care. Extreme caution needs to be exercised in adopting strategies from other nations in a piecemeal way and well outside of the timelines with which other countries have successfully implemented them (eg Singapore had previous pandemic experience and were early implementers of preventative measures. Late implementation of parts of their model may not be effective.).

There appears to be excellent preparation at some hospitals (Westmead Hospital and RPAH) and less well coordinated preparation at many others in both metropolitan and rural settings.

We are surprised that there is not a uniform approach to the appropriate use and availability of PPE across all LHDs. The provision of appropriate PPE and required training leads to better outcomes for patients and less risk of dangerous and life-threatening exposure to the Health Care Workers (HCW) who assess and treat these patients in the Emergency Department and on the wards.

We are also aware that there is a shortage of face masks (P2/N95) as well as eye protective googles or (preferably) eye shields which are obviously necessary for user protection from droplet spread. Such shortages or even perceptions of shortages invoke additional stress and worry among healthcare workers.

Rural areas represent a particularly vulnerable group of hospitals, currently with such poor supplies of PPE equipment that P2 masks are kept locked away so that staff or members of the public cannot steal them. Having P2 masks locked in clinical areas is completely untenable and dangerous for staff. There are already examples of staff resuscitating a potentially positive COVID-19 patient with crash intubation, **without** P2 masks and any appropriate PPE being available. There is another case of a HCW examining and taking a history from a viral pneumonia patient on droplet precautions **with no P2 mask or shield available** (only standard mask and shield) resulting in the staff member being under quarantine pending swabs. Regional and rural areas have a tenuous healthcare workforce at the best of times and increasing risk to staff of serious illness or even just quarantine for COVID-19 or due to contracting other respiratory illnesses, will rapidly lead to a HCW crisis in regional areas.

We have been made aware of disparate approaches to mandatory special leave for HCW affected by COVID 19 being applied by LHD's. HCWs are facing the thought that their chosen career may be placing risk on their families and loved ones. A poorly communicated and piecemeal approach to leave, remuneration etc. will add to their anxiety. We are likely to be relying on locums and VMO's and casual employees. What support is given to them if they face self -isolation and/or infection as a result of helping out? Extending remuneration to them would convey good will to such staff. We are aware one rural LHD has communicated their support to staff in this matter.

Further to this, it can be predicted that rural and regional and outer metro centres will almost certainly have a risk of more patients at the more severe end of the spectrum per capita than healthier areas of the state, generating a greater ICU and ventilator demand in these areas. This is expected due to a greater number of elderly patients and even patients in younger brackets who have high rates of the co-morbidities of HT, cardiovascular disease and diabetes, well known to be associated with greater risk of ICU and dying of COVID-19 in literature and epidemiology from China and Italy.

During the recent bush fires some local councils became the lead agency in support of the community and they did a wonderful job and were highly trusted and respected. Could this model be extrapolated to the current disaster via a partnership between LHD's and councils. We believe Councils would require an invitation from the Ministry. We have been informed that those LHD's that have attempted this will require a delay of 2 weeks to process permissions from the Ministry or LHD executive

In a recent open letter to the Prime Minister signed by over 3000 doctors, they stated the need to do the following immediately:

1 Ensure all staff who are likely to come into contact with these patients have appropriate training in and an adequate supply of the 5 item PPE equipment. Appropriate training in PPE means someone watches you "don" and "doff" as this may be important in terms of catching the disease with potentially severe consequences. The Westmead document cover this well with lanyards, pocket cards and wall charts

2 The immediate cessation of all elective surgery in order to free up beds for these patients

3 An immediate increase in ICU capacity

4 Increase in cleaning of potentially affected areas 24/7 which decreases spread of the disease

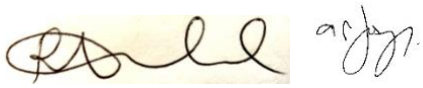
5 Another important issue is that of staff retention and replacement during periods of fatigue or illness.

The NSW MSEC understands that both you and the MOH are working hard with the Federal Government to mitigate the effects of the COVID 19 pandemic in NSW.

We are happy to assist this effort in any way that you feel would be helpful.

We believe that there is a need for immediate action and leadership to address our concerns to avert unnecessary deaths among both patients and health care workers

Signed



Dr Anthony Joseph and Dr Ruth Arnold
Co-Chairs NSW MSEC

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Cc Ms Elizabeth Koff, Secretary NSW Health
Ms Susan Pearce, Deputy Secretary NSW Health