Canterbury Primary Response Group

20 November 2019

Dear Colleagues

We acknowledge the response to the Canterbury measles outbreak in 2019 was an extremely difficult time for general practices and their staff. We understand general practice teams faced many challenges during the response, including being inundated with calls from concerned patients, the need to constantly reschedule appointments due to vaccine supply issues and constantly changing vaccination priorities, and these challenges had a financial and workload burden.

Despite all of the above, practices responded in an extraordinary manner and vaccinated around 27,000 patients within a short timeframe.

The CPRG team would like to thank you all for your efforts.

The review conducted, which many of you made valuable contributions to, was reported to the Canterbury DHB and Community and Public Health (C&PH).

These recommendations and a further submission from CPRG were considered by a group chaired by Professor Mike Ardagh of the Canterbury Initiative on 19 November 2019. The recommendations from this review and submission follow.

As result of that meeting a small working group with representatives from across the health sector will be formed to implement improvements to the way a response to an infectious disease is coordinated in the future. The focus of this group will be on roles and responsibilities, coordination structures, communication and the supply chain.

We regret that there has been a delay in providing recommendations for future responses based on your valuable feedback, but this was beyond our control.

The CPRG team wishes to express our gratitude for your work during the response.

Sincerely

Dr Phil Schroeder (GP Primary Care Coordinator)
Kelly Robertson (Practice Nurse Representative)
Gareth Frew (Pharmacy Representative)
Graeme McColl (CPRG Strategist)

Recommendations from the CPRG report on review comments from Practices

Control and Coordination

1. *That roles and responsibilities be defined and agreed early and documented to avoid any confusion and to ensure compatibility of planning.*
2. *That written plans be prepared and shared early for the same reasons as above.*
3. *That any plans prepared by the MoH also be shared with those managing the response.*
4. *That consideration be given to establishing a joint EOC in all aspects of the response.*
5. *That more CPRG members and admin support staff be trained in log keeping.*

Communication

1. *That an early decision be made on the response strategy along with possible limitations and this be communicated to practices before or at the same time as the media.*
2. *That information to practices be supplied from a single agreed source.*
3. *That media releases be coordinated and made by an agreed spokesperson(s).*
4. *That practices be advised early of the roles, structures and contact details of any response management team.*
5. *That response agencies share information to ensure accurate communication can be made to practices.*
6. *That updates to practices be in a concise format for ease of dissemination amongst staff.*

Vaccine Supply, Allocation and Distribution

5. *That an immediate consultation take place with the MoH and PHARMAC on the availability of vaccine for use in any response strategy.*
6. *That PHARMAC require all pharmaceutical suppliers to have emergency business continuity plans to ensure any urgent increase and demand can be managed.*
7. *That these plans be audited to ensure that they are practical and achievable. (Note the MoH Regional Emergency Management Advisers would be qualified to complete such audits)*

8. *That the ordering and supply of vaccine to practices be managed by the DHB in the response area to ensure that the needs according to the enrolled patient demographics be met. Such management to be arranged in consultation with practices to ensure special needs such as University Students and unenrolled migrants are met.*

Practice Workloads

7. *That clarification is established for supply chain and priorities before recommending responses.*
8. *That initial media and practice communication include details of possible limitations in the response due to lack of vaccine supply, clinic times and actual vaccination priorities.*
9. *That dedicated call centres be considered to manage general public calls and information.*
10. *The specialist vaccination clinics are considered where/when necessary to vaccinate a large number of people in a short time. (Provided vaccine is available).*
11. *That there be a financial package is made available to practices to cover the workload over and above actual vaccinations.*
12. *That the use of pharmacy vaccination services be considered where/when mass vaccination is necessary.*

Prepared by

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