

SOUTH AUSTRALIA COVID-19 EVIDENCE TASKFORCE

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This is an adaptation of a presentation given at the online ALIA HLA "Now, Next, Beyond Covid-19" online conference on July 16, 2020. The basis of the presentation was how my work during Covid-19 differed to that in my usual role. My substantive position is as a reference librarian for the SA Health Library Service, known widely as SALUS. I have been with SALUS for just over two years, after moving from a liaison librarian position at Flinders University.

In early March 2020 the South Australian state leadership tasked Paddy Phillips, the Commissioner of the Commission on Excellence and Innovation in Health (CEIH), to pull together a team of experts to synthesise emerging evidence on Covid-19 in order to support the State's leadership executive in developing evidence based public health responses. I was approached to become a member of the newly formed 'SA Covid-19 evidence taskforce'. The taskforce is a multi-agency collaboration between the CEIH, the South Australian Health and Medical Research Institute (SAHMRI) and Health Translation SA (HTSA), led by Professor Caroline Miller at SAHMRI.

Our task was to respond rapidly to requests for evidence, with these requests coming from a variety of sources, primarily from the SA Chief Public Health Officer, but we also received requests from senior clinicians within our hospitals, from the State Minister for Education and from Australia's Chief Scientist. Often we only had a day or two to produce a summary on these requests.

Before Covid-19 I would often partner on review teams, including rapid reviews, so in many regards this was a fairly normal task for me. However in this assignment there were many unique features and challenges. I am a strong follower of methodologies and established processes, and rely on this guidance in my practice; but much of what we were doing in this situation was emerging and undefined. Here I will detail some of the challenges I faced in undertaking rigorous searching and applying evidence based search techniques in the unique environment of a global pandemic. When searching for decision making purposes we are looking for the highest level of evidence. At the start of the pandemic the highest level of evidence available was primarily case studies, modelling studies that were based on limited data, and clinicians' observations; evidence that would not normally be strong enough to base

these vital decisions on. Initially many of these papers were also published in Chinese journals and not in English.

Speed was of the essence and search alerts were much too slow in this environment; PubMed Medline was updating quicker than Ovid Medline, and Google Scholar was faster than PubMed. The journal home pages and the preprint websites were the first spaces to update and the publishers were also attempting to push out information as quickly as possible. However this meant that their article records would usually initially only consist of a title and an attached pdf. Often key evidence was located in the letters to the editors of the key journals, again a resource type that we would often not include in reviews. For me this meant a trawl through each journal website for every topic, opening every pdf to assess the content, which was very slow going. Another issue we had to navigate was that researchers were disseminating their evidence through the media before their research was available in any online spaces; this meant we were often trying to find evidence on emerging topics that were being widely debated but there was no actual evidence to locate. This was demonstrated by the case of anosmia (lack of smell), which we were asked to research after the statement was published by ENT UK (Hopkins & Kumar, 2020). At that primary point we could not find any case studies at all, just a few mentions in epidemiological reviews. Ultimately we wrote three editions of this review and we were struck by the huge increase in available studies between each iteration.

In the meantime I was aware of other evidence teams who were doing the same thing across the world and tried to keep an eye on what they were doing, primarily the CEBM at Oxford University, and McMaster University in Canada. Thankfully Trish Greenhalgh at the CEBM is a prolific tweeter and often commented on their processes, which was invaluable during this time of uncertainty. It did however seem that we were all following a very similar method and using similar resources, which was reassuring.

The database providers and indexers were also playing catch up, which meant search terms were also changing rapidly. The World Health Organization were the first to pull all the Covid-19 papers into a 'global research' repository very quickly in early March, closely followed by LitCovid from the National Center for Biotechnology Information, but both of these data sets were only searchable by full text keyword (WHO 2020, Chen 2020).

A key change from my own usual practice was that I was undertaking the primary screening process. After conducting as comprehensive a search as possible I would then screen through these results, along with a second reviewer, to pull out any empirical evidence, expert consensus, or key descriptive cases. In total during the early months of the pandemic we created 19 full evidence summaries, four updates and a number of smaller evidence responses directly for our clinicians. My

secondment with the CEIH finished at the end of June, but I am still a member of the taskforce. We still receive evidence requests but the frequency is less often and the urgency much reduced.

The secondment to the SA Covid-19 evidence taskforce raised the profile of the SA Health Library Service and we have since been approached by other teams for further collaborations. After the placement ended I was contacted by the Covid-19 State Control Centre (CSCC) and also by the Communicable Disease Control Branch (CDBC). The taskforce including myself have now worked with the CDCB to develop guidelines for best practice in contact tracing and second wave prevention and suppression, which has turned out to be extremely prescient as South Australia is experiencing its first outbreak in seven months as I write this. I also curate an evidence page for the SCSS on topics that they suggest (May 2020), and also escalate topics that seem relevant to the taskforce to their attention. Outside of Covid-19 I am currently working on some new projects with the Office for Research and the Continuous Improvement Unit at one of our local health networks, and other team members are working on other local projects.

Personally I have gained immeasurably from my work with the task force. Due to the circumstances of the situation I was forced to think on my feet and undertake tasks that I previously would not feel qualified to undertake. It also has highlighted some weaknesses in my ability to quickly analyse research data and so I am looking into undertaking some additional study next year.

References:

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