LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE COVID-19 PANDEMIC RESPONSE

(Reference: COVID-19 pandemic response)

Members:

MR A COE (Chair)
MS T CHEYNE (Deputy Chair)
MRS V DUNNE
MS C LE COUTEUR
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 16 APRIL 2020

Secretary to the committee:
Mr H Finlay (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

COLEMAN, DR KERRYN, Chief Health Officer, ACT Health Directorate **10**

McDONALD, MS BERNADETTE, Chief Executive Officer, Canberra Health Services **10**

PEFFER, MR DAVE, Deputy Chief Executive Officer, Canberra Health Services . **10**

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children, Youth and Families, and Minister for Health **10**

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Amended 20 May 2013

The committee met at 11.07 am.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children, Youth and Families, and Minister for Health
McDONALD, MS BERNADETTE, Chief Executive Officer, Canberra Health Services
PEFFER, MR DAVE, Deputy Chief Executive Officer, Canberra Health Services
COLEMAN, DR KERRYN, Chief Health Officer, ACT Health Directorate

THE CHAIR: Welcome to the second public hearing of the Select Committee on the COVID-19 pandemic response. The committee intends to hold public hearings every Thursday, alternating between the ACT government and community representatives. On behalf of the committee I thank you, minister, and your officials for attending today. I understand that you have been forwarded a copy of the privilege statement. Could you please confirm for the record that you understand the implications of the statement?

Ms Stephen-Smith: I have read and understand the privilege statement. I advise the committee that my chief of staff, Cath Bergin, is also in the room with us today.

Ms McDonald: I acknowledge the privilege statement.

Mr Peffer: I acknowledge the privilege statement.

Dr Coleman: I acknowledge the privilege statement.

THE CHAIR: Is that everybody?

Ms Stephen-Smith: Yes. We have a couple of people outside the room in the Health Directorate if we need them. If we do, we will call them in and they will introduce themselves.

THE CHAIR: Thank you. Did you say your chief of staff is there as well?

Ms Stephen-Smith: Yes, she is in the room in the same way that she would be in the gallery, or one of my staff would be in the gallery, during a normal hearing.

THE CHAIR: Okay, thank you. I note the difficult circumstances today. Let me say at the outset that this is less than ideal. The committee's preference is for everybody to appear via Zoom. It is easier for Hansard and much easier for the scrutiny of government and for anybody following the web stream. I am personally disappointed that this direction has been chosen, and the committee will be discussing this at a later date. Minister, are you able to provide a brief insight as to why you are not appearing via Zoom?

Ms Stephen-Smith: I understand that the Chief Minister has written to the committee explaining why the government's decision at this point is to not appear via Zoom. That is not a decision that I or the Health Directorate or Canberra Health Services

have taken; it is a decision that the Chief Minister has taken, on the advice of the relevant officials, who have a much better understanding than I do about the security implications in relation to that particular technology. I understand that the Chief Minister will be appearing. It will probably be more productive to have that conversation with him than with me at this point in time.

THE CHAIR: The Assembly has called you, minister, and your officials, so this is your decision. You have to be accountable for this decision, especially as it relates to this committee. Are you able to provide any reason, other than that you have been directed, as to why you do not feel it appropriate to participate via Zoom on a public broadcast?

Ms Stephen-Smith: I am taking the advice of officials in relation to the security implications of Zoom, which has been passed on to the committee by the Chief Minister. I am appearing today in my capacity as Minister for Health. I am not the minister responsible for whole-of-government IT security and I did not provide the advice to the committee. If you want to continue asking me for another 10 minutes about this, I will continue to provide the same answer, but you do have the Chief Minister appearing. He may well have the relevant officials with him to talk further about this. I am appearing today in my capacity as Minister for Health and I am appearing under the instructions that we have been given, in line with the security advice.

THE CHAIR: Okay. Again, I express my personal disappointment at this arrangement. I think this is not best practice for the Assembly. To kick off with substantive matters, I want to ask about the facility that is being proposed for Garran Oval, the $23 million facility. Can you please advise what is being constructed and the purpose of it?

Ms McDonald: The facility being constructed on the Garran Oval is a facility that we are calling a temporary emergency department. It does have some flexibility in the business of that, but primarily it is to receive patients who are presenting with symptoms that require medical attention. Those patients may or may not be positive for COVID-19. The facility will be designed so that patients can be streamed either as positive for COVID-19 or as suspected as COVID-19 and receive medical attention, as any emergency department would be able to provide. It will be stood up with 50—

(Audio interrupted 11:15:31-11:15:37)

—and will have five resuscitation spaces available as an emergency department. Its primary focus is as an emergency department. However, in the early stages of standing it up, we are looking at staging that. It may start off doing respiratory assessments and early treatment and triage of patients who present there.

Mr Peffer: In the design of the facility we took advice from experts in health services overseas, as well as the WHO, on best practice for designing the facility to manage an infectious disease. It has been designed very clearly to have six separate pods. Those pods can be activated and start at a time that is suitable. So we do not need to stand up and operate the whole facility at the beginning; we can operate the facility in a way that matches demand as it comes, and we can scale the workforce to support that as

well.

THE CHAIR: Who has been contracted for this facility? Under what procurement type was that contractor engaged?

Mr Peffer: The work has been occurring through discussions with Aspen Medical and in partnership with Shaw Building Group, which is currently working on preparing the footing for the facility.

THE CHAIR: Who actually has the contract?

Mr Peffer: Aspen Medical will be the head contractor delivering the facility. Separately, the territory is working through Shaw Building Group to prepare the site for the facility to be constructed. Aspen Medical is then contracting a range of subcontractors and equipment suppliers, some domestic and some international, to provide the necessary equipment for the facility to operate, as well as supplies such as PPE and medical supplies.

THE CHAIR: You say that the head contractor is Aspen. Who is engaging the builder?

Mr Peffer: There are two elements to it. The first is site preparation. The territory is undertaking the site preparation. This includes utilities work, clearing the space and providing for the car park works. Aspen will then contract for the construction of the facility. We are working with Aspen to deliver a facility and staff and operate it. However, the site preparation works are being undertaken by the territory.

THE CHAIR: But I think you mentioned Shaw Building Group. What are Shaw Building Group doing?

Mr Peffer: Site preparation work—they are from the government panel.

THE CHAIR: Who is building the structure for Aspen?

Mr Peffer: My understanding is that it is being prefabricated off site, in partnership with an organisation at Fyshwick. The name of that organisation I do not have at my fingertips, but I would be happy to take that on notice. It is being produced locally by a local manufacturing and construction firm.

THE CHAIR: What is the value of those two contracts: the site preparation and then the Aspen head contract?

Mr Peffer: The site preparation costs—just bear with me for one moment.

Ms Stephen-Smith: While Mr Peffer is looking that up, we will be able to get you fairly quickly some of the building partners of Aspen Medical in relation to the facility itself. Aspen spoke about those at the media event on Thursday and provided in that media conference pretty much a full list of the partners that they are using, including some of the local companies. We will try to get you that information in the next few minutes.

THE CHAIR: Thank you. Can I please also request that the contracts be published as a matter of urgency and that the design of this site and perhaps of the actual structures also be published?

Mr Peffer: We can take some advice around the contracts. We would be very happy to make available the details of the design and some of the thinking that went into that—because I think there was some excellent clinical input both locally and from overseas.

Going back to your previous question, Mr Coe, the value of the contract for the site enabling and utilities is in the order of $3.5 million. I should add that the design of the facility has incorporated the ability for us to deconstruct and re-use the facility at a future stage if required. The construction of the facility itself, including prefabrication and installation, is in the order of $9.5 million.

THE CHAIR: This pretty much means putting a concrete foundation or concrete footings and a car park on the current Garran Oval—is that correct?

Mr Peffer: In terms of site enabling—is that the nature of your question?—there is a quite detailed package of works that occurs there in terms of geotech and various studies. We need to make sure that if we have heavy rains and during winter the facility is going to withstand the conditions. It includes a range of utilities work. We have to run sewerage, power and water to the facility as well so that it can function.

THE CHAIR: Sure.

MS LE COUTEUR: How long are we planning that this facility is going to operate for? Does $23 million get us six months, a year, or what?

Mr Peffer: The cost of the facility has a fixed component, which is the design and delivery of a functioning facility. Then it has a variable component, which relates to the workforce and ongoing operation. The way that we have engaged with Aspen provides us considerable flexibility with the timing and the rate at which we activate those latter elements in terms of the workforce and operation.

The $23 million was an original estimate, and funding for that has been provided. However, the ongoing recurrent cost will be demand dependent. So it could be more than that if we were to see a large spike that accelerated in the territory, or it could be much less than that if we were not to see that spike and there was a slower, gradual increase. So it is impossible to give an exact figure for what that is going to be.

MS LE COUTEUR: But you must have said to Aspen, "We expect this is going to be a six-month, one-year or whatever operation." So what sort of modelling have you done to say, "This is what we want," and what did you ask for?

Mr Peffer: We worked with Aspen on a workforce model of what we thought we would need for a well-functioning, high-acuity emergency department. That included looking at what was necessary in a medical, nursing, allied health and administrative workforce to stand up a facility like that. Aspen has come back with some suggestions

about how it could work, plus some suggestions about the make-up of that workforce. They are conversations that are had between their clinical team and our senior clinicians as well about what is possible and what is practical. So I guess it will continue to evolve, but the territory is not locked into a particular workforce model and a particular timing for that to come online.

MS LE COUTEUR: I have a much more parochial question, as a member for Murrumbidgee. You are going to be crossing the road. I presume that is not going to be a tunnel; it is going to be elevated, given the site. Is that going to be something which will stay long term?

Mr Peffer: With the design of the facility and how it will function with Aspen, they are providing a retrieval team—a skilled paramedic and potentially a retrieval doctor, and it is support that will work with motorised transport so that people will not be walking for hundreds of metres with sick patients. It is a retrieval team and a vehicle that will move patients between the facility and the hospital campus as required. We are certainly not digging a tunnel, and there will not be a skybridge, either.

MS LE COUTEUR: I was looking forward to a skybridge, I must admit! I could ask more questions, but I know there are people who want to ask supps on this, so I will hand over to them.

MS CHEYNE: Mr Peffer, I believe you said that a significant number of people, including locally, have been consulted on the development and design of the plan and the facility. Are you able to provide a more granular level of detail about exactly who was consulted, including people in the medical profession?

Mr Peffer: A lot of the work has been led by our senior clinicians in the emergency department, including our clinical director, the head doctor of our emergency department, in looking at how this could function. The clinical director for the COVID response, one of our senior intensivists in the territory, has been a part of designing the model of care and how this will integrate with the hospital system. We have some terrific expertise in our emergency department, with senior clinicians who have experience in ebola and other types of circumstances overseas. They have been able to bring some of that experience into the design and the thinking as to how the facility will function. As I mentioned before, conversations have been held with medical staff overseas, in Singapore. We have taken advice from the World Health Organisation as well.

MS CHEYNE: Is everyone that has been consulted united in the view that this facility is necessary?

Mr Peffer: There are differing views about the role of the facility. When you take that expanding capacity, we have to look at what the worst-case scenario is and how we are going to cope with that. We have to plan on that basis, while building in the flexibility to respond if that does not eventuate. The design of the facility, the way it is built and the arrangements for the workforce involve our best efforts to account for that, so that if we do need to stand up the capacity we can do that quite quickly. But if we do not, in a best-case scenario and if we do not have to stand up all of the capacity, we do not need to do so.

MRS DUNNE: My question follows on pretty much from Ms Cheyne's, but it goes back a step. Why did you come up with the notion of a 50-bed ED rather than an ICU or a mixed facility that could provide medical treatment beds and ICU as well as emergency response? The national cabinet has said that we need to triple our ICU capacity, but this particular facility does not do that, or does not contribute to that in the ACT. What was the thinking regarding an ED facility rather than something else?

Ms McDonald: In terms of planning for capacity expansion across the territory, we have done extensive consultation with our clinic leads in both intensive care and emergency departments. The principle that all of our clinicians, especially in an intensive care capacity, have given to us is that we need to stay as close to our current ICU capacity as possible and expand out from there. With our capacity planning for intensive care, and with that doubling and tripling that the commonwealth has talked about, we have taken that principle and that lead from our lead clinicians. Our capacity plan is around expanding ICU, expanding and flexing within the current footprint, and then being as close to the current footprint as possible.

With emergency departments, there is the same sort of principle, but we are limited in both of our emergency departments with the physical space close to our emergency departments, with regard to being able to expand. This model was proposed, in terms of creating a standalone emergency department that is close to a major tertiary facility. It can function, just like this model has around the world, and give us that capacity and an extra front door. This actually gives us three emergency departments which are our front door for patients to flow through, into the expanded capacity, such as expanded intensive care capacity.

Whilst the commonwealth has talked a great deal about expanding intensive care capacity, we also need to expect that those patients, especially if there are very large numbers, will flow through emergency departments in order to become inpatients. So the decision was taken that expanding our ED capacity was the right decision. This model, though, is flexible in that patients can be treated in those cubicles for significant lengths of time, if required, until they are either discharged home, discharged to a step-down type of facility or moved directly into intensive care if required. Mr Peffer has talked about that transport team, that retrieval team, that can then take those very sick patients directly to intensive care units.

MR PETTERSSON: The stated cost of the facility will be $23 million. Is that going to be entirely borne by the ACT taxpayer?

Ms Stephen-Smith: The national partnership agreement with the commonwealth means that half of the cost of our COVID response will be borne by the commonwealth so that it is a cost-sharing agreement. All directorates, but particularly the Health Directorate and Canberra Health Services, are very closely monitoring the costs associated with the response to COVID-19 and what can be included under that national partnership agreement. The fundamental answer is that the ACT government would be bearing 50 per cent of the cost, in line with that national partnership agreement. Does that answer your question?

MR PETTERSSON: It does indeed. Is there consideration that, as the

commonwealth is chipping in, this facility would be for the wider region and not just the ACT?

Ms Stephen-Smith: I might ask Ms McDonald to talk about the planning that is going on with the wider region.

Ms McDonald: Our planning across the territory has also included the southern local health district region, and we are working closely with them in terms of patient flows. All of our capacity modelling and predictions have factored in the population of the southern region as well. We are working very closely with our colleagues there to provide capacity across the whole region. Yes, that will be part of that capacity that we are standing up.

MR PETTERSSON: I have some questions about the service provision. Aspen Medical will be providing the workforce that fulfils the services in this facility. Do we know where that workforce will be coming from?

Mr Peffer: We are having conversations about what the make-up of that workforce might be. Aspen's traditional business model is to draw from both a national pool and an international pool, but for obvious reasons the focus is a national one. We have talked to them about the capability that might be brought in potentially from the region, recognising that we are taking that regional approach where we will shoulder the load not only for the territory but for the southern New South Wales local health district. However, it is likely that the workforce will come from right across the nation.

MR PETTERSSON: With the rates and conditions that these workers will be employed under, are they commensurate with or the same as the ACT government agreement?

Mr Peffer: I could not really comment on that. That is a matter for Aspen. We contracted them as the service provider, and the arrangement that they have with their employees is not necessarily of direct concern to us. I could not comment on whether it is comparable or not.

MR PETTERSSON: Do you think that potentially it could be a problem if these workers employed in our temporary emergency department are paid less than the workers in the permanent emergency department?

Mr Peffer: Given the market conditions that prevail and the shape of the national health system and services being delivered, I cannot see a situation where that would be likely, on short-term contracts.

THE CHAIR: Just to wrap up, if you are able to publish those contracts as quickly as possible, and if you are able to publish the list of subcontractors that are being used, and any plans, it would be appreciated not only by the committee but by the public at large, I am sure.

MRS DUNNE: Ms McDonald talked about the modelling and predictions that they had used in relation to the region. I was wondering whether that could be published as well.

THE CHAIR: As a rule of thumb, erring on the side of publishing more during this crisis would be appreciated by everyone, I am sure.

MS LE COUTEUR: While we are on this, with the rehabilitation plan for Garran Oval, what will be left there afterwards—whenever that is?

Ms Stephen-Smith: Yes, absolutely, the oval will be rehabilitated when this facility is no longer required and it is removed. I will hand over to Mr Peffer to answer the other questions.

Mr Peffer: In terms of the modelling that has been done, I am sure you would be aware that the Prime Minister released national modelling on Tuesday last week, I believe, which looked at the nation's ICU capacity and the target capacity that we would need to respond to—

MRS DUNNE: Is that what Ms McDonald was talking about when she talked about modelling and predictions?

Mr Peffer: Yes.

MRS DUNNE: So that is it?

Mr Peffer: In terms of the regional component of that, let me step back. With the modelling that the commonwealth has been doing—and the AHPPC has been doing a lot of the heavy lifting; the Chief Medical Officer, Kerryn and colleagues—the commonwealth has been talking to the states and territories for some time about indicative numbers that are likely to come out. It is not that anyone saw those numbers and thought, "Okay, that's the target; that's what we have to strive for." There had been conversations going on for some time.

If you have your abacus handy and do the maths, you will see that our population share of the 7,000 is around 120. However, the minister has announced 170. That is because we are taking a regional approach. We have looked at what are the current patient flows, the referral patterns, that we experience in the territory, recognising that we are the big territory hub. The higher the acuity of the patient—

MRS DUNNE: Could I interrupt? I am very mindful of the time, and this is a very lengthy answer, Mr Peffer. If there is something that is written in this space, it would be much more expedient for the committee.

THE CHAIR: I am also conscious of the time. If you are able to provide a very succinct answer now, that would be good; otherwise, if you are able to provide something in writing, that will allow us to move on to other questioners.

Ms Stephen-Smith: I am happy to take that question on notice and try to provide a succinct answer. I would note, however, that we have said multiple times in press conferences et cetera, in talking about the modelling, that there is work going on in relation to AHPPC and national cabinet, and it is not for the ACT government to release information that is currently before the national cabinet. The Prime Minister

has been very clear that there is that next stage of modelling work, now that we have further information about what we are seeing with COVID-19 in Australia and the experience in Australia. That work is ongoing. But we will provide a one-pager on what we can deliver.

THE CHAIR: Thank you. As always, please publish as much as you can.

MS CHEYNE: This is on quite a different tack and I suspect it will be in Dr Coleman's area. I have multiple questions on contact tracing. I might state them and we will see the extent to which you can answer them, just in the interests of time.

My broad question is: how is contact tracing being undertaken and to what level? How many staff or resources are devoted to this? More specifically, what are the difficulties with the two cases which are under investigation? I note that, by tomorrow, one will have been under investigation for three weeks. I appreciate there has been a lot of commentary that extensive testing is being undertaken, and that is commendable, but I am curious to know what sort of tests they are and what the complications are in getting answers in these two cases.

Dr Coleman: Our contact tracing activities are actually done consistently with the national guidelines, which are dictated by the Communicable Diseases Network Australia SoNG. "SoNG" stands for "series of national guidelines". We have those SoNGs for every infectious disease that we deal with from a public health perspective. That is our basis, and we are doing that in line with the other jurisdictions in Australia.

The purpose of contact tracing is twofold. The first reason that we need to conduct it is to try to find the source of exposure, which is where this person was exposed and got infected from. The second point of the contact tracing exercise is to identify anybody who was potentially at risk of being exposed so that we can lock down and reduce the risk of further transmission.

With respect to how we do that, we get notified as soon as every positive case comes hot off the lab. We make contact with that individual as soon as possible and we take them through a day-by-day, hour-by-hour interview to identify as far back as when their symptoms were onset, 24 to 48 hours prior to that, depending on how sure we are about when they were sick, where they were, what they did and who they did it with. We identify when they were infectious from; then we carry that forward until the point at which they were isolated. Those periods of time are dictated within the SoNG, and they are based on evidence that has been collected nationally and internationally.

In terms of the staff and the resources for that, we have a core group in our health protection service whose business it is to do this on a day-in, day-out basis. I know people have had experience with our measles and other contact tracing. This is our core group; then we have an ability to surge capacity as required, up and down. One of the avenues that we have tapped for that is medical students at the ANU. They have really appreciated the experience; they have also been excellent because they are used to talking to people and having that conversation on the phone.

I cannot tell you exactly about our staffing and resources. We could get you some

numbers about what our current capacity is and what ability we have to flex up. Our aim over the next several months is to have that capacity to flex and respond as needed, based on our case numbers and what the risk looks like.

One of the major challenges in contact tracing is when it is not clear where somebody has been exposed to the virus itself. It is very clear if they have come from overseas or if they are a known contact of a confirmed case. And that is the case with these two people under investigation. For these two people, we have to reinterview them several times. Sometimes when we cannot identify that they have come into contact with a known case, we might go back to other cases in the same area and have another discussion with them around whether they were maintaining their own isolation, whether there were potentially any unidentified exposures that we can lock it down to, or whether they took any trips out of the jurisdiction and may have been exposed themselves.

There is a lot of reinterviewing, as you can imagine. Two weeks ago—I cannot remember what I did last week. It is often a very difficult process and people's memories get jogged as we do this process over and over again.

With testing, one of the tools that we have now is the ability to do serological tests, which is not a test that is appropriate during the acute phase of the illness but it can tell us potentially if someone has been exposed in the past. Some of the testing that we can do is to look back and say, "Maybe this person was sick and they came into contact with this person." If a serological test can tell us that they may have been exposed at some time in the past, this could be our point of exposure. Unfortunately, these tests are taking us a little bit of time at the moment because they are still under development and progressing, as this is still a new virus, and the focus was on getting the RNA testing up and running quickly.

MS CHEYNE: With those two cases under investigation, has it now got to the point for both that serological tests are being undertaken for them?

Dr Coleman: Definitely in the first case, which is the longest outstanding. We are still waiting on a couple of final serological tests. With the second one, we are still trying to lock down the contacts and the exposure risks. That one is a little bit more recent.

MS CHEYNE: With those numbers that you said you might be able to give about resourcing, if they are readily available, it would be great to see them.

MR PETTERSSON: I have a question about the interstate travel. What is it about interstate travel that makes it so much harder to trace who they have been in contact with and why? When someone has travelled interstate, is the presumption that they got it interstate and not within the ACT?

Dr Coleman: There are two parts to your question there. I think that we know that the period during which they could have been exposed is well defined. In terms of identifying their period of exposure, we look at where they were during that period, that week of time. For the people where we have decided that it is out of our jurisdiction, we know that for that entire period they were not in the ACT. But we do

not stop there. We actually look at where they were and we contact that jurisdiction and say, "Do you have any possible cases in this area? Do you have any clusters?" and those types of things. Several of our cases fell into that category where there was known community transmission within south-east Queensland as well as in some of the really topical places in New South Wales, with some of the readings that have been quite problematic from a jurisdictional outbreak perspective.

I think with contact tracing there are two issues from a cross-jurisdictional perspective. One is around people arriving from overseas. They fill in the passenger information card, and we actually know who is coming in and where they reside from that information. For domestic flights, for getting access, there are no passenger information cards and it is much more difficult to get that information. It is impossible to actually get that information.

The second aspect to cross-jurisdictional is that there is a lot more sharing required across different public health units within different jurisdictions and we have normal processes for that to happen and be in place. But it is just another step that we need to go through. As you can imagine, some of our New South Wales colleagues have been extraordinarily busy with their contact tracing, so we have been trying to assist them where possible as well. Does that answer your question?

MR PETTERSSON: Yes.

MS LE COUTEUR: What sorts of supports are you providing for people who are required to self-isolate at home because they have actually been diagnosed with COVID-19?

Dr Coleman: We understand that it can be quite challenging for some people and so we have a team of managers who are responsible for making contact regularly with people who are self-isolating with the illness at home. That is their job and they make contact with them by telephone call or SMS, depending on how it is going. The majority of them have friends and family or have enough stuff in their houses and have not really needed a lot of support, apart from a telephone call and checking. But we also have contacts with our non-government organisations and other things about food that we can get to them if need be. We are looking at putting in place a stronger process around that, recognising that we may have increasing numbers of people in isolation and quarantine as we move forward, but also the impacts of social distancing.

I think the second thing about people who are in isolation is that we need to do a daily check, whether that is by phone or SMS, just to check on their symptoms and make sure that they are well and there is no other clinical or medical care that we need to offer them.

MS LE COUTEUR: And they do not get hospital in the home-type treatment? If they were at that level you would take them into the mother ship hospital?

Dr Coleman: I like the reference. We have an ability for a number of different places to make a clinical assessment as required. Often people present to the emergency department or the walk-in centre initially and have an assessment done. We can manage people in isolation both at home and in hospital as required. As you are aware,

we have several people admitted to hospital and managed quite effectively as well.

MRS DUNNE: I want to ask some questions about preparedness generally. We have had a little discussion about modelling. The national modelling that we saw a couple of weeks ago shows a number of scenarios, but our actual on the ground experience is that we are much lower than any of those scenarios. Going back to the planning, when did ACT Health generally begin to plan for ramping up hospital and medical services in relation to COVID-19?

Ms Stephen-Smith: If I can just provide a bit of context in relation to planning for pandemics, the committee will be aware that there is an emergency plan for the ACT. There are a number of sub-plans underneath that, one of which is the health emergency plan, and then there are further sub-plans underneath that, one of which is the emerging infectious disease plan. It is not that it is either at a local level or at a national level but there are also plans in terms of emerging infectious diseases and the potential for an influenza pandemic. It is not as if this planning just commenced when we started seeing—

MRS DUNNE: I understand that and I understand—

Ms Stephen-Smith: I am sure that you understand that, but I recognise that there are other people watching and listening to this who may not have that context. With that context, I will hand over to the Chief Health Officer to speak more about this particular pandemic plan.

MRS DUNNE: Also, while we are at it, I have asked in private briefings a number of times for a copy of the plan. Maybe it is time that the committee asked for a copy of the pandemic plan and the emerging infectious diseases plan.

Ms Stephen-Smith: I can advise that I have also asked the same question, in that I think they would be incredibly useful documents for the committee. We are just going through a process for that. As I mentioned, there are a number of sub-plans to the emergency plan. A number of them are not released because a number of them contain sensitive information that could be exploited. So we are just going through those plans to ensure that there is nothing that could be exploited in those plans, should they be publicly released. We are working through that process right now.

THE CHAIR: Feel free to release anything to the committee and to state that it is your preference that it not be published but that it may be useful background for the committee's role in scrutinising the government during this process.

Ms Stephen-Smith: That is very useful. I will hand over to the Chief Health Officer.

Dr Coleman: I just want to talk a little about our Health Sector Emergency Management Committee or HSEMC, which is the key governance and operational committee that we have that includes all the hospitals in the ACT, the ambulance, Capital Health Network, several directorates and other key stakeholders, including several NGOs. They sit on this committee. We have regular meetings during the year to revise our current planning and forecast, looking forward to threats that are emerging.

As soon as there was an increase in notification of this issue from China, come December last year, within the ACT Health protection service we ramped up our visibility of what was going on, set up reviewing our existing plans and sent out a message to all our HSMEC members to give them a heads up that this was happening and it would be appropriate for them to be reviewing their plans and making sure that their emergency plans were up to date.

Since that time, this year we have convened several meetings of HSMEC to give updates on the situation, talk through some of the strategies, some of the planning, those kinds of aspects, answer questions, get information out, meet those needs moving forward. We were well advanced in those before we even had the first case in Australia, and I think that has specific aspects for hospitals themselves. They were well advanced in terms of being able to leverage the capacity. I am not sure if Bernadette would like to add anything to that.

Ms McDonald: You would understand that each hospital across the ACT has its own business continuity plan which includes how we scale up capacity in response to increasing patient demand for whatever reason—pandemic, infectious diseases being one of those reasons that we may need to scale up our capacity. CHS is a member of the committee that the Chief Health Officer has referred to, and we were heavily involved right from the start, as were other health services across the ACT. Each of the health services commenced their own build-up and review of their plans as the impact of the COVID-19 pandemic became more apparent.

We have progressed from there to bring those localised plans together into a total regional plan, and we are working with our clinicians and all clinical health services across the ACT and the southern New South Wales region to really tighten up those plans and be very clear about our capacity and our surge and flex capacity.

MRS DUNNE: We have spoken a number of times, including today, about the ideal of obtaining 180 ICU beds in Canberra from, I think the last time you answered a question in the Assembly, a base of 60 or 69. I am open to correction on that. Where are we in that continuum? Where are we in the process of moving from 60-odd to 180 ICU beds?

Mr Peffer: Our baseline is between 50 and 60, depending on whether you count the regional contribution that can be made. Our ability to double that is a practical reality that we have today. If we experience a surge in presentations and high acuity of COVID patients then we are positioned to double that capacity without relying on any additional equipment coming into the territory. That is through the repurposing of transport ventilators, anaesthetic machines and expanding ICU footprint in a number of facilities.

As we then look to surge above that to the 170 target, which is our regional share of the 7,000 that is talked about nationally, that then requires equipment coming into the territory. Those orders have been placed. However, the ACT is facing similar challenges to all jurisdictions in actually bringing equipment into the country, particularly where there is a lot of competition for the same equipment from other big sovereign nations such as the US. Legislative changes there around the defence

manufacturing act have materially impacted different countries' ability to actually import some of these materials and equipment.

We are working both through industry ministers and other groups that are coordinating an approach to that. There is a big focus on domestic production, where that is possible, and looking at the capability of home-grown manufacturing to avoid some of those import challenges that we have had. But our ability to move from 100 to 170 is dependent on those factors. That is our target, but it is dependent on those factors.

MRS DUNNE: Sorry, the figures keep moving around. You said, Mr Peffer, that we have between 50 and 60 baseline ICU beds but we can double that, but then at the very end you said moving from 100 to 170 is a problem. Do we actually have the capacity to double?

Mr Peffer: Yes, we do. There are six ICU beds in Bega and there are 50 here in the territory. We can double our capacity by repurposing machines, but that does not get us to the 170 target, which is our regional share of the 7,000 ICU—

MRS DUNNE: I just wanted to clarify because you said double the capacity and then you said 100, which was not doubling the capacity.

Mr Peffer: I beg your pardon. Within the territory we have 50. To double our capacity we can do that in a matter of days if we have to. To get to 170, which is our regional share of the 7,000 in the Prime Minister's modelling, or the modelling that was released by the Prime Minister last week, does require the importation of equipment.

MR PETTERSSON: I have some questions about the provision of accommodation to people self-isolating. How many people has the ACT government provided accommodation to?

Ms Stephen-Smith: I think there have been some, but I do not think we have got the number up at the moment. It is a low number. It is a handful of people. But we will need to take that question on notice and come back to you.

MR PETTERSSON: Would you be able to potentially expand on the classification of those self-isolators? Are they healthcare workers? Are they travellers?

Ms Stephen-Smith: They are people who are self-isolating and in terms of the technical description they are people who are COVID positive, people who have COVID-19. Otherwise people are described as being in quarantine if they do not have COVID. We have been supporting the accommodation for a small number of people who are COVID positive and who have had to isolate somewhere outside their home and also not in a hospital setting.

There has been some work as well around providing potential alternative accommodation for frontline health workers, for other essential services workers, if and when that might be required, if people are unable to return to their family home because someone there might be in self-quarantine or isolating or if they are

concerned about returning to their family home if they have been working with COVID patients. That is also a work in progress. Again, we can provide some further information about that on notice. Dr Coleman looks like she has got some more specific information. No? I misread that look.

MR PETTERSSON: In regard to the future consideration of healthcare workers, can you potentially flag how far away that information might be?

Mr Peffer: We are already providing accommodation options for team members. However, there are only a couple of people who have taken up that opportunity so far. We are working on the policy with directorates right across the government to have consistency in approach and we will be bringing it to the minister and to cabinet very shortly.

MR PETTERSSON: In terms of the sites where these people would be accommodated, is there any particular rhyme or reason or understanding of how sites would be chosen or purposed?

Ms Stephen-Smith: That is part of the policy development that is currently underway. That is part of the work that will be coming to me and to the cabinet to consider. But we have had a lot of offers. As you can understand, there are a lot of empty hotels and motels in the ACT at the moment and people have been very generous in offering their facilities as well to us. That is part of working through the logistics of making this happen.

Chair, I am conscious of the time, and I have another commitment, but Mr Peffer has something that he would like to add.

Mr Peffer: If I can just respond to an earlier question around the contractors for the Aspen facility, the contractor for the main works is Manteena. For the construction and framing for that facility it is Austruss.

Ms Stephen-Smith: I have further information as well. The contractors that Mr Keys talked about in the press conference were Manteena and Shaw Building Group that we have talked about, Monaro Plumbing, Canberra Commercial Partners and Benmax, a mechanical contractor. If we have any further information we will provide that on notice as well.

THE CHAIR: I think that is all we have time for today. Thank you very much for presenting to the committee for the first time, minister. You will be sent a draft *Hansard* transcript. Please note that the Hansard team have got their work cut out for them, given the difficulty in obtaining information about who is speaking. Please review that very carefully to make sure that the right comments are attributed to the right people. The committee's hearing for today is adjourned.

The committee adjourned at 12.06 pm.