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

FRIDAY, 14 AUGUST 2020

Secretary to the committee:
Ms Annemieke Jongsma (Ph: 620 51253)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

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Amended 20 May 2013

The committee met at 10.02 am.

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

THE CHAIR: Welcome to the Select Committee on the COVID-19 pandemic response public hearing—the 47th meeting of this select committee. Today we have the Chief Health Officer, Dr Kerryn Coleman, and the Minister for Health, Ms Rachel Stephen-Smith. I note that there are some other officials who are joining us today as well. As usual, could you please confirm for the record that you understand the privilege implications of this hearing?

Ms Stephen-Smith: Thank you, chair. I have read and understand the privilege statement, and I will throw to Meg Brighton.

Ms Brighton: I confirm that I have read and understood the privilege statement.

Dr Coleman: I confirm I have read and understood the privilege statement.

Ms McDonald: I confirm I have read and understood the privilege statement.

Mr Peffer: I confirm I have read and understood the statement.

THE CHAIR: Thank you very much. As usual, the proceedings are being recorded for transcription purposes and we are being webstreamed live by the Assembly's website. Before we go to questions, minister, or Chief Health Officer, do either or both of you have a brief opening statement?

Ms Stephen-Smith: I do not have anything, chair.

Dr Coleman: No, thank you.

THE CHAIR: The first question is from me. With regard to the situation in Victoria and perhaps the situation emerging in New South Wales, what is the risk to the territory of similar events taking place here?

Ms Stephen-Smith: I will hand over to Dr Coleman.

Dr Coleman: Thank you. As everybody is probably aware Victoria actually has community transmission in Greater Melbourne, and also, over the last couple of days, increasing risk of quite high levels of community transmission in three regional areas. So the risk of importation of a case from Victoria is very high, which is the reason the ACT as well as other jurisdictions have put in place measures to reduce the risk of that. What we are trying to do is not to try to prevent any cases from entering the ACT

but to reduce the flow or the risk of cases appearing in the ACT. So we have now put in place requirements for people entering from Victoria to undertake 14 days quarantine if they meet certain criteria.

With respect to Victoria, the risk is high. There is probably a fairly stable risk being posed by New South Wales at the moment from the Greater Sydney area. There continue to be a small number of cases in which the New South Wales health team cannot identify the source of exposure, which indicates that there may be low levels of unidentified community transmission. With respect to the impact and the potential for there to be a similar situation in the ACT, I would never say never, but we are extremely well prepared in the ACT. We have reduced our flow of people coming in from Victoria and hence reduced the risk of importation. We know who those people are, when we do allow them in, and they are undertaking quarantine.

For essential workers, we are reducing the risk, if they develop COVID and are performing their essential work, that they will spread that. We are doing that by requiring them to limit their exposure to others within the community and wear a mask when they are around the community. We also have a very rapid testing facility for people who are tested and a very strong surge capacity to respond to a case or a positive case to contact trace. Finally, the other important piece of that puzzle is the level of community restrictions and the current potential for spread within the community if there is a case that is not identified for several days or a week. At the moment there is potential for spread, but that is nowhere near as high as it was prior to community restrictions being in place.

Our indicators that tell us what the effective reproduction rate is within the ACT say that it is higher than currently in Victoria and New South Wales but lower than all other jurisdictions. So we are actually sitting in a very comfortable, good, positive position in the ACT, where we would have slower spread, which would give us time to identify and get on top of any cases. Thank you.

THE CHAIR: What is the current advice regarding travel to Sydney?

Dr Coleman: We are currently strongly recommending that people do not travel to Greater Sydney or travel to Canberra from Greater Sydney and Newcastle.

THE CHAIR: What is the threshold for that recommendation switching to a more definitive stance?

Dr Coleman: There are a couple of things that we monitor to determine whether there is an increasing risk that Greater Sydney might pose to travel into the ACT. If we start to see significantly increasing cases, increasing clusters and outbreaks that are continuing to accumulate, cases that are unidentified, and significantly increasing cases which do not have a known source, all of these would increase the risk of community transmission being present in Greater Sydney, which would increase the risk of people travelling here.

I guess the question around when we would escalate a measure beyond a recommendation not to travel is balancing the impact on the ACT of putting a legal hold on people travelling into the ACT. I am sure people have heard, on the radio this

morning, discussions about the impact in Victoria of travel across the borders of essential agricultural workers as well as healthcare workers. It is a really important balance to consider what are appropriate measures to put in place to reduce the risk as far as we can while balancing the needs of the community and the economy. But that is the kind of risk assessment consideration that we take into account.

THE CHAIR: Thank you. Minister, have you or any of your colleagues in cabinet travelled to Sydney in recent weeks or months?

Ms Stephen-Smith: I certainly have not. As far as I am aware, none of my colleagues has. That certainly has not been drawn to my attention.

THE CHAIR: Okay; thank you.

MRS DUNNE: Dr Coleman, can I go back to something that you said which I do not think that I followed entirely. Please be patient with the non-scientist. You talked about the reproduction rate, and I may have misheard you, but you seemed to say that you thought the reproduction rate was higher in the ACT. Could you clarify that, please?

Dr Coleman: Sure. The effective reproduction rate is a measure of the ability for an organism to transmit in the community. It gives us an idea about how quickly and rapidly it will spread through a community. Measles has an extraordinarily high reproductive rate, whereas something such as Legionella has a very low reproductive rate. It gives us an indication of how many people an organism will infect. If I had the infection, a reproduction rate of two would mean that I will infect two people. Those two people will each infect two people. So what we need to do is to try to reduce that reproduction rate using our social distancing, our hygiene and our other community restriction methods to get the risk or the rapidity of spread to a level that we would be able to get on top of in terms of the contact tracing, and get in charge of it.

MRS DUNNE: But you said that you thought that the reproduction rate in the ACT was higher, which seems to be counterintuitive.

Dr Coleman: One of the things that we are able to get early advice on, or indication from modelling on, is how that reproduction rate is travelling, based on people's current movements—how they are moving around and what they are doing. The ACT has a higher estimated reproduction rate than both Victoria and New South Wales at the moment, but that is because Victoria is in significant lockdown and New South Wales have recently introduced some further measures, based on their continuous exposure. We have a far lower reproduction rate than any of the other jurisdictions which have opened up considerably more. I think that is the ranking that I was referring to.

MRS DUNNE: Okay, I now understand. So it is not an essential characteristic of the disease; rather a characteristic of how we are managing the disease?

Dr Coleman: The reproduction rate itself is a characteristic of the disease; the effective one is what we are doing.

MRS DUNNE: Right. Sorry; I now see the distinction. Thank you very much.

MS CHEYNE: Minister and Chief Health Officer, what is going on with our relationships, particularly with New South Wales and Queensland? I think that many people were caught unawares last week with Queensland declaring us a hotspot. To me it seemed that the one case of a person travelling to Queensland was Queensland's fault for not picking them up at the border. I would be happy to hear your thoughts on that as well. That caught people unawares.

Obviously, what happened with New South Wales and the Victorian border was that it appeared that there was a resolution on the weekend and then there did not appear to be a resolution anymore. There have been these peaks in the last six or seven months where people have had to readjust, but this was quite a lot in a week, where it really seemed that our counterparts in Queensland and New South Wales could have at least made a courtesy call. I am just curious to know about what is going on. What is the nature of our relationships with them and is there work underway to improve that, or is this just what we have got to get used to?

Ms Stephen-Smith: I think, Ms Cheyne, what we have seen throughout the pandemic is state and territory leaders making announcement without necessarily providing advance notice to others, whether that is commonwealth or other states and territories that might be affected. That is something, I guess, we have become used to watching at press conferences and waiting to see what other people are going to say.

In relation to Queensland effectively including the ACT within New South Wales as a declared hotspot, yes, we can make the argument that we are a separate jurisdiction, but from Queensland's perspective our border is entirely porous with New South Wales. It would not make a lot of sense for them in some ways to include western New South Wales and other parts of New South Wales that do not have any COVID-19 cases and then not include the ACT as a hotspot. So I think it is just part of our geographic reality that, from a Queensland perspective, we are effectively part of the New South Wales community from a border restrictions point of view and a travel point of view.

People did at least get some notice of exactly when the new restrictions were going to come into place, and I think they also had a better understanding of what Queensland's border restrictions mean because it is not the first time that those border restrictions have been applied to the ACT. In relation to New South Wales, this has been a bit frustrating and awkward. For those people who did arrive at the border last Friday thinking that they had a valid transit permit—and obviously they have exemptions from the ACT to come into the ACT—that has been a very frustrating experience and it has taken a bit of time to resolve.

But in terms of the actual resolution, I would say that the relationships between myself and the New South Wales health minister, the Chief Minister and Premier Berejiklian, NSW Health and ACT Health, and New South Wales police and ACT Policing, are actually very strong. It was just a question of working out what was going to be acceptable for New South Wales in terms of minimising the perceived risk of people coming from Victoria and stopping in regional New South Wales on the way back to the ACT.

Obviously. there are some inconsistencies there which people have pointed out, particularly in relation to the Victorian MPs and senators being able to travel the same route and getting the transit permits to do that. They were on a very tight time frame. If they did not get here they would not have been able to meet their quarantine requirements for the start of parliament. But, again, why they are treated differently to ACT residents is probably a valid question.

The other thing to take into account is that, from a New South Wales perspective, ACT residents were being treated the same as their residents. So people who live in Queanbeyan were not allowed to drive through New South Wales to come home to Queanbeyan, Jerrabomberra or Googong, or wherever people might live around the ACT. All of those New South Wales residents were required to fly into Sydney, do their 14 days quarantine in Sydney, and then make their way home from there. I think we have reached a good resolution with New South Wales. It did take longer than we would have expected and hoped, but in the end I think the relationships that we have and our capacity to keep that conversation going and to work through the details actually gave us the resolution to the issue.

Bernadette might want to talk about the relationship with the local area, in terms of NSW Health, because one of the other things that has come up in relation to these relationships across borders is how we provide health services to one another. Part of our relationship with New South Wales is clearly that we are a major provider of health services for people who live in regional New South Wales. Our relationship with New South Wales from a health perspective is already very strong. I do not know if it is going to be helpful for Bernadette to talk about that as well or whether it is really about these other border issues.

MS CHEYNE: I think perhaps briefly it might be worthwhile, because I have certainly had it suggested to me by some people: "How would New South Wales feel if we just turned off that service, just like they turned off the border to us?" I know that is a very important relationship that we have, so knowing how it is working at this time might be useful.

Ms McDonald: I am happy to oblige, Ms Cheyne. In terms of our relationships, Southern Local Health District is, I guess, what we would call a partner in care for people of our region—both the ACT and southern New South Wales. We have a very close relationship with Southern NSW Local Health District, and their clinical health emergency coordination centre has Southern as one of our partner hospitals that come together on a regular basis. Once a week, minimum, I talk with the CEO of Southern NSW Local Health District.

In particular, the flow of patients between our health services is really, really important. There are specialist services that we provide that local southern New South Wales residents need to access, and we continue to provide those and will continue to provide those for as long as possible. The other service in particular that we need to be aware of is intensive care services. We provide a virtual service to their intensive care service in Bega and between our intensive care clinicians and their intensive care clinicians, as well as the transfer and retrieval of very sick patients who need to come to a tertiary intensive care unit. Those services are critical for all of our region, both

the ACT and southern New South Wales, and we will continue to provide those services and build on those relationships.

Ms Stephen-Smith: Just very briefly, Kerryn, I do not know if you want to just touch on the information-sharing side in terms of NSW Health, because I know there have been some questions raised about when we get information about ACT residents who might have been in a Batemans Bay hotspot or something like that.

Dr Coleman: Yes. Thanks, minister. As per the clinical services, the public health units have a pre-existing and strong relationship with us. We often work across those because people move freely between those areas of New South Wales. One of the challenges with contact tracing is that when details are provided for contact tracing it is just a name and a telephone number. So it is not until that New South Wales public health unit actually contacts that person and they let them know where they live that we can be transferred with that additional information.

So the reason we go out asking for the community to contact us is so that we can find them quicker than we would otherwise by New South Wales ringing them and getting that linkage of information. But we often provide crossover support as well when there is a combined response, if there is a situation that lies across a border.

THE CHAIR: Thank you.

MS LE COUTEUR: Thank you. Given that we are not so different, obviously, from New South Wales and Victoria, are you doing any additional monitoring so that, if we do have any transmission in the ACT, we would find it very early?

Ms Stephen-Smith: I will ask Kerryn to talk about the testing regime.

Dr Coleman: Yes; thank you. The most important thing that we can do to detect community transmission or detect cases early before they become community transmission is to get the message out that people who are at all unwell or feeling any different should get tested. So we have recently reviewed, and do continuously review, our current testing capabilities and stand-up various testing sites. We are increasing our supply as much as we can. Our testing numbers are remaining very high; I think the latest testing numbers for yesterday were around 800 in total.

We also do enhanced surveillance in other spaces. Every time there is an aged-care facility that has an influenza-like illness that arises, they are tested for flu as well as COVID and all other kinds of respiratory illnesses. So there is a whole lot of baseline testing which is conducted, which we would hope would pick up undetected illnesses before it becomes community transmission.

MS LE COUTEUR: I have read about waste-water testing. Are we doing that? It seems to be one of the most interesting things in terms of getting your asymptomatic person listed.

Dr Coleman: There is a lot of research into waste-water testing at the moment, and the majority of jurisdictions are doing that research within their different jurisdictions. There is a national approach to sharing those learnings. One of the challenges with

waste-water testing is understanding what the actual result means and what that tells us about the number of cases or the level of risk within a community. Does it need to be four cases or eight cases or 20 cases in a community before you are able to detect COVID-19 in the waste water? If we are not detecting it in the waste water, what does that tell us with confidence about a lack of cases in our community? Those validation tests are still being conducted, but they are being conducted in a really coordinated way, where different jurisdictions are kind of answering different questions.

We are working in collaboration with ANU, which is doing local-level research, and it is in close contact with some of the other jurisdictions around this. We also get the New South Wales results of relevance, and you would have heard the Perisher results that were publicised. At the moment we do not know enough about this to put this in place in Australia as a comprehensive surveillance system. I agree with you—and I think AHPPC agrees with you—that it has great potential value, but we really do need to understand those baseline triggers and what they mean before we can rely on it.

MS LE COUTEUR: The other business of testing that I have read about elsewhere is testing to see how many people would appear have already had it. You have probably read, as I have read, about very high figures from India and from Peru. Are we thinking of doing anything like that in the ACT?

Dr Coleman: I think you are talking about seroprevalence studies.

MS LE COUTEUR: Yes.

Dr Coleman: That is where we look at serological studies and determine what the level of antibodies is in the community. This is actually part of the national surveillance framework. There are plans in place and several jurisdictions have already stood up, using existing samples that have been collected by the blood bank. New South Wales in particular is kicking this one off. So we have a whole system where these seroprevalence studies are done in other diseases, and they have used stored samples from the Red Cross blood bank, which are used for other purposes; therefore, we can get a bit of an understanding. In the next month or two, hopefully there will be some preliminary results coming through around that.

MS CHEYNE: I am sorry if you just covered this—I was momentarily distracted—but I have some constituents who are required to get regularly tested due to the nature of their conditions. I guess they might have a chronic condition that generally often shows symptoms that fall within COVID. Obviously, the test is quite intrusive. Are there other tests that might be available for someone who is having to have a test once every fortnight or something?

Dr Coleman: I understand there have been several in the media, and there are definitely different types of tests around the landscape. The problem is that the current PCR test is the only one that we know enough about and we are confident enough in that if we get a negative test that means it is negative, and if we get a positive test that means it is positive. We are still in that stage of learning about this disease and this virus, and they are still developing these tests to suit those particular needs. So, unfortunately, not at the moment.

MRS DUNNE: My question is about the COVID testing at the surge centre and what the cost arrangements are. What bucket of money is that being paid out of? Is it being paid out of the $23 million that was allocated to the building and operation of the surge centre, or elsewhere?

Ms Stephen-Smith: No, it is being funded out of elsewhere. It is part of our normal COVID response, but I will throw to Bernadette and Dave.

MRS DUNNE: Thank you.

Mr Peffer: We have not issued a work order to Aspen Medical to stand up the workforce to support the testing effort. That workforce has been drawn from our existing Canberra Health Services workforce. So we are not incurring an additional cost for external employees. Does that respond to the question that you asked?

MRS DUNNE: Yes, thank you. So it is not being stood up under the Aspen arrangement?

Mr Peffer: No; that is correct. Within the contract that we had with Aspen there was flexibility for how we use the centre.

MRS DUNNE: Yes. Can you explain that a little? As I have said before, the ownership is opaque. I know that we paid for it, but my understanding is that the operational ownership was with Aspen. But this is not something that you have asked Aspen to do, so how do we sit in relation to Aspen for the running of the testing?

Mr Peffer: Yes. There is an overarching contract that we hold with Aspen, and that provides an avenue for us to issue individual work orders which can be specific to the work that we might require Aspen to do. For example, if it were to be stood up as an emergency department, we could issue a work order for Aspen to stand up that workforce and support that level of operation. Within the contract there was flexibility for the territory to use the surge centre however we felt appropriate. Aspen Medical has been very good in providing that flexibility and supporting us to use the facility in a way that we have chosen to do, which is to support our testing effort.

MRS DUNNE: So the cost for the testing is borne fifty-fifty between the ACT and the territory through that arrangement? Is that right?

Mr Peffer: The cost of the testing effort is fifty-fifty ACT and commonwealth; that is correct.

MRS DUNNE: Great. Thank you.

THE CHAIR: Thank you. I have a new question but on a related note. With regard to the national partnership on COVID-19 and the payments being received from the commonwealth, what are the terms of those payments insofar as what you actually have to present to the commonwealth in order to receive funds?

Ms Stephen-Smith: I will hand over to Ms Brighton to respond to that.

Ms Brighton: We provide a forecast to the commonwealth and then we do a reconciliation of that forecast, based on actual payments made. The commonwealth has been initially providing a cash flow and then we do a true-up with the commonwealth on expenses actually incurred.

THE CHAIR: Right. So funds are being deposited in the territory's account on a monthly basis or something like that?

Ms Brighton: The arrangement with the commonwealth is that when COVID first started and the national partnership was put in place, the commonwealth was conscious of cash flow in each of the jurisdictions. So, based on projections, it provided funding into the jurisdictions. And now we are going through a reconciliation process. As we were doing that, we got to the end of the financial year and did a reconciliation. Then, in the event that our forecasts were more than our actual expense incurred, that money is being held and consistently and regularly reconciled.

THE CHAIR: Okay. How has the revenue received from the commonwealth compared to any lost revenue that the territory has forgone as a result of not undertaking elective surgeries during the fourth quarter, in particular, of the last financial year?

Ms Stephen-Smith: There was an agreement, Mr Coe, in relation to the national health reform agreement and the national partnership agreement, that we would get a minimum amount under the national health reform agreement payments so that we were not essentially losing funding under those arrangements for the staff that we permanently employ, the things that we need to continue to do in our health system and the things that we need that were not available to be planned under the national partnership.

There was a recognition that there are some fixed costs associated with the activity that we were projected to do, and so there was an agreement with the commonwealth that the combination of what we were anticipating to receive from the national health reform agreement and what we were receiving from the national partnership agreement could not be less than what we were projecting to receive from the national health reform agreement in the first place. I might hand over to Ms Brighton for some more details on how that worked out.

Ms Brighton: Thank you, minister. Mr Coe, I do not have the detail before me, but, as the minister has outlined, that is how the arrangements have worked. There is effectively a floor in the agreement.

THE CHAIR: Okay.

Ms Stephen-Smith: That is f-l-o-o-r, not f-l-a-w.

THE CHAIR: During the period where elective surgeries were stopped, were there any staff savings for Canberra Health Services?

Ms Stephen-Smith: I will hand over to Canberra Health Services.

Ms McDonald: Thanks, minister. During the situation we did have a reduction in activity, in line with the commonwealth guidelines that said we should reduce all non-essential procedures, elective procedures and surgery. And we did need to reduce our outpatients and our close contact, due to social distancing requirements. At the same time, we needed to keep staff available because, you would remember, we were not sure exactly what community transmission would be like or what our demand for inpatient beds or emergency or ICU would require.

So we kept our staff on board and ready to stand up at any time. We kept the same bed capacity open and ready to staff. Those staff were not standing around doing nothing; they were actually training and getting really good with their PPE training and their hand hygiene and all our infection control processes. So we did have to maintain our staff levels just in case, ready to respond, to surge up in response to any demand, but at the same time we did reduce all of that elective activity.

Mr Peffer: I might just add to that, Mr Coe, if I could. At the Canberra Hospital campus, because our focus is typically on emergency and category 1 and some of the more complex category 2 procedures, we still had quite a heavy theatre load for lists going through.

THE CHAIR: Okay. Was there a significant reduction in overtime, for parts of the hospital at least?

Ms McDonald: There was some reduction in overtime in some parts of the hospital, yes. And there was a reduction in the need for some locums because we had staff available. But there was still quite a lot of activity going on in the hospital. People were still becoming unwell and coming through our emergency department. So, whilst some of our elective work was reduced and in other hospitals across the jurisdiction that was certainly felt—the private hospitals, in particular—across Canberra Health Services we still had quite a bit of activity going on. There were some reductions in overtime, but there was quite a lot of training going on at the same time. And we did have staff who stopped taking leave so that they would be available to surge up if they needed to, as well.

THE CHAIR: I guess the final question is: for the fourth quarter of 2019-20, for the hospital, did you actually go below? Were you under the budgeted expenses?

Ms McDonald: That information is being put together at the moment—our end of financial year. That information is being put together and audited for our financial reports for the 2019-20 year at this point in time.

THE CHAIR: Yes. What about the unaudited figures which the Assembly would usually get—the consolidated financials for the territory? You would still need to supply information to Treasury even before you have been audited. In terms of what has been supplied to Treasury, was quarter 4 below budget?

Mr Peffer: Mr Coe, you would be aware that the government injected considerable funds into the health system.

THE CHAIR: Yes, but I am talking about the hospital.

Mr Peffer: And the hospital is obviously a large part of that. In terms of how we performed financially against our 2019-20 budget, we would have been above because we were spending to support the COVID response, including the fact that at the start of the year we had not foreshadowed that we would be spending millions of dollars on PPE, for example.

THE CHAIR: But I am still talking about Canberra Hospital—quarter 4, not the year. Were you below budget?

Ms McDonald: We would have to take that question on notice.

THE CHAIR: Okay.

Ms McDonald: It does have a whole lot of costs in there that were related to COVID and not necessarily related to our normal activity, so there are a lot of additional costs.

THE CHAIR: And there was also an additional $5 million from the commonwealth for hospital service payments. I appreciate that. That is why I asked the question—to get a grasp of the change in operations that took place because of COVID, but also the reduction in other services that might have otherwise been provided.

MS CHEYNE: My questions relate to our aged care, which obviously is a very hot topic everywhere. It does seem that things are a little more consistent in the advice across aged care, but I appreciate that plenty of private companies are operating within their own levels of comfort, particularly around things like visitors.

I guess my first question relates to whether we have any role in working with aged-care providers regarding things like planning—particularly if staff, for example, become unfortunately affected or are taken offline for whatever reason. Because volunteers are not in the aged-care homes at the moment like they used to be, I am getting quite a lot of reports that residents' quality of life has diminished—that they are quite bored and they do not have those things to look forward to—which seems to be creating a problem in and of itself. I think that is probably two questions about staffing planning and making sure that we are prepared in that space, but also about what we can do to make that sector better.

Ms Stephen-Smith: Thanks, Ms Cheyne. Before I hand over to Dr Coleman, I will just say that there has been a lot of work with the aged-care sector. But, as you say, they are independent organisations and commonwealth regulated. Some of them have chosen to go significantly beyond the public health directions in terms of locking down and seeking to protect residents, but, as you rightly point out, there are mental health risks of isolation and boredom for residents around that. The Health Protection Service has been trying to work through those issues with aged-care facilities about what the directions really mean for them.

But there is also an ongoing relationship between the Health Protection Service and aged care in the ACT, as there would be in other jurisdictions, in relation to infectious

disease outbreaks. So planning for the flu season goes on every year, which means there are those existing relationships between the communicable diseases team and aged-care facilities. At that point I will hand over to Dr Coleman to talk about how that work has been expanded and built on for the COVID response.

Dr Coleman: Thank you, minister. Absolutely, this is the highest risk setting we have in Australia and internationally, and we have seen some really challenging and very sad stories emerging from various places. I think we are all really saddened by this. Since the very early indicators at the start of this year, when we saw what was happening internationally, we reached out and strengthened our liaison in a working group arrangement with our aged-care facilities. As the minister said, we run a pre-existing program of assisting aged-care facilities to manage flu and gastro. So we have built on those relationships, assisted them to strengthen their outbreak management plans and improved our prevention and planning responses.

We have been conducting several webinars with them to assist in training around what the first 48 hours of an outbreak might look like, what they would need to do, what we would be doing, and what kinds of documents and templates may assist them, and assisting them with that. We are backing up online training now with face-to-face training. One of the major learnings that has come out of Victoria is that, while you can tick a box that this many people have done this much PPE training, it means nothing when you get in a crisis and you are on the ground. So we are starting to get people out and about in these facilities and provide that face-to-face training, in collaboration, which is a great piece of work.

I think the wraparound service is probably something fairly new to us. By the "wraparound service" I mean responding to the wider impacts on the facilities. For example, we have never before seen this level of requirement for replacement of staff in a facility. So I think it is definitely challenging all of us. There has been some great workforce planning in this space already, and we have now brought in the Chief Nurse and Midwife, Anthony Dombkins, to continue that piece of work in our planning to make sure that each aged-care home has a plan, with our assistance and the commonwealth's assistance, about who and how we would bring staff in. That may be just a couple of people who are furloughed, or it may be an entire staff workforce that needs to come in (a) because the staff are too scared or frightened to come to work, or (b) because they are all furloughed because they are all contacts of a case.

I think one of the really important lessons that has come out of Victoria is that we cannot just focus on the staff who do the stuff. One of the challenges is about the leadership of that facility. Some are really strong; they have really good, strong, national support. Other, local ones that are independent might require much more leadership support at that level about how the facility runs. That is why it is very much a whole-of-government approach in terms of supporting the facilities. Is there is anything else you would like to know about that? I think that is a bit of an overview about how we are trying to wrap around aged-care facilities.

Ms Stephen-Smith: If it would be helpful for the committee, next time we appear with Health Services, for the Chief Nurse and Midwife to appear to talk a bit more about that, we would obviously be very happy to facilitate that.

MS CHEYNE: I am not sure you are appearing again.

MS LE COUTEUR: Thank you for that information about aged care, because I was going to ask, otherwise. We are presumably in this for a lot longer but, of course, we have no cases in the ACT. For someone like me or most people in Canberra, this is a media story, not a lived reality, if you know what I mean. How are we going to keep people—I was going to use the word "enthusiasm"; that might be pushing it—doing all the things that we need to do to keep it in check?

Dr Coleman: I am happy to take that; I was looking at the minister. Yes, as we have discussed a couple of times, this is one of the major challenges that we have, not just in the ACT but around Australia, and we do talk about it and acknowledge it at AHPPC frequently, as well as at national cabinet. We have a really strong communications and media team here which is looking at the current community feelings and engagement and what their perceptions and understandings are, as well as what they think and what kinds of needs they have from a communication and confidence perspective. We are always reviewing our communications and looking at options for campaigns and marketing, but also information needs, and adjusting that, moving forward.

We also get shared learnings from the commonwealth, and we are coming together now with a bit more of a narrative around it. As you say, we are in this for the 18 months or the two years now. I think there is this story that we cannot be scared about a case or two anymore. We are going to have to be prepared and we need to work with our communications and our communities much more strongly to move forward.

Just to finalise with that, we all have identified that our hard-to-reach population groups are really difficult to engage with through traditional mechanisms. Some areas of government and communications are looking quite closely at how we use the mechanisms of community development to identify several leaders in those communities and enable ourselves to outreach into those communities and spread the word through our community leaders to try and maintain this—to get the right information, the right level of awareness, but not too much fear, and to maintain that, moving forward. I am not sure if the minister would like to add anything to that.

Ms Stephen-Smith: No, I think that is a really good summary, Kerryn. We have continued to learn and improve in terms of the way that we reach out to different communities and use, as Kerryn said, community organisations and community leaders to do that for us. But it is a really hard balance between overly increasing anxiety and making sure that people are aware, because we have groups in the community that are extremely anxious about the risk and we have other groups who are potentially becoming quite complacent about it. The second group make the first group even more anxious, so calibrating those messages is an ongoing challenge for the PICC.

MS LE COUTEUR: You talked about communicating to hard-to-communicate-with groups. I have been listening to someone saying that some other jurisdictions are having real problems with translations into other languages. How are we going as far

as translating things,, at the very least into other languages?

Dr Coleman: We are constantly working with the PICC as well as our translation service and the Community Services Directorate around those. We identify our key documents to get translated as quickly as possible. Because there is such a demand on a service that was never used to this, I agree, it does take around a week to turn around those key documents, but we now have bedded down quite a good system for identifying those high priority ones and getting them through, and also leveraging off other jurisdictions' information when it is relevant in that space.

MS LE COUTEUR: Are you finding that graphically presented information is working because it is somewhat language independent?

Dr Coleman: I know specifically from the Indigenous community that that is a very useful tool and we are certainly leveraging that. I must admit, I am not as familiar with the other hard-to-reach populations, but we can get some of that information, if you would like.

MS LE COUTEUR: Thank you, and that's enough from me.

MRS DUNNE: I just want to continue on the issue of messaging. I want to raise with the minister specific feedback that I have received from constituents. Woolworths in New South Wales announced that it was going to go with masks, and I understand that the epidemiological reasons for the ACT saying maybe it is not necessary for us in the ACT, but that came across to constituents as being less than enthusiastic about the notion of masks and unsupportive of businesses who may want to implement mask-wearing. I think that it came across as a sort of failure in messaging. I have had a lot of feedback about that. Minister, have you reflected on the tone that you used in relation to Woolworths announcement?

Ms Stephen-Smith: I think it is interesting, Mrs Dunne, that you talk about the tone that I used. I certainly have been on radio indicating that we are very supportive of businesses making their own decisions and noting that a number of businesses have previously made decisions. You only have to walk through the Canberra Centre first floor to see the business there that has, from the very start, been providing masks to people and requiring people to wear masks in store, and we have never been critical of that.

I did hear a description—I think it was on ABC Radio; certainly on one of the radio stations—of our approach, saying that Woolworths' decision was in conflict with ACT Health advice. We have never used that description and I was very clear in my interview with ABC radio that that was not an accurate description of Woolworths' decision—that it was not in conflict; it was just going beyond ACT Health advice and that we have always been supportive of businesses making their own decisions in relation to this. So I encourage you to look at the transcript of what I have actually said as opposed to how other media organisations have interpreted the relationship between Woolworths' decision and ACT Health advice.

MRS DUNNE: This is not my comment, minister; this is the comment from constituents who have said to me that they believe that your messaging was not

supportive. If you are saying that your message was supportive of Woolworths, I would be very pleased with that, but the impression that was given was that ACT Health was not supportive of Woolworths' decision. So you are saying that that is not the case?

Ms Stephen-Smith: I do not think that we have ever intentionally given that message or tried to give that message, but I think that was the way that some media outlets interpreted the difference in advice.

MRS DUNNE: How would you account for that, if you were being so positive? How is it that some media outlets got it so wrong?

Ms Stephen-Smith: The ACT provides factual information to media outlets about what ACT Health advice is on mask-wearing, and the ACT Health advice is that it is not seen as being an important protection in an environment where we do not have community transmission. So there is no current recommendation from ACT Health that people in the ACT should be wearing masks in public settings, because there is not community transmission. That is absolutely in line with AHPPC advice in relation to the wearing of masks.

But that wording, when we provide that to the media, is that there is no current recommendation from ACT Health to do this, not that it should not be done. And that is where I think sometimes it has been interpreted as, "ACT Health recommends that people do not wear masks." It is one of those logic things where we are not recommending that people do wear masks, but we are not recommending that people do not wear masks.

MRS DUNNE: Perhaps, minister, with all the highly paid communications experts in the government we might come up with better, more explicit and more understandable information that is passed on to the media.

Ms Stephen-Smith: Mrs Dunne, we can provide accurate information to the media and they can make a logical distinction, and we have no control over them doing that. But the Chief Minister was very clear in putting out his statement that was 100 per cent aligned with New South Wales's statement, when that came out, about masks being a fourth line of defence. We have also been very clear with the ACT community that we support people and we encourage people to prepare for a time when mask-wearing may be recommended in the ACT community. So we have actually actively encouraged people to prepare for a time when there may be community transmission in the ACT, and we may be actively recommending that people wear masks. But that is not the current recommendation. We try to be as clear as we can in our messaging, but we cannot control how other people interpret that.

THE CHAIR: Have you concluded, Mrs Dunne?

MRS DUNNE: I have a different question, if the committee could indulge me.

THE CHAIR: I am happy to give way.

MRS DUNNE: Thank you, Mr Coe. On the reannouncement that was made about the

hospital expansion earlier this week, the Chief Minister said that the number of beds would be reviewed because of COVID-19. Can the minister explain exactly what that means?

Ms Stephen-Smith: I do not believe the Chief Minister did say that, Mrs Dunne. I think that is a misinterpretation of what the Chief Minister said. I think he was saying that our population growth rate will probably change and that our estimations of future population growth will change as a result of COVID-19, but we do not have any plans to review the number of beds in the Canberra Hospital expansion.

MRS DUNNE: So how many beds are in the Canberra Hospital expansion?

Ms Stephen-Smith: That is 148.

MRS DUNNE: Okay, thank you.

MS CHEYNE: I have a quick question that kind of relates to what we were talking about with respect to how we are presenting information. I am not sure if you can see this—hopefully I will scroll the right way—but on 12 August we were presenting how many tests were done in the last 24 hours, but yesterday it changed and it was not there anymore. Is there a reason why it was not there yesterday? And is it going to be there today?

Ms Stephen-Smith: Kerryn.

Dr Coleman: I think it was an error and that there was no intention not to. I think later on it was provided when it was pointed out to us. I do not think it was a deliberate thing, and it will be fixed.

MS CHEYNE: It did seem that yesterday there were quite a lot of tests. I was just wondering if, perhaps, there was some sort of psychological reason behind not including it or maybe including it, but if it was just an administrative error, that is perfectly satisfactory. Thank you.

THE CHAIR: Okay; I think that wraps up our committee hearing today. Thank you very much, minister, and Dr Coleman, Ms McDonald, Ms Brighton and Mr Peffer. I think there was a question taken on notice regarding the budget and the actuals for quarter 3 at the hospital. Otherwise, I am not sure there were any other questions taken on notice. If so, please get back to the committee in a timely way, given that we are hoping to report in the coming fortnight or so. Again, thank you.

Ms Stephen-Smith: Thank you very much, chair, committee.

The committee adjourned at 11.01 am.