T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the Victorian Government's COVID-19 contact tracing system and testing regime

Melbourne—Wednesday, 18 November 2020

(via videoconference)

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WITNESSES

Adjunct Professor Russell Harrison, Chief Executive Officer, and

Dr Clare White, Clinical Services Director, Geriatric Medicine, Western Health.

The CHAIR: Hello, everyone. Welcome back. I am very pleased to be joined by representatives from Western Health. We have Russell Harrison, the CEO, and Dr Clare White, Clinical Services Director, Geriatric Medicine. Thank you, both, very much for joining us today. I am here with committee members Deputy Chair Tien Kieu, Dr Matthew Bach, Ms Georgie Crozier, Ms Kaushaliya Vaghela and Dr Catherine Cumming.

If I can just begin by way of some procedures. All evidence taken at this hearing is protected by law, and that provides you with parliamentary privilege. This is under our *Constitution Act* but also under the standing orders of the Legislative Council. Therefore the information you provide during the hearing is protected. However, if you repeat the comments outside, they may not have the same protection. Any deliberately false evidence or misleading of the committee could be considered a contempt of Parliament. Obviously we are recording this; we have Hansard listening to every word. You will receive a proof transcript of this, and please, I encourage you to have a look at it to make sure that we have reflected everything that you have said accurately. Before we open it up for a more general committee discussion, I welcome you to make some opening remarks. Are we going to hear opening remarks from both of you or just one?

Adjunct Prof. HARRISON: Just from me, Chair.

The CHAIR: Great, thank you.

Adjunct Prof. HARRISON: Thank you, Chair and members of the committee. I would like to start by acknowledging the land on which I am currently standing, or sitting, which is of the Wurundjeri people of the Kulin nation. I pay my respects to elders past, present and emerging and also acknowledge the resilience of the Aboriginal and Torres Strait Islander people as we have just celebrated NAIDOC Week and 65 000 years of ongoing custodianship of the land.

As you mentioned, joining me today is Dr Clare White, who is a senior medical leader at Western Health, is a geriatrician looking after aged care and is a very passionate advocate of elderly care both in and outside of the hospital. I would like to commence by thanking staff across the healthcare sector in what has been a significant event—described as a one-in-100-year event—but also especially the staff at Western Health, which I am incredibly proud to lead, for the great work and sacrifices that they have made to care for their community in the pandemic, among some of our highest impacted areas of the state. The staff have been phenomenal across this period of time, changing roles, supporting each other and also working in new environments to make sure that no role went unfilled and staff were supported, patients cared for and the community at large provided for.

To support Western Health's planning for preparation for the response we took the decision in early February to take a team of experts offline to plan, looking at the international developing picture and also advice coming from the Department of Health and Human Services. That team consisted of senior operational managers, infectious disease physicians, infection prevention staff and senior nursing leadership. They looked at what our plans were, what they may need to be and how we would learn from the international evidence, and the team has stayed in situ through wave one, the gap between waves one and two, and right through wave two and are still in place today.

In relation to the areas that this inquiry is looking at and supporting, it is fair to say that Western Health supported the department of health in a range of areas in delivering care to community, but we did only do contact tracing for our own staff, as I believe Felicity was telling the committee previously, and we did not do outbreak management. We were deployed to provide support, but not in those areas. We were heavily relied on to provide on-the-ground teams to support aged care, for instance, and I am sure Dr White can answer any question specifically on that, and in testing we were setting up a number of testing centres—seven in total but three of which remain—and through those assessment clinics and testing centres we have tested just over 80 000 people, I believe. We have cared for over 400 COVID-positive patients in our hospitals, we have covered 70 patients in our ICU that were COVID-positive, mainly across wave two, and many hundreds of suspected COVID patients both within and outside our hospital. Our ED, screening clinics and community

partners that we have worked with, including our general practitioner colleagues, have supported lots more—many thousands of patients in the community—with concerns and issues.

At the height of our pandemic we supported 28 aged-care facilities with outbreaks in them and supported almost 1100 residents in those outbreak facilities, and it is fair to say that this work took a significant toll on our staff, who experienced grief and trauma on a scale never seen before and hopefully will never see again. We did a lot of support for end-of-life care planning with both residents, family members that could not get in to see them and also the staff of those facilities, and that was both face to face and over Zoom and other products.

In the future, as you may be aware, we are setting up a local public health unit and working with community partners to do that. I think it is a really positive step for the future and we are very excited about this, and we have been working very carefully and closely with both Barwon Health to get their expertise and learnings from their dealings and also the department of health CCOM team. We have been able to operate on a local level, building relationships with councils and with general practitioners—and I must declare an interest that my general practitioner was on earlier today. But we have been building those relationships to ensure that in the developing period of time we can get very clear and concise public health messages into our very diverse communities and hopefully ward off any future waves—it will be very easy to jump on any outbreaks that we get. Thank you, Chair, and thank you to the committee.

The CHAIR: Thank you very much, and I am hoping that your team is coming out of this having finally had time to get some sleep and the like. Just in regard to the local public health unit that you are establishing, will that have a contact-tracing component?

Adjunct Prof. HARRISON: Yes, it will. It will have a contact-tracing unit. We are training those staff now, and we have been doing simulations with Barwon and the CCOM team and others to ensure that they have got the skills to do that and build on the learnings that we had from contact tracing our own staff from outbreaks and positive cases in hospital.

The CHAIR: Yes. And are you getting assistance and training from DHHS for this?

Adjunct Prof. HARRISON: Absolutely. A lot of the training packages are coming from DHHS and there are cases even where I would say we are using both that service and also Barwon, doing as much learning as we can because we do not want to get this wrong going forward; it is too important.

The CHAIR: Indeed. And with that, with the contact tracing and working with DHHS, will you be automatically plugged into the new Salesforce contact-tracing system that DHHS is now using?

Adjunct Prof. HARRISON: Yes, our staff are being trained on the product as we speak and have had some training already, so we will be using that as part of our establishment.

The CHAIR: Right. Have your staff made comment about whether this is a vast improvement on what they were relying on before or have they made any comments about how this is going to further enable communication between your organisation and DHHS?

Adjunct Prof. HARRISON: I think, Chair, we are fortunate that we have an electronic medical record, so my staff and contact tracers have been using that as part of our work throughout the COVID pandemic and before that as well. We work with DHHS in terms of notifying them of the positive cases. Several months ago we had an online portal to submit that through, so we were doing that online and taking our data and sending it. So I think the staff are there. I think the availability of digital tools is crucial to health care in the 21st century. More digital availability means there is sharing of information and that human error in entering data is cut down significantly. As I say, we were fortunate to have an electronic medical record—we had our system pretty much end to end for our hospital—and we could export that to our colleagues at the department when we needed to.

The CHAIR: Thank you. If there is time, I would like to ask Clare some questions, but I will move to my Deputy Chair, Tien Kieu.

Dr KIEU: Thank you, Chair. Thank you, Russell and Clare. Once again I would like to express our gratitude and appreciation for your work in this very difficult time just past. We are in a better position now, but the pandemic is not over. I would like to ask a question: particularly in the west we have very large and diverse

communities with very different languages, cultures and religions, so what lesson could you tell us about how to manage the communication and information dissemination to those communities? The other question is about aged care, because Dr Clare White is a geriatric. So this has been a very big—

The CHAIR: A geriatric expert.

Dr KIEU: Sorry. I would just like to find out whether there is some confusion that contributed to what has happened—confusion due to the demarcation of responsibilities between the federal and the state and the private sector, because aged care is essentially a federal issue. Could you tell us a little bit more about that?

Adjunct Prof. HARRISON: I am happy to let Clare go first with the aged-care piece, and I will come back to the bit about communities if that is okay.

The CHAIR: Thank you.

Dr WHITE: Thank you. I think you have really cut to the chase with one of the critical challenges, I suppose, in managing residential aged-care COVID outbreaks. This, I think we knew from the start, was going to be one of the key problems that we would face. From my experience—and I probably should provide some context to that—as a geriatrician within Western Health I had responsibilities previously to COVID within the hospital, predominantly. We had a smaller residential in-reach service which was about five or six people prior to COVID. This was boosted substantially during the second wave to be around 75 staff members. So it grew quite significantly, and my exposure to the outbreaks in our region was as clinical director of this residential in-reach service.

Now, it had a core function of providing specialist nurses and doctors to go in to assess individual patients and on an individual basis look at their care needs and whether care could be delivered within the home or, if they needed hospital admission, to expedite their transfer to hospital. So that was our and Western Health's core business I suppose in the outbreak. We were not responsible for coordinating and managing the entire outbreak—and that is obviously, you know, a complex matter that involves a task list of 25 things all having to be done in a very short space of time. But we were in a unique position because of the number of outbreaks that we were witness to, and we were also some of the clinical teams on the ground every day able to witness and to observe how the pandemic was playing out—because obviously this was a public health emergency and a crisis that we had not seen before. We had not managed something like this before and we were learning as we went very quickly and as adaptively as we could, so we were in a unique position to sort of observe how that changed over time.

And coming back to your original question, we knew from the start, coming back to March, that this was going to be a really tricky place to be, trying to do something very complex in a rapid environment with quite quick escalation. When it is one government body it is tricky enough, but when there were two government bodies to deal with it was going to be a major challenge. Now, we have not completely fixed that problem, but we are worlds away from where we started, I think, and there have been lots of improvements that we have managed to come up with along the way. One of the main improvements was the implementation of the Victorian Aged Care Response Centre, which was a combined enterprise with collaboration from both the commonwealth and the state—DHHS—and that made a huge difference to the coordination and communication to health services, particularly to providers and to the other agencies involved. So one thing I was thinking when I was going to be asked about residential aged-care outbreaks is this is a massive topic and whenever we start a conversation about this it can go on for a long time, so I suppose it is hard to know when to stop. But I suppose that is a bit of a summary in answer to your question. And let me know if you want any more detail.

The CHAIR: Thank you. We may well. Georgie Crozier.

Ms CROZIER: Thank you very much, Chair, and thank you both for appearing before us this afternoon. I just direct my question to Dr White. You talked about the difficulties of the dual government responsibilities, if you like. Clearly there are aged-care facilities right across the nation that did not have the devastation that occurred in Victoria due to the large-scale community transmission that occurred here in Victoria and the breakdown in the contact tracing and obviously people moving from various industries and a whole range of other specifics. The public health unit here in Victoria has a responsibility to assist with the response in any public health crisis such as what we have seen, so I am just wondering if you could explain to the committee your involvement with that, the public health unit, in response to the aged-care facilities, the outbreaks, and in

addition the federal government setting up of the—I have just had a blank—the name of the rapid unit that they set up to assist in the public health unit and the people like yourselves dealing with the crisis that was unfolding. Could you provide some comment to the committee on those points, please?

Dr WHITE: Yes. Just to clarify, do you mean the hub or cluster model that was—

Ms CROZIER: Oh, no, the aged-care response unit I think it was called.

Dr WHITE: Yes. VARC, we like to—

Ms CROZIER: Yes, VARC, thank you. It was set up by the federal government to assist the state government in terms of dealing with the response here, and I would just like to get your input about that.

Dr WHITE: So, I suppose my view and my knowledge come from my role at Western Health, and I have explained to you exactly how Western Health were involved. In my role as clinical director of our residential inreach service I was involved in regular daily meetings certainly during July, August and September where there were representatives from the commonwealth, from the facility and from the health services. The Aged Care Quality and Safety Commission and the public health unit were involved in multiple meetings, usually more than once a day for particular outbreaks.

My experience was that it was a complex and changing situation that presented unique challenges on a daily basis that we had not faced before but that there was a great will to solve those problems. It was really a matter of trying to quickly set up structures and systems for efficient communication and coordination. There was no shortage of people willing to attempt to work hard. There were lots of resources coming in from the commonwealth and from the DHHS. But because of their complexity and the rapidly escalating nature of the situation—there was a point in time when we had eight outbreaks declared on the one day, so this was a very rapidly surging situation—I think people were doing their best with the resources that they had. But my experience is that the public health unit at the DHHS were heavily involved and were involved in those meetings as a key stakeholder on a daily basis in those outbreaks and certainly a key stakeholder and heavily engaged in the VARC when it was set up; they were one of the key players at VARC, along with the commonwealth.

Ms CROZIER: Thank you for that. I am probably out of time, am I, Chair?

The CHAIR: You are at the moment. There might be some more time at the end. Kaushaliya Vaghela.

Ms VAGHELA: Thanks, Chair. Thanks, Russell and Dr White, for your time and your submission and the great work that you are doing in the western region of Melbourne. Now, what are the specific learnings from the first and the second wave of the pandemic in Victoria, including specifically in the western region of Melbourne? And how confident are we that if there is a third wave we will be able to stop the third wave?

Adjunct Prof. HARRISON: That is a big claim, committee member, so I am not going to claim to be able to stop anything. I think the learnings have been great and significant. As Clare has said, in relation to aged care we have learned a huge amount. Six months ago if you had told me that Western Health would have been supporting private sector aged care on the ground with clinicians and staff, then we would have thought that that would not be the case. I think we have learned a huge amount about staff willingness to respond to a crisis across the healthcare sector. We have had a great network of sharing information and learnings from all of the public health services, rural, regional and metro, and I think we have been sharing things with the Alfred and Peninsula and vice versa and doing learnings. So I think that sense of health service camaraderie has been really important as a learning.

For me as well, I think the power of the electronic medical record has been an absolute boon to Western Health for the patients that we were supporting, for those positive patients that we had and for the asymptomatic patients that became symptomatic. We could do a lot of contact tracing very, very quickly from the system that with paper and things we could not have done as fast, which is great for getting on top of outbreaks.

So I think we have had a huge learning, but I think the overriding piece from me is that the calibre and credibility of the health services staff working together across community and hospital sectors has been second to none and I think has put us in very good stead for the future. Hopefully we do not have to put those learnings

into practice, but we are certainly not being complacent. I think that the big thing that stands out for me is the incredible ambassadorial role of my staff and others. We are very fortunate—about 65 to 70 per cent of the staff at Western Health live in our catchment population. They are very multicultural as a group, and therefore we have been using the staff to put the messages of those preventative steps about washing hands and social and physical distancing out to communities in languages and in methods that are understood. We have been taking DHHS comms and our own comms and using those, and we have a great link through our foundation with the Vietnamese community. So we have had a lot of links back out into the community with volunteers and staff to get those messages out there, and I think that is another great learning that we will be harnessing for our public health unit—that that engagement with community is absolutely crucial.

The CHAIR: Thank you, Kaushaliya. We will go to Dr Matthew Bach and then to Dr Catherine Cumming.

Dr BACH: Thanks very much, Chair, and thanks again to you both for coming and being with us today. It is important to hear from you. I have got a question that goes back to some evidence that was provided just a little while ago now to the Parliament's Public Accounts and Estimates Committee by Cedar Meats. Staff at Cedar Meats informed the committee that the organisation had received an email on, I think it was, 30 April from the Department of Health and Human Services regarding the fact that testing sites at four locations were being considered. I think the four locations were Sunshine Hospital, Bunnings Footscray, Pacific Werribee and Djerriwarrh—excuse me for my pronunciation—Health Services. Can I ask: were you contacted on or before 30 April as to your ability to help with the set-up and staffing of the facilities at these four locations?

Adjunct Prof. HARRISON: Djerriwarrh is a separate health service down in the Bacchus Marsh-Melton area. Certainly Sunshine is our respiratory assessment centre, as we call it, or testing centre, so yes, that was established and was in place and that was running before that date because we had it in place to test community from wave one, so DHHS were aware of our testing centres. Bunnings was not ours. For our services that we ran, particularly that one at the Sunshine clinic, DHHS were aware of that and I know that we have tested Cedar Meats employees. I do not know the exact dates or numbers off the top of my head but we did test Cedar Meats employees for the department and our clinic was available and ready to be there.

Dr BACH: All right. Thank you very much. So Sunshine Hospital, that obviously was you guys, you have spoken about Bunnings and the other health service in Melton West, but then I gather from your response that Pacific Werribee also did not sit within your purview?

Adjunct Prof. HARRISON: No, I think that is Werribee health service at Mercy, so that certainly was not us.

Dr BACH: Great, thank you so much. Now, you referenced, Mr Harrison, Cedar Meats and the role that you played in supporting the staff there and the management of that broader outbreak. Would you mind providing us with any further details about exactly what role Western Health played in seeking to subdue that significant outbreak?

Adjunct Prof. HARRISON: I do not think we have a role to play in subduing an outbreak. We are not an agency that does that. We are a responder. As the committee will no doubt be aware, we had a patient that came to us through an emergency pathway from Cedar Meats that was asymptomatic. They were not symptomatic for COVID so they went through a pathway at that point in time that was for patients that did not have COVID symptoms. Later that patient developed COVID, so that was reported back to the DHHS. As I said, we had a testing service that was available for the public that met the criteria for testing that DHHS set and they were aware of that, and that was made available to Cedar Meats employees to come and be tested—a number came and were tested, I should say, sorry. Also we worked with the department to do the clearance test at the end of the isolation period for that workforce for those that wanted to come that lived in our catchment area.

Dr BACH: All right. Thank you very much.

The CHAIR: Thank you. Dr Catherine Cumming.

Dr CUMMING: Thank you, Dr White, and thank you, Russell. I am pleased to hear the amount of work that you have done, and my community is very thankful for all the work that you have actually done so far. I would actually hope that all the learnings that we have learned we actually do not lose—that we can actually tidy up all of these stats and we actually have a better public health system for Victoria because of this. I guess

my question is around—and it runs from, like Dr Bach was saying—the test sites. Would it be helpful to have more of a say where those test sites are or be part of it, rather than having those private sites such as Bunnings, and it was at Highpoint at one stage? I guess the other question that I have is around some of the earlier learnings around what was occurring with the testing down in Maidstone when it was community testing going out. Does Western Health have a role in helping with test sites? My community has concerns around the testing site that is in West Footscray just placed next to a sporting facility, and the council at the very start were concerned that DHHS was only really contacting them to actually open up a community facility rather than having that staff available to them.

Adjunct Prof. HARRISON: I cannot comment on conversations with DHHS and council, because I was not party to those. But certainly for the testing centres that Western Health were asked to run—and at the peak we had seven on the go—we were heavily involved in working with council and DHHS for the location of those. We worked with other health providers, so I know my colleagues at Cohealth and IPC Health also had testing centres. The logistics for us were about how many staff we could physically deploy to a testing centre to do it safely and properly and how many we had to set up other facilities. It was a logistical balance between how many staff we could deploy safely and what we could do. We had those robust conversations with the department and they accepted what was possible. And then, as I say, other parties like Cohealth, IPC and health services like the Royal Melbourne—everyone stepped in to support access to testing by community. Those conversations were had in a very collegiate way around who could do what, how many staff could we deploy and who was then going to run it. We were all very clear that governance was very important, so if it was a Western Health-run testing centre, we ran it, and we ran it our way, and the same for Melbourne Health et cetera. Certainly from my perspective those testing centres were set up safely, appropriately, and we ran the ones that we ran. The feedback from community was very positive—that they could get tested and get results back through that process.

Dr CUMMING: Do you feel that they understood where those tests were going—what labs they were going to and which sites and who was actually looking after those sites—the community? So would that information have been fed either to a GP or to others, so they actually knew who was looking after them at that particular time?

Adjunct Prof. HARRISON: I cannot comment on the wider policy piece of that. I know certainly for our sites that the patients that came for testing were very clear that they came to a Western Health site, that was where their results were going, that the information would be shared with their general practitioner as we captured that data and that results would be fed back.

Dr CUMMING: Yes. I have had surgeons in our area who obviously were not very happy with the lockdown, knowing that they have got very large lists. Could you just maybe explain how you are working through that and what is the way forward?

Adjunct Prof. HARRISON: Yes. We are bringing back online our elective surgery capacity in line with the government's road maps. We are going through stages. Probably by the end of this month we will be bringing it back up to, potentially, 100 per cent—and I say potentially because we are also balancing the significant fatigue and exhaustion of staff. Whilst they have not been in theatres, they have been redeployed to critical care outreach teams, they have been supporting aged care and doing very different roles, so I am really very careful, as are all of our senior leadership group and staff, around how we support our teams and get back to fully functioning. Whilst they may not have been doing their normal activities, they have been very, very busy doing a lot of COVID-related activity. We want to make sure our community can have treatment but also that we do not suddenly turn everything back on straightaway and just fully exhaust our staff. That is where we are sort of heading, but it is a careful plan that we are bringing back online, because we know that our community needs access to care.

The CHAIR: Thank you. I would just like to ask Dr Clare White a question. In thinking about the terms of reference of contact tracing and testing, how can we better work at that end of life with people in aged-care facilities where they are in isolation? We know that we want to protect them, but there must be some better ways that we could do that that could be more caring and that could provide that contact that people just lost through this process. I wonder if you have had any thoughts about this.

Dr WHITE: Look, it is a very good question. I think one of the main learnings—lessons—through the outbreaks in residential aged care has been the harms that we have seen that have been consequences of the isolation in quarantine and in particular some of the facilities that were locked down for a long time and that visitors were not able to be present in any circumstances. That has caused a lot of harm; there is no doubt. There is a large conversation going on, I think, in the sector about how we can safely continue visitation and under what circumstances throughout the next COVID-normal period and even into periods of increased COVID activity, because I think one thing that we have seen is that visitors were not really a main source of bringing COVID into facilities and that now that we have good PPE use and know what we are doing, we should be able to safely manage visitors in facilities and continue usual activities, outings and other things for older people as a priority, rather than having a more stringent approach. I think that that is part of reflecting on what has worked and what has not and being able to really make sure that that is a key priority, because it was certainly one of the harms that we saw.

The CHAIR: Yes. So it just feels like given the contact tracing and the facilities we have and given the testing we have got, we could do this in a much more humane and sympathetic way.

Dr WHITE: Absolutely.

The CHAIR: Yes. We have got Georgie and Tien—both very quick questions. I will go straight to Georgie and then finish with Tien.

Ms CROZIER: Thank you. I just want to follow up from the Chair's questions. Was DHHS able to contact-trace effectively in aged care?

Dr WHITE: As I said before, my involvement in outbreaks was a direct clinical involvement with our clinical teams. We were not tasked with contact tracing and certainly did not have any involvement—

Ms CROZIER: Well, from your observations, Dr White—because that is what we are trying to ascertain about the impacts. Clearly we had this widespread community transmission that ripped through these aged-care facilities, especially in your area, and we need to understand whether it was effectively undertaken within those aged-care facilities by DHHS, who had the responsibility to do it.

Adjunct Prof. HARRISON: I think, Chair, if I may in response to the question from Georgie—

Ms CROZIER: Thank you.

Adjunct Prof. HARRISON: certainly the intelligence that was being shared at the meetings that Clare reported that she attended earlier on a daily basis, if not several times a day, was very helpful from the public health unit to show that they were contact tracing. I think one of the issues that Clare mentioned that did cause challenge in the aged-care sector was the PPE guidelines used there of education of the staff in how to use it and how to stop the spread. Clearly that has got significantly better with the work that has been done across the board, but certainly we were getting very quick and very clear updates of which staff were being furloughed and which residents were positive—

Ms CROZIER: Sorry, not the PPE—I know there were issues with PPE across the board—but the contact tracing, actually being able to follow up with those infected community members, workers, staff.

Adjunct Prof. HARRISON: We do not have sight of that. All we got was the intelligence from that process, which was very frequently, every day, about who was now positive, which residents in those homes were positive, who was being tested, where they were at et cetera. That was being fed to the clinical teams and the management teams through that process, but we were not privy to how that was being done or who was doing it and where it was being done.

Ms CROZIER: Thank you.

The CHAIR: Thank you. Clare, was anything else you wanted to add to that? Dr Kieu, Tien.

Dr KIEU: In the interest of time I think I will hold my question.

The CHAIR: Thank you both so much. This has been again very enlightening and has been very helpful to us. You will receive a proof of the transcript from today. I would encourage you to have a look at that and make sure we have not misrepresented you, as I said. If there is any other information you would like to provide to the committee, feel free to send it on to the secretariat. Thank you both.

Dr CUMMING: Thank you, Russell. Thank you, Clare. Thank you. See you in the playground, in the hood.

Dr WHITE: Thank you.

Adjunct Prof. HARRISON: Thank you.

Witnesses withdrew.