PUBLIC

PARLIAMENTARY STANDING COMMITTEE OF PUBLIC ACCOUNTS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON WEDNESDAY, 4 NOVEMBER 2020

INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSE TO COVID-19

Mr STEVEN OLD, CEO AND **Mr CARL ROBERT WINDSOR** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR (Mr Dean) - This is a public hearing. It is being streamed online as well. It is being recorded on *Hansard*, and will be transcribed eventually. During this process, parliamentary privilege applies to you, the same as it does to all of us, but, once you leave here, it's an unknown factor so you're probably on your own - so be aware of that. Steve, you would have read all of the detail that was sent to you.

Mr WINDSOR - No, I haven't gone through a lot of the detail.

Mr OLD - Carl is one of my board members. He runs a restaurant, so he was just going talk about a couple of experiences he has had as an operator, to give you a bit of a summary. I'll answer most of the questions.

Mr DEAN - You are familiar with the current processes we have here and what happens. It's reasonably informal - first names are okay. That's really about all I need to say.

Steve, we don't have a submission but I give you an opportunity to make any opening statement you might want to make to us and we'll go from there to questions, if that's okay.

Mr OLD - Thanks, Ivan. I'm happy either way. I'm happy to make a brief statement, I'm happy just getting the questions, bearing in mind I don't know how caught up we are with time. I don't have a prepared statement, so I'm more than happy if you would prefer to ask me questions because I'm sure during questions I'll get it all out.

The very quick summation from the hospitality industry's point of view is obviously COVID-19 has been something no one in the world expected. Carl and I were having a discussion that when it hit in March we all didn't know whether this was going to be a one-week issue or two-week issue or a five-year issue. I start by saying I take my hat off to the Government about how they've had to deal with it. I think the Premier has done an unbelievable job in relation to it. We talk about mental health and all these sort of things at the moment - I just can't believe he's in a mentally sane position at the moment doing what he has had to do.

Mr DEAN - Sorry, I forgot - and I apologise, Ruth - we have Ruth Forrest on the line, so Ruth is listening in.

Mr OLD - Hello, Ruth.

Mr DEAN - I apologise for that but Ruth will be here shortly.

Mr OLD - Yes, okay. As I said, I think it has been a tough job. I think there has been some learnings from it. Let's hope we never go through something like this again. There are many things the Government has done extremely well and I take my hat off to them. There are

probably some things from hospitality's point of view that we're frustrated with and think could change but, you know, hindsight is a wonderful thing as well.

We have a lot of information and a lot of feedback from operators - not just members of ours but operators. One of the things the THA did at the start of this COVID-19 pandemic was to take the decision, being a membership organisation - I'm sure David, Josh and others know, you are a union for employers in the hospitality industry so, just like other unions would do, you represent your paying members.

We made a decision at the start of COVID-19 to say we were going to look after the whole hospitality industry no matter whether they were a member, to make sure we helped them out. We're still doing that to this point now, just to make sure that those non-members got all the support they did because, you know, in fairness it is something that no one expected and no one could deal with.

So, we've offered a lot of IR support; we've had a lot of contact with - I think it's over 2500 hospitality/tourism-related businesses throughout the state over the last six months to offer support.

I'll put on the record the Government funding we get means we do a lot of programs. One of the programs we do is a Great Customer Experience Program - we have some contractors do that work. It has allowed us to use those contractors to reach out to every operator in the state and offer a raft of assistance to them, telling them about the grants the government has put out, check if their mental health is all right, all those sort of things. The feedback we've got from operators right around the state for the assistance THA has been able to offer through the assistance of the state government has been fantastic. I want to put that on the table to start with, that without the support of the Government and the funding they give us, we wouldn't have been able to do a lot of work we have done for the whole industry. We take our hat off to them for that and thank them.

CHAIR - Thanks for that, Steve. I will go straight to David.

Mr O'BYRNE - Thanks, Steve, and, Carl, thanks for coming along.

Mr OLD - Can I refer to him as Collingwood filth or do we keep on a first-name basis?

Mr O'BYRNE - That is outrageous. Not a good start, Steve.

Mr OLD - Yes, that's right.

Mr O'BYRNE - Let's cast our mind back to the early days. There's a number of programs that both state and federal governments rolled out. The decision was made to shut the industry down at quite short notice, and then there was a delay between announcing the JobKeeper and the kind of wage subsidies that I know that your industry very much relied upon. My question is in two parts.

How important was JobKeeper? I think we probably know the answer but it would be good to hear from your members' perspective. Also, how difficult was it in terms of managing people when they were making decisions around their businesses, at a time when some of the

subsidies were unclear? It's really a question around timeliness and the implications of a staggered roll-out of support.

Mr OLD - Yes, obviously, the JobKeeper program was hugely beneficial, not only to our industry but a lot of industries. Our industry said early on we want to see it extended to Christmas, if not into the new year, which did occur. We would have preferred that the program eligibility changed slightly. It was pretty hard for a lot of venues past 27 September to get eligibility for the program.

We did a survey of our board alone - the board members run about 58 venues. About 10 were going to be on it after 27 September, for a variety of reasons - one being that a lot of them have bottle shops and bottle shops are high turnover but not high profit. That bumped them out - you have to be at least 30 per cent affected to get JobKeeper. I believe the program itself from the federal government was unbelievable. We had a lot of support from the Premier and minister Courtney. We had a lot of support from the Labor Party in opposition as well to talk to the federal government to get that program extended, even though it wasn't everything we wanted. In response to the first question - it was hugely important. It's fair to say without the JobKeeper program a large number of businesses in hospitality would have gone under.

A number of grant programs were rolled out over periods and a lot of them were very beneficial to some of our members. There were some members that didn't qualify for certain grants and that put them in difficulties. I understand Carl was one of those, and he'd be happy to talk about it after this.

I consider one of the biggest problems we had with the vast majority of the grants programs rolled out was they were oversubscribed. There was an under-appreciation by government departments of how many businesses were in trouble. The end result was on the day of lockdown, hospitality - and I had this conversation with the Premier - would have preferred to lock down straightaway and hopefully come out of it more quickly, rather than a slow death of slowly closing our businesses down. The Premier listened to us, which we appreciated. The end result is that hospitality businesses were all in hardship. They were all in a difficult time.

Any grant program was beneficial, but again some of the criteria made it a bit harder. For example, the energy deal was put out there saying you can get energy assistance, but only a few of them are Aurora customers. Not everyone's with Aurora now, because a lot use contractors to get their energy deal because they can't get the best deal through Aurora. The message came back that you got a good deal through someone else so you don't need a grant. I'm not sure that's the correct way to deal with it either.

So, a lot of grants were put out, but there were also caveats around who could apply for some grants. You had to meet eligibility criteria. At times I think there were messages going out to industry that there were all those grants programs, but when you dig down into the criteria they weren't all Christmas presents for all the venues. A lot of them missed out, which made it difficult. Again, I'm talking about all this through hindsight, and it's a wonderful thing. It's feedback for if we ever have something like this again; let's hope we don't.

I firmly believe the hospitality industry was probably one of the hardest ones hit. We can lead on other questions. I don't think there's been the full respect given to the hospitality industry and what the operators have gone through with COVID, and currently. I don't think a

lot of people appreciate the difficulties a lot of hospitality venues are still going through. A lot of them have delayed bills, but all they've done is prolonged paying those bills. They might be still open at the moment, or they might be about to open their doors again, but I can tell you those bills are still sitting there ready to be paid and at some point they are going to get called in.

A lot of hospitality businesses out there are facing a lot of hardship. I talked to Ivan and the TasWater committee yesterday, saying I don't believe we've reached the toughest period for hospitality venues yet. I said yesterday, Ivan, to put this into perspective - we've come off a winter where the tourist industry does it tough. We are now going through summer, which is the period when they normally make a good amount of money, but it's going to be another winter because they've been in lockdown, and then we're going to face another winter. So, hospitality is basically going to face three winters in a row before we face another summer in, let's say, September/October 2021. If any other business put themselves in that position and thought about three winters in a row, you'd be worried about how the balance sheet is going to look in September/October 2021.

There's a real need for grants. We've said this to the Government. We sent a document to the Government on Monday, 28 September, about where we saw assistance to industry was needed going forward from that time - the day JobKeeper ran out. That document basically said there are two options. Get rid of restrictions and let Tasmanians get out and about and enjoy all things hospitality - let them stand up and drink, have no 'one-in-two', because if there are no corona cases in Tasmania, let's let the businesses make money. If you are not going to do that, then there is a raft of stimulus measures you are going to need.

It is quite clear from our operators that they don't want a hand out. They need a help up sometimes but if you let them trade they would have tried to trade out, but if you are not going to let them trade out you are going to need to provide a raft of stimuli to them, things like payroll tax assistance, and energy assistance.

I know we still do not have answers on a lot of those questions. We are still waiting to get answers. I haven't had an official response to my letter of the 28th, which we are waiting for. There have been a few murmurs saying some of it will be looked at in the Budget. We have no idea what they are going to put in the Budget. We have no real answers to a lot of a 28 September questions,

Again, I am getting questions from every operator in the state through our contractors asking, what assistance is here? Where are we at with this? We are saying we are still waiting for a response. That just frustrates venues more because in the height of the anxiety and all they are facing from a business perspective, it doesn't take a lot to click someone over the edge, in relation to them getting frustrated.

A lot of businesses at the moment are in the situation: what do my next couple of months look like? It might sound like a simple thing to some people. They say why do you care about stand-up drinking? We are getting that much feedback from venues. People are saying why can I stand and have a water but I can't stand and have a beer and so on? The number of events that have been cancelled by people ringing up venues. I have got this feedback yesterday. People were saying that we want to do an event but we want to be able to stand up and do it. If we can't we will do it at home or in our office. The amount of money that is not going back

through hospitality businesses and those out there who are saying you just want to profiteer from your businesses.

The idea of these businesses making money is to employ staff. The third largest employer industry is hospitality, but it's not the third largest at the moment. How do we get it back to being the third largest employment industry and get all those young and old Tasmanians back to work? We need to get people in the doors. We need the businesses to make money so they can employ people and invest in their infrastructure and all those sorts of things. We need to get back on track.

Hospitality deals with the health of people every day of every week of every year. COVID didn't change hygiene for our members. Carl is a chef and hygiene is the paramount thing for Carl every day. COVID didn't make Carl go, 'I had better start doing this better'. Other industries probably had to improve. Hospitality did a lot already. They didn't necessarily have a sanitiser on every bar but sanitisation and hygiene is one of the paramount things that hospitality has to do every day. It wasn't new to our people. It is not going to be new to them post-COVID. We're not going to be one of these industries that suddenly says that we don't worry about hygiene anymore. It is part of our industry every day of every week of every year.

A lot of our businesses have done it tough. They are still doing it tough. As I said, I don't think we have hit the peak of the worry for our members yet. I think a lot of them have just done the old 'we will put that bill to the side'. I know from talking to the breweries in Tasmania, they won't give any specifics, but they have said the creditors' list that the breweries have in relation to people is, in their words, 'scary'. If you think of the brewery, food producers. Carl could talk. He probably deals with 50 to 100 that he pays bills to every week. If you think they are not paying the breweries, who else aren't they paying? The list flows on - superannuation, all those sorts of things. It puts a lot of pressure on these businesses. Some of them think that if I just park it for a little while.

Ivan, you made the point yesterday or it may have been Tania in relation to the TasWater one: it is nice getting interest-free loans. Don't get me wrong, they are great when a bank won't give you assistance. But at some point you still have to pay back that debt. It might be interest-free. We fully support it and fully appreciate it but I make the point that the debt still has to be paid at some point. All these things that get racked up with 'we'll give you an interest-free loan, we will give you this', is fine, but any business knows that bill has to be paid back at some point.

CHAIR -I wondered if Carl wanted to add anything new?

Mr WINDSOR - Just to put some perspective into it. Looking at any industry; I am in the café/restaurant side of hospitality and that is what I have been doing for the last 25 years. Our restaurant is generally profitable with somewhere between 3.5 per cent and 7.0 per cent profit. A drop in turnover of 30 per cent is the golden mark for JobKeeper. Once you're making a 29 per cent loss in turnover, you are still making a loss; there is still this massive shortfall of money that we are not making.

Yes, we have these interest-free loans and things coming into us but they are not going to take us forward. There are guys who are just chipping away at whatever kitty they have built up or whether they are able to borrow or lease out their own homes or whatever it was. Hopefully, they've been able to get through until this summer which is not going to be until the

end of 2021. So they've got 12 months to try to chip away and deal with all of these costs to get these bills paid back because a restaurant doesn't sit there with a massive kitty in the back waiting to pay for its month's bills. We buy food on account. The money we make the next month pays for the last month's bills so we're always a month behind. If you think of a restaurant that's got $100 000 in food and grog bills outstanding and you shut off their income straight away, there's still $100 000 there that's got to be paid.

JobKeeper comes along and it's great but you've got to stump up the first four to five weeks of wages yourself before you can actually do it. We turned around and we still had Etties - one of our restaurants - operating as a company so we potentially could have put 25 staff back on JobKeeper but we didn't have $70 000 sitting there to stump up those initial wages.

All of a sudden you've got these guys who totally missed out on JobKeeper. I did my JobKeeper form declaration yesterday. It gives me a big list of all the staff who I could put on there. I couldn't put any of them on there because I just couldn't afford it.

Mr O'BYRNE - You have two venues - Etties in Elizabeth Street in the city and Willing Bros in North Hobart. Two very different markets. I understand you had to make the decision to close one. Could you talk us through why the difference of those two and the kind of impact you had to cope with?

Mr WINDSOR - Etties is a much larger venue. Etties had a floor space of 490 square metres - a big space. With that a bigger rent, bigger costs involved, a lot more staff. We employed about 25 staff at peak times. Over winter we were down to around 19 and we were coming in to our winter period anyway so a couple we weren't replacing as they were moving on to other jobs. We made the decision to close Etties because our lease was expiring on 30 September. We weren't confident about where the market was going forward to sign another six-year lease and put that noose around our neck for that period of time. Our landlords came and said to us, 'We'll give you a 12-month extension at the same rate'. Whilst appreciated, there was still a massive risk there. It was still a huge undertaking of rent. We just didn't think the market could actually give us enough money to be able to get through and pay that.

Etties is a venue which was relying on about a 60 per cent tourism market. The majority of the tourism market was out of Melbourne and Sydney; a little bit out of Brisbane and a small amount from overseas. That market goes - we don't know how that market's going to bounce back in the next 12 months so we made a decision to pull the pin on that. With that, 19 people have no job to come back to.

We now have Willing Bros up in North Hobart. It's a venue that is designed for locals. At the moment, with the current restrictions we can have 26 people in there. We can run that with a chef and front-of-house person so we can make it affordable. JobKeeper is still helping to stump that business up. Without JobKeeper we'd be really struggling to do that. Also our landlord was great. Before any rental codes came in, the landlord said, 'Don't worry about the rent until you get this sorted and we will deal with it at a later date'. The support directly from our landlord was amazing.

The State Government Grants were a really great offer but we had one blemish in our bookkeeping. One staff member had given us an incorrect superannuation number, so our super wasn't complete as at 1 January and we couldn't apply for the State Government Grants. So we couldn't apply for that money. We've since fixed up that one staff member. We're

working in the restaurant, cooking the food, doing our own books, and our own IR; we're doing all of this ourselves with the qualification of a chef. There was one small mistake, therefore, we're doing it a little bit tougher again.

CHAIR - I will ask you to keep your questions and answers as succinct as you can because we're going to run out of time unfortunately.

Mr O'BYRNE - I have a question for Steve about the energy stuff, but in terms of Carl's evidence, those decisions are very difficult. People are losing jobs and therefore that shrinks the size of that kind of service offering for the Tasmanian tourism industry, which has an ecosystem effect because of all your suppliers. Are the restrictions that have been and are currently in place - and you are unsure about what the future looks like - harder to deal with in a smaller venue or a bigger venue?

Mr WINDSOR - I think it's harder to deal with in a bigger venue, just because the cost is so much bigger and therefore the cost can blow out so much quicker. At least with a small venue we can mitigate those costs. We can do it ourselves if we have to. My business partner is front of house and I cook. When push comes to shove, we lay off the one staff member we now have and we do it ourselves just to get through. At the moment it's not coming to that. We hope it doesn't come to that but we have that as an option if we have to.

Mr O'BYRNE - Essentially with a larger venue your costs are X amount, but the restrictions mean your capacity to earn is significantly decreased. Is that right?

Mr WINDSOR - Yes, we're allowed to have 50 per cent of what we can have in there.

Mr O'BYRNE - But you're paying 100 percent of it.

Mr WINDSOR - And that rent now is 100 per cent due, so we have to pay all of it. All the other costs are 100 per cent at the moment. Our suppliers still need to get paid every week. We have actually turned around now and don't take anything on account, so that we know on Monday morning when we wake up the money in the bank is the money that is ours. We made a loss last week and made a loss the week before. The week before that we made a profit. That is looking at actual figures.

Mr O'BYRNE - It's week to week, isn't it?

Mr WINDSOR - It's very much week to week.

Mr OLD - Carl represents the restaurant industry on our board, just so you know.

Mr WINDSOR - Across restaurants this is what we do. There are obviously exceptions to the rule. There are some that are doing quite well out of this, but there are others which aren't. Once JobKeeper fully dries up and the system dries up, come March next year I think we're going to see a lot of venues fall off the perch.

Mr O'BYRNE - You mentioned the lack of access for a large proportion of your members getting access to that energy concession. That has been raised publicly. In another example, the Government changed their position on an energy concession for those in large tenanted buildings, but that wasn't afforded to the hospitality industry. Where there was an

initial program, they realised there was a cohort that didn't receive it so they changed it and made sure that some of those small businesses got access to it. Was that kind of opportunity forwarded to you?

Mr OLD - I know what you're talking about when they made changes, but we have had no feedback that it allowed more of our hospitality venues to get energy bill relief. The one thing we asked for regarding energy relief was to say that if you were through a contractor, ERM or whatever the services might be, they still should be able to get that level of assistance, because after you take out staff payments, energy is probably the biggest payment businesses make. We were talking about saying if you are going to provide relief to a hospitality business specifically, especially through COVID-19 to try to get them some money back in their pocket to pay their staff and pay their bills, energy is an obvious one, as payroll tax was.

The industry was appreciative of the payroll tax relief the Premier initiated at the start. Payroll tax is a massive payment that every business makes, especially hospitality, every day. That one was a massive tick winner, and we appreciated it. Energy was the other one that would have provided a lot of assistance to a lot of venues if they could have got it.

Mr O'BYRNE - But they didn't get access.

Mr OLD - From the feedback we got from not just members but non-members, a lot of them weren't eligible for it.

Mr TUCKER - Steve, you've talked a lot this morning about the grants and everything like that, the monetary values. I would like to come back to the human element of this and how the business owners and the staff are coping with their mental health and things like that, and what people are saying to you in regard to that.

Mr OLD - It's still really tough. A lot of them are still going through a lot of worries, and as I said before, from a hospitality perspective I don't think we've reached the worst of it.

A lot of things for the hospitality industry was probably culture - they parked the bills and just pushed them back. Banks have said they'll put that on hold for six months but that doesn't mean you're not going to pay it back in a bigger way.

The Government has been really supportive of the THA and the hospitality industry in relation to mental health. We have done a couple of things with mental health. We have just launched a new website recently and are doing some work with our department, which is State Growth, which looks after hospitality in the mental health space. It is something the THA on behalf of the hospitality industry has had a big focus on and the Government has been very supportive of that.

I know that our Australian Hotels Association nationally is really worried about the mental health welfare of hospitality people right around the country going forward and it's one issue we have to continue to be aware of and focused on. We are conscious of this, we're not mental health experts by any means, but we can promote as an industry that there is a website for assistance and all that sort of stuff.

A vast number of people just do not want to talk about it. They will hide the issue until let's hope they don't do something catastrophic, but there are a lot of proud business people in

the hospitality industry and every other industry who have been in the industry for a long time and they won't admit defeat. One of the things we are trying to do, and the Government has been very supportive and I have had a lot of conversations with the Labor Party as well, is how we keep trying to get those messages out there. I don't know if that is the answer but it is still a real worry for us. The state Government from our perspective could not have been more supportive to us and the Department of State Growth has been the same in relation to the support they have offered us to go out to the industry on.

It is one that we are going to have to keep a close watch on, however we can do that, because I have talked to restaurateurs, pub owners and accommodation venue owners who are very professional and run a very good business. Even then I worry about where they are at in relation to their mental health at times because it is very easy for me. I run an association where I am out there trying to help these people, but I can't imagine what it would be like if you ran a business for 35 years, you built it up and were ready to hand it onto your daughter or your son, and in six months a thing called COVID has come in and wiped that completely out. I can't imagine what that would be like for these operators. There are so many operators in the hospitality industry who have faced that and are still facing that. I have tried to think about how I'd put myself in their position and I just can't imagine what those people are going through and are still going through.

I don't think from a hospitality perspective we are by any means out of this yet and I worry about that. Carl knows a bit more about the mental health side of things than I do. He and I have had numerous conversations around mental health and it is one that we are really worried about for the industry over the next 12 to 18 months, two years, depending on whether we find a vaccine and how COVID goes as to the welfare of operators. Part of the reason Carl came onto our THA board three or four months ago, to be frank with you, was about training for the industry and the mental health of our industry. It's actually an area that Carl is better at. I hope I have answered that.

Mr STREET - Do you get many businesses coming to you asking for assistance with mental health, or is it more about your organisation educating your members about where the services are for them to go to? Do you have somebody on staff who deals with this, or do you direct them to an external body?

Mr OLD - If we have someone come directly to us we would know the services like Lifeline and stuff that the government put out earlier that they could go to. We got all that information from the government straight up. We have also set up our own website now which has all that sort of information on it such as Lifeline and who you contact, et cetera.

With the contractors we have running the Great Customer Experience Program, one of the things we got them to do through COVID was to basically be like a call centre. They rang every operator in the industry, member or not, and just kept touching base with them telling them about the latest grants that had been put out, giving them information and asking how their mental health was going and all that. Our contractors are people like Dave Noonan; I say Dave because a lot people in southern Tasmania know who he is. They are out there doing that work touching base with operators. They have been able to get in touch with every operator in the state probably four, five, six times throughout COVID. That is a credit not only to the Government for the support they gave us for the Great Customer Experience Program, but the contractors have been able to touch base with every operator to ask, 'How are you going, are you alright, is your family alright, is there anything we can do?'. The contractors know where

they can actually refer them to, if that makes sense? Having said all that, as I said to John, I've had conversations with the contractors as has my manger, Steven Long, who runs that program. You might think that David needs some help, but how do you then say to David, I think you need some help? It's not an easy issue to face.

Again, we're not experts. We're trying to get as much information through our circles with our website and all that sort of stuff, and be the best we can through our contractors and staff to offer whatever assistance we can. We're not saying we're doing it perfectly, but we're trying our hardest. In fairness to the Government on this one, I think the mental health programs they ran from day one, funding Lifeline, and so on, has been a great support for our industry. How many people have taken it up? I couldn't tell you to be honest; Lifeline could probably do it. From day one, I think they've been very supportive of our industry in relation to the mental health side.

CHAIR - Ruth had a question on the back of that too, John.

Mr TUCKER - I just wanted to get Carl's opinion on this as well before we move.

Mr WINDSOR - I've been across the mental health now for about 18 months, just due to personal experiences and so on. It's also driven me to the point now where there's so many shortcomings in the mental health sector in Tasmania. Steve gave me the opportunity to come on the board and I thought this is a great way in our industry to really push it. I think there is a high proportion of mental health issues in hospitality than in any other industry, especially in kitchens. If you look at the make-up of chefs in particular, they are someone who goes to work, they work in a high-pressure environment. It's hot, there's fire, there's sharp knives, lots of yelling. It's a high adrenalin job and they sit at this high adrenalin for 12, 14, 16 hours a day and then they go home. They start drinking because they want to keep the buzz going on. They take drugs because they want to keep the buzz going on. All these things are due to a mental instability. They're self-medicating. They don't realise what's going on.

Also, they're young. 'I'm just going for a beer to my mate's, I'm just doing this'. In all seriousness, it's okay and it's social because they're all below 30 years of age. All of a sudden they start hitting that age over 30 and they are getting a bit older, a bit slower. The body is not bouncing back as quickly. They're moving into a different stage of their life - meeting life partners, having children, having families. They're opening their own businesses. This is where the shortcoming of the self-medication for all those years is now coming out but it's not enough.

I was 120 kilos, drinking every night, partying as much as I could. Lost a wife over it. That wasn't enough for me to turn around and go, hey I've got a problem. It was about 18 months after that when I fell in an absolute heap, sitting there thinking it's time to just get off this earth and finish it all. I actually then chose to park that for a day, went to the gym the next day, and got some exercise. I got something happening. I saw my GP. The GP was amazing and got me focused in the right direction. They got me on a mental health plan and sent me off to see a psychologist - great. Three-months' wait to see a psychologist -

Ms FORREST - That was pre-COVID, you're talking?

Mr WINDSOR - This is pre-COVID. It's going to be even worse now. All of a sudden, it's great turning round for those of us like me. I've got a great psychologist who I see every

month. I'm okay. I can cut my extra 10 mental health plans and go and get stumped up. But there are all these guys who are new into this, flooding the market effectively right now. There's no one there who can actually help them. There's a massive shortfall there.

THA has a great website to give people direction but, unfortunately, after your GP there's nothing, unless you're already in the system. That's where we're going to see a big problem.

Ms FORREST - You've gone to some part of the area I wanted to go to. The minister might like to come in because he's the minister for mental health. One of the girls could get him in.

A lot of what you talked about, Carl, was the pre-COVID experience. We've all heard stories about chefs and how they can be quite volatile, and I understand the high-pressure condition. I wouldn't say that alcohol is actually medication, but anyway -

Mr OLD - It's coping by them at the time, is what he means.

Mr WINDSOR - You are self-medicating by getting drunk at the end of the day.

Ms FORREST - It's a coping mechanism to deal with it.

You talked about the lack of available services pre-COVID-19 in mental health. I know the Government has chipped in a significant amount of money, as was needed. It was needed without COVID-19 quite frankly. But they put in extra, I believe, to support the mental health response because it wasn't just people in your sector, it was people in health and education and just about every area. That uplift in funding for mental health obviously would have filled some of that void, but how much unmet demand do you believe there is from the experience in your sector?

Mr OLD - That would be hard to answer, to be honest. I'd totally be guessing if I said how many people are trying to go to a psychologist or get mental health support to the nth degree. I honestly would be guessing.

I'm probably hitting on the fact that I don't think we've hit the worst of the hospitality perspective. Answering your question, there have been issues pre-COVID-19 with services and assistance available. We are going to need to get that right coming into the next few months and year for hospitality. I talk about that specifically because, as I say, I don't think we've hit the worst of it for our industry yet. I don't know how many are taken up at the moment but I would hasten to say I think there will be a lot of people who will need some assistance into the future from a hospitality perspective. If the services weren't up to scratch - and I'm not the expert on that, but I'm probably referring more to before COVID-19 - then my worry is we need to fix it post-haste.

Ms FORREST - You can't pluck psychologists out of the air either. They've got to be trained and experienced, obviously.

Do you think the additional investment has made some inroads into this though, because the Government has put a fair bit more money into mental health?

Mr OLD - I think it has. The end result - and again this is from a very basic level of mine - is that it's highlighted the fact there is assistance out there. It's been allowing industries like ours to promote it out there. One of the first things to be able to do is to promote it out there to people and say it's actually okay to say you've got a problem.

Ms FORREST - You're not okay.

Mr OLD - Yes. I think things like Speak up! Stay ChatTY and all these things have done an unbelievable job over the years and government has been funding them. It's about how do we get to the part of the sector that needs it the most in hospitality. It's as Carl was saying, it's the chefs. The chefs work 12- to 14-hour shifts. How do we get to them to get the message there's help?

Ms FORREST - Just to try to cut time down a bit. The program you mentioned - was it government funded?

Mr OLD - Great Customer Experience Program, yes. It's not a mental health program; it's a program that gets out to all venues in the state. It's about -

Ms FORREST - It's an opportunity to outreach for those businesses and it's an opportunity to connect.

Mr OLD - Yes, they know to use it for that through COVID-19.

Ms FORREST - Is there capacity in that program to specifically target those most at risk like the chefs?

Mr OLD - Potentially, yes. The short answer is - yes.

Ms FORREST - Does that require additional funding, or can you do that within your current resources?

Mr OLD - The frank answer would be it would depend on what level of support we had to offer. If it's basically tooling up our contractors to do something, it could be easily done; but if it was saying that you need to employ two psychologists or whatever then we'd need additional funding, not being rude. We will do everything we can currently.

Ms FORREST - Have you thought about that as an option?

Mr OLD -To be honest, Ruth, no, we haven't. We haven't got into that in depth.

We started our website a couple of weeks ago. We are in conversation with the Government at the moment about adding some more assistance, through applying for some money through the recently-announced - I think it was on the weekend or the one before - about mental health support. However, you're talking about psychology - it's probably a completely other level if we went to that point of view. We're open to conversations, but we'd need to understand the cost and how we could offer the services so we're not wasting the Government's money - or taxpayers' money, sorry.

Ms FORREST - Or linking to another service that can provide it.

Mr OLD - Yes, or link to somewhere else like Lifeline Tasmania or whoever it might be - but we're very open -

Ms FORREST - I find to provide counselling at a point in time - you're talking about another service here, I think.

Mr OLD - Yes. We acknowledge the THA role in this, and that's why we have people like Carl involved. Moving forward mental health has been an industry issue. I think it is going to be a bigger industry issue, and we're probably starting to grapple with what our role is in that, Ruth. We haven't identified it fully yet but we are going to have to identify it, if that answers your question?

Mr O'BYRNE - Thanks for sharing your experience, Carl, that was pretty powerful, and it really does remind all of us that there's a hell of a responsibility that we've got to step up to help people get through this.

In the submission that you referred to, that you've given to government, do you touch on the mental health challenge facing our industry. It's sort of an extension of Ruth's question the kinds of programs and support, because there is no other industry that has been impacted as much by COVID than hospitality.

Mr OLD - We did.

CHAIR - Would you be able to table that document?

Mr OLD - Yes, I was just going to ask Ivan if he wanted me to do that.

CHAIR -Yes, if you could table that document, that would be good.

Ms FORREST - Is there anything you want to add that is not in that?

Mr OLD - Hopefully we've answered it. In that document there's only a very short statement. They're all just short statements about support services but all I say is we're taking little steps. We've got the website. We're about to look at another program and get a well-known industry person involved in how we engage through the industry, so we're going step by step.

The simple answer to your question, Ruth, is we're going to do everything we can as an industry to help those people out, whether they're chefs or whatever. We're still probably learning what role we can play, if that makes sense, but we're committed to making sure we do everything we can.

Ms FORREST - One last question on this. I know it's 'how long is a piece of string' in this - and we would all like to know how long that string is - but in terms of the recovery, how long do you think these sorts of more intensive services are going to be needed? Do you have any idea?

Mr OLD - For hospitality?

Ms FORREST - Yes. Any idea about the length of time that they might -

Mr OLD - I was saying before that hospitality is basically facing three winters in a row. We've had the winter, we've got summer now, which is going to be a winter because of trade, and then another winter and so on. Talking to a lot of our industry, they're not going to potentially see decent revenue come back in until probably September/October next year.

Ms FORREST - Okay.

Mr OLD - And then your question about the piece of string comes down to when can we stand up and drink, when can we get rid of one in two square metres, when can you dance in venues, et cetera. If someone can give me those answers then I could probably predict how long it's going to be to come out of this situation. But the longer stand-up drinking is not allowed, the longer one-in-two stands - and I appreciate that some states have one-in-four - that has massive impacts on our industry. While those things are around it's going to be a slow process out because our venues have 100 per cent of their bills coming in now but they're at less than 50 per cent of their earning capacity. It doesn't take an accountant to work out that that means it's tough.

CHAIR - Thank you for that. David virtually has a yes/no answer, as I understand it.

Mr O'BYRNE - Well, as best as you can, Steve. You've touched on a lot of those restrictions which relate to earning capacity but also keeping patrons safe. Obviously understanding the restrictions for you to apply is really important, so what engagement has the industry had directly with health officials to understand and dig in? Have you had direct negotiations or discussions with health officials about those restrictions?

CHAIR - Steve, could you answer that quickly? We may well have to ask you back because I had quite a few questions I wanted to ask of you.

Mr OLD - That's fine. We've had really good dialogue with the state Government and both the ministers for Hospitality and Health throughout COVID. We've had good dialogue with yourself and I've had reasonable dialogue with one or two people in Health, but I would say our dialogue with Health has been far less often and productive as it has been with the state Government. Having said that, the guy I have met with a couple of times in Health has been absolutely brilliant. I wish I could think of his name - he's one of the senior people, you will know him - but he has been absolutely brilliant in every conversation we've had.

One of things he's said to me in a couple of conversations I've had is, 'Steve, it's amazing that when we talk to the industry body that you're actually pretty much on the same journey as us. We might slightly disagree on how we get there but we agree on the end result.' I think he was pleasantly surprised that safety of patrons and all that is paramount to us, all of those sort of things. We're not trying to get to a different outcome. We might slightly veer off on a different journey but we're actually all trying to achieve the same thing. We would have liked to have had better conversations with Health and we would have preferred to have been engaged in conversations before an announcement is made and that's the first we hear about it.

CHAIR - Thanks, Steve, I appreciate very much the quick response.

Mr WINDSOR - Just on Ruth's question with regard to mental health, we need to normalise mental health.

Ms FORREST - Absolutely.

Mr WINDSOR - If we haven't normalised it, people aren't going to come forward and seek help.

Mr OLD - That's true.

Mr WINDSOR - We've normalised the common cold or the flu to the point that we go to the doctor and get help with that. We need mental health to be in that spot.

Ms FORREST - Destigmatising is what you need to do.

Mr WINDSOR - Yes, once we've normalised it, everything else will then be a lot easier to implement.

MR OLD - Going back to your question, with the work we're doing with the Government denormalising it is the start of the journey.

CHAIR - It's a good point and a strong point to finish on, Carl. Thank you for that. Thank you very much for the way you have answered our questions. I think we may well have to ask you to come back again, Steve.

Mr OLD - That's fine.

CHAIR - We will look at that as we move forward. I appreciate it very much. Thank you.

Mr OLD - Thank you. Cheers.

THE WITNESSES WITHDREW.

Hon. JEREMY ROCKLIFF, MP, MINISTER FOR EDUCATION AND TRAINING, WAS CALLED.

Mr TIM BULLARD, SECRETARY, AND **Mr KANE SALTER,** DIRECTOR OF BUDGET AND FINANCE, DEPARTMENT OF EDUCATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR -Thank you. This is a public session. It is being streamed live and will be transcribed by *Hansard* as well. You have all given evidence to these committees so I don't think I need to go into great detail, other than to simply say to you that parliamentary privilege applies in here. Once you leave here it does not apply. You are all conversant with the terms of reference for this inquiry. It is an interesting inquiry to say the least and we are trying to move forward as quickly as we can at this stage to get an interim report in later on this year.

Minister, we welcome you here. No submission has been made but we will give you the opportunity to make any statement you would like and then we will go to questions from that.

Mr ROCKLIFF - Thanks, Chair. To my right is Tim Bullard, the secretary of the Department of Education, and Kane Salter to my left, the Director of Budget and Finance. We have Jenny Burgess, the deputy secretary of the department, here as well should she be required to answer questions.

There is no doubt that the COVID-19 pandemic has had significant impact on our entire Tasmanian community, including our child and family centres, schools and libraries. At every stage of the pandemic the Department of Education has been strategically focused on the following priorities: supporting the safety and wellbeing of learners and staff; supporting the ongoing learning of our children and young people, as well as providing ongoing access to our library resources; and supporting our families and communities. This has required the department to be agile and responsive around the use of resources. We have seen frequent and regular communication and collaboration with parents and carers, principals, department leaders, Catholic and independent schools, other agencies and unions and maintain a clear focus on the department's values of courage, aspiration, growth and respect. It is utmost importance to me that all students are well supported to succeed and we keep people safe.

The purpose of this inquiry into the Tasmanian Government's response to the COVID pandemic is to examine the timeliness and the efficacy of the Government's economic response to COVID. By way of introduction I have prepared an infographic which provides an overview of the department's key initiatives and work that has supported our learners and their families, our staff and our communities during the height of the pandemic. In terms of the financials, it is relevant to note that they are generally premised on costs as of 30 June 2020. I can table that to be consumed as you wish.

Of particular note is the department's focus on maintaining the wellbeing of our learners and staff. Guided by Public Health advice, schools were able to undertake additional site cleaning and there was centrally arranged provision of supplies of hand sanitiser, liquid soap and PPE.

As at 30 June, the combined expenditure on these items for schools was $2 million dollars, with funding able to be recouped by the national partnership being managed by the Department of Health.

To support staff to not turn up at work when feeling unwell, the decision was made for relief arrangements to be simplified and made accessible, with all school relief costs for all unplanned relief to be met centrally. For the period April to June 2020 the cost of relief for covering personal leave, COVID-19 relief, maintaining casual hours and additional cleaning relief was approximately $6.8 million dollars more than the same period in the prior year - as you would appreciate.

The department also redeployed internal resources to work with the Department of Communities Tasmania, to establish vulnerable student panels to mitigate the impacts of COVID-19 on our most vulnerable learners, and ensure relevant supports were put in place.

As the COVID-19 numbers rose in Tasmania, a decision was made to support children and young people to learn at home; however, all sites remained open for those learners and families who were unable to do so. Reflecting our focus on equity of access, 6400 electronic devices were loaned to students who did not have access to technology. Internet dongles were made available to students without internet access.

The department redirected resources to support the development of learning-at-home materials and the delivery of professional learning to support online delivery of learning. Over 200 online professional learning opportunities were provided for staff in the last two weeks of term one. There is much to celebrate and be thankful for, about the flexibility and responsiveness of our staff.

As we move back to onsite learning, $227 000 was invested into Bounce Back to Learning in schools, supporting our early learners; and $283 250 has been invested in 2020 for the Back on Track initiative to support the reengagement of learners in the senior secondary years who have not commenced their learning at school.

In recognition of the economic impact that COVID-19 had on our families, all school levies were waived for 2020 at a cost of $14.4 million. In addition, $1.1 million for other student charges such as international and interstate trip deposits, camp fees and miscellaneous charges such as band fees, swimming and vocational clothing and equipment was also waived.

Supporting our partnership with the early childhood education and care sector, 81 rent agreements that the department has with services co located with school and CFC's were paused for six months. Combined with 35 rent agreements for other businesses, the total waived cost was $354 483. Subsequently rent waivers have been extended for a further three months. For both levies and rent relief, schools have been provided funding to offset the revenue reduction in order that they could maintain resource levels to support students. The government also allocated $16.5 million towards the maintenance of schools, libraries and child and family centres, which will provide ongoing benefits to our learners, while supporting business around the state in the recovery from COVID-19.

As you can see from the infographic, our libraries were able to quickly pivot and loan more than 250,000 online resources and develop and new click-and-collect service.

It is too early to know what - if any - impacts COVID-19 will have on student learning in the longer term. However, the early indicators around students perceptions are positive. In September 2020, the student wellbeing survey was undertaken by approximately 24 000

children and young people. The 2020 data indicates that the wellbeing and engagement of our learners is comparable to 2019 - despite COVID-19. Of note, 96 per cent of students reported they had a good relationship with teachers, and expectations for future success in years 10, 11 and 12 has increased.

The department is closely monitoring the impacts on staff and students as business returns to the 'new normal'.

In no way could this year be described as business as usual. I have been heartened by the commitment of our staff, members of the broader community, our families and our learners working together and facing the challenges presented with energy and optimism. I would like to thank them all very sincerely for their efforts, particularly our team across the Department of Education: all our team within our schools, our principals, relief teachers, cleaners, assistant teachers. Our teachers have done a fantastic job, and indeed, the collaboration between sectors has also been outstanding.

I will leave my opening statement there. I do have another infographic, which is the time line of key COVID-19 initiatives from the Department of Education starting from 16 March when the Department of Education COVID-19 Co-ordination Team was established, and of course between 17 and 19 March, Tasmania declared a public health emergency, a state of emergency, and introduced some of those first restrictions.

That time line goes right through the end of June, and then we go into Term 3, and ongoing support, et cetera. It covers the stakeholder engagement snapshot, professional learning to support learning at home. It has been a wonderful contribution from the Professional Learning Institute. It covers, basically, the time line, and that is indicative of the responsiveness and advocacy which aligns with your terms of reference. I will table that.

CHAIR - Thank you very much.

Ms FORREST - Thanks, minister. I have a couple of different areas I want to look at following up from that.

You spoke about the Student Wellbeing Survey in September 2020. I am interested in the outcomes of that, but also I want to know whether you did a staff wellbeing survey. The teaching staff, teacher aides, their cleaning staff, administrative staff are all impacted. Have you looked at their mental health and wellbeing?

More detail on outcomes of the students and then have you done any proactive assessment of the welfare of your staff?

Mr ROCKLIFF - Certainly. In February 2019 we launched the Principal Wellbeing Action Plan, which has been very timely, in terms of supporting our leaders during this time. Of course, the wellbeing of our staff has been paramount. Except, of course the vulnerability that a number of staff members felt during the pandemic, and their anxiety levels particularly working in a relief support there. Certainly, provided some support there. I will ask Tim to speak.

Ms FORREST - Just before Tim answers, minister. I want to acknowledge the fact that you actually personally rang some of the teachers in the north west. I know, I, and I am sure others did too, and that was really quite important for some of the teaching staff..

Mr ROCKLIFF - And of value to me as well to get a true understanding of exactly what it was like on the ground, particularly in the north west.

I can speak about the Wellbeing Survey. We released it just a few weeks ago. There are reasonably positive results in that as I have highlighted. There is a slight dip in wellbeing overall, but we do drill down on certain areas within that as well. That is publicly available on the Department of Education website. I would commend you to that particularly.

Other areas around wellbeing. We developed a wellbeing check-in app to support teachers to touch base with students while learning at home, and as they returned to school. That app is still being used by a number of schools to monitor and respond to the wellbeing needs of individual students.

Professional support staff continue to provide services to our most vulnerable students during COVID-19, including ongoing risk assessments, counselling, and the development and implementation of online support where appropriate.

The Department of Education is working closely with other agencies and non-government services to meet the emerging and immediate mental health needs of children and young people, and continuing to monitor the impacts of COVID-19 on student wellbeing to inform immediate and long-term responses to recovery. We have record numbers of professional support staff, including social workers and psychologists. The reintroduction of our school nurses has assisted there. Your previous, witness, Steve, spoke about Speak Up, Stay ChatTY, and $250 000 for two more years in 2021-2022 to deliver the Speak Up, Stay ChatTY schools' program to Tasmanian government schools.

We're rolling out now our trauma initiative, which is $7.25 million. It's part of the bilateral agreement funding over the next four years to support trauma-informed practice and therefore supporting our students impacted by trauma. Understandably some families during the pandemic would have been traumatised depending on their economic and social circumstances and so our schools were there to support that.

Before I throw to Tim, I was pleased to see the very good collaboration between the Department of Communities and the Department of Education, which worked closer together than perhaps ever before in supporting our more vulnerable students. When there was some discussion around whether school sites should be closed or not, this was a cohort of students that I was particularly mindful of around the need to keep those sites open to learning for those students that were unable to learn from home. The work between Communities and Education has been very heartening.

Mr BULLARD - Do you want me to talk to staff wellbeing?

Ms FORREST - Yes, staff wellbeing, if you wouldn't mind.

Mr BULLARD - Yes, absolutely. Thank you for that question. It is a very pertinent one.

To start off in regard to your question about a survey of staff. The Tasmanian State Service survey underway during COVID-19 was unfortunate timing. We certainly have that as a data set, although we recognise that due to the pressures of COVID-19 not as many people as we would've liked filled it in. There was still around 2000 responses.

We haven't surveyed staff around their wellbeing, but what we have done is have a cascading approach to how we've looked after the wellbeing of staff, which has started with senior leaders and principals across the department. As the minister referred to, we already had a principal action plan underway. Part of that is really responsive support for principals who maybe aren't tracking as well as they would hope in terms of mentoring and other supports that we can make available through the department. Certainly, we put those in place. Personally, between myself and Deputy Secretary Learning Trudie Pearce, we're available 24/7 for principals who needed support. We recognise that people have different set points about how they dealt with the pressures.

We also put in place similar supports for other departmental leaders. We commissioned an organisation called FBG, they're workplace psychologists. They worked closely with our senior staff in the agency around two things: around their own wellbeing, which obviously is really important to make sure that they can continue to operate, but also really importantly how they were going to look after the wellbeing of staff members more broadly.

Those strategies combined, I think, gave us a really strong basis for supporting staff. We are also very flexible in working arrangements. We recognise that for some staff, either because they were medically vulnerable, especially in the early days just psychologically unfit to attend work, that we made, wherever we could, working-from-home arrangements for those staff. If they were staff who couldn't work from home - as you can imagine in a large organisation, it's hard to mow the lawn from home if you are an education facility attendant. We just looked at leave that they could take and some meaningful duties such as training.

Mr ROCKLIFF - I have some information to support that, Tim. The Department of Education provided $2.1 million to directly support medically vulnerable staff.

To Tim's point, during terms 2 and 3, a total of 255 738 hours was worked at home by 1716 staff. Based on public health advice, employees identified as vulnerable people were initially directed not to attend the workplace and remain at home. The Department of Education supported these staff through working-from-home arrangements where possible. When working from home was not possible, we continued to pay staff their normal salary, with provision of up to 20 days COVID-19 special leave, access to the employee assistance provider and regular updated communication of the latest public health and departmental advice. During terms 2 and 3, $1.4 million was expended in salary costs excluding on-costs on COVID-19 special leave and $739 000 was expended on salary costs excluding on-costs to support staff where working from home was not possible and the employee continued to receive the normal salary.

Ms FORREST - To clarify, the support Tim spoke about was really the support for senior staff like the principals and that sort of thing. Was it then the principal's responsibility in each school to check on the wellbeing of all their staff? I had calls from those below principal level often. Sometimes I had calls from principals but it was often the staff who were in that vulnerable category or fearful generally. There was a lot of fear in our community at the time.

You remember it well, I am sure. Can you explain to me the responsibility role there for the staff further down the chain?

Mr ROCKLIFF - Certainly. I know our secretary met with principals on a very regular basis through the Webex platform. Principals naturally wanted direction and consistency across the department in terms of the advice but they also showed great leadership in supporting their staff as well and were encouraged to do so.

Mr BULLARD - We ran it two ways. Business unit managers and leaders across the system are responsible for their staff. That is their duty of care and certainly we supported principals to support staff but we also recognised that for a number of reasons that might not go according to plan, so we set up and HR helpline for any staff member to call in. We encouraged all staff to go to their principal or business unit manager or child and family centre leader or library manager in the first instance, but if it was not working for them then HR was set up as a central point of referral.

It is also important to note that during the period of COVID-19 just because of the way the tender came up we changed employee assistance program provider away from Converge and we found that the services they were providing in terms of phone counselling support and going to sites that weren't maybe running as well as we hoped was very responsive.

Ms FORREST - You talked about vulnerable students earlier and mentioned the resourcing that was put into supporting them. Do you have any numbers on the number of vulnerable students who perhaps haven't returned full-time to school and what you are doing around that? We know this was the cohort of students you were particularly concerned about. We all were, but I am interested in any statistics around those students who remained at school, those who were educated at home and how many came back.

Mr ROCKLIFF - Yes, we can provide those figures.

Mr BULLARD - Whilst the minister is waiting on the figures, in terms of our response we have said where students are unable to return to site because they are vulnerable we will continue to support them to learn at home and that's what schools have done. We recognised that we swung from predominantly on-site learning to predominantly learning at home, but in the transition back we've recognised that there are some students that still can't return.

Ms FORREST - Which increases your teacher's workload.

Mr BULLARD - It does, absolutely.

Ms FORREST - So the pressure remains on your teaching staff.

Mr BULLARD - But the number of students is not enormous.

Mr ROCKLIFF - Attendance of students, days of learning at home - 19 days primary schools and senior secondary schools and 29 days secondary schools. I have a table of attendance rates here and if I go to the average from 28 April 2020 to 22 May 2020, the total attendance including learning at home and learning at school was 96.1 per cent. Learning at home was 71.9 per cent and learning at school - school sites remained open for those who were unable to learn from home - was 24.2 per cent on average.

If we go to term two, week 1, week 2, week 3, week 4, attendance at school sites during learning at home, the average on site attendance was approximately 25 per cent, so total learning participation was 96 per cent. As to the number of students who have not yet returned to school during COVID-19, I am advised 70 students reported learning at home as at term 4, week 1. Only students who are medically vulnerable to COVID are being supported and recorded as learning at home and this has been the case since the beginning of term 3.

Ms FORREST - These are medically vulnerable students. Have there been students who are from some of the more disadvantaged backgrounds who went home for home education and haven't returned? That is the question.

Mr BULLARD - I think in terms of our attendance rate what we can see is that we have returned mostly to normal across the system.

Ms FORREST - Pre-COVID?

Mr BULLARD - Actually, compared to the same time last year, which is probably a better measure. From memory there is probably a 2 per cent reduction in attendance across the board.

Ms FORREST - Are you able to provide to the committee later a comparison of those attendance rates for different periods during the year last year compared with this year?

Mr ROCKLIFF - We can.

Mr DEAN - What is the dropout rate over each period, those not participating in education at all at this present time?

Ms FORREST - That is what I am asking.

Mr BULLARD - Because of the way we have structured the new act so that you are staying until you are 18, it would be showing as 'not engaged in learning'. That figure would be underlying.

Mr WILLIE - The unauthorised absentee rate has increased since the lockdowns. If we can go back to the student wellbeing survey, it is a really good step to measure wellbeing of our students and I commend you on that. I am interested in the outputs from that. You talked about an app and about record numbers of professional support staff. What that means in reality, though, is that there are about 70 school psychologists and 79 social workers for around 60 000-odd students across the system.

In your own Wellbeing Action Plan, I think it is action 4 from memory, you are committed to improving access to professional support staff. You and I have visited a lot of schools. You don't have to have many conversations to know that there are a lot of students and parents frustrated because of the access delays to professional support staff, so I am interested in your thoughts around that and whether there is going to be some sort of commitment to bolster those numbers so that our students can get the help they deserve. Given that the student wellbeing survey showed that there are certain cohorts that are really struggling

with their emotional wellbeing at the moment, whether that be girls or some of the older cohorts of our students, they deserve that support.

Mr ROCKLIFF - Thanks, Josh. All those points are very valid and the last part of your question was around that particular part of the survey where we drilled down on some of those figures, particularly when it comes to our female students in years 8, 9 and 10 where there was a noticeable drop-off in the wellbeing of our students. If you look at the primary school years, and this survey is from years 4 to 12, there is a decline. It starts in years 8, 9 and 10 and then increases in the secondary years of 11 and 12.

For both male and female, as I recall it, there is a drop-off but it is particularly more dramatic with our female students throughout those years and that is why we do the survey so we can learn and provide those supports. The data is there for everyone to look at, debate, discuss and come up with alternative policy suggestions to support our students. I am not interested in doing surveys for the sake of it. The reasons we do this and that is why we drill down to a micro level and release that publicly so that people can absorb that and have those discussions. So we're absolutely committed to looking at that. In terms of our wellbeing team with the Department of Education they'll be meeting with groups of students over the next few weeks to put faces on the data, if I can put it that way, and understand their view - the stories of those students - to help us further tailor those supports. What was being released publicly is the statewide snapshot but of course each individual school gets the drilled-down data from the Student Wellbeing Survey so the schools are able to respond more locally, if you like, in terms of supporting student cohorts with particular needs but there's an overarching message for us as a department of Education team as well.

The Trauma Resource will be of a lot of assistance. I am pleased we have the resource when it comes to school nurses who have been implemented since and around 2015. So that's good and access to more psychologists will also be good. Some of that is a workforce challenge in that sense, as you'd appreciate.

Mr WILLIE - It's good there's an acknowledgement from you, minister, but I'm interested in some real change in this area, as you know. I don't think the ratios are sufficient to support our students. I'm interested in a commitment from you to improve that for our students.

Mr ROCKLIFF - I am committed to that. I have seen your suggestions around that. Mental health nurses in every school is regularly raised and that's your suggestion, but we have done a lot in this area including establishing the Child and Student Wellbeing Unit within the Department of Education and listening to the student voice and responding to that as well. We are committed, absolutely.

Mr BULLARD - Just adding to the minister's points. We absolutely need to be looking at where resources are going and how they're been allocated. If you look at the student support teams at the moment, we didn't have the Child and Student Wellbeing Survey when they were established. They are certainly doing a fantastic job but in an old paradigm. So one of the things that we are exploring is the current way that the structure of that team works fit for purpose? Is it actually supporting the objectives that come out in child and student wellbeing? We've got the ARACY domains. Now we know how we define child and student wellbeing so we actually need to be looking at making sure that that's the way the resource is allocated.

Another observation is that we are maturing in the way that we think about wellbeing. If you went back 10 years you would have wellbeing being looked after in schools but a slight view that really that was happening outside the walls of schools and now schools absolutely see this front and centre to learning.

What that means though is that we need to be much more deliberate in looking at the responsibilities and accountabilities of everyone in our system to look after child and student wellbeing. There are elements that are universal and schools should be managing but there are elements that are really pointy as you know and complex and should not be the responsibility or remit of schools. So with other agencies we need to be really clear about what we take on but also then how we access other services outside the school gate.

Mr WILLIE - Minister, you've talked a little bit about bounce back. Could you tell me where those nine educators have been deployed who were part of that? There was $180 000 for a Talk and Read Project.

Mr ROCKLIFF - Yes, in terms of exactly the areas in schools?

Mr WILLIE - Yes, how they're supporting schools and the early years Bounce Back to Learning at School, as you have said.

Mr ROCKLIFF - The Bounce Back to Learning at School Program was developed back in June 2020. I mentioned we would be having a program in a question that I was asked in the parliament of a similar nature in terms of making sure that, particularly in our early years, which are so important in education, that there wasn't a noticeable gap in that engagement with our young people. That initiative was implemented to support our youngest learner, K to 2, who missed opportunities for face-to-face learning to build on the momentum of family engagement and also support educators and schools.

The Bounce Back package included additional classroom support provided by early learning educators who worked in partnership with teachers to identify learner needs and provide resources and tailored learning opportunities. These measures recognise the significant impact that a good start in early years has on our educational outcomes. Identifying whether support would be best placed was determined based on various data sets including literacy and numeracy levels in kindergarten students and information from the school improvement team.

In terms of disengagement, a back on track pilot program is now underway, aiming to reconnect young people who are not currently enrolled with the approved educational training provider and address their values to learning, assisting them to re-engage education or training and that pertains -

Ms FORREST - 'Not currently enrolled'. Does that mean they were not enrolled at the beginning of the year before COVID-19 actually hit?

Mr ROCKLIFF - Young people with an approved education training provider, yes.

Mr WILLIE - They might just be non-attending.

Ms FORREST - Yes.

Mr WILLIE - Again, minister, a good first step but it's not enough, is it? You're talking about Bounce Back; I think from the annual report there are about 4500 students just in kindergarten alone, let alone the other grades. You're talking about nine educators and $180 000 after a significant period of lockdown.

CHAIR - Make sure we keep on track with our terms of reference.

Mr WILLIE - We're talking about the response to the COVID-19 shutdown, Chair.

Mr ROCKLIFF - I understand where you're coming from, Josh, but we haven't taken any resources away from our schools. As the student survey points out, our students have been remarkably resilient in the face of this pandemic, which is heartening and a testament to the parents and carer support that they are provided at home but also in the community, but most particularly the schools as well.

We have a ministerial advisory council which we've set up as well to this very point, Josh. I'm going to talk about that because it is absolutely what you're referring to. In order to continue the cross-sector collaboration - and I commend the head of Catholic Education and independent schools. Every three or four days, sometimes a lot more, I met on Microsoft teams with Tim, and also the head of the Catholic education system and, of course, independent schools and our educational registrar as well so we could all get a consistent response.

As you would appreciate, some of the messages that I was sending from our public schools might have confused some of the other . So we try to get that messaging as consistent as possible around school sites and learning from home as much as possible. We established the ministerial advisory council on 1 July. Throughout COVID-19 all education sectors worked well together with the Government to ensure that no Tasmanian students are further disadvantaged as a result of the impact of the pandemic and that student wellbeing is placed at the centre of any decision-making.

This proved to be a successful working model that was formalised through the establishment of a ministerial advisory committee with representatives from each sector. Sector heads met with me throughout COVID-19 and the Ministerial Advisory Council held its first meeting on 29 July 2020 and will continue to meet weekly until March 2021 but can be extended, of course, at my discretion or the minister's discretion.

Membership of the committee is voluntary and members are not remunerated. The key focus areas of the committee will be early years learning, 11 and 12 student wellbeing, and approaches to a second wave, should that eventuate. The committee will address the concerns around disruption and impact from kindergarten to year 2, and our most senior students in years 11 and 12; the processes put in place to support learning across the use of schooling; innovative practices which have been developed across all sectors and year groups during the response to the COVID-19 pandemic, including how to adapt, share and embed these practices for the benefit of all students; the approaches undertaken by TASC to adjust courses and external assessment processes for years 11 and 12 students; and any other matters impacting the education sector as a result of the response to the COVID-19 pandemic and provide it with regular reports and recommendations on the work of the committee. I have appointed deputy secretary of strategy and performance in the Department of Education, Ms Jenny Burgess, who I referred to earlier, as the chair of that committee, and the appointed members are appointed for their expertise and understanding of education in each sector.

To date, the committee is receiving Early Years data to consider probable impacts on learning; providing feedback to TASC on its 2020 workplan, including a stakeholder engagement communication strategy and the risk register; having input into discussions with TASC around vocational education and training and the current complexities in this space; and considering advice from sector representatives on the impact of learning from home on students with disability, which I can speak about as well.

What was interesting, just to finish off, and I'm interested in continuing, is that for some of our students, their learning at home environment and engagement with education was actually more than in school because some students feel more comfortable learning at home, and probably felt more one-on-one support with a connection with the teachers, and some are less anxious at home in their own comfort rather than in the school population. I am interested in seeing how we can be innovative and adaptable in providing learning for all students, irrespective of the way they engage in learning.

Mr WILLIE - Again, minister, good stuff, but it's not really an emergency response for our students, is it? Clearly some of them are struggling. On a question on notice in the Legislative Council around absenteeism, you said in the first term the absentee rate across the system was 5.9 per cent. It's now 9.4 per cent across the system and there are schools really struggling, such as Claremont in the northern suburbs which has a 26.4 per cent absentee rate. Bay View College has 13.6 per cent, Campania District School has 14 per cent and Don College has 14.6 per cent. These are kids who are not attending. It's quite scary when you look at it. Huonville High School, 14.1 per cent; Jordan River Learning Federation, 15.3 per cent; Port Dalrymple School, 15.5 per cent; and the E school, 28.1 per cent. There's a number of schools that are really struggling post the lockdown.

CHAIR - Josh, we're getting those numbers in document form shortly. You can ask a quick question because I need to go to John and Nick in the time we have left.

Mr WILLIE - I'm interested in the resource to actually go through the school gate to support our students. It's great that we're having a look at this sort of thing. Often I've suggested that.

Mr ROCKLIFF - Thanks for your suggestion, Josh.

CHAIR - If you could give a fairly quick answer I'd appreciate it, minister, so we can go to other questions.

Mr ROCKLIFF - As to the data you're referring to, if I had set up the ministerial advisory council in a month's time and found that data, I could see why you'd be questioning that, but we actually established the ministerial advisory council back in July to ensure we were on top of these issues. You've highlighted some figures and yes, they are concerning to me as Minister for Education and Training. Why wouldn't they be? We're very focused on being proactive in this area. I've mentioned the Back on Track year 11 engagement pilot which is an example of that.

Chair, I take your advice in terms of not being too long in this explanation - verbose, I'll use that word - but the pilot is currently funded at a cost of $283 250 for six months commencing in September and is focused on reconnecting with students and addressing their

barriers to learning and engagement, particularly as we look at the recovery phrase of the pandemic.

I am happy to provide more information on that but this is why we have data and why as a government we've been very transparent in our data through our annual report and budget Estimates. There is more data on Education than ever before, including the wellbeing survey, so we can learn and understand what's happening and respond.

Mr TUCKER - Minister, I'd like to talk about right at the start and the decision-making around the schools and how the dates were set for closing them and why that occurred. I know hindsight is a wonderful thing but is there anything that you would have done differently now with what you know?

Mr ROCKLIFF - At the height of the in the community around the pandemic there was a lot of discussion about whether should school sites should be closed and there were varying opinions on that. I believe we've managed it the best way we possibly could, with all the advice and work with our secretary and the engagement with Public Health. We ensured that every communication we presented to our teachers, our parents and carers - and the secretary and I wrote a number of letters directly to staff parents and carers and families - contained as up-to-date information as possible, always taking Public Health advice in that sense.

I believe we generally got the balance right. I was most concerned about the impact of closing schools completely on our more vulnerable student cohort for obvious reasons and we kept sites open for those students who were unable to learn at home, which included students whose parents or carers were involved in the frontline of the pandemic response in health and the like. I believe we had a really good strong working relationship with Public Health and I could ask Tim to cover that very briefly. In providing that support for our learners during the pandemic, we took a variety of activities to prepare and support the provision of learning at home, providing a variety of supports to students and their families including a learning at home website. A number of resources were translated into different languages for families in our communities. We focused on clear communication between schools and homes and tailored learning opportunities for students depending on their ages, learning needs and curriculum content.

That infographic highlights the number of devices and dongles and all those sorts of things that we made available and we provided a wide range of professional learning opportunities for our educators. In one of the boxes there on the time line I presented - I think it might be the yellow one - we highlighted the professional learning institute and the professional development and all the courses that were available to our educators. I think there were 200 initially and there are now 260 following that if I have those figures right, which was all about keeping our educators up to date on that.

I commend the Department of Education team for the work they did, particularly around consulting and listening to the principals' and the staff's voices, because there was a lot of anxiety on the ground in schools. The COVID-19 pandemic and the transmission was unknown. There were no guidelines or rule book for this but what was a consistent theme was particularly the engagement from our secretary and deputy secretary heads directly with the principals on a very regular basis to ensure they were as informed as possible and getting that information as soon as possible once decisions were made in terms of decisions that I had to

make and of course the broader government and the Premier. Tim, would you like to talk about that.

Mr BULLARD - Would we have done it differently? Hindsight is great, but I cannot see that we would have. We were very fast to establish the COVID-19 coordination team; we redeployed people across the agency and filled half a floor with people working just on this. We did not have information; we had public health information, but we did not have general information when we started. Other states and territories were communicating with me regularly, and other secretaries around what they knew and could see.

As the minister said, our best advice came from principals about the reality on the ground, and meeting with them three times a week on teams, with chat boards running and questions being asked and answered was fantastic. I also have to thank the collaborative way the AEU assisted us. They put their organisers out into schools and were very quick to bring back information about things that were not going right. At any point in time across the continuum, we were making decisions based on the best evidence that we had available at that time - but we also needed to recognise that it changed incredibly rapidly. So, we had to build a culture where people were very happy to hear from me that something was going to happen on Tuesday but on Thursday we had undone it, and people were very responsive to that as well.

Mr ROCKLIFF - I mentioned unions in my opening statement, but the Australian Education Union was outstanding. The communication we had with Adam Clifford and Helen Richardson on a very consistent basis was excellent, and we listened to them about extra professional development days at the end of term one, if I recall. Then, at the beginning of term two there was a request from the AEU because they had good sight of their members and their member's needs, and we listened and responded to that. We had a very collaborative and good working relationship through that time - as you would expect - but I really want to thank them very much for their work with us.

Mr TUCKER - Minister, the year 11 and 12 cohort - it is a very important time in their education. Can you expand a little bit more about what support was given to year 11 and 12 students?

Mr ROCKLIFF - We have a number of areas here, and I will be as brief as possible of course which is hard actually, because there is a lot to talk about in this area.

CHAIR - Minister, it is going to be clear that we may well have to ask you back because there are a lot of questions coming, so I think you need to spend the time on this answer if you can.

Mr ROCKLIFF - We surveyed our year 11 and 12 students as well - some 1800 students, from memory - to get an indication in their voice as to what the year was like for them and how they would like, as best as possible, the lead up to their exam times to be. It is an anxious time anyway for years 11 and 12 students. I thank the University of Tasmania for their schools recommendation program, and the work done there. There were around 1700 students who received that school recommendation program in terms of the university; 1600 received an offer through the school recommendation program, which reduced a lot of the anxiety too, within that student cohort. So far this year UTAS has received 2150 applications from Tasmanian year 12 students - which is 43 per cent of all year 12 students - and that represents a 13 per cent increase on the total number of applications received last year. The number is

still climbing, but more than 1600 students have received offers from UTAS with applications still open until the end of November 2020, in terms of the school recommendation program. Development and implementation of this initiative was managed with existing resources, as outlined in your brief pack, as part of the department's recovery plan as well.

Noting that the 11 and 12 space, John, is an anxious time anyway for our students, but the uncertainty around the pandemic naturally would have heightened cause for concern. However, the engagement with TASC; the Ministerial Advisory Council; the student survey - listening to their voice; the work with the University of Tasmania - we have done all we can to support our students in what has been an extraordinary year.

CHAIR - I have a question on that point as well. Are we satisfied that the achievement levels of these years moving forward and into university and into college, that they have met the achievement levels that are required this year to move forward because of the tough times? What is the judgment there? Have students reached the levels they should have reached had it not been for COVID-19?

Mr ROCKLIFF - We will get a better appreciation once the exams have taken place and we have the results from those exams. I am confident that all has been done to support our students.

Mr O'BYRNE - Was there any consideration with the moderation of those results, in terms of how you respond to the particular year we have had?

Mr ROCKLIFF - I will ask Jenny Burgess to the table, because we do have an answer for that.

Mr BULLARD - Could I just finish off on that point before we move on to the next one. Interestingly - and we need to understand this - but expectations for success for our students in years 10 to 12 have increased from last year. So, more students in years 10 to 12 believe that they can succeed, than did in 2019. I am not saying why. We are curious about that. You would have actually thought it would have gone back the other way.

Mr WILLIE - Do you that some of them might have secured a place at university?

Mr BULLARD - That could well be the case and what a great thing for them.

Ms. JENNY BURGESS, DEPUTY SECRETARY STRATEGY AND PERFORMANCE, DEPARTMENT OF EDUCATON WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms BURGESS - A number of measures have been taken over the last few months to ensure that we are responsive more broadly to the needs of students in years 11 and 12. That work commenced with TASC reviewing and giving consideration to all of the TASC courses for years 11 and 12, to make sure that any adjustments to those courses that didn't impact on the overall learning outcomes could be made so that where, for example, practical requirements suggested a number of hours and that opportunity had diminished through students not being on site, that was adjusted within the course documentation.

An additional adjustment was that, for those courses that are externally assessed, a working group led by TASC and working with setting examiners and teachers of the subject then adjusted the external assessment specifications. That is about reducing the pressure from an external examination point of view on students. Quite a number of those courses were adjusted, some of those adjustments being less volume of information having to be prepared for the written examinations. In addition, out of the PESRAC Report you will have noticed that for students who undertake vocational education and training there may have been diminished opportunities for them to fulfil the practical requirements of that course. So, out of that we have developed six short qualifications based on the general capabilities that students can undertake as part of their program of work prior to the end of the year, to ensure they get recognised for their learning.

In addition, as part of the attainment levels for the Tasmanian Certificate of Education, they will require standards to be met against literacy, numeracy and ICT. Often those requirements are met through courses. When that is not the case. Students are able to take a short examination to demonstrate their skills in that area. Previously there were some strict restraints around how frequently those students could take those. I think it was three months. In consultation with stakeholders, TASC has waived that requirement and as soon as the results are through for the students they can then resit those tests again. Those measures have been taken to ensure that there is as minimal impact as possible on that.

CHAIR - So there will be no readjustments made, no lowering of the standards, or levels required of these students to move forward?

Ms BURGESS - That's correct, but in addition to that there is also the recognition that for students who have been impacted by COVID-19 there are mechanisms that are usually available through the TASC processes to allow adjustments to occur based on medical advice or advice from schools. Those parameters are also there. We don't want to reduce standards, but we will make -

Ms FORREST - Those programs were pre COVID-19, they were already there. They are being applied in this circumstance.

Ms BURGESS - That's right, and we anticipate the numbers of students who will request those special considerations will increase through this year. We are also very prepared, should there be another COVID-19 outbreak, with our risk mitigation strategies in place.

Mr STREET - In terms of service delivery and programs for students and support for staff, are there things that were put in place in the last six or seven months that you think will be retained that maybe weren't in place before COVID-19 hit?

Mr ROCKLIFF - Yes, there will be. I have the page open to the implementation of PESRAC recommendation 51, support for vulnerable student panels, as an example, which I mentioned in my opening statement. I have referred to it as well in terms of that collaboration between the Department of Communities and Department of Education.

An example of that would be that the department has already undertaken significant work to develop a new case management system which will be the vehicle to deliver on recommendation 51 and support the work of vulnerable student panels, which I think was a question of Ruth's as well.

The department is engaging with other relevant agencies across government to investigate the option of leveraging the new case management platform to modernise current data-sharing practices while increasing security of information being shared. This collaboration hasn't been seen before and COVID-19 really brought to the fore the need for that sharing of data between two agencies. It is intended that the case management platform will deliver functionality for recommendation 51 of PESRAC in two phases.

Phase 1 will deliver a cross-agency view of learners facing vulnerability, where appropriate officers will be able to update limited pertinent information in real time, and it is intended this functionality will be delivered by term 1 of 2021. Building upon this capability, phase 2 will see additional functionality become available to add cases and notes to individual students. It is intended that this functionality be delivered during the middle of 2021. That work started because of our concerns around vulnerable students, and will continue as we move forward and be strengthened in that sense.

I suppose we also need to look at the digital space. I was quite exercised at the time about what might be a digital divide around our online learning environment but also in digital literacy as well. I think we need to work on that more broadly, not just within perhaps education, and on the work we have done in terms of ensuring that we have a range of online and offline learning materials so all students could continue learning through the COVID-19 pandemic. We need to be mindful of carrying that forward as well. As I mentioned, 6400 devices were loaned to students and 650 internet dongles for students without access and we need to be mindful of that. We also purchased a number of computers as well.

Mr BULLARD - We did, which weren't required, but we purchased an additional 2000 devices which will now be deployed to schools in terms of the normal turnover, but as a contingency we thought it was better to have them not have them. It appears that iPads are in very short supply - 3000, that's right.

CHAIR - Anything else to add, minister?

Mr BULLARD - If I may build on that, the devices are one thing but the ability to deliver the courses online is another. We were really fortunate to have the five professional learning days and you can see from the stats the minister has quoted that 462 online courses have already been delivered to 3400. Teachers never would have had that opportunity in the past to get people up to speed with using technology, but the other thing now that we know is that when we design courses through Curriculum Services they need to have dual delivery mechanisms, especially years 9 to 12. Moving forward curriculum writers will all be required to articulate how you deliver the course online, how you deliver the course physically and how you might have a mixed blend in the middle. Rather than trying to work out how I am going to deliver these components, that's the way that we'll design courses. You will see us moving more toward that learning anytime, anywhere mechanism because one of the great things we've learnt is that freeing up the ability for students to be learning in different ways at different times is really important.

Ms FORREST - This question is to take on notice. You've touched on a lot of the areas that I think there are great learnings from that we should take forward post COVID-19 whenever we get to that bit, so I am just wondering if you could provide a list of things as learnings during this period that have been useful around the increase in confidence in the

future of things for years 11 and 12. There has been a number of other areas you've covered. I just wondered if you could just have a really good look at that and provide to us some of those learnings that you've had that need to be considered and adapted for the future. It's not all bad. It was pretty bad for a while.

Mr ROCKLIFF - We absolutely will provide that and of course we've learnt a lot. One of those areas is that collaboration between sectors of education as well, which has increased. When we are doing our regulatory review which is a process we are undertaking now, that relationship we've developed over the course of the last six or seven months throughout the pandemic between different sectors of education is continuing.

Ms FORREST - We can't afford to lose the good things.

Mr WILLIE - Chair, could I put a question on notice too? Could the minister and the department provide a response around how the educational adjustments were catered for during the school lockdown?

Mr ROCKLIFF - In terms of students with disability?

Mr WILLIE - Yes, in terms of how their needs were catered for at home with remote learning.

Mr ROCKLIFF - I have that covered here but I will do that.

CHAIR - We don't have time for the answer to be given, so if you can take it on notice and we will put those questions to you in writing so we are clear. We may well have to recall you, minister, moving forward.

Mr ROCKLIFF - I wanted to clarify that I'll provide information to Josh regarding his question. The absentee rate I referred to applies to time absent, not students absent - just to clarify that.

CHAIR - Will the levies that I think you've held off on be required to be repaid by the parents, or are they simply only on hold?

Mr ROCKLIFF - We waived all the levies for this year, some $14.4 million. We waived all the debt owed in previous years for parents which was around $2.5 million to $3 million.

Ms FORREST - It was $2.8 million.

Mr ROCKLIFF - So $2.8 million as well, and in the midst of that we've broadened our levies adjustment to include people with a health care card in terms of access the Student Assistance Scheme (STAS) and that has enabled some 9000 additional students to be able to available to STAS moving forward.

Mr BULLARD - The Student Assistance Scheme - we calculated a model in the background where we'd work out whether or not families had to pay levies and now we've just moved that to a Health Care Card which has increased the scope.

CHAIR - Thanks, Tim; thanks, minister; thanks, Kane for being here. Thank you for the questions that have been answered. I am thankful for you agreeing to stay on for the extra quarter of an hour. I think we will have to recall you eventually, minister, because there are a lot of issues here and the recovery process is a very important part of our terms of reference. So thank you.

THE WITNESSES WITHDREW.

HON MICHAEL FERGUSON, MP, MINISTER FOR SCIENCE AND TECHNOLOGY WAS CALLED.

Mr BRETT STEWART, ACTING GENERAL MANAGER BUSINESS AND TRADE AND, **Dr GLENN LEWIS**, CHIEF INFORMATON OFFICER WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Dean) - I will just very quickly to go through it. Most of you have given evidence here before in these committees. It is online and streamed online. It is being recorded as well by *Hansard* and there will be a transcript provided eventually. Parliamentary privilege applies whilst you are in here but, once you leave here, you're on your own - or possibly on your own so you just need to be aware of that.

As I said, you are familiar with these systems, familiar with the committee process, so that is really all I need. The terms of references are clear; you would have seen our terms of reference. What we need to do now is just progress.

Minister, as no submission has been made, I give you the opportunity to make a statement and we will go straight into questions. The minister has indicated he has to be gone by 12, so thank you, minister.

Mr FERGUSON - Thanks, Chair, and members of the committee for the time this morning. It's great to be here with you and I look forward to your questions, particularly around issues around the Government's response from an ICT perspective to the pandemic. I will make my opening remarks quite brief.

We've done a lot of work in the last six years building up our ICT capability from a cyber-resilience point of view as well as ensuring that we have service providers who are able to deliver on our architecture and our needs.

We've built that architecture and I am very pleased to be able to say that in the leadup to the pandemic when the Government needed to rapidly scale up, particularly from a point of view of resourcing the public service to be able to work from home, we had that architecture in place and were able to use those panels variously to scale up and to quickly adapt to those very different circumstances and working conditions. We've released our strategy for digital industry and service transformation.

That is, of course, Our Digital Future, which was released this year, and which I've provided to the committee. That is the first strategy of its kind for our state. It has been drafted in consultation with all of the government agencies and working in partnership with the ITC sector, Tas ITC the Australian computer society. We are very proud of the road map that our digital future sets out and in future as we continue to make investments in this space from a Tasmanian government point of view I will be very clear that my priorities continue to be around cyber security and digital transformation. They are the key areas where I feel like Tasmania still has a lot of catching up to do and I am happy to discuss that with the committee today.

I am happy to take questions with my departmental staff today.

CHAIR - Minister, no doubt you would have seen the report that came in from the Auditor-General last week in which there was quite a lot of criticism really of the position of the state in relation to its information technology moving forward. Did you have any comments that you wanted to make in relation to issues raised there by the Auditor-General?

Mr FERGUSON - Yes, I and Dr Lewis are happy to respond to that. My own response to that is documented inside the report itself so I have provided the Auditor-General with a government response as has Jenny Gale. Instead of providing multiple responses from each of the departmental secretaries, Jenny Gale is chair of the Digital Services Board has provided a response unanimously on behalf of secretaries.

I welcome the report from the point of view that it is a contribution to thinking. We continue to learn from the COVID-19 experience. We are continuing to build strong foundations to support our digital economy and our work force. The audit I note and advised was primarily focused on ICT technical issues and related funding priorities. As Jenny Gale in her response says, it ignores the risk and opportunities relating to the provision of securing user-friendly digital services. However, the audit acknowledges the Government's focus on digital transformation. It recommends the development of a technical or ICT vision in his words and strategy. In fact, that is a key action; I think it is the second action under government in Our Digital Future. We are heading that way but we are not apologising for making the digital strategy the broader vision and strategy the priority. It allows for the ICT vision or as we call it the technology road map to be developed as a next step. In in Jenny Gale's response on behalf of the public service that is taken onboard as a future action.

Mr O'BYRNE - Minister, we have received evidence from Tas ICT around not only the COVID-19 response but the general preparedness of the Government and their ability to impact and assist. You would have seen their evidence. They were very critical of the state Government. What do you say to their criticisms?

Mr FERGUSON - If you would like to give me an example I would be happy to respond to that.

Mr O'BYRNE - There is a chronic under investment in ICT; there is a lack of a clear road map; that your tendering arrangements are not supporting local industry; the recommendations they made around your digital future strategy were ignored. There is quite a few. Have you read their evidence?

Mr FERGUSON - Yes, I have and I am happy to respond.

Investment was an area I dropped out of my opening statement in the interests of time. Regrettably we have had significant under investment in ICT in Tasmania under previous governments. It is something I have been very clear on the record about for all the time I have served in this role; it has been very significant.

Mr O'BYRNE - Seven years. I was referring to your years in this role.

Mr FERGUSON - Decades of under-investment, Mr O'Byrne, which has led to significant risk areas. I have been very restrained and felt unable to talk about those for most of the time, particularly around those areas where we have had security risks that we have been

quietly dealing with and quietly mopping up those areas of key risk. I feel more empowered to talk about that now because some of those key risks have been now addressed.

We are coming from a long way behind and I refer to Labor-Greens government days. That is history and as we move forward -

CHAIR - Order. I ask that you answer the question, minister, rather than simply trying to bait the subject. That is not the wisest way to answer our questions and for us to move forward. I ask that you simply look at the question and answer the question. Looking forward rather than backwards.

Mr FERGUSON - As I was just saying, looking forward and moving forward, we have been making significant investments in every year that this Liberal government has been in office. My continued priority remains cyber.

In respect of the claims that were made around Tasmania's level of investment taken as a whole, I think there were remarks made around comparing Tasmania to other states and New South Wales, I was surprised by those comments, and unfamiliar with those numbers. So, I asked my department to find out about it. The best advice I'm able to obtain is that in speaking with Tas ICT, Tas ICT advised us that they had drawn those figures from a website, IT News, which is a well-known IT journal online. We were unable to source the figures that they had used for that.

I'm happy for the committee to speak to Dr Lewis about unpacking that. The advice given to me is that it is not plausible to compare different jurisdictions spending on ICT in a confident way because it depends on how each jurisdiction might choose to bundle it various cost centres into ICT provision.

Ms FORREST - In answering that question - a portion of the Tasmanian budget is somewhere about 1.5 per cent. I'm making that comparison with New South Wales as 4 per cent to 4.3 per cent. So, in answering the question, are you able to give us some indication of what percentage of the budget is spent in ICT? Acknowledging it's very broad and across all departments.

Mr FERGUSON - And subjective. I'm happy for Dr Lewis to respond to that. As I have said, there is no interjurisdictional measure or comparison report that enables any assessment or those claims to be made. As I say, Tas ICT advise DSS, our digital services and strategy section, that they had obtained the New South Wales expenditure figure from an earlier IT News article, but there are no details available on how that New South Wales figure had been complied. I guess we'll continue to have a potentially interesting discussion around this because it depends entirely on what will be classified as ICT. I would like to throw to Dr Lewis as the expert on this.

Dr LEWIS - In terms of looking at ICT expenditure, as the minister said, it really does depend on what you define as ICT expenditure and there's no common definitional standard around that. It could range from standard IT operations to include staffing, contractors, et cetera, infrastructure. But then you get into questions: does it include telephony and video-conferencing services. In a number of departments in government there are major projects and major systems going in that have an ICT component, such as health, health systems, et cetera, and new health equipment which have major ICT components. Are they classified as ICT or

not? That's where some of the challenge comes into actually finding and then being able to compare apples with applies. But other organisations, or jurisdictions around ICT expenditure.

Mr O'BYRNE - You had Tas ICT make those claims, and you're refuting those claims. But you've also had the auditor identify in their report a significant under investment in ICT in Tasmania. Are they both wrong?

Mr FERGUSON - I'm actually not going to allow you to put words in my mouth. What I'm saying is, we've been unable to source those figures. What I'm indicating is, on the advice which you've just heard from Dr Lewis, we're not able to cite, and if others around the table are able to produce that I would welcome, but we don't have access to any interjurisdictional comparisons.

Mr O'BYRNE - What do you say to the Auditor-General's -

Mr FERGUSON - I welcome the Auditor-General's contribution to our thinking. Our priority remains that we do have as the second action under government released in Our Digital Future, the technology roadmap is something that is a key action to be developed in the future. The secretary of DPAC, Jenny Gale, has responded on behalf of other secretaries with some different responses and some different points of view in relation to the report and its recommendations.

Mr O'BYRNE - One of the other points from the Tas ICT submission was that a lack of digital capacity across sectors - particularly in health - across departments has inhibited their ability to respond to COVID-19, and also to allow people to remotely fill out government forms and follow their processes because of a lack of a myGov-type facility at a state level. What do you say to that?

Mr FERGUSON - I quite agree. It's actually a shortcoming that's a real legacy issue for Tasmania. I've been on the record on this and am happy to do so again today. To me, a citizen identifying themselves to government is a key opportunity. It's a barrier right now, and it's an opportunity to provide government services much better in the future.

To that end, the Tasmanian Government is working with all other states and the Commonwealth on a better framework to allow Tasmanians - or it would be better to say, Australians - to be able to access government services from the Commonwealth level but also from their own state Government, so that is quite exciting. It's something that the federal Government is making investments in.

You'd be familiar, I'm sure, with myGov. An evolution of that is myGovID, and it's something that potentially is a framework that states like Tasmania would be able to utilise in order to allow our government services to be transformed in a way that doesn't reinvent the wheel, or produce unnecessary cost to make an investment in putting, for example, gun licences online. I think Ms Forrest made some reference to this, could you apply for your gun licence online. Well, yes, you could. We could build a bespoke service to achieve that outcome, or we could potentially use the myGovID which is being developed by the Australian Government's Digital Transformation Agency. If we can use that architecture to allow Tasmanians to only have to identify themselves once in order to achieve a range of government services - whether it's enrolling their child in a school, applying for a gun licence, applying for

their learner driver's licence - that is I think the exciting and the appropriate way forward. So, I do agree with those comments.

Mr O'BYRNE - TasICT was quite frustrated about the lack of action on that, and a number of other states already have this myGov sort of technology to enable those sorts of forms to be filled out and people's identity to be registered.

If this was something new on the horizon we understand, but given their frustration in the seven years you've been minister, could you outline what the Government's done to progress that project, for example?

Mr FERGUSON - It's being progressed now by digital ministers working collaboratively together and the expectation -

Mr O'BYRNE - But other states already have it.

Mr FERGUSON - No they don't actually. myGovID is in development.

Mr O'BYRNE - Not ID, myGov technology.

Mr FERGUSON - I'm simply repeating to you that myGovID is in development. I'm not sure that other states are advanced quite as you have suggested, but again it's an area where, rather than make significant - indeed tens of millions of dollars of investments - in individual transformation projects which might achieve a nice outcome for a particular service, I would like to see Tasmania being able to leverage the benefits of the significant federal investment. It's something that Dr Lewis and I have discussed on numerous occasions and is being progressed. It is the way of the future and it is the better way, because it would be ideal - given that our Tasmanian people are transacting with the federal Government. I would like it very much that our future transformation takes account of that and if possible, allows us to face our services using that framework, using that digital identifier.

It is definitely the way to go.

Mr O'BYRNE - Clearly, during COVID-19 we're hearing from a range of stakeholders and key people inside various service delivery organisations and departments, that they are frustrated the majority of the information is paper-based. The lack of action on this, and the frustration from TasICT on progressing a roadmap towards resolving the issue, and its exposure to further risks if there's a second outbreak - what have you done over the last six months since the outbreak to bring forward that kind of digital response to the need of departments?

Mr FERGUSON - I think I've given a solid answer to the principle of the need to provide increasingly services that are available online. In some cases, potentially agencies might argue that they wish to retain a paper-based service, but allow it to also be offered online and that would be fair enough.

I will ask Dr Lewis to respond further in terms of what we can be doing and particularly with a recognition that Our Digital Future does have specific actions around Government services being -

Mr O'BYRNE - Sorry - not what could be done, what has actually been done in the last six months to lift the tempo. Everyone has had to respond at a high level. We have heard from the Education department about the work they have done to accelerate investment and accelerate work in this area, not just in their digital support of students, but also their capability. As the overarching minister of this, what has happened in the last six months which has lifted the tempo?

CHAIR - Probably in answering that question, if I could add the comment made by the Public Health Association of Australia. You may have seen their submission to us where they made the comment - you would need to read the whole paragraph on this, but I will cut it shorter -

> … and outdated information and data systems are unable to meet the requirements for supporting an effective response of the scale required. Local government involvement in response has been limited, with the potential of locally based staff and environmental health officers not fully realised …

And they go on to the state system as well. It was just not good enough to sustain an epidemic.

Mr FERGUSON - Thanks again. To both of you gentlemen, I will respond. In the COVID-19 pandemic the first responsibility was not digital transformation per se. It was keeping Tasmanians safe. However, as I articulated earlier, we spent most of the last parliamentary term, those four years, investing in new ICT procurement arrangements. We call it NT3 and they positioned Tasmania perfectly to be able to scale up back in March when we needed to start saying to public servants that you need to work from home.

A key component was to rapidly increase the capability of the Government ICT network itself and its associated resources to support the sudden and significant increase in the number of employees working remotely. You would have barely heard about this, because it worked so seamlessly. Focused ICT coordination across Government enabled:

1. Remote working solutions, which included virtual private networks and internet traffic management;
2. Additional cyber security protections;
3. Increased network capacity and band width;
4. Telephony solutions, including soft phones and enabling remote working call queues; and
5. Inter-agency collaboration and facilitation of inter-agency solutions.

They are the whole-of-government responses. Each agency needed to do different things to address their particular business needs.

I want to mention again, before I throw to Dr Lewis, that in very short time frames we were able increase the corporate internet links from two, 1 gigabyte per second services to two, 4 gigabyte per second services. The corporate internet usage showed that we met that demand increase. It went from less than 2000 megabytes per second at the beginning of the month of March to nearly 4000 megabytes per second at the end of that month. Those internet upgrades

that occurred during that period were seamlessly procured and a real testimony to the capability that we have developed here in the Tasmanian Government.

Ms FORREST - How much of that procurement was local procurement? That was another issue - Tas ICT felt a lot of procurement was not from Tasmania.

Mr WILLIE - Because of the way that tenders were structured.

Ms FORREST - That is right.

Dr LEWIS - In terms of the particular technology the minister is talking about, which is networking technology, the contracts there were tendered through a standard procurement process and awarded to Telstra as the supplier of that service. They have a local component and local benefits in terms of local economy there. That enabled us to really increase the number of connections and the bandwidth, as the minister was saying.

Ms FORREST - Particularly for uploading?

Dr LEWIS - Yes, uploading and downloading - and the number of people who could work securely and remotely from home as part of the Tasmanian Government. We could increase the number of VPN connections allowing people to work remotely from home, from what was originally - pre-COVID - 5000 available connections, up to 25 000 connections which was available.

Mr FERGUSON - We were able to do that virtually overnight.

Ms FORREST - And that was all funded how? VPNs don't cost nothing. They didn't when I had to have one.

Dr LEWIS - Again, that was facilitated through the contract we have with Telstra and we were able to negotiate a whole-of-government approach in relation to those VPN connections funded by the agencies. Each agency funded their component.

Ms FORREST - The agencies funded it from within their own operating expenditure or capital expenditure? Where did they fund it from?

Dr LEWIS - Yes, from within their budget.

Ms FORREST - Okay.

Mr TUCKER - Minister, what has been offered to businesses to respond to COVID-19 from your department in the science and technology area?

Mr FERGUSON - Predominantly, we have been continuing our work with Digital Ready. We have actually ploughed an extra, I think - Brett - half a million dollars into Digital Ready for business.

Mr STEWART - We've actually applied a few different tranches of additional money, so we've applied in total an additional $650 000.

Mr FERGUSON - I might get you to break that down for Mr Tucker. I will just continue for a moment, and say that we have been working right across the government, and with the economic portfolios - including with the Small Business minister - and we have provided significant support to businesses through a range of grants programs but this, particularly in the science and technology space, has been a continuing program. It has been a really good program. It has actually been a great success.

We have targeted that program more at providing a wider reach, and we have been able to claim significant numbers of businesses; but COVID-19 presented an immediate challenge to a number of businesses and their business model. While it might have been just fine up until March, they needed to transform and, in some cases, that needed to happen very rapidly, and so Digital Ready for business has been instrumental.

Interestingly, a number of local governments have stepped up as well and, of course, working with the small business minister, we have the Buy Tasmanian website up and running as well. That is about further encouraging Tasmanian businesses to list online - if they do not have their own digital presence, come and use ours - and, of course, encouraging the Tasmanian community to buy local as much as possible. I'll ask you to break those figures down, please, Brett.

Mr STEWART - In the 2019-20 financial year, we provided an additional $100 000 - that was obviously at the back end of that financial year as a result of COVID - and a further $50 000 for next financial year. Then, as a result of an element of one of the small business response packages, we've also boosted this program by a further $500 000 over the next two financial years. That's a total additional commitment of $650 000.

As the minister pointed out, we've had a significant increase in uptake of this program. For the 2019 calendar year we had 287 000 coaching sessions made available - they are free, two-hour coaching sessions. For the period from March until a couple of weeks ago we had 713, so a significant uplift in demand in that area.

Through our contacts with the Tasmanian business community it was very clear that not only being able to access that coaching was important, but then being able to go back for a follow-up session with a further two hours was really a vital, additional requirement, and so we've made that available.

Mr O'BYRNE - Obviously these grant programs are welcome and they play a crucial role. Minister, do you call any of these grant recipients to congratulate them on getting access?

Mr FERGUSON - You know I do, Mr O'Byrne, because I have told you that before, but what you have done wrong is -

CHAIR - Order, again. You need to answer the question here because this is a PAC inquiry.

Mr FERGUSON - Chair, with respect, if I am asked a political question, I would like to be able to answer it fully.

CHAIR - No, no. Order. The question was asked. It was a proper question so -

Mr FERGUSON - Well, I have answered it, then.

CHAIR - It does not matter what you have answered previously in another place. So you need to answer it.

Mr FERGUSON - Okay. Fine. If it is appropriate, then I will choose to call somebody and I have had some wonderful conversations with Tasmanian business people. I am not embarrassed about it and I will continue to do so. I think it is the right thing to do if you can find the time to speak personally with the Tasmanian community and Tasmanian business people who have, in many cases, expressed huge relief and gratitude when I have spoken with them but, unfortunately, with time limitations I am not able to call absolutely everybody.

I have had some people express to me what a difference it made to have a phone call from the government minister responsible for a particular program, and I have spoken about it publicly and I will continue to do so.

Mr O'BYRNE - Did you call successful and unsuccessful applicants?

Mr FERGUSON - In some cases. As I've said to you, I've not been able to ring everybody.

CHAIR - Would you prefer to take that question on notice if you don't have the answers?

Mr O'BYRNE - Let us know which ones you've contacted.

Mr FERGUSON - No, I am answering to you that I support a lot of businesses in Tasmania and businesses that I've been able to call. It's something I'm proud to have done and will continue to do. It's part of my job.

Mr TUCKER - You've sort of answered it with your answer there, but I was more interested in the response from people and how you felt their mental health was on the end of the phone. It's a great initiative to ring these people up and we need to do more of it ourselves as politicians, talking to the grassroots and keeping an eye on them and also as a community member doing this sort of thing.

Mr FERGUSON - I don't want to gild the lily here but I've spoken to people who are traumatised. I've spoken to people who are thinking of doing bad things to themselves. I've spoken to people who weren't sure how they were going to get through the pandemic. I've spoken to people who, in some cases, were disappointed that they weren't able to obtain a particular outcome of support. I'm not a counsellor. None of us here around this table are, but all of us around this table have assumed the role of counsellor at times to try to give people some inner strength to carry on.

When the Government has at times been able to support people - in my own portfolio, particularly with the business support loans, falsely attributed for calling people for the hardship grants, but I've been calling people and will continue to call people when I am able to find the time who have been able to get a government loan. At times that's been quite useful in allowing them to know about other areas of support which they could apply for, whether through other Tasmanian Government schemes or even Australian Government schemes.

Ms FORREST - I want to go back to the past a little bit. There was an Auditor-General report released in March 2015 but it was work the former Auditor-General had done in 2014-15. He didn't release it immediately at the time because to do so, as he told us at the time - and the Chair would remember this - it would potentially pose a significant cybersecurity risk, so he held the report back and gave the departments time to get themselves sorted.

I agree with you there's been under-investment for a long time. That was in 2014 when that work was done. You said you spent a lot of time as minister in building up the IT capacity in the state. I have heard a lot of concern around cybersecurity, particularly with so many people working from home and using a variety of video meeting platforms. Zoom had to up their security significantly, for example.

Can you talk to the cybersecurity matters here? Have you and the office been aware of increased threats and that sort of thing? We haven't heard of any successful hackings or anything like that but you know what they say about that, minister, don't you?

Mr FERGUSON - It's an inspired question because it's actually the current risk we're managing as well and I think I'm not alone here. Every government in the world is working through this and nobody can claim to be on top of the risk either because there are emerging threats. I might take this on notice and provide a further answer to the committee that might be taken confidentially. That might be the appropriate way to provide you with some further insight.

I can on the record say quite openly - and I'll ask Dr Lewis to respond as well - that we're making investments into cyber. The previous audit report was quite helpful and we've done other protected examinations into individual agency risks as well and that's highlighted some quite concerning risks. Not all of them were cyber risks, by the way; some of them were physical security risks. For example, servers that were just in cleaning cupboards that anybody could -

Ms FORREST - That was identified by the previous Auditor-General.

Mr FERGUSON - Maybe that was in there but I remember very clearly that some of the risks were physical risks and too many people having access to the server room, for example, or a power supply.

Ms FORREST - They were definitely matters raised in the 2014-15 report.

Mr FERGUSON - These are the responsibilities of each agency and each agency secretary and Dr Lewis and Jenny Gale as chair of Digital Services and Strategy provide a lot of support and guidance to agencies to manage those risks.

Before I throw to Dr Lewis, I have emphasised the work that we do in partnership with the Australian Government, predominantly through the Australian Cybersecurity Centre. The Prime Minister publicly said in June that there is a state actor threatening Australian parliaments, Australian government departments and Australian businesses. In this room we're all aware of those statements and that is an insight into the risk governments have had to manage for many years before me and no doubt for ever in the future. That's why, while there are so many competing priorities for the budget, for me the priority remains cybersecurity. Dr Lewis, I wonder if you could articulate further?

Dr LEWIS - The threat to cybersecurity is increasing significantly and exponentially so we are constantly working and have a program of work to protect Tasmanian government systems and information that Tasmanian government agencies hold for citizens around cybersecurity. In particular, we've seen quite a significant increase of COVID-19-related activity during the pandemic, a lot of COVID-19-specific phishing emails, spam-type emails, and SMS phishing-type emails where fraudulent text messages come in. That cybercriminal-type activity is quite sophisticated. We saw an increase of well-articulated spam or phishing emails that were often timed and related to major announcements by the federal government in particular around things like JobSeeker or JobKeeper, with people trying to take advantage and put in place malicious approaches for citizens around some of those initiatives.

Ms FORREST - Have they been identified and mitigated predominantly? I suppose you never can be 100 per cent sure on some of these things.

Dr LEWIS - Yes, we have protection mechanisms in place to block those emails as much as possible and we are also working with agencies to educate staff and citizens around what they should be aware with respect to those types of campaigns.

Ms FORREST - When you have a COVID-19 test and receive a negative result you get a text message to say it's negative, so you always know it is bad news when you don't get a text message. Is that another potential area of risk there? It's probably better to give someone a false positive than a false negative in terms of the implications of that. That was brought in to try to expedite the return of results when the north-west outbreak was in full tilt.

Mr FERGUSON - That would be a question for the Health portfolio. I'm sorry but I don't have that information.

Ms FORREST - We can follow it up with them.

Mr O'BYRNE - You say cybersecurity is of high importance, and we take that at face value. We all agree that it's an important area. We have advice and a view from TasICT that there was no deployable cybersecurity team. I understand there are existing resources around cybersecurity, but if there is a major issue or if there's heightened concern, what do you say to the comment made by TasICT, which brings into question your commitment, broadly speaking, at face value?

Mr FERGUSON - We do have a team and Dr Lewis will tell you about it.

Dr LEWIS - Each agency has its own staff responsible for cybersecurity within that agency. In addition, and over and above that, we have a central whole-of-government cybersecurity team in Digital Strategy Services in the Department of Premier and Cabinet. That team is responsible for coordinating an overall cybersecurity program for the Tasmanian Government, advising the agencies of the protections and supporting them to mitigate the risks.

Mr O'BYRNE - When you read the Auditor-General's report there is a criticism that there is lots of plans and lots of proposals and lots of ideas, but there is not a commensurate follow-up with an investment in capacity and resources to respond to those kinds of forums around cyber security. What do you say to that?

Mr FERGUSON - First of all, Mr O'Byrne, we have just corrected the false impression that you may have obtained that there isn't a cybersecurity team. There is. It is deployable and its intention is that it provides support to agencies if and when they are required, and to work closely with the Australian Government's Australian Cybersecurity Centre because they are, in a way, an incredible resource to our state and have been providing us with incredible support and assistance in checking over our systems, particularly post the Prime Minister's announcement in June that we were able to really use those services, so our team was running those tools, if I can put it that way, in this public forum to check over and clean our systems.

Mr O'BYRNE - I understand that is the existing capacity, but my second question was more related to the observations made by the Auditor-General. It almost fits in with the criticism from TasICT that you have a lot of existing systems in place. You have a lot of ideas and plans but there is not the commensurate investment to respond to recommendations from a cybersecurity team. That is the second question.

Mr FERGUSON - I would say watch this space. Government is going to be making announcements in the future. Of course, as you know, there is a budget very soon and as I have made it very clear before today my priority remains cyber-resilience for our Tasmanian government systems. I am concerned about risks and I want to ensure that we are managing those risks, but also that we are forward-thinking and not just being reactive. I want to ensure that agencies and all public servants have the benefit of improved resources to allow them to be cybersafe in their workplaces, whether that is at their government desk or at their home.

Mr O'BYRNE - So in the absence of any announcements, the criticism from TasICT and the Auditor-General stand, effectively.

Mr FERGUSON - Unfortunately I've had to correct you again, and now for the third time. There is a cybersecurity team -

Mr O'BYRNE - No. It is a question about resources, that's all.

Mr FERGUSON - If I can be permitted to answer, it is to refute the notion that we don't have that commitment being demonstrated. We have, in Our Digital Future, a clear demonstration that we intend to continue to manage these risks appropriately and resource them.

Ms FORREST - One of the things I'm hearing a lot, and I know it has been put into a number of submissions in that regard, is that we have a focus on economic recovery around investment and infrastructure but that tends to be focused on hard infrastructure. Obviously digital infrastructure is just as important. Can you give us some indication of what investment and focus you are taking to digital infrastructure and investment, rather than just roads and bridges?

Mr FERGUSON - I can do that, but really the credit for those investments will still reside with individual ministers who, through the budget process, request funding - for example, for digital transformation initiatives, or the one that Mr Shelton announced only this morning for Project Unify in the Department of Police, Fire and Emergency Management, that $46 million for the next phases of Project Unify. There are some really serious dollars, Tasmanian Government taxpayers' money going into these projects. They continue to be

investments that are made on a case-by-case basis through the budget process, and through the individual ministers and their agencies.

Ms FORREST - It might be different this year. I haven't seen the budget papers this year, but from memory there is not a line item that I am aware of that has digital infrastructure investment in each agency. Maybe there is in some agency annual reports, but I don't know. So that will clearly be able to be identified in budget Estimates for each agency. Is that what you're saying?

Mr FERGUSON - Well, the one I've just cited will be, because it is a specific advance indication of something that will be funded in the Budget. You will remember from previous budgets that when the Government has made significant funding available for digital projects they have been itemised in the Budget. You will remember that the Department of Treasury and Finance had a special fund available for agencies to apply for through the SIRT process.

Ms FORREST - The Auditor-General comments about the SIRT process.

Mr FERGUSON - He does, and Ms Garland has responded as well, indicating that Treasury will have a look at that recommendation. We're certainly not close-minded to what those recommendations might offer, and they will be appropriately considered by not just the agencies but by the respective minsters. I accept your point that digital infrastructure, while you cannot drive on them with a car, is very important.

Ms FORREST - We all use them every day.

Mr FERGUSON - I agree with you and the citizens of Tasmania. That is infrastructure that they do use and it will allow them increasingly to live a more productive, efficient and safer life.

Mr STREET - Obviously pre-COVID-19 there was a gap between businesses that were digital-ready and those that were not, and the lack of face-to-face interactions exacerbated that gap between businesses that were able to cope during COVID-19 and the ones that were not. As a government, are investments being made into helping businesses get themselves digitally ready now? Obviously, it would have been better if they were ready beforehand, but are you bringing them up to speed now?

Mr FERGUSON - The answer is yes, Mr Street. Thanks for the question and it is a pertinent one. I touched on it a little earlier and Mr Stewart has articulated some of the extra funding but I think it was a reminder of the importance of making sure your business is flexible enough to meet the public or your customer base where they are able to be reached. Through Digital Ready for Business we have been encouraging Tasmanian businesses to go online not just for their Tasmanian customers but for their interstate customers and potentially their international customers so they can have wider marketplace, given of course that they are competing with your Amazons and your eBays and other places.

The answer is yes and your question highlights as well that were the prepareds and the not so well prepareds particularly amongst our small business community, and that is why we want to always encourage people to find themselves a pathway to going online. They can use ours, the one that is sponsored by the Tasmanian Government called Digital Ready for Business which is continuing to be funded and we will continue to run it. As of last month,

713 Tasmanian businesses took up those two-hour free sessions. They are one-on-one sessions with a digital coach and that is entirely around helping them find their next step along the way. Some businesses have no digital presence. Others might just have Facebook or a basic website, so we are helping them with their next step. It might be an e-commerce step or a rewrite of their presence.

I will mention that the digital inclusion initiative, which we call Digital Ready for Daily Life, is about equipping people who are not comfortable with technology. I am going to generalise now but it might be your parents or your grandparents or somebody who is not strong with literacy. It was an idea we had worked up with TasCOSS and Telstra that we have taken to market and we launched it just when COVID-19 hit. Of course it is not appropriate during COVID-19 for vulnerable people to be having digital coaching sessions so we had to throw it back online. Now that we are emerging from COVID-19 we are going to go back to that face-to-face model.

Mr TUCKER - Minister, what work has been undertaken to move government data to a more secure cloud database?

Mr FERGUSON - I am going to ask Dr Lewis to answer that. We have evolved our Tasmanian cloud policy. It served its purpose for the first five years of our government promoting the Tasmanian data industry and we have evolved that to the new cloud policy which Dr Lewis will speak to.

Also, we are making our first steps with whole-of-government procurement. In fact this morning I announced that TechnologyOne has been the successful provider for taking seven Tasmanian government departments to a cloud solution and that means the data will be stored more securely. TechnologyOne has a facility for protecting critical systems up to protected status. It also means a more efficient way that our workers in the finance sector in government departments can be working. It also means they can be working from home with the same level of security as if they were at their desk in their government department office. I will ask Dr Lewis to touch on the cloud policy briefly.

Dr LEWIS - The cloud policy recognises that there is a need to look at our systems and make a risk-based assessment on whether and how they should be best supported and how they're securely supported. That allows us to move those systems to highly protected data centres where needed and that work is progressing on that risk basis.

We've made an initial start on that with a number of systems. As the minister mentioned, just announced today is Technology One moving finance systems to their highly secure centre. We've also done it for email and are working on a number of other whole-of-government aspects and systems as well as each agency looking at where they are and the risks around their data and how it's secured. At the moment, agencies make that assessment based on a whole range of factors including where the data is stored. There is a whole suite of metrics to look at when looking at risk around data.

CHAIR - A further question and then we've got to finish right on 12. Our next witness is online.

Mr O'BYRNE - Minister, you've talked a lot about the Digital Future strategy and you've talked about the importance of connections with the local ICT industry. In their evidence to

this committee, they stated that most of the recommendations that they made in the formulation of your policy weren't taken up. What do you say to that? That, obviously, must be of concern.

Mr FERGUSON - I'll have another look at that transcription, Mr O'Byrne, and check what you've said, but I think it's actually been a real joint effort -

Mr O'BYRNE - A direct quote.

Mr FERGUSON - I'm actually really proud of it. It's something that's been not my product; it's not Dr Lewis's product. It's actually been the product of a lot of engagement across government agencies with the ICT sector. I include TasICT very deliberately in that, as well as the Australian Computer Society. They've been brilliant to work with. I'll investigate those comments further that you've represented -

Mr O'BYRNE - I can give you a direct quote. It's on page 2 -

> As you indicated in the letter you reference, most of our recommendations weren't taken up in our -

Mr FERGUSON - If I could just continue to - if I could just be allowed to - Could I just be allowed to answer?

CHAIR - Order. It is a direct quote taken from the evidence so, minister, if you could answer it.

Mr FERGUSON - I am just answering the question. I have offered to have a look at the transcript. I am not troubled by that.

TasICT has been a brilliant partner with this Government. Our Digital Future is a direct product of the summits that we held in November last year. We'll keep working with TasICT. I'll have a good look at those comments. We never ignore good ideas. I'm sure you'll understand, chair and committee members, that government does need to make the policy on the basis of some good ideas that have been put forward in good faith. I will repeat that I love working with TasICT.

Mr O'BYRNE - In my defence because you've cast an aspersion that I'm misleading the committee and quoting out of context -

Mr FERGUSON - I would never say that.

Mr O'BYRNE - That's what you inferred and I take offence to it. Let me be clear, the direct quote from the ICT industry is -

> Most of our recommendations weren't taken up in the final Our Digital Future policy.

Minister, whilst you say you welcome their input, clearly, they're disappointed with your response.

Mr FERGUSON - Thank you. Again, I reject you. I didn't say that you'd misled the committee. I would never say that.

Mr O'BYRNE - That's what you inferred.

CHAIR - Order. If there is anything further to add to that -

Mr FERGUSON - I don't like to allow a scenario to be implied where anything other than the case is true, which is that we work really well with TasICT. They've been a brilliant partner and their ideas continue to help us form good policy. The update to the Tasmanian Cloud Policy is a very good example of that.

CHAIR - Minister, a final question. Moving forward, would we be in a better position now than when the COVID-19 epidemic commenced earlier this year? Would we be in a better position moving forward in relation to our technology and the control, the use of it and the security of it

Mr FERGUSON - On the first part, without a doubt. We have a much stronger capability today. The COVID-19 pandemic accelerated the trend towards remote working, which was not engineered by government but it's a very good capability that now sits virtually with every government department and many of the GBEs. Cyber is a continuing risk that worries me, that I continue to work on. As I have said, it remains my priority if and when I am able to obtain Budget funds for capital in ICT, that is where I want to put it.

CHAIR - Thank you very much for your attendance today. I appreciate that. There are many matters for us to consider. You did take a couple of matters on notice.

Mr FERGUSON - I actually proactively suggested that if the committee is happy to receive it on a confidential basis it would be useful for me to provide a little more insight into the cyber preparedness.

CHAIR - If you made that clear in your response the committee would receive it in that form and in confidence. Having said that, thank you very much for your attendance today.

THE WITNESSES WITHDREW.

Mr PETER FOWLER, PRESIDENT, SOCIETY OF HOSPITAL PHARMACISTS OF AUSTRALIA (SHPA), WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Peter, this is a public session. We are streaming online as well and it will be eventually transcribed by *Hansard*. I need to say that parliamentary privilege applies to you in this environment and the way we are doing this today but once we finish with this connection then you are not any longer given that privilege, so you need to be aware of that.

I'm not sure whether you've given evidence to these committees before. I will give you the opportunity to make a statement if you want to and we'll be asking questions following on from that.

Our terms of reference are fairly clear and hopefully you would have seen our terms of reference as well. Peter, you have provided to the committee the submission made to the Senate inquiry.

Mr FOWLER - That is correct.

CHAIR - We have that copy here. I will give you an opportunity, if there's any statement you'd like to make to the committee at this stage relevant to the Tasmanian position.

Mr FOWLER - Thank you very much, Mr Chairman, I will do that.

I would like to clarify that whilst I am the federal President of the Society of Hospital Pharmacists of Australia, I am also an employee of the Tasmanian Health Service. I am the Critical Care Pharmacist at the Launceston General Hospital. The evidence that I would like to bring is from the perspective of the Society of Hospital Pharmacists of Australia and the work they have done and the information they have garnered from the various activities that were undertaken to help understand the needs and responses during the COVID-19 pandemic rather than as the employee of the THS. In that capacity I actually had little to do with many of the issues that I am sure that the committee would like to focus on.

CHAIR - Thanks for that, Peter. Any statement you wish to make?

Mr FOWLER - Certainly. I have a fairly detailed statement and I am happy to be guided by the committee as to how they would like to manage that. I would like to introduce our organisation and explain its role. Then I can talk about the initial response to the COVID-19 pandemic, particularly from the point of view of medicines procurement and medicines management and the role that pharmacy and our members took in supporting that response; then move on to the effects of the stress, the strains that were placed on the medicines supply chain; the national implications that they had; the information that we, as an organisation, garnered from our members and how that was used to further support the procurement of medicines; the securing of the supply chain; and then we can perhaps look at some Tasmanian-specific data that we have.

CHAIR - Peter, that would be very good. As long as we leave some time at the end for some questions, that would be great, but that covers our terms of reference well. Thank you.

Mr FOWLER - I would be happy to do that. I also invite questions as we go through.

CHAIR -As we go through. Okay. Thank you. So, jump in.

Mr FOWLER - Thank you very much for the opportunity. The Society of Hospital Pharmacists of Australia is a member organisation. It has over 5000 pharmacist members as well as a smaller number of members from pharmacists-in-training and pharmacy technicians and others supporting the pharmacy workplace in the Australian health system.

In response to the COVID-19 crisis, the organisation introduced a number of activities to support the workforce generally. This included convening bi-weekly meetings with directors of pharmacy across the country via video means. We instituted a hospital pharmacy workforce relief register, inviting pharmacists who did not specifically work at this point in time in hospitals to register their interest or their availability to take on roles if that became necessary. We produced, through consultation across our more highly skilled sites, a preparation or a checklist for hospital pharmacies and that was promulgated across the country.

We provided education packages for upskilling pharmacists to take on critical roles. You must remember in these early phases, we were really expecting the brunt to be borne within our intensive care units of large numbers of critically ill patients. We were expecting an attrition rate from the frontline staff, including hospital pharmacists, and so we undertook significant upskilling of the workforce in that area. We conducted five weekly snapshot surveys over the months of April and May to understand what issues our directors of pharmacy were encountering, particularly with regard to the procurement of the critical medicines necessary to provide the support for acutely ill patients.

This survey process had respondents from over 300 hospitals which were geographically and functionally representative of the Australian health system. The results of these surveys were used to inform the Medicine Shortages Working Party, which is convened by the Therapeutic Goods Administration and consists of representation from medical pharmacy and the pharmaceutical industry stakeholders.

In terms of the initial response to the COVID-19 pandemic, in March the Australian hospitals were directed start to implement jurisdictional government and hospital management plans to rapidly increase the capacity of the intensive care units and that really means ventilator-capable beds. We were doing so in the expectation of an increase in the requirement to manage patients with an acute severe respiratory illness.

The initial modelling indicated that we would be requiring up to 20 000 hospitalisations to be managed at one time and up to 5000 ventilator-capable intensive unit beds would be needed to support this. This was largely a response to an emerging pattern we were seeing in Europe and also Asia and North America. When I talk about intensive or ICU-capable beds we really are talking about a ventilator capacity ability there.

In addition, some of the smaller and regional hospitals across the country were being required to establish this capacity that they had not had before on the basis of an anticipated fly-in, fly-out critical care workforce when those more isolated or rural and regional centres started to require those facilities to treat patients who would not be able to be evacuated to a large or tertiary centre.

Tasmanian hospitals responded by initially essentially increasing their intensive care unit capacity, their ventilator capacity, to 150 per cent of their pre-COVID-19 capacity with plans to bring that up to 200 per cent if that was necessary. Hospital pharmacists played a key role in enabling this development and some of the key areas of their work was ensuring that all medicines were available on site to be able to support both the treatment of COVID-19 patients as well as other patients in terms of our business-as-usual models. We were refashioning the medicine supply to areas that were having their role changed, so additional ICU or areas that were being turned into ICUs if needed or high-intensity or high-dependency areas for moderately ill COVID-19 patients.

We were also investigating the procurement of a number of trial medicines that were being focused upon as hopefully having the ability to modify the course of the disease and we were also continuing to execute our business as usual, ensuring that medicines were being dispensed safely and effectively for all patients, not just those with COVID-19, and we can talk more about that if needed.

In these early days the Australian New Zealand Intensive Care Society, together with the Society of Hospital Pharmacists, undertook a preference survey of our respective members, so the intensive care doctors as well as the intensive care pharmacists were asked to identify their first, second, third and fourth preference for the critical medicines that we know are needed to treat these acutely ill patients with prescriptions. We were very interested in knowing that so we could understand what medicines would be in high demand, but if the high demand preferred medicines became unavailable, what our go-to alternatives would be so we could be securing the supply chain of those second and third-choice medicines if that was necessary.

The types of things we are talking about are the medicines that are needed to intubate and ventilate a patient. That includes anaesthetic sedative agents, analgesic agents, including the morphine-like opioid drugs, and medicines to paralyse muscle activity or neuromuscular blockers. These are used commonly in our intensive care units but are also used in elective surgery, so you can see the linkage that occurred there and decisions made to limit or cap elective surgery procedures allowed us to bolster our supplies of these medicines for COVID-19 patients if that was to become the case.

Ms FORREST - Just on that point, Peter, you obviously have your choice of medicines that most anesthetists would use to intubate a patient. Were there any supply issues in Tasmania with the usual ones as opposed to going further down the line to some of the others that may not be so regularly used?

Mr FOWLER - As we attempted to procure medicines to meet our preparedness requirements we were certainly running into very substantial issues about first, second and, in some classes of drugs, our final choices of medicines, so it is our belief that it would be fair to say that we were in a situation, particularly in those early days, where our ability to manage critically ill patients with COVID-19 was not limited by the number of ventilators we had but with the medicines we had on hand to be able to support the management of those patients whilst ventilated.

Ms FORREST - You may not be able to answer this but obviously people end up on ventilators for reasons other than COVID-19, so was there any negative impacts on patients? I don't know whether you ran out of propofol or it was hard to get, but were there negative impacts on patients who weren't COVID-19 patients but required ventilation?

Mr FOWLER - I will answer that question because in fact it does relate to feedback we received through our survey work and feedback from our directors of pharmacy. I am sure the committee knows that the actual number of critically ill COVID-19 patients in Tasmania has been very small and whilst a COVID-19 patient may require that very high level of intensive care support for a period of up to and around 20 days, their consumption of those medicines is in fact very high, much higher than would be used through elective surgical procedures, for example.

Although the usage was high, the number of cases was low and spread out over a fairly long period of time, so we were not being confronted with situations where a medicine shortage was compromising the treatment of any critically ill or intensive care patient regardless of whether they were COVID-positive or not.

Ms FORREST - So even someone with myasthenia gravis or something like that, because they're on a ventilator for a long period of time, wouldn't have been impacted?

Mr FOWLER - I am unaware of any impact and I think it extremely unlikely that we would have had that impact.

CHAIR - Peter, during these very early stages, who were you working with through the Health department and Government? What was the connection and position there?

Mr FOWLER - In terms of who the society was working with?

CHAIR - Yes.

Mr FOWLER - The answer to that question varies from state to state. We were working principally with the Therapeutic Goods Administration and their medicine shortage working group. That was our main interface with respect to the procurement of these critically required medicines. Some jurisdictions, however, sought out the SHPA for advice on preparation and planning specifically, and we had a much closer working relationship with other jurisdictions. That did not occur in Tasmania but I think Tasmania is in a minority of Australian states in that there are many elements of our health system and our pharmacy service in particular that served us very well in this regard. I am happy to expand upon that or we can deal with that later if you would like.

Ms FORREST - One further point while we are on this area. We know that Victoria has had a pretty rugged time of late and thankfully it's looking much more positive now. Has there been a call for us to supply some of these usual drugs that you use for intubation and ventilation to Victoria from our stockpile, if you like?

Mr FOWLER - I believe that that is not the case, but it does highlight an important feature. One of the recommendations we made in our Senate inquiry submission was that, in the early days, there was little evidence of a cooperative approach to manage the stock of critical medicines across the country. Without clear communication occurring at a jurisdictional level, each state - and in some cases within some states - each health network or indeed each hospital on either side of the road was out in the marketplace competing with the other to try to meet their plans. Thankfully, that level of cooperation has increased

significantly, and part of that is also through much improved modelling of medicine requirements in comparison to the functionality of the supply chain.

That's allowed us to be much more confident of the situation that stands at the moment. Looking specifically at Tasmania, we have a state-wide pharmacy service, as I am sure you are aware. We have an established culture, we have visibility of medicine supplies across the state. Someone working in the Launceston General Hospital can see where medicine supplies are across the state, and we have a culture of ensuring that the medicine is brought to the needy patient. So, we have a cooperative, collaborative approach of sharing the resource around if that is required.

Mr WILLIE - Peter, how prepared are we if we do end up in a second wave situation, in terms of the supply chains? Have those issues been addressed for that scenario, and has there been an effort to stockpile in preparation for something like that? Let's hope it never happens.

Mr FOWLER - I can answer this question from the perspective of the information that is shared through the national Medicine Shortages Working Party. A number of things have happened, both from the initial phase of the pandemic and indeed in the second wave that occurred in Victoria. The first thing is that time has passed, and the supply chain has been able to progress at whatever rate it was able to progress. However, bear in mind also from the pharmaceutical industry's point of view, orders for medicines may be placed six months or 12 months ahead of time - so the pharmaceutical industry is trying to respond to this with a very long lead time as well.

The second thing is that some sophisticated modelling has been commissioned by the Working Group, which allows a number of COVID-19 scenarios to be modelled against the known medicine stockpile. It can be applied at a jurisdictional level or through cooperation and information sharing across the national stockpile of medicines, both within pharmacy departments and within strategic reserves that may have been procured by jurisdictions for example, and then the known capability of the supply chain at that point of time. So, we know what there is, we know what is expected to come in and against that we can model growth phases of a surge in COVID-19 activity, for example, as has been seen in many European countries at the moment.

The information that has been fed back is that Victoria has not been stressed at all, as far as the supply chain is concerned, for the surge that they have undergone in recent months. They have continued to provide elective surgery at pre-COVID-19 levels, so they haven't had to limit elective surgery to bolster those supplies - and that's just the jurisdiction of Victoria.

I am not in a position to give detail about it, but we do know that jurisdictions have prepared strategic reserves quarantined from the usual stock being held in the pharmacy departments, and the modelling which has indicated that we are in a position that would be able to manage a surge much greater than has been seen in Victoria in recent times.

Mr O'BYRNE - Peter, I have a question, not so much about supply chains. What were the practical implications of the shutdown of the North West Regional Hospital systems in terms of your ability to, not only protect your staff, the members, but also to respond to what you would assume was a high workload in quite an unusual environment? It is probably not a

supply chain question. It is about how you responded to a large part of our system being closed down, and the impact on your members, and the working environment you were placed in.

Mr FOWLER - That is a question that the society neither sought, or was provided with specific information about. I again ask you to appreciate that my substantive position was in fact, as a frontline pharmacist in the Intensive Care Unit at the Launceston General Hospital, at that time. So, I really am unable to provide any sort of system-wide analysis. There are, of course, many people in the Department of Health who would be able to give that information in detail. I have to revert to what I was doing at the time, which was operating in my normal capacity in a very busy Intensive Care Unit.

CHAIR - Peter, we interrupted you, so I will let you return to where you were.

Mr FOWLER - I am happy to proceed in whatever way you like, but I will continue to make a few further observations.

We got to the point where we were preparing for a scenario that hasn't played out. We are in a position, and we maintain the position, with adequate medicines to treat what came before us. However, that was well short of what we were preparing to be able to support.

Remember also that, at these early times, there was also a consumer led run on medicines. This was played out mainly through community pharmacies, but we were also seeing shortages of asthma inhalers, paediatric analgesics, and anti-inflammatory medicines for some very specific auto-immune diseases - most notably hydroxychloroquine, which has had a lot of press. We were also working to secure supplies of those, because they are medicines used within our hospitals as well. Ordering critical medicines, we were receiving pushback from the suppliers, the wholesalers, indicating that those orders could not or would not be met. But as I say, Tasmania fared better than others, for the reasons I have described there.

If we look at medicine procurement challenges in particular, certainly COVID-19 has provided significant stress to our medicine supply chains. Bear in mind that Australia represents less than 2 per cent of the consumption of pharmaceuticals worldwide, but over 90 per cent of our medicines are imported. That gives us little bargaining power on the international field, and little capacity if our supply lines are impeded.

Medicine shortages quickly emerged as a key issue, then, to meet the jurisdictional preparedness plans, and whilst the Australian Government had placed a high priority on procuring supplies of personal protective equipment and ventilators - and this was well reported in the media - the procurement of the medicines necessary to support that was left to the normal supply channels and the normal commercial processes that are there.

Medicine shortages in Australia are not a new thing. Currently, the Therapeutic Goods Administration website indicates that there are 456 medicine shortages across the country at the moment; 44 are anticipated to emerge and 47 of those are described as critical - that means these are medicines on a list of predetermined critical medicines for the treatment of life-threatening or serious conditions, and they are unlikely to have an acceptable alternative and their supply is unlikely to be adequate.

One of the things that pharmacies or hospital pharmacies do continuously is manage this situation. We now had, on top of it, a number of key critical medicines to deal with as well.

Now, increasing purchasing efforts by the pharmacy department was being described by other elements of the medicine supply chain as 'stockpiling'. While stockpiling really relates to the procurement of a resource beyond an anticipated requirement, we really challenged that consideration.

Plans had been put in place and we were attempting to respond to those plans. The directors of pharmacy across the country commonly cited the model that they were working to, which was to have medicines on hand to meet at least the requirements of the first patient to be placed on each of the ventilators that they had commissioned within their hospital, and to be able to manage the anticipated duration of treatment that first patient would have. That is, to have enough on hand to treat your first patient, and then your supply issues were about the next and subsequent patients - not the ones in your hospitals on the ventilators at that time.

That's a model that was commonly being applied, and the application of that model was stressing the medicine supply chain.

To put some details around what we were finding from our surveys - from our initial survey on 17 April we found that 80 per cent of orders nationally for the key medicine propofol were not supplied in full. That is, 80 per cent could not be supplied in full, either being placed on back order with no supply and no indication as to when supply would be available, or a part supply was issued.

Across all key medicines over each week of our survey 50 per cent of all orders nationally were not supplied in full. They were back ordered, supplied in part or the order was simply cancelled.

Nationally, the burden was shared unequally, and rural and remote hospitals fared worse. Part of this perhaps was the tyranny of distance and disruption to transport across borders. While it is absolutely appropriate that priority be placed to our major tertiary hospitals, which were being prepared and expected to support the key response to this condition, there were many other hospitals that also had a role to play or an expected role to play, were attempting to prepare themselves to do that and were finding it difficult as well.

In one week, just 5 per cent of the neuromuscular blocking drug cisatracurium - a first-line identified agent - just 5 per cent of those orders could be supplied, with one third being partly supplied and up to two thirds of that order going on to back order.

Directors of pharmacy did report an awareness of the national medicine stockpile and increasingly over time the jurisdictions were increasing their strategic supplies, but they also reported no real knowledge or understanding of what would be available and how it would be accessed.

Again, that highlights our focus on the importance of good communication to allow the directors to modify their purchasing behaviour or understand what capacities exist in reserve if medicines were to run out. I'm happy to take some questions or move on to some Tasmanian-specific issues.

Ms FORREST - You talked about the hydroxychloroquine and I'm not sure if you want to elaborate on that in terms of access to patients who need it for reasons other than COVID-19.

Also the other area you haven't touched on is access to vaccines such as the flu vaccine and pneumococcal. I understand from some of my community pharmacies in my electorate that they ordered them and their order would not arrive, so carers working in aged care couldn't go into the workplace without it. We managed to sort some of that out and they did get it, but it was a real challenge for a period in the north-west. I'm not sure if that was across the state, so do you have any light to shed on that?

Mr FOWLER - Certainly I can shed light on that. Hydroxychloroquine is a medicine that is used in a limited number of cases now of inflammatory or autoimmune diseases. It can be arthritis-type conditions or lupus, or a variety of those. When rumour first emerged that the medicine may have some ability to modify the course of the disease, we recognised the vulnerable position that those who were reliant upon this medicine for the treatment of their chronic illnesses would be placed in, so it was a very common activity across the country to reserve those stocks for those who require that medicine and certainly that happened across Tasmania.

I am unaware of any patients being denied or any longstanding patients not being able to procure that medicine in an ongoing manner. There may well have been brief hiatuses but, largely speaking, I am not aware of any significant impact of that as a response to the strategies that were taken there. It highlights an attitude that was taken by health departments generally, and certainly it was the case in Tasmania, that we would not engage in the sort of broad trial of various medicines that were popping up on social media or whatever without an information base to indicate that they were of use. And, if that was the case, they would be incorporated into a proper clinical study so that the utility, safety and effectiveness of those unproven medicines could be clearly understood for future benefit rather than just trying various things for whatever reasons.

Ms FORREST - We aren't going near the bleach. Just go onto the vaccines.

Mr FOWLER - Moving on to the vaccines, there are a couple of issues with vaccines and the flu vaccine in particular. First, because this is a respiratory disease and COVID-19 is a respiratory illness, it was widely anticipated, or clearly understood, that concurrent influenza and COVID-19 would be a combination that would greatly increase the severity of a patient's condition over and above either of them alone. So, there was a public health message to receive vaccination earlier than would be our normal preferred time to vaccinate for influenza. We know that the vaccine doesn't have a particularly long enduring effect so we tend to delay vaccinations such that it will still be effective at the time of the late winter period where the majority of cases of influenza historically occur. We now had the situation where we were anticipating the pandemic and so the message was to vaccinate earlier rather than later.

That in itself put a stress on the supply chain that was geared up for one particular scenario. The other is that we had a high uptake of vaccinations as well. The demand was shifted earlier and increased. Certainly, whilst this is not an area that the society's surveys looked at in particular, and it is more of a community pharmacy issue, it was certainly an issue for hospitals wanting to vaccinate and protect their staff. So, there was considerable effort put in at a federal level to secure and procure increased supplies and earlier delivery of what was anticipated.

Ms FORREST - The pneumococcal vaccine is not given to all people obviously, but there was a delay with that, as I understand it.

Mr FOWLER - That is the case. That was not a principal area of our focus but indeed that is a vaccination that will be provided to elderly people because of their vulnerability to that disease but again we know that the elderly are particularly vulnerable to the effects of COVID-19 so the increase in demand was following exactly the same pattern.

Ms FORREST - The increase in demand created the delay in getting additional supplies?

Mr FOWLER - An increase in demand and, if you like, almost a synchronisation of the requirement. In early March these were identified as public health strategies that had the ability to modify the severity of the illness and so a demand that may have been spread over many months suddenly became a demand that was seeking to be met at one point in time.

CHAIR - Peter, it would be good now to hear from you in relation to the Tasmanian position.

Mr FOWLER - Okay. As I alluded to earlier, Tasmania actually fared better than a number of other states in some regards. That is to say, our centralised pharmacy service meant that a coordinated approach could be taken to the procurement of these critical medicines and we have a coordinated or centralised contracting system for those as well so there was no uncertainty or competition across sites. It was the state of Tasmania acting as one to support its population in this time.

On the other hand, Tasmania actually did fare a little worse than other states in terms of - let's call it a pecking order - for the supply of medicines. Tasmanian hospitals and directors of pharmacies in our surveys were reporting higher rates of unfilled or partly filled orders than was generally being seen in the rest of the country. In some regards that may not be such a bad thing in that our surge was coming somewhat later and was never anywhere near as high an impact. Yes, medicines needed to be provided to the sites where patients were but there is no evidence of any coordination occurring in that capacity.

Wholesalers were making the decisions as to how much of an order was to be supplied to which site based upon the orders received. Information was coming back to our directors of pharmacy that those decisions were being made based on historical usage figures rather than any actual assessment of the roles the hospitals were preparing for and the need for the medicines they had. Again, that highlights the need for a higher level of communication and control or oversight of the distribution of a scarce resource at a time of critical importance across the country.

The other thing of note is that the Tasmanian Health department, in common with hospitals across the country, Tasmanian pharmacists collaborating with other clinicians, worked out conserving strategies within their hospitals. For example, it was common to see a collaboration with anaesthetists, emergency department doctors and endoscopy services to work out what options could be used to perform their services to preserve the critical medicines for COVID-19 purposes.

I am not sure if you are interested or would you like to hear how the Tasmanian hospitals responded beyond medicines procurement. It's probably best in the time that remains to open it up for questions if you are happy with that.

CHAIR - I think so. I had a couple of questions. Do the pharmacies in Tasmania order their products, their medicines, through a central group here in Tasmania? Is that how that is done?

Mr FOWLER - A statewide tendering system operates. So, through a collaborative process at various THS hospitals, anticipated requirements for medicines for a period of time are determined and tenders are offered for that. Once the tender has been established, each hospital will essentially purchase on that contract independently but they are not negotiating with providers for best price or anything like that; that is all managed through the tender process. There is no longer a central medical store or body such as that which did exist a number of decades ago.

CHAIR - You are saying that the wholesalers of these products then were dispensing these medicines on previous history not on the urgency that it might be required in a certain area.

Mr FOWLER - That is consistent feedback that we received from many sources. Also, directors of pharmacy, or those operating the ordering systems, really had very little information flow back. They did not know why their order was not supplied, what they needed to do to try to get themselves a higher priority in the ordering system, or even explain their need. Yes, the feedback was that it was being based upon historic usage records.

Ms FORREST - Peter, I am not sure if you are in a position to comment on the procurement and supply of PPEs. It is one of those areas that we have heard quite a lot about. We know that the state has their own emergency stockpile and there is also the national stockpile, but I am not sure if you are able to make any comment on the procurement around that from your perspective. That would be helpful.

Mr FOWLER - Personal protective equipment did not come under the remit of pharmacy so any information I would have would be anecdotal.

Ms FORREST - On that basis, in the hospital pharmacies did you have adequate supplies yourself to continue to work.

Mr FOWLER - Essentially we did. We responded in a number of ways. Most importantly was that we limited the exposure of our hospital pharmacy staff to risky situations. That was largely around rearranging the way we provided our business. We separated patients from pharmacists wherever possible. We worked remotely. We introduced distance or telehealth activities, for example, for a number of activities, education about medicines counselling support, that sort of thing. We introduced capability to support those to protect both patients and ourselves. That meant that the vast majority of our staff were able to operate applying appropriate social distancing, et cetera, within the workplace for example and not require PPE use.

For those who had frontline roles, then we had adequate personal protective equipment to execute those roles. Certainly, we still had pharmacists working in acute medical wards that were receiving COVID-19 patients and in emergency departments and intensive care units and they were adequately provided for in that way.

Mr O'BYRNE - Peter, in terms of procurement obviously within the public sector there's a range of procurement guidelines and Treasurer's Instructions and departmental minimum standards and processes which I know at times can be frustrating, but necessary. During the period of time that we're talking about were there any restrictions on your ability to respond because of either a prohibitive procurement guideline or a system which made it more difficult for you to deliver the outcome that you were hoping to achieve?

Mr FOWLER - We did not receive any feedback during our surveys or other processes that indicated that that was a problem and so have no evidence that that was the case.

CHAIR - Peter, we've run out of questions at this stage. Is there anything you would like to leave us in conclusion? You did say that you could touch on the hospital system a while ago. Is there anything you can pass on to us from there.

Mr FOWLER - I would wrap up by saying the important things that will allow both the state of Tasmania and the country generally to be in a well-prepared position to respond for any sort of global emergency that may present itself and require the use of critical medicines to respond to it relate to Australia's vulnerability, with its high dependence on imported medicines. So, a greater self-reliance is critical there.

Improved modelling has been really important in us understanding where we stand and giving us confidence to be able to respond to reasonably foreseeable events and that's in place. Critically, also, is just as we have a history of doing in this state of Tasmania and that is being collaborative, cooperative sharing of our information, if that was to be built into our systems across the country then we would also be in a much stronger position to respond.

CHAIR - Peter, thank you very much for your presentation. Thank you for answering our questions. We appreciate that very much. We may want to come back for any further issues that we have so if you'll accept that, that would be good. Thanks, Peter, for providing your time to us the committee today.

Mr FOWLER - Thank you very much for the opportunity.

THE WITNESS WITHDREW.

Mr TIM JACOBSON, STATE SECRETARY HEALTH & COMMUNITY SERVICES UNION (HACSU), WAS CALLED VIA WEBEX, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Tim, this is a public session. We are streaming online as well. It will be recorded by *Hansard* as well and parliamentary privilege applies while you're with us on this committee, but after this you stand on your own and I'm not quite sure what the situation is.

Tim, I think you understand, you've given evidence to these committees many times so I don't need to go through any of that with you from this point on, other than to say you would have seen our terms of reference. You didn't make any submissions to us, Tim, or HACSU didn't, so I'll leave it open to you at this stage.

If you would like to make an opening statement to us or raise any issues, and then we can go into some questions after that if that suits you?

Mr JACOBSON - Yes, apologies first for us not providing a submission. Unfortunately, submissions were called for this inquiry at the same time as we were developing our response to the review of the State Service Act and the north-west outbreak. I am a national assistant secretary of the union as well, putting significant work into a number of responses that we were asked to provide to the Aged Care Royal Commission. I may well talk a little bit about aged care in the context of our state preparedness in response both early and as we sit now, particularly in the context of workforce matters. Unfortunately, there were several deadlines - one of those we couldn't meet and at the same time we had some of our own staffing issues. That's not to suggest however that we don't believe that this inquiry is important. It is important.

Clearly, we're confronting circumstances that are unknown to all of us. We're in unchartered waters still in the context of COVID-19. The broader issues - not just state issues, but national and economic impacts of COVID-19 - I think still from our perspective are unknown, particularly in relation to health. When we look at the circumstances that exist, not in Australia fortunately, but in other countries, we can see that we are certainly a long way from the end of this pandemic. How the pandemic will affect us ultimately, and the fact that now as we open our borders we need to be more live to the circumstances that exist, particularly outside Australia in relation to our response to the pandemic.

CHAIR - We understand it was a busy time for a lot of people at the time we came out asking for submissions. We understand and accept that. We saw HACSU as a very important part of our inquiry, COVID-19, hence the reason we've invited you here today. We appreciate your situation and what you were doing at the time.

Mr JACOBSON - I could probably talk for well over the time - as most people know I do get on a bit of a roll and I continue to talk. From our perspective there are two elements associated with our response - the Tasmanian Government's response to the pandemic, particularly in the early stages during the outbreak at Burnie and the North West Private Hospital, and the two aged care facilities on the north-west coast, and the circumstances that flow on to where we are today. I would like to address a broad range of issues out there for us.

I would say more broadly, that the guidance that's been provided to the Government by Public Health has been very good. From our perspective, the guidance that has been provided

by Public Health officials to the Tasmanian Government, in relation to those prevention strategies and control strategies that needed to be put in place, was very good. I suggest that given the unchartered territories that we've been in and we are at, particularly the circumstances on the north-west coast, some very good, sound decisions were made in relation to those decisions, particularly as we moved through the early stages.

My commentary probably will largely be confined to the Department of Health and the Department of Communities, and what we see as a particular disconnect between the way that Public Health and government - when I talk about 'government', I am talking about the Liberal Party, the party in charge, the minister, the Premier, and so on, of the state - and there being a complete disconnect between the two.

Could I say from the outset, and I made this comment to a number of people, the communication that we've had, particularly with Government and the minister, was very good - particularly in the early stages. That's continuing today in relation to issues for stakeholders, us being the significant stakeholder for the workers in public health, but across all of our health and community service industries. We found the communication with the minister's office, the extent to which the minister did pick up on a number of issues that we raised, was very good. So, I will put an underline there.

The issues for us really sit at an agency level. One of those issues relates to communication. From the outset, we have encountered both at a micro level - so, at a workplace level - but, more importantly, at a big-picture level, at a macro level, a severe disconnect between announcements of Government, and the time limits around the information that was provided to the workforce, to those people who were supposed to operationalise or implement decisions as they were being made.

We, from the outset, put our hand out to the department, because we had open communication with our members. We had additional resources at our disposal - particularly given that we were all sent home in those early stages - that we could lend to provide some support and assistance to the department.

I have to say that at no stage did the department ever take up our offer of assistance, particularly in delivering key messages, and to a large extent, what I would say is that the department, in spite of the Government - the Government's communication with us - acted almost in an opposite way.

The department found it difficult to communicate with us. I would argue on a number of occasions it went out of its way not to communicate decisions with us -and, when it did, the communication was piecemeal. We would be advised from a senior officer level on one day of - or in advance of - an announcement by Government of a major announcement, but on another day where a similarly major announcement was made, we would have no contact. We would be left to our own devices to attempt to find out what was going on - often with a degree of futility.

It was difficult to get to the person who could actually give us information. Obviously, from our perspective, we take a significant number of calls from workers in the context of decisions like this, particularly where they affect people in their workplaces. We are often the first port of call to try to get some consistent advice back to them, and often we were found in

a situation where we weren't able to provide that information, leading to a whole lot of confusion.

Similarly, on a micro level - particularly in the early stages, when it was well known that as a state we had difficulty obtaining adequate supplies of PPE, particularly P2 masks - the messages, particularly in our hospitals and health facilities were very mixed - particularly messages to workers who wouldn't normally use personal protective equipment.

Equipment orderlies, cleaners, et cetera, were not used to using it. Certainly, in the early stages, they had not been trained in their use of it, and there were mixed messages given to them by senior staff members as to whether they should or shouldn't use certain types of personal protective equipment. Again, leading to a significant level of confusion, a considerable level of concern and fear, and often a view that decisions were made not on the basis of staff safety, but on the basis of rationing the PPE for themselves or for other staff.

Particularly at the Royal, for example, in the very early stages, not only were we unable to obtain PPE masks, but we were unable to obtain a consistent supply of hand sanitiser. We know that in the uncertain circumstances, sanitiser was being taken from some wards and moved to other wards - from less 'hot' wards to more 'hot' wards - simply because of lack of supply, leaving those workplaces without even the most basic of protections. Cleaning supplies, et cetera - again, confusion about their use and implementation of their use.

Right from the outset, while decisions were certainly being made at a macro level, there weren't people controlling the decision-making, and the level of information and stream of information going to employees.

In terms of the information going to employees, what I would say is that a lot of that information was being distributed by electronic means, but not everyone in our health service has access to a computer. Not everyone has access to a computer at home. A lot of those workers were often left out of the loop, simply because there was no regard given to how information should be directed to them, particularly among certain cohorts of workers.

The other issue - and I will come back to it - was workforce preparedness. I have to say, in the beginning - certainly in March, April and even subsequently - we had been raising concerns about workforce preparedness, about the extent to which the department had put adequate resources into sourcing, identifying and investigating, and securing, a dedicated surge workforce, particularly in the event of further outbreaks.

In the outbreak at Burnie in the north-west, to some extent it would be right for me to say we were fortunate or lucky that, given the distance between Burnie and Mersey hospital, there was an opportunity to decant patients and deep-clean the Burnie facility, and to continue to operate a level of health service in that region. Were it to occur in Launceston or Hobart, one of those two major hospitals, in the absence of a secondary facility of the likes of Mersey, that task, those circumstances, would have been a whole lot more difficult.

We were engaged very early in the piece at our request, not because the department made a decision to do it. The department took an arm's length approach to dealing with us, and I would argue continues to do so in relation to workforce preparedness. We still at this stage are unclear as to what processes and programs have been put in place to ensure that we have an adequate supply of workers in the event of a major outbreak.

I would say one of the issues around government response and agency response that has never been factored into any discussions is the extent to which the public health system would need to respond to emerging needs in our aged care and disability sector, if we were to have an outbreak the likes of what we've seen in Victoria. I would argue that at both federal Australian Government level and Tasmanian Government level, a hands-off approach has been taken

We know Victoria has some economies of scale that we don't have here in Tasmania. They have access to a number of those facilities that the federal government has put in place that we don't have access to in Tasmania. No-one seems to have turned their mind to that in terms of a state public health approach to our community - including our aged care and disability community - and the extent to which our public health system might be able to support an outbreak in that system, while at the same time caring for a number of residents - and possibly workers - who might contract the virus in the aged care system and need hospitalisation.

It's a big concern for most of the stakeholders I've spoken to. I know my colleagues in the other health unions share our concerns. In the conversation this morning with the ANF and the federal government on aged care workforce preparedness we both raised this as a key issue, but six months down the track we find out what the plans are in the context of an outbreak in aged care and disability.

The terms of reference makes reference to the impact, progress and outcome of the Government's economic recovery plan for Tasmania. I have been a little bit of a naysayer in that I think the Government has made two announcements in recent times. One is the Government's economic response to COVID-19 recovery - 'recovery' being the operative word. Second, the Government's review of the State Service is premised on the basis that we are in a recovery period from COVID-19. We are not. I don't know how anyone could possibly suggest that we are in a recovery phase when we can see what is going on across the rest of the world.

The fact that we have done a very good job of keeping COVID-19 out of our state isn't in and of itself a declaration of success. We know that COVID-19 will be around for some time. It is possible, particularly as we open the borders, that we may see another outbreak. We may well see COVID-19 back in the state and community transmission back in the state. So, I have been very cynical about the word 'recovery' and learnings as well.

As I said very early, one of the big concerns from our perspective is the extent to which the world economy will affect our capacity over the next 12 to 18 months or two years, possibly even longer in the absence of a vaccine. That will obviously continue to inform our economic response.

I think we can base things on what we know now but we are still learning from what is happening in other jurisdictions. Some of the reviews, particularly the review of the State Service, is being rushed. It is far too early. Having read a number of the submissions, it is clear to me that the majority of those who put in submissions largely fail to recognise the unique circumstances that we are in as a state at the moment, and the heavy reliance that we are going to have on our health system, on our public health system, but also on our public services in general.

Maybe if I stop there. As I said, I can rabbit on for hours. I'll open up to questions and then I could probably add some things further.

CHAIR - Thanks for that, Tim. I have quite a few questions lined up from members here. I ask members if they can to either stick to the one area or just ask a couple of questions so I can get through everybody within reasonable time.

Mr WILLIE - Tim, in your opening statement you touched on PPE and access for workers. It's been well documented that there were locked cupboards, there were health workers speaking out because they couldn't get access to PPE. The Premier provided a response to the committee. I will read the response to you -

[TBC]

> The first order of PPE, other than hand sanitiser, was placed on 15 April 2020 at a cost of $30 million. This order was for 8 million surgical masks, 120 000 face shields, 750 000 wipes, respirator masks, gloves, goggles.

Does it surprise you that the Government took so long to replenish PPE stocks, given that was at the height of the lockdowns?

Mr JACOBSON - Yes, it does. In the early stakeholder discussions that took place with the minister and the Government the primary concern of all the stakeholders was PPE supply. That related to the health workforce, the aged care workforce, GPs and the medical workforce in general. Issues were raised at the time that the limited supply of P2 masks meant that adequate fit testing could not take place. There were certain people who were not suitable for the P2 masks that we had. There was a raft of issues raised around PPE. It is of concern that it took that long for that order to be placed, bearing in mind that the department ultimately put in place additional resources to manage that supply, to manage the ordering process.

One of the things that needs to be pointed out is that before we headed into this pandemic we had a health system that on pretty well every measure was the poorest performing health system in the country. Adding to the issues that we had already was an enormous task of addressing and responding to an outbreak and ordering supplies. It became apparent from the outset that there were just too few people to do to many jobs. Often things were not done as quickly as they should have been. It should have been something that the department and Government were aware of given that they were the people that made some of these dramatic cuts.

Mr WILLIE - The north-west outbreak obviously took a big toll on the health service and the workers involved. We have heard from the ANMF that staff morale is low. There was an example given of two health workers who resigned when a COVID-19 case was transferred back to the Burnie hospital. Are you able to talk about that? How is morale with the health workforce and what is their confidence level like in the systems that have been put in place to handle any further COVID-19 cases?

Mr JACOBSON - It depends on who you talk to. Generally speaking, the broad health workforce is the people on the ground delivering services. I do not think there is any greater confidence today than there was 12 months ago. Morale was already very poor at the time, particularly with the Burnie closure. I don't think it should be lost on anyone the extent to

which not only the circumstances but the emotional response to those circumstances affected the workforce in general.

In the north-west, where some staff did contract COVID-19, in some circumstances there were additional health side effects as a result of that. There are serious concerns in those workplaces exacerbated by the experience of other workers who did get COVID-19 at the time. There are a lot of concerns around it.

The other thing I would say, particularly having spoken to my delegates over the last month or so, is that the extent to which there seems to be a prevailing view that it is almost back to normal now. People would say that it is almost like people think that we are through it, that we beat it and we can go back to normal. Largely speaking that is the way things are now.

For some of the additional measures that have been put in place in terms of tracking and tracing, most members would say that they are observing what they consider to be unacceptable work practices starting to reappear.

Again, one of the things that I would say about the closure of Burnie and the North West Private is that people were just told to go home. They were sent an email or a text message and told that they were to go home with their family and isolate. That came completely out of the blue. Whilst people knew the circumstances at the time that it might happen, it came completely out of the blue.

What we did at the time is that - that happened roundabout - I am just looking for the date. But when the hospital was closed, they were sent home and we set up our contact centre. We used Technology Through Text. I don't know if people have heard about it. It's where you can have a peer-to-peer conversation with people, not just a one-way text message conversation. We used it with those members that we had listed in our membership as being employed in that facility. We kept in contact with those people well beyond their two weeks' isolation because the facility was closed for longer than two weeks.

Ms FORREST - I am interested in how many members you have in the North West Regional and the North West Private?

Mr JACOBSON - I haven't got that in front of me but certainly -

CHAIR - Take it on notice.

Ms FORREST - Can you give us a breakdown of how many nursing staff, how many cleaning staff and other ancillary staff?

Mr JACOBSON - Yes

CHAIR - Tim, if there is anything taken on notice so we will give it to you in writing.

Mr JACOBSON - I am happy to provide that.

We have significant membership at the hospital. In a lot of cases, workers indicated to us that they hadn't heard from anyone so they were sent home and hadn't been contacted by

anyone. We immediately wrote to the department and said, 'What are you doing about contacting workers who have been sent home, first and foremost just to inquire as to their health and wellbeing?' Nothing was done.

We didn't even receive a response to that letter. We tried to engage with Human Resources at the time. There was indifference to our request. We also asked the question about contact with workers, trying to get them back to work, which they actually did do. That was the first time that the broader workforce was provided with PPE training. So, there was consistent training provided to all workers but it was inadequate.

Mr WILLIE - Was that after the hospital had been shut down?

Mr JACOBSON - Yes, that was after the hospital had been shut down.

Ms FORREST - Tim, just to clarify here if I might, nursing staff would have had training with the use of PPE previously, but probably needed a refresher. You're talking about cleaning staff and other ancillary staff who don't normally use PPE - medical orderlies, people like that? Is that who we are talking about?

Mr JACOBSON - All other staff - allied health professionals, social workers, et cetera. Yes, you're right. Nurses, obviously, are trained in infection control although in some cases may well need a refresher, bearing in mind that we have mental health facilities there as well. They are not often used to using particularly the sort of PPE that's required in a hot area.

Mr O'BYRNE - Tim, in your opening statement you referred to communication and the lack of communication. We heard evidence from the Australian Nursing and Midwifery Federation (ANMF), particularly on the north-west coast, how they were communicated with about the decision to shut the facilities. We heard the evidence that those members of that union found out by way of the daily update from the Premier. Is that the same situation with your membership?

Mr JACOBSON - Yes, that was the first time anyone knew about it. Then there was an email communication that came out from the department. But that wasn't the first time that happened. The second time that happened was when the state Government announced the closure of the Emergency Department at Mersey. It took some 12-odd hours between the time that the Government made the decision to close the ED at Mersey, and for there to be any operational management advice get out to the ambulance workforce in the north-west.

Mr O'BYRNE - Does that mean that they were still sending patients to the North West Regional Hospital.

Mr JACOBSON - No. They knew as much as not to, because it was closed. But in terms of there being any consistent, particularly detailed, operational management guidelines provided to workers, it took some 12 hours.

Mr O'BYRNE - On the issue of communication, obviously closing those facilities on the north-west, and given that health issues don't go away, you still needed to provide a response. What was the communication to your members at the Launceston General Hospital about procedures, responses? How would they need to respond given that decision?

Mr JACOBSON - The only broad communications that I have seen, and I am sure there were other communications, were the updates that were provided by the State Health Controller to workers. There certainly didn't seem to be any detailed information at a facility level provided to the broader workforce. I have no doubt, however, that there were some communications, particularly with the operational areas affected, for example, the 'hot ward' orderlies and some of the key people at the LGH, around that decision.

Mr O'BYRNE - You said in your opening statement that there was a good level of communication with the minister, and the minister's office, but then there was a massive disconnect between the minister's office and the agency in the department, and you say that is continuing. What are the consequences for that disconnect?

Mr JACOBSON - To be frank, the consequences are either that the workforce is unaware of what plans the department has in store for them, in terms of preparedness of a future outbreak. Largely speaking there has been no further communication around surge, around what would happen in the event of an outbreak at any of our facilities, what arrangements have been put in place and so on. Or, none of that work has been done at all.

Our experience with the bureaucracy has been disappointing to say the least. We were promised by the department, fortnightly industrial relations meetings where we would deal with a raft of matters including things like work health and safety, infection control, workers compensation matters, surge, contingency planning, et cetera, so that we could all be on the front foot, and we could all provide consistent advice to workers in the event that something were to happen.

I think we only ever had one fortnightly meeting. They have been ad hoc. Largely speaking, they are really only initiated by the department when the department wants to talk to us about something as opposed to dealing with those broader issues.

Ms FORREST - To follow up on a couple of those points in another area. You talked about communication probably coming a bit later, even after, the Premier's daily updates. You talked about the timeliness issue. You also raised some questions about consistency of information. Can you clarify what you meant by that? Did you ever have the opportunity to raise this with the minister, or the Premier, and what was their response?

Mr JACOBSON - We did, and, I think I made reference to it. But the consistency of information largely related to use of PPE and particular measures that were being put in place at a workplace level to ensure patient/staff safety.

At the time, there was no broad, detailed communication that went out to all staff. That created a vacuum, which enabled some people often to give false or speculative advice about what should happen.

You would be aware of the media story about LGH staff being asked to keep single use facemasks in the event they might need to be re-used. That's clearly incorrect advice. You can't re-use a single use facemask. That was clear advice that had gone out to staff. We had raised that a week or two before - and it was well known - a week or two before the department even issued any advice to workers in that facility.

Ms FORREST - What was the response from the Premier or the minister in regard to that?

Mr JACOBSON - The response was what we always knew - that is, that you cannot use single use masks.

Ms FORREST - I'm just wondering: was there some sort of effort to improve the consistency of the communication after those sort of incidents?

Mr JACOBSON - There was, I have to say. I'm talking about the circumstances around those first weeks of the outbreak, probably the most critical period as well. Whilst it would be easy to say we were learning, it was the most critical period for us as well because it was when we had the outbreak at Burnie. We had some transmission and we were trying to limit transmission. That inconsistent and wrong advice, which was known very early, was advice that should have been responded to very quickly.

Ms FORREST - You talked about the need for a dedicated surge workforce to be in the whole preparedness framework. You needed to know where you're going to get the additional staff.

Are you aware of any work that's being done in that area? What do you think is actually needed? When we talked to the ANMF - as you probably know, Tim, when rosters are done and you have gaps in them at the outset, you are already starting from the backfoot. Can you provide a bit of insight into that matter?

Mr JACOBSON - Just on that issue, - and I think I share this concern with most of my colleagues - I am very concerned about that. Victoria has an economy of scale that we don't have in Tasmania. They have a health system that is, I would argue, in a better shape than the health system we have in Tasmania. We have a very high casual and part-time workforce across the complete health and human services sector, including aged care and disability, which creates significant risks for us.

We don't know how many staff in the event of an outbreak will simply make themselves unavailable if they're casual employees. We don't know, for example - and this was an issue we raised with the ambulance service very early in the piece as well, and they didn't know - how many staff had co-morbidities that would necessitate that worker being stood down in the event of an outbreak - for example, if they have an autoimmune issue et cetera. None of that information is known.

The problem we have had from the outset is that we don't even know how many workers we have available, let alone in the event of an outbreak. We have an ageing workforce, particularly in the aged care sector as well as in our public health system, which would probably exclude from the outset a lot of workers, simply on the basis of age and risk,.

From speaking with the federal government, it has initiatives. It has Mable which is an app source you can source a workforce from. It's not particularly useful in Tasmania, particularly in our regional areas. Mable doesn't have the sort of workforce in Tasmania that we have in Victoria.

As for medical, we probably won't be able to stand up as many workers in Tasmania as they have been able to in Victoria simply because Aspen Medical doesn't have a dedicated workforce here in Tasmania. In addition to that, the extent to which we would have to fly in workers from other jurisdictions is something I don't know. I don't think any contingency planning work has been done around as well, and it is likely that we would need to call on AUSMAT resources in the event of an outbreak again.

Ms FORREST - Another area I wanted to touch on, was that you talked about when staff were furloughed or put into quarantine in the north-west and it was just an all-out sort of approach. It was, literally, overnight. Of course, patients still get sick - not just from COVID-19 but from a range of other things, and women still give birth, and so all those people who required medical care had to go to Launceston, predominantly. They weren't doing surgery at the Mersey and they certainly weren't delivering babies there either. I know the pressures the LGH midwives particularly were under, but also in other areas when they were receiving patients reluctantly at times from the north-west. What support are you aware was given to the staff at the LGH to manage that?

Mr JACOBSON - I am not aware of any significant support that was provided at all, to be completely frank.

Ms FORREST - Have you heard anything to the contrary?

Mr JACOBSON - No, I haven't.

Mr TUCKER - I want to come back to the communication issues here, so I can make it clear in my mind what you're saying. The communication channel with the Premier and the minister was open and clear -is that correct?

Mr JACOBSON - Yes.

Mr TUCKER - The communication channels with the department weren't clear, or were they?

Mr JACOBSON - Well, we were clear in terms of who we should talk to. The problem, however, was that when we attempted to engage we found it difficult. I have to say I was tired even when we did get to sit down with the acting secretary at the time and various other senior officers of the department. When we raised significant issues, we were consistently told that matter would be taken offline for a further conversation, and can I tell you, on pretty well every occasion, that conversation never came back online.

Mr TUCKER - Right. Did you raise these issues with the Premier and the minister?

Mr JACOBSON - Yes, we did.

Mr STREET - Was there an improvement in the situation after you raised these concerns, Tim?

Mr JACOBSON - That was the point at which we raised it very early in the piece. It was at the point at which the department stood up their fortnightly engagement meetings with

us, that continued I think for two fortnights and then literally fell off a cliff for about a month and a half.

CHAIR - Looking at the aged care area, which was an area of grave concern for every state, not just Tasmania. Are we now in any better position moving forward in that area, if COVID-19 returns - and there's every chance it could well do unfortunately. Are we in a better position now to handle that in our aged care homes?

Mr JACOBSON - There's two parts to an answer to that question.

One is at a facility level: yes. There has been, subsequent to the New South Wales early outbreak and then the Victorian outbreak, some significant resource planning and even testing of facility management strategies. On a facility-by-facility basis around COVID-19, and I know visiting those facilities that they have very robust processes for screening visitors, et cetera, so I would say at a facility level, yes, we are in a better position. But we are in no better position in the event of a broad outbreak, and the extent to which we're again able to look towards a surge workforce and a cooperative aged care sector working with each other to provide support to each other in the event of outbreaks in facilities.

I'll put it into context. Whether you are a for-profit or a not-for-profit provider in Tasmania, it's a sector that competes with each other. They compete for beds, they compete for funding; so, they're not particularly well known - particularly around workforce and industrial relations matters - for working around with each other. They compete for workforce, et cetera, there has never been a real conversation - and there hasn't been a broad conversation with the industry - about, as an industry, what can we do to support each other in the event of an outbreak.

We know, for example, there are very large facilities and I will just pick one - Southern Cross, largest provider in Tasmania that perhaps would have some capacity to provide to smaller facilities in the event of an outbreak, particularly given the extent to which they are a state-wide service. There is no conversation happening in that space at the moment. No one is aware. Everyone has their own specific workplace or organisational plan, but there isn't a workforce plan for the sector.

Ms FORREST - If I might follow up on that. The reality, as I understand it, Tim, is that the aged care sector has - I will say it - inadequate staffing levels to even enable the RN, who is often the only RN in the facility, to undertaken a medication round and appropriately use PPE to prevent cross-infection, for example, and that's current. That's without any infectious disease outbreak, regardless of whether it's a gastro outbreak or whether it's a COVID-19 outbreak currently. And you're saying that there's currently no discussion going on around any additional capacity in that?

Mr JACOBSON - No.

Ms FORREST - The ANMF also talked about this, and are delving for more nursing hours per patient day model to be implemented.

Mr JACOBSON - Yes.

Ms FORREST - Do you have a view on this? I mean the baseline is so skint, if you like, it doesn't even take a COVID-19 outbreak to put it under pressure.

Mr JACOBSON - It's already under pressure and the Aged Care Royal Commission spelt that out in their interim report, the counsel assisting's submissions that were provided last week, it is under-resourced. One of the issues there relates particularly to infection control, and the extent to which that is adequately able to be rolled out in the event of an outbreak. Staffing levels are so thin at the moment that, as you say, simply having sufficient numbers of staff to assist donning and doffing between residents is a pipedream at the moment. It can't happen operationally.

It would be difficult - and I am not necessarily being critical of the employers here because we know the funding circumstances are particularly bad - but at the end of the day, being able to manage simple infection control practices with current staffing levels would be severely problematic.

In terms of staffing, the counsel assisting has suggested a minutes-per-patient allocation for funding, based on a four- or five-star rating system. That just doesn't relate to the Mersey workforce, but the broader caring workforce and scaled-up, depending on the size of the workforce, which we would support. We are about to make our response to the counsel assisting's recommendations and that would be one of the recommendations that we would be supporting.

Ms FORREST - The other thing with that is I heard consistently up on the north-west - and it probably was the case in other parts too - about the lack of access to PPE in aged care facilities. It seems there was a bit of a disconnect there. Arguably, you could say you could have a pile of PPE from the floor to the ceiling, but if you don't have enough staff it wouldn't make any difference. Well, it would make some difference; but you still have to don and doff.

Mr JACOBSON - There is still a significant risk; and the risk is being able to appropriately utilise it. We know that donning and doffing requires two people - and if you're in a facility on a night shift, with up to 50 residents, and there's only two or three staff, it can be very busy. You can only imagine how difficult it would be for there to be someone to assist with donning and doffing, leaving only one person on the floor, on their own.

CHAIR - Any other questions on aged care issues? Tim, I had a question which you might be able to answer. Through the COVID-19 period and now do you have any members who have not been able to return to work through stress-related matters or mental health issues, where all these issues have caught up with them? Are there any issues there, numbers that you can provide us with?

Mr JACOBSON - We unfortunately do not get the numbers. I am aware of workers who contracted COVID-19 who haven't returned to work.

Ms FORREST - Can you say what categories of staff they were?

Mr JACOBSON - Not nursing staff.

Mr O'BYRNE - Based on what you've said today, you are not aware and your members are not aware of any plans or procedures if something were to happen? We are also hearing

that the physical layout of health facilities in terms of the number of staff means it is very difficult for them to socially distance and to really follow the instructions of their own employer. How is that presenting as a risk? Following that, if something were to happen, what impact would that have on our system?

Mr JACOBSON - Unfortunately, our facilities weren't built with COVID-19 in mind. Nurse stations and so on are generally a small room where you do your handover. Handover needs to happen with some degree of confidentiality so it is problematic. We know that there have been limits placed on the numbers of people who should be in or behind nurse stations, handover rooms, tea rooms, and so on. It has been difficult to manage, difficult to operationalise, particularly given that a lot of people stay on a ward for their whole shift. They need to go and eat their lunch. There is only a certain lunch period. That creates some logistical issues for people being able to isolate. There are a whole lot of logistical issues around it.

We know that, particularly in our rural facilities, staffing levels are inadequate. We know that their capacity, particularly in that context, is limited, similarly to some extent aged care. The concerns that we have around the rural health facilities are equal to those we have for all aged care facilities. Where we'll find the workforce, the extent to which they are able to manage social distancing and other things, and the extent to which they're able to manage risk by way of trying to separate our workforce as much as possible to ensure that in the event of someone contracting COVID-19 the bare minimum of staff would need to be furloughed as opposed to the complete staff establishment.

I have to say that is a big issue in ambulance as we well - the extent to which they are able to isolate their crews to ensure that in the event that someone needed, or a group of workers on the basis of contact with someone need to be furloughed, that they are not adequately able to manage that at the moment.

CHAIR -Tim, another question you raised during your statement to us was the State Service review coming on top of what we have just gone through and still going through, COVID-19. Have you had discussions with the Government in relation to stalling that, putting it off to say 2021? Have you taken that up with them?

Mr JACOBSON - We have. We wrote to the Government about a month ago, prior to the closing of submissions, making that point that we thought it wasn't the right time, that we are too early at this point to be making any adequate decisions about the composition and structure of the public sector, given that a lot of things are still unknown in terms of what demand is going to be on our public sector over the next 12 to 18 months, two years, three years, who knows.

The Government is pressing ahead. It doesn't appear that the Government intends to listen to that advice. My understanding is that the first report is due out any time now. That will make some recommendations. I am not clear about what the recommendations will be. There will be a further report in March next year.

The last time I saw a review of the public sector was before the change of the State Service Act in 2000. That was in fairly normal circumstances and that review took two years to complete. We have a review that was supposed to commence in the midst of the pandemic. There was a recommendation from the economic recovery council that it be sped up and now we have a review that's going to be finished lock, stock and barrel within six months.

CHAIR - Tim, thank you very much. We're out of time. We could keep going with the number of questions but we have to call it time. Thank you very much for the information you've passed on to us. We appreciate it. We will write to you of those couple of issues taken on notice. If there's anything else that you feel that you might have missed out on raising with us, would you please provide that to us? The committee would receive that because it is a very important area and they are a very important part of this whole thing.

Thank you very much.

THE WITNESS WITHDREW.

Hon. SARAH COURTNEY, MP, MINISTER FOR HEALTH, WAS CALLED.

Ms KATHRINE MORGAN-WICKS, SECRETARY, DEPARTMENT OF HEALTH AND **Mr MARK VEITCH,** DIRECTOR OF PUBLIC HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR – Thank you. Welcome minister and welcome to Mark and Kathrine and the rest of your staff. I am going to dispense with a lot of the formalities because the witnesses are already sworn from the last part of giving evidence to this committee. We all know who we are so I am not going down that path either. We are online, I think you are aware of that. It's public. Hansard will be recording all this information. I remind members that parliamentary privilege applies. You are aware of that. Once you leave here, maybe it doesn't.

Minister, we would like to direct our questions to your staff. If any issues or policy issues come out of that, no doubt they will refer back to you, or you will intervene.

Ms COURTNEY - I am very comfortable with that. Kath is the State Health Commander with the responsibility within the public health emergency. I will be directing them through Kath, because there are different mechanisms of responsibility of governance through our emergency management structures, so I think via Kath is appropriate.

CHAIR - If there is any short statement to be made, or any additional information or matters you would like to pass onto us, minister, I would like to provide that opportunity, but if you prefer we will go straight into questions.

Ms COURTNEY - That is fine, I'm happy with that.

CHAIR - I will open it up to members.

Ms FORREST - Minister, I appreciate you coming back and allowing us to more directly question Health officials. What I would like to touch on first is our preparedness for another outbreak. Borders are open, people are very nervous. In fact, in the north-west, people are not going out anymore where they were; things just shut down really tightly again up there - voluntarily.

I am interested in a pretty detailed explanation about our tracking and tracing capacity, and how it works, from a basic level right through, because I think it is important we understand how it works, and the public can have confidence in how it works.

We have seen what happened in Victoria - a few problems there - so I'm really keen to understand how our system works, from the initial notification, the test, and where to from there.

Ms MORGAN-WICKS - Thank you, Ms Forrest. In terms of our state's system preparedness, really our key planks are about -

- ensuring high levels of COVID-19 testing in the community, and also in facilities that are managed in terms of entrance to the state

- maintaining our public health capacity, including an effective contacting and tracing quarantining capability, as you have noted

- maintaining our rapid response capability to plan for and prevent, manage and treat any outbreaks;.

- ensuring our hospitals and ambulance service are resourced, equipped, trained and ready to provide the best clinical care to our COVID-positive patients

- maintaining, for as long as possible, all our other health services - as we saw, for example, during the pandemic, with various step-downs in health services so that we could prioritise for COVID, and this includes an assessment of our capacity to provide business-as-usual health services.

Our surge capacity to respond to an outbreak is monitored on a very regular basis, noting what is happening in terms of our FTE, our staff, our sickness, and presentations - for example, at hospitals - and also in terms of the surge capacity that is coming through.

Our bed capacity - so, including our reconfiguration plans for our hospitals to provide our 'hot' and 'cold' ED capacity.

Our levels of critical PPE - including ventilators, our blood products, medication and consumables.

Those are all things we are monitoring on a very regular basis. It is not a 'set and forget' - for example, after an outbreak, or assuming zero for so many days. We are continuing to monitor our health system preparedness on a weekly basis.

In terms of contact tracing, I might pass to Mark to make some comments about both our rapid response capability within public health, and also the measures we are taking on contact tracing.

Dr VEITCH - Thanks, Kath. Ms Forrest, I will just go to the heart of what happens.

When we get a notification from the laboratory, it is usually run through that someone has been diagnosed with coronavirus, and that is then run through to our communicable disease response team - and broadly what happens there is they contact the case, gather information about the case and about their movements, and try to understand the circumstances about where they could have become infected, and also look at where that person may have posed a risk during the time they were infectious.

This is a very familiar process. The team that runs this has been doing this sort of thing for whooping cough, meningococcal disease, measles and the like for many, many years. At its heart, it is a very familiar process for those core members of the team who have been doing it for a long time.

The process in relation to coronavirus is defined in a national guideline, which we call SoNGs - one of the Series of National Guidelines - and that is a nationally agreed protocol for how you approach the management or the investigation of a case of coronavirus.

We have a whole series of operating procedures and the like that define how we do that in the Tasmanian context, but essentially in line with the national approach.

Once the case has been interviewed, clearly, we need to ensure they are in the right kind of clinical care, so a clinical pathway is happening at the same time as the Public Health response.

For most of the cases we had in the first wave, many people were actually fit enough to be managed at home. Once that case is then isolated, at home, or wherever it is appropriate from either a clinical or public health standpoint - if they are too sick to be managed at home, they will be managed usually in hospital if the circumstances at home aren't appropriate for a person with coronavirus. They could put a vulnerable person at risk, for example. Then again, they may be moved to some alternative place for their care.

As part of that process of interviewing the case, we then go back to where that case was moving at the time when they could have been infectious to others.

Ms FORREST - So what time frame is that?

Dr VEITCH - The time frame is really from 48 hours before the onset of their symptoms. We figure that people could have potentially been infectious for a little while before they actually presented with symptoms, and then until the point they are diagnosed and quarantined. We then identify the people who were the contacts of those people.

Ms FORREST - Define 'contact'. What constitutes contact?

Dr VEITCH - This has changed over time. Historically, we have regarded it as being either close contact, or not a close contact - a casual contact. The focus of contact tracing has been the focus on close contacts, and that is defined as someone with whom you have 15 minutes or more of face-to-face contact in total, over the time they are infectious.

Ms FORREST - That is cumulative? If they had five minutes today, and five minutes the next day?

Dr VEITCH - Yes, it adds up. Or alternatively, I think it is two hours in a single room with that person, but not necessarily face-to-face. I would have to check this. I am not sure whether it is one hour, but I think it is two hours over the course of a week when that person was infectious in a room. Their close contacts are far and away the most likely people to be infected by an infectious case. Individually, the chances of them actually getting infected is not 100 per cent, and most people don't infect all their close contacts. They only infect a proportion of them - and often quite a small proportion - but most of the people who do get infected are among that close-contact cohort.

Beyond that, there is a less precise definition of what we used to call 'casual' contacts, which are people who had been moving in the same general environment. If a case can define where they have walked and moved, and the rooms they have been in, and the places they have been where their contact with people doesn't amount to a close contact, but is something less close, those people could be regarded as casual contacts.

Ms FORREST - Would we test those? Say there was a case that arrived from New South Wales?

Dr VEITCH - The approach has changed a little over time. The main change over the course of the pandemic is that we would now test anyone we identify as a close contact as soon as we have identified them. We would test them and have them quarantined for 14 days.

With casual contacts, we would generally make them aware of the fact that they could have been in the proximity of someone with coronavirus, and they are generally only recommended to be tested if they develop symptoms.

Mr DEAN - What is a close contact? Is touching more likely to contract this disease? Is it airborne?

Dr VEITCH - It is airborne, but there can be some contamination of the near environment. In the end, it has to get into your lungs and airways, and the tissues inside your mouth and nose to infect you. So, it is not going to infect you just from being on your skin. You have to then touch your mouth.

Clearly, when we are assessing whether someone has had close contact, we would err on the side of caution, and include them as a close contact, rather than saying they are not.

I wanted to add that much detail because I think -

Ms MORGAN-WICKS - May I add, in terms of Mark's answer on contact tracing, that we have strength in contact tracing, but that can't actually start until we have a case that is identified. It really flows from the strength of testing across Tasmanian communities.

We are up to now some 118 000 tests that have already been conducted in Tasmania, and are seeing incredibly low rates of influenza-like illness symptoms being reported in the community. Again, that proves challenging for encouraging anyone with very minor symptoms to come forward and get tested, because that is what will start the contact tracing from that event, from identification of a positive.

Ms FORREST - I commend the Government for getting the smaller swabs, too. They have been much more comfortable. I have heard from people who have had both.

I go back to the beginning of what you were saying, Dr Veitch - a test is undertaken; a positive result is obtained and it is a phone call to your team. Some questions there: How many are in the team normally, pre-COVID-19? How many are there now? How long is that likely to be the case?

You also talked about a phone call, and there are always risks of transcription errors. Some people have unusually spelled names, someone writes the date of birth around the wrong way, something like that - so you end up contacting the wrong person, or you cannot find the person because of an error. When you get a phone call, and write John Smith, and it is John Smyth, how do you go?

Dr VEITCH - We do well at that. I issued a guideline requiring the notification of coronavirus in, I think, February, and that specifies the details required to be provided by the laboratory or the doctor about that case.

Ms FORREST - So they send them electronically as well as via a phone call?

Dr VEITCH - Yes, we get them electronically, and we transitioned from fax to email recently. In practice, we don't have a problem. It's nice to observe the Smith/Smyth thing, but we do have a team that is very acute with those sorts of issues. I am not aware of any problems in that process of laboratory to Communicable Disease Unit information transmission about the notification.

Ms FORREST - Staffing numbers?

Dr VEITCH - We, like many jurisdictions around Australia, had really quite a small Communicable Disease Unit and Tasmania being a small state, it was smaller still. It depends here on how you define the unit. If we are concentrating on those core staff who are making the calls to people with infectious diseases and following them up, we normally have a staff of three or four nurses doing that work full-time up until now, with some other nurses in other parts of our Communicable Disease Unit - such as the vaccination section - who can be called upon to supplement that in peak time, if we get a slight surge.

With the onset of the pandemic in January, and the expectation of the need for more staff, we brought some more casual staff on, and some short-term contract staff, around February and March. Those staff enabled us to respond to the outbreaks in the north-west from Hobart, and also did the other cases of coronavirus that were managed in the course of the first few months. That group has now been supplemented. We sought additional funding - and Kath may have the actual numbers somewhere in here, but it is up to around 20.

Ms COURTNEY - We had 20 additional recently and we have had a lot of interoperability from other agencies, as well as nurses coming across from different parts of the THS into Public Health to supplement it earlier in the year around contact tracing, as well as originally the Public Health Hotline as well, so we had significant additional resources.

We have also developed some really strong partnerships with the University of Tasmania, to be able to utilise some of the expertise they have there. In regard to the detail of that, if it is convenient, we can take it on notice and provide a breakdown and a bit more information about how we use that. The university and other organisations were very helpful around the expertise as well.

Ms FORREST - We heard in one of the hearings about the New South Wales model for training their staff working in public health, and they have a very well organised, regular and almost like a mandatory training-type approach. They've a well-skilled public health response there. Victoria didn't have that in terms of the training of their staff.

Can you tell me what sort of training, and the regularity of it, that people who work in this area of contact tracing and communicable disease management - whether it be COVID-19 or some other infectious disease - how that actually works, and what they have?

Dr VEITCH - The staff who are there routinely are a combination of doctors and nurses with specialist skills in communicable disease control, usually through a Master of Public Health degree, and epidemiologists, also with a range of qualifications from masters degrees to PhDs. They're the basic training skills of our people.

As you know, New South Wales does have a public health training scheme. We don't have one of those here in Tasmania. However, we regularly bring through our team, doctors in particular who are training either for their public health medicine fellowship, or are training in a higher degree in epidemiology, or sometimes both.

Those schemes will provide a good, sound basic training in communicable disease response. Communicable disease response is a really fundamental part of any public health practitioner. That's from the time when that was all public health was - managing infectious diseases - but it's still a very important part. Those people do come with training.

There is a gap nationally in continuous professional development for this somewhat eclectic group of people who work in this field. What has been developed recently by Professor Craig Dalton in the Hunter-New England region, is a professional public health officers' group. It's an attempt to try to develop an umbrella organisation that's able to provide peer support and training in professional development.

Ms FORREST - A professional body, you mean?

Dr VEITCH - Yes, trying to develop a professional body, because you have nurses and epidemiologists. You have doctors. It's a disparate group of people who are all doing much the same thing, but there's been a gap in an umbrella organisation. So, that's very new; I don't know whether it's going to deliver, but it's a good initiative and it works.

Ms FORREST - Do you think that would be an avenue for regular and contemporary training? As a nurse you have to have annual CPR training. You don't do CPR every day of the week.

Dr VEITCH - I think our team is quite good at providing support within the group to train each other. We have also been working on developing some training modules with the University of Tasmania to provide, if you like, a bridging course for people who might come in as surge capacity and who need to understand the basics of infectious disease surveillance, outbreak management, case and contact management. So, we're working with UTAS to develop that. There's also some online modules that are being developed to give people the basics of how you do contact tracing -

Ms FORREST - Through UTAS, or is that through the department?

Dr VEITCH - I think it's built on an ANU model, but I think they're working with UTAS on it.

Ms MORGAN-WICKS - If I can comment in relation to the layers, because at the very heart we have a core of very experienced public health officers in relation to contact tracing. Throughout probably the first wave of COVID-19 in Tasmania, we trained up a surge capacity - typically, nurses from areas of our health service which we had actually reduced

service in. So, we have maintained them well, continuing our contact with them and their training, so they are ready to be stood up again if required.

We also have teams of people doing things around contact tracing, which might be the continued contact, for example, with a positive case, a close contact or other people involved in terms of clinicians or their care. They are contacting them daily throughout a 14-day period. We've got a testing hub and teams that are actually contacting and requesting or not information about their symptoms and whether they need testing whilst they are in isolation.

There are teams of people actually situated around this core contact tracing ability, which is the person who actually has to either sit down, or on the phone, interview a positive case to find out as much as possible about their movements and travel and contacts in the period.

Ms FORREST - Do you access things like credit card records and phone records, which did give some geographical data?

Ms MORGAN-WICKS - There are prompts in the questioning. Certainly in one of our early cases we might reflect that we did get down to certain levels of financial detail to aid the memory of a particular case.

Ms FORREST - You can do that without any extraordinary powers or anything?

Dr VEITCH - I think they are a very imaginative and clever sleuths. When we brought our colleagues from the police to give us some support at one point, we found they were affirming what we discovered rather than giving us new clues or ways to find it.

Ms FORREST - There's a lot of information in there. You know where I've been.

Ms MORGAN-WICKS - Depending on, for example, credit card information and the delay in which it might attribute to a date or a statement etcetera, those types of transactions were an aid to at first determining whereabouts in movements et cetera.

In terms of an interjurisdictional scam, we've been closely in contact with other jurisdictions to determine not only training resource levels they're employing in terms of contact tracing but also the systems they are using for contact tracing. In terms of Victorian support, we had our contact tracers supporting the Victorians to assist, particularly with their very heavy loads of case volumes. We received very positive feedback in relation to the quality of the tracing and interviewing that our Tasmanian staff were employing.

Dr VEITCH - Which we were doing remotely.

Mr O'BYRNE - - I've a number of questions, but I want to extend what Ruth talked about.

There are a number of entry points where critical decisions are made when people call. Can you talk me through the Public Health line? The kind of staff you have on there? What training. what support and what numbers you have? Over the journey of the last six months we've heard some interesting stories about conflicting information provided or them not being able to provide information.

I want to get my head around what's happening at the minute. Now the borders are reopening, what does the Public Health line look like? What kind of staff are in there? And what kind of training are they having?

Ms COURTNEY - Can I make a comment on this before Kathrine gives the detail? The Public Health Hotline transitioned its responsibility - and correct me if I'm wrong - it started within Public Health under Health's responsibility and effectively under the Health ECC. It then transitioned on to the State Control Centre's responsibility. Did you mean the response for the time that the SCC was responsible? While we have a lot of input into what is asked and how it's done, we might have to take some of that detail on notice because it was underneath a structure that is not beneath the Health Commander or me, it's the Secretary of Health. I wanted you to know those caveats because it did transition.

Mr O'BYRNE - Can you clarify then, in terms of a call coming in from, for example, someone with symptoms, would that come under your purview or would that stick with the transferred powers?

Ms COURTNEY - It comes through a central portal; then there's a series of numbers; then some things can be triaged to Public Health or to Health because through the SCC hotline that we had originally, people are still able to contact Public Health for non-COVID-type things as well that may occur.

Ms MORGAN-WICKS - Meningococcal, for example.

Ms COURTNEY - Yes, meningococcal. I might get Kath to talk about that and then we can provide, if we need to, more detail about the SCC.

Ms MORGAN-WICKS - Thank you, minister. I can speak around the contact centre but I don't have the numbers because it's managed through our state control environment.

Certainly it started off as a hotline sitting within Public Health. Public Health still provides a significant amount of advice, particularly in terms of the scripts used within the call centre. We transitioned from probably what was a smaller state response call centre that would typically stand up, for example, in flood, fire or other emergency events and transitioned over to the Vodafone centre. We took an emergency lease and transitioned to that environment.

The call centre, itself, is basically the front door which then, through a series of prompts, takes people to other various lines. But if you're ringing with symptoms, it is straight to the Public Health Hotline. It is basically providing them with your information and you get a call back from a Tasmanian Health Service testing hub team which has access to our patient information management systems.

What you are doing is booking a pathology test. We are dealing with sensitive patient information. They call back and are able to input your information straight into our systems and provide you with a time to attend the testing clinics. When you roll up in your car, they will then recheck your information to make sure they have the right Smith or Smythe. for example, test again, similar to when you get a blood test at a GP or pathology lab, your date of birth et cetera. They are testing all that information. They are also asking more detailed information when you are in the car about symptoms and time of onset et cetera.

That is in the booking but other calls go to a response centre, whether it is about assistance, or the interpretation of one of the Public Health directions or one of the Emergency Management Act directions. There are a lot around border and travel restrictions, for example. They are operating as a main call centre hub and trying to get down to more specific expert advice lines as required.

Mr O'BYRNE - I had an experience with a hotline. I had some symptoms and it wasn't very smooth to be honest. I don't want to bring it up as a personal case but they didn't keep my information. I had to remind them. I had a call from Public Health later that day. I was frightened when the number came.

CHAIR - Surely you can turn this into a question?

Mr O'BYRNE - My concern is in my experience there were three points of contact with the call centre, two of which they made mistakes on. That concerned me.

The reason for the question is in terms of the Public Health line, when people are calling you, what kind of people are they? Are they professionals? Are they administrative people? Are they casuals? Are they permanent? What control measures do you have on that system that ensure the correct information is taken and the response is followed up?

Ms FORREST - And consistent information too?

Ms COURTNEY - Kath, can talk about when it comes through to Public Health. I am more than happy to look at the details and get a question on notice through the Premier's Office or through the SCC on that one because I can't comment.

Mr O'BYRNE - I don't want to use my personal experience.

Ms COURTNEY - This entire process feedback is useful, to be frank.

CHAIR - A question coming from that could well be: have things changed in relation to this as we have moved through? What have we learned? What has come up?

Ms COURTNEY - I think the process has evolved from the very beginning in terms of standing up for people, in terms of the systems we used and in terms of the actual physical locations. There has obviously been a huge ramp up in demand. As the breadth of things coming through the call centre also stood up in terms of questions about all sorts of different things, it has continued to evolve.

Having visited a number of times, we have really good teams of people on the ground and we have really good management to support the staff. I am more than happy for us to provide some more detail.

Ms MORGAN-WICKS - It's been quite a hard environment for this call centre team to continuously evolve, learn, train and be able to then pick up that knowledge and translate it through the phone calls. They have done an amazing job.

Mr O'BYRNE - This was only about four or five weeks ago when things weren't as intense and that heightened my level of concern.

Ms MORGAN-WICKS - Certainly in terms of having, for example, and I don't know the current number of staff, it was heading up towards the 80s, it felt like at one stage but that also be staff that were around the periphery and supporting that call centre. They can't all have access to our patient information management systems within the THS. They are not qualified to have that so they have to basically try to funnel the calls. There was a bit of weeding out, certainly in early months around the symptoms and whether you qualified for a COVID-19 test. I am certainly very happy to take any feedback on board, talk to them again and also make sure that our testing hub team in the THS, which rings you back, books the test and also should answer any calls if you haven't received your test results. That is certainly within our health scope in terms of our responsibility.

Ms FORREST - Mine was seamless, by the way, with a big swab, I might add.

Mr O'BYRNE - My original line of questioning was around testing capability. My understanding is that we can test up to 2000 per day. My question is: if there were an outbreak, how long and how far could that capacity run if there is an extended testing demand? How long could that last for?

Ms MORGAN-WICKS - Our regular testing capacity is around 1000 tests per day. That's what we can comfortably do. With a surge capacity, in an outbreak situation like the hospital outbreak that occurred in the north-west, it can surge up to the 2000 tests per day. Beyond that escalation trigger point, we would be similar to the Victorian situation, looking at interjurisdictional assistance, for example, during testing. We also have a private capacity on the island, which has really come on over the last couple of months.

Sonic is able to provide on-island testing. It has capacity for up to 400 tests per day, currently.

Mr O'BYRNE - So you could surge to 2000. How long could you realistically sustain 2000 per day for?

Ms MORGAN-WICKS - That surge is actually laboratory testing. We also need to make sure we have the staff who are on the ground who are able to take the sample in order to test. That will depend upon the fixed lane environments we have in each of our big four cities. For example, at PW1, we have seen it go up above the 200 or so a day. When we have run mobile respiratory clinics - for example, out at Glenorchy - we were seeing in the hundreds pushing through.

We have fixed capacity in taking the sample but we also have mobile capacity, which we can send straight into an area if we are concerned there is an outbreak.

Mr O'BYRNE - If there were an outbreak in Hobart, could you bring people down from Launceston?

Ms MORGAN-WICKS - Yes. We would move and shift, and we did. We have practice at doing this, for example, getting testing capacity quickly into Smithton.

Mr O'BYRNE - Again, the question is: modelling that, how long could you sustain such a high level of testing if there is an outbreak? A week at that 2000 level or two weeks?

Dr VEITCH - If we foresaw a need for going much beyond a week, we would certainly be planning pretty quickly to work out how we would add sufficient resources, particularly, as Kath says, to actually collect the specimens because that is, in a way, the rate-limiting step.

Mr O'BYRNE - You do a double test, don't you? The first test is to narrow it down?

Ms MORGAN-WICKS - Yes. There are various ways - for example, in the laboratory - which we have explored at various times. It is the number of swabs you are actually placing in each receptacle. I probably haven't used the scientific term there, but pooling of swabs. In other jurisdictions they have gone higher than three, but we need to make sure that we test that number and calibrate our systems and analysis of the results to suit that pooling.

CHAIR -Before the next comment is made, are you happy to stay on, minister, after 4 o'clock?

Ms COURTNEY - Yes, that is fine.

CHAIR -I need to know so I get my questioning right with the members.

Ms COURTNEY - Obviously, the head of the laboratory at the Royal Hobart Hospital has done an amazing job. We have moved into a bigger footprint and have done a lot of work in procuring complementary machines to make sure we have different supply lines, which is really important.

My latest advice is, and this may have evolved, that those supplies are still coming in sufficiently at the moment. My understanding is the companies that provide those have worked hard to make sure that either a jurisdiction or a country does not stockpile gallons of things, meaning that other places cannot get it.

The companies have worked very responsibly and we have a really good relationship with all the suppliers. That has been really positive. We have different types of machines that can be used. We also have strong relationships with others, such as the university and other parts of government. We have parts of government that also have laboratories, such as within police and other areas. There are opportunities, should we need to surge for extended periods of time, to also look at how we can use interoperability across different areas. So, there is opportunity should we get a sustained surge, so to speak, to look at mechanisms to support that with suitably qualified people from either other parts of government or other areas such as the university.

Ms MORGAN-WICKS - For example, 2000 is much higher than where we ever had to surge to in our first wave of COVID-19. I think we hit a limit of around - not a limit, we processed some 1400 tests in one day when we had tested the three aged care centres in relation to a case.

Mr O'BYRNE - Was that all state-based resources, or did you need the private sector as well?

Ms MORGAN-WICKS - That was with the assistance of the private sector in taking the swab, but it was using our Royal laboratories to run the 1400 tests. We have had the assistance of, for example, forensic laboratory technicians that came into the Royal and were trained and now know that environment.

I think 2000 is what we've talked about with the Royal labs in terms of pushing beyond that and pulling in staff that are able and capable of running the PCR testing, without looking at other testing kits or types. There's plenty of room from what we've seen from our first wave of COVID-19 but we're not becoming complacent about that number. We are pushing and stretching in terms of the different technology that's coming.

Mr WILLIE - My question is to the director of Public Health. It's previously been confirmed that there was a one in 10 million chance of COVID-19 entering the state when we're opening up to states that didn't have community transmission. New South Wales is currently dealing with a small outbreak in the south-west of Sydney where there has been locally transmitted cases.

Opening up on Friday, has that risk profile changed? If so, what's the new figure?

Dr VEITCH - The number of one in 10 million was based, I think, on, when we were talking about it, all the non-eastern seaboard states and possibly Queensland as well having a cumulative population of about 10 million. They had in recent days only had a single case of coronavirus in that population of 10 million. It's not quite the same as saying that someone has a one in 10 million chance of coming into Tasmania from those places with coronavirus, but it was an indication of the fact that the likelihood of someone coming from those states that weren't seeing cases of coronavirus was very small.

Mr WILLIE - Has the risk profile changed?

Dr VEITCH - The risk profile in those states is almost incalculably small at the moment. The states and territories of Queensland, Northern Territory, Western Australia, South Australia and the ACT have not had a case of unexplained community transmission in their states for, I think, over six weeks. They have all had some cases who've come in from overseas and developed symptoms in quarantine but they pose no risk to the wider population. So it's not necessary to count those as contributing to the risk of people travelling to Tasmania because they're not travelling to Tasmania when they're in quarantine.

There's no nationally agreed way to risk categorise the various Australian states at the moment. We have taken a lead from some discussions that have occurred at the Australian Health Protection Principal Committee - AHPPC - that I sit on, which comprises the chief health officers of the states. It's informed by the communicable disease experts. We've taken a decision to categorise the states into three broad categories.

In particular we focus on what some jurisdictions call mystery cases, cases that occur without an explanation or a link to known other cases. We also consider cases that are occurring in small confined clusters, so they may actually may actually be explained - but are continuing to occur.

Mr WILLIE - Like New South Wales.

Dr VEITCH - Which is what is occurring in New South Wales. New South Wales - as of tomorrow - will have had, I think, three or four unexplained cases in the last 28 days. They also have a cluster of cases in south-west Sydney, where the New South Wales health department has essentially joined all the dots - they understand the links between is a hospital associated with it, and a couple of other particular settings - but New South Wales understands the setting there. They have identified people who have been in those settings and required them, if they are at high risk, to quarantine -like a close contact we are talking about.

Ms FORREST - Except for one who did not. It was reported in the news that there was one who did not.

Dr VEITCH - Today or -

Ms FORREST - It was today or yesterday; I cannot remember now.

Dr VEITCH - I have not heard of it. I think we have to trust the efforts of our states to do the best they can, and short of actually locking people up, you cannot completely contain them. But as far as New South Wales is concerned, the overall risk in New South Wales - because of the rarity of those cases of unexplained mystery cases - is very safe. In a population of 6 million people, over the last 28 days only three or four people have popped up with coronavirus without an explanation. They have an outbreak; they are seeing still a small number of cases - one or two cases every several days - but they are linked to a known outbreak, and they have their own control measures in place in New South Wales for people in New South Wales who could be in contact with them.

With all those measures in place and with that risk assessment, we think it is safe to recommend to the Deputy State Controller that we enable people from New South Wales to enter without quarantine. We looked at whether we could set a single threshold, a single number, to say at that number it is safe or it is not safe. I think we have all realised that the difference between four and six cases in a population of 6 million is not an appreciable difference in the risk profile. The other reason why we have to be very careful about very precise thresholds, is that you could find yourself in a situation where someone is in a plane coming down from New South Wales, and another case is announced, and rather than going on a holiday they go into quarantine. We have to have a way to assess what is going on in the states that uses.

Ms FORREST - Assuming they have been in contact with that person, on the plane?

Mr WILLIE - No, if you are ruling that state out - before it arrives.

Dr VEITCH - Just anyone in New South Wales. Because of that, we need to both have both benchmarks or criteria where we think it is safe, but we also have to use some public health judgment that looks at the trends and the circumstances of the cases that are also occurring at the same time to make that call.

Mr WILLIE - We have talked a lot about testing and contact tracing. What happens if it fails? It is another threshold question, but how many mystery cases do there need to be in the community before further action is taken? If further action is taken, what is the plan? Is it

further restrictions at a regional level, or would there be a more conservative approach? I think a lot of people are unclear on what will happen in all of those stages.

Ms COURTNEY - Can I just clarify this so that in my mind we are answering the right questions? In terms of the system failing, are you talking about -

Mr WILLIE - If contact tracing is unable to -

Ms COURTNEY - It is so overwhelmed -

Mr WILLIE - Yes, the outbreak - that there are unknown cases appearing in the community because contact tracing has not been able to link them to known cases. What is the threshold? How many unknown cases? What are the plan and strategy from then on? I think that is unclear.

Dr VEITCH - The general process of contact tracing is very context-dependent, I am just trying to think how to best approach that question. We will take any unexplained case very seriously. When we see an unexplained case, we do two things. We look downstream, to see whether they could have had contact with people who could be cases - that is probably what we are mostly talking about, and what most people think about contact tracing: trying to find out who could be next then and quarantining them. We also look upstream. If we see a case of coronavirus we do not understand, we look to where they have been in the preceding two weeks, and are there any clues from their movements or the places where they have been that could signal where they acquired it. We use that sort of information to target testing, to see if there is testing out in a setting where they might have acquired it, as well as downstream.

Mr WILLIE - I heard an epidemiologist talking about this on the radio.

Dr VEITCH - That is a bit of the answer. We also look very carefully at the significance of the case. We would take any unexplained case very seriously. We would think - does that pose a risk of getting away, that single case? We would do all of our testing, and there might be a need for localised or very specific restrictions. If someone had worked in a large business, or had been in a particular setting where there are a number of people, we might actually require those people to isolate or quarantine for a period, or be tested - or some combination of those things.

Mr WILLIE - To clarify, that would be if there was one unknown case, and you have gone downstream and upstream?

Dr VEITCH - The generic answer is, if we saw one or more unexplained cases, whether linked to each other or not - geographically or in time - we would consider whether it is necessary to put localised or wider restrictions in place to prevent further spread. What we have learnt from Auckland is a good example. You have to go hard and you have to go early. If you see one or two mystery cases, and they cause six cases in three or four days, and two dozen cases a week and a half later, things can very quickly lose control. I would have no hesitation if I thought there was a measure that was commensurate with the risk to contain it, to impose such public health restrictions as might be necessary to contain it.

We would be going like billyo with our contact tracing and our testing and so on as well, but we have to keep the possibility of restrictions in mind - because we know, for example, if

we think back to about March/April, we were well spread apart back then. We weren't mixing. The RF or the reproductive number - which is what the epidemiologists talk about - was well under one, which meant that there was a significantly reduced potential for spread in the community.

Ms COURTNEY - Can I add to that? If we look at our experience earlier in the year, it's very rare, which is very good, that you have this unknown or mystery case. If we looked at the ones earlier in the year that we had, they would very quickly ascertain the likely cause - because they had either travelled from somewhere where there was a high risk, or were a close contact. In terms of those, the team did a very good job of being able to ascertain exactly where it came from, or a high probability of where it came from very quickly. It just in the context of the fact that this would be very serious, but also very rare.

Mr WILLIE - It is a relevant question though, because other states are dealing with unknown cases so to get some information about that is very relevant.

Ms COURTNEY - Absolutely.

Ms MORGAN-WICKS - We have a series of escalation management plans sitting within Public Health that look at numbers of cases and what triggers would provoke another team being formed or established. We have that laid out. We have escalation management plans within our hospitals that look at how many positive cases are occurring and the steps or restrictions it would place across Health services and all our facilities, and link through to aged care and primary care in the community, for example. We would be watching those numbers closely and triggering already prepared escalation and emergency management plans.

Mr O'BYRNE - Mark, it seems like you use quarantine and isolation interchangeably. They are different, though. I know there are some people who say, 'I have symptoms but I am allowed to stay at home with my family and infect them'. There are a whole lot of misconceptions around isolation and quarantine, so could you clarify, in the context of Josh's question, that kind of response?

Dr VEITCH - Strictly, quarantine is what you do to someone who is not a case, but is someone who has the potential to be a case by virtue of being exposed to either an individual or having come out of a high-risk setting. People coming from overseas from high-risk countries go into quarantine - a close contact who you tell to 'Go home, stay home', that is quarantine.

Isolation is the process of what you do with a case. The case may be sitting at home until they get better and they have reached the clearance criteria. One of their contacts may be sitting in another home, being in quarantine. One is in quarantine and one is in isolation. It is not much different really for them, but the term 'isolation' is used to refer to cases, 'quarantine' is referred to people at risk of becoming cases.

Ms FORREST - It was really a follow-up from the one before this. Kathrine, you were talking about coping if there were an outbreak. You mentioned earlier about hot and cold areas within the facilities. Can you talk us through how you would manage that if there were cases in Tasmania, particularly if they required hospital admission? What measures are in place to reconfigure if you need to in areas that you can? You could close down the Burnie hospital and use Mersey but you cannot do that at the Royal so easily.

Ms MORGAN-WICKS - No, and we would not wish to close down the Royal in that type of environment. In relation to our safety measures and safe staffing of the North West Regional Hospital, that was what was required at that time.

Ms FORREST - It was the right thing to do at the time, I agree.

Ms MORGAN-WICKS - Concerning escalation management, each health facility has an escalation management plan. For example, I have a copy of the south in my folder today but each district hospital also has one.

Ms FORREST - Can that be made available?

Ms MORGAN-WICKS - These are published for our staff. The information is available internally in the Tasmanian Health Service so they are aware of the escalation management.

Ms FORREST - Can you provide hard copies of each of those to the committee?

Ms COURTNEY - They are living documents so they will be at a point in time.

Ms MORGAN-WICKS - The four major acute hospital health plans are reviewed on a regular basis at our THS Emergency Operations Centre meetings, tweaked, and with each change in border restrictions, they are reviewed again and determined. Things that we may have trialled in relation to hot or cold ED configurations, for example, we learn through the process whether that was working or what was working - our waiting room capacities and so on.

If we are reaching particular limits with social distancing in waiting rooms, whether people are required to wear a mask while waiting, for example.

In each plan and according to the different services provided at each facility, noting that the Royal probably with the major amount of services that could be impacted, we follow various triggers. For example, we look at the number of tests done each day or screening assessments, we monitor influenza-like illness presentations to the ED per day, we look at patients admitted with COVID-19 for treatment within a hospital facility, patients admitted requiring ICU for a COVID-19 case and have various trigger points which we move through a level 1, 2, 3 and 4 response.

Ms FORREST - If anyone presents to an ED around the state, why wouldn't you require them to wear a mask?

Ms MORGAN-WICKS - With respiratory systems?

Ms FORREST - Yes, with any respiratory systems.

Ms MORGAN-WICKS - I will ask Mark to comment in relation to the use of PPE in accordance with the CDNA - SoNG - requirements. At the moment with our ED environments and our social distancing, people who are presenting with respiratory symptoms are instructed to wear a mask. That is upon presentation.

If you are sitting there with a child with gastro or something else, we also have to protect patients from them as well, not only respiratory illnesses. Where we are reaching social distancing limits, I have been speaking to the EDs about the wearing of masks within ED for all patients. Do you have anything to add, Mark?

Dr VEITCH - I do not have anything to add. The protocol for managing the respiratory illness, regardless of what it turns out to be, whether it's flu or rhinovirus or coronavirus, the triage process, I understand in most places now and I think quite reasonably, puts a mask on those people.

Ms MORGAN-WICKS - Absolutely. Treat it as suspected COVID-19 in this environment.

Mr TUCKER - I have been waiting to ask this question all afternoon. Minister, can you provide the committee with an update on the PPE stockpile?

Ms COURTNEY - Yes. I'll get Kath to talk about the detail of it. It's been one of the key focuses over the last few months. We said publicly several months ago that we're looking to build up a significant stockpile of PPE in Tasmania. We know that obviously during times of surge or COVID-19 the use goes up highly. A lot of this work was implemented earlier in the year on our supply chains, on storage and rotation and on the procurement team to make sure that we've constantly got the required volume and preference as much as possible. There are still challenges regarding the preferences in the types of mask. We are working really hard to make sure we're getting as many different ones for clinicians and making sure we have good distribution mechanisms around the state to ensure there is PPE where it's required.

I'll get Kath to provide an update on the quantum.

Ms MORGAN-WICKS - Thank you, minister. At the beginning of the pandemic we were talking about stockpiles we've always maintained. We've had a state pandemic stockpile within the Tasmanian Health Service. We've also had national pre-positioned stockpiles.

What we have done throughout COVID-19, using modelling we've developed from off-peak consumption periods - for example, during the north-west outbreak - is develop target levels for key COVID-19 pandemic items. Starting with the small list, it quickly grows out. You'll see a lot about N95 masks, for example, but there is a lot more we're actually monitoring through what is now our state emergency management stockpile.

Ms FORREST - Including medications?

Ms MORGAN-WICKS - Yes. It's probably into four key areas. We've got PPE, pathology, critical care and elective surgery medicines and our ventilators. With PPE, before this week about 60 per cent of the statewide emergency medical stockpile items were at or above their stockpile target and some 85 per cent all being fully ordered.

Ms FORREST - Is that across all regional district hospitals, as well as the major hospitals?

Ms MORGAN-WICKS - No, this is a separate emergency medical stockpile. This is above current normal general stock usage and ordering. Hospitals are continuing to operate,

but this is a stockpile we've separately provisioned. We are going to make sure however that stockpile items are circling and rotated through the hospitals given use dates, expiry and so on. There are some items that we need to make sure we're carefully managing life periods. For example, some drugs, or medicines, or consumables for ICU.

In terms of the P2 or N95 respirators, we currently hold 74 per cent of our stockpile target with some 400 381 N95 respirators with a stockpile target of 554 000. We wanted six months' worth of use which we were attempting to stockpile, but we've increased that now from the 544 000 as a target and we have current forward orders of some 3 440 000.

What we're now achieving is through a monthly drop of N95s. By the end of January, based on our peak COVID consumption modelling, we will have enough N95 masks to last for a year, so 356 days worth of use just from our extra and above stockpile. We will -

Ms FORREST - To be rotated through the general stocks of the hospital and then replaced?

Ms MORGAN-WICKS - Yes, that's correct.

So, that's the N95 masks. We also are monitoring surgical masks, gowns, gloves, eye protection, hospital-grade hand sanitiser. All of these things are being pulled in as a COVID-19 key PPE item. We are well above our target for all those. Probably the ones we are watching are aprons, which are at about 84 per cent of our target but we expect to receive another 375 000 next month, and, funnily enough, shoe covers. Shoe covers are also featuring, but we have an order of 375 000. They are currently in Victoria and we should be receiving those next week.

Ms FORREST - Are these things manufactured in Australia?

Ms MORGAN-WICKS - Yes. We've had various approaches from manufacturers all over the world, certainly, throughout this pandemic. We have committees though, depending on the type of PPE or ventilator, for example, or pharmaceutical consumable that we must absolutely assess and tick off, whether it's a TGA approval or other approval, so that we don't end up with 25 different types of ventilators, for example, which wouldn't suit in terms of training and ease of use in that type of environment.

In terms of PPE on pathology, we are holding very good levels in terms of swabs, our extraction reagents, our consumables for our PCR tests and our rapid tests. We have a very good relationship with Roja, our primary supplier for these types of items. All listed critical care medicines are at 100 per cent target stock levels and also all listed supportive care medicines are at 100 per cent target stock levels so that we have enough treatment and concurrent treatment for patient targets that we've said.

CHAIR - The Therapeutic Goods Administration is the ultimate determinant and decider in these matters and so on?

Ms MORGAN-WICKS - Different associations according to different items. TGA, for example, on masks or PPE et cetera.

CHAIR - The point I'm getting to is that no other group, like TMAAC, can override those positions. You are right, not too many people know about it.

Ms FORREST - Who are they?

CHAIR - TMAAC - Tasmanian Medicines Access and Advisory Committee. It's a Tasmanian organisation. You will hear me talk next Tuesday on the medicinal cannabis matter about who has the right to overrule in certain circumstances. I have written to your office, minister, to get more detail on it.

Ms MORGAN-WICKS - Chair, I don't have my Chief Pharmacist with me but it's certainly something I could take on notice.

Mr STREET - I don't want to put the cart before the horse but, in terms of a vaccine, at the start it was sort of trumpeted as the silver bullet for all of this. We get a vaccine, vaccinate everyone and we're fine. The more I read about it, the more it seems that the efficacy of a vaccine is probably something that's questionable, anyway.

Dr Veitch, I guess my question is: what's your view on the vaccine, itself? Then to Kath: once we do get a vaccine, have we already started putting plans in place for the rollout of a vaccine when it comes?

Ms COURTNEY - Can I make one comment before we go to Dr Veitch on this?

From a public health perspective, we talked more about contact tracing but around immunisation vaccines it's a core part of what Public Health does. It has had really strong experience, in recent years, through meningococcal and other medical things like that when we've needed to provide vaccination across the community.

We also have very strong relationships with our GP networks as well as our pharmacists who have partnered in a lot of the work that we've done in recent years to make sure that we can get vaccines safely into the community. We've had some really good outcomes here in Tasmania in terms of our vaccination rates.

I'm not sure whether Kath or Mark will talk first about their views on it.

Dr VEITCH - There are two questions. One is: what's the vaccine outlook look like? The second question is: what are we doing to make sure that when a vaccine appropriate to use becomes available in Tasmania, we can roll it out?

I think it was a very important observation that we shouldn't necessarily expect a vaccine to be a silver bullet.

Every vaccine that gets to market is tested against two principal things - its safety and its efficacy. Safety is pretty straightforward. Does it cause short-term or immediate or longer term harms? Are they mild or are they severe? Are they familiar or are they new? That is something we get information from as a vaccine is used in larger numbers of people and sometimes for very rare events only when the vaccine is in widespread use; because something happens once in every 5 million doses of the vaccine, you won't know about that until it is in widespread use. Certainly the more common side effects of a vaccine, the sore arm, the bit of a fever, that sort of stuff we will know about that well and truly before a vaccine goes to market.

The other question is: how well does it work? That's currently being investigated in a number of trials of a number of vaccines. A couple of hundred vaccines worldwide are being trialled either at the preclinical or the clinical stage. There are, I think, 40 or 50 vaccines in one or another form of human trial worldwide and there are half-a-dozen vaccines currently at some stages of human trial in Australia.

We will learn about the safety of those vaccines from those studies and we will learn a little bit about how well they work and what sort of immune response they elicit. So we won't necessarily know whether they protect someone because it is difficult to do challenge studies where you actually give them the infection and see whether it protects them. But that may be a possibility; I have heard some discussion of that. We particularly look at whether it makes antibodies and develops immune responses, from which you can infer the vaccine will provide some level of protection. However, it is probably only when we get to some very large trials, or perhaps only when we get the vaccine actually rolled out in practice, that we will know how well it works.

The sort of things we want to know are: Does it prevent you from getting infected entirely? That is, does it stop you from becoming a case and stop you from getting sick and also stop you from spreading disease That is the kind of gold standard of a vaccine. Some vaccines we have are very close to that. Things like the measles vaccine- once you have had two doses, it is very close to that; hepatitis A vaccine and hepatitis B vaccine are very close to that kind of level of very high level protection. It both protects the individual and also prevents transmission so it has that effect of protecting the community and even people who are not infected.

So that would be the gold standard but, as you allude, it is possible the vaccine will be less effective, a bit more like flu vaccine where its main benefit to prevent people from getting some of the more severe complications of the illness such as hospitalisation or a very severe outcome, such as death, but it may not significantly interrupt the transmission of the disease in the community. With coronavirus we certainly want to hope that the vaccine will have the effect of reducing spread in the community, because that is what we are really waiting for, as well as protecting the individuals.

Long answer but essentially agreeing that there are a couple of important things we need to understand about how well the vaccine works. We are little way off understanding that. I think we will have a considerably better idea by early next year, which is around about the time when the most optimistic might expect that a vaccine might become available for us to implement our mass vaccination program.

Ms MORGAN - If I might comment on the mass vaccination program: we run a mass immunisation program every year in relation to influenza, so there is certainly a significant body of experience within Health and Public Health in relation to that program. Currently the division of responsibility between the Commonwealth and the states is evolving. Obviously, with the Australian Government responsible for the area of vaccine procurement and working through storage and delivery in the provision of consumables for the particular vaccine, it's important we have interjurisdictional coordination between the states and territories on issues around transportation, storage, distribution and waste management plans. That is currently occurring through our AHPPC, our Communicable Diseases Network Australia - CDNA - and also the Jurisdictional Immunisation Committee. Tasmania is engaging with this planning via

our representation on the national working groups through our Tasmanian COVID-19 Mass Vaccination Working Group.

Really in terms of all of the areas - and particularly the large-scale logistics around the distribution, prioritisation and delivery of vaccines - a lot will rest on the particular vaccine that is identified, noting that the Australian Government has already entered into three agreements in relation to supply.

Certainly, in knowing the vaccine, we are able to then determine those final requirements on storage. For example, the temperature at which a particular vaccine has to be stored will have different consequences for the way in which it is transported, held and then distributed in Tasmania, the training or delivery in relation to the vaccine, and the logistics and general communications with the community around the particular vaccine. It will continue to narrow down as the vaccine is identified for the mass immunisation program.

Ms FORREST - We hope it will be. We don't know for sure.

Ms COURTNEY - There is a working group within Public Health at the moment that is working through all these logistical things and looking at scenarios, and doing a plan that would be in place. A lot of work has been done to make sure that with the more 'known' of the 'unknowns', we are locking in plans around what we would do.

Ms FORREST - There was an example in the north-west where we had the flu vaccine blitz, if you like, to try to reduce the risk of the flu. We had drive-through jabs there, even though you were supposed to hang around for half an hour.

Mr O'BYRNE - As more of the State Controller, you have talked about the plans in response to positive cases in the community, but obviously we need to war-game and look after our critical assets. Hospitals are our critical assets. Is the same level of planning occurring inside hospitals if there is a case inside a hospital, or inside a health setting? Could you articulate that? We have heard evidence from the health unions - both the nursing and midwifery union, and also the Health and Community Services Union. They have made clear to us that they don't believe there has been an adequate level of planning, or their members have not been informed of plans in response to a positive case inside that kind of health scene.

Ms MORGAN-WICKS - Can I answer as state Health Commander, not State Controller? As state Health Commander, there has been a significant amount of preparation and planning across our hospital environments, particularly for outbreak management.

On 28 April, I think it was, we published our interim report in relation to the north-west outbreak, which made some 17 recommendations, with a significant number focused on improving our outbreak management capabilities, our training, our contact tracing within hospitals, our systems that are going to respond to quickly identify, and also the testing of healthcare workers and associated households of healthcare workers in the event of a hospital outbreak.

Each hospital has an outbreak management plan. We have a governance structure in place which has regional health emergency management teams. In terms of our RHEMTs that have stood up and are currently operating, at the moment, with a zero-case environment, all hospitals are at a level one response level.

In terms of staff awareness and communication, I note communication will frequently come up - about the need for information and the sharing of information across our some 13 000 to 14 000 or so staff in the health service. As State Health Commander, I have regularly communicated to share information about our governance structures, our level of critical PPE and stocks, for example, and publishing tables to staff, talking them through the levels of our escalation management and planning, and also the key training of key individuals within those hospital environments about when we move, for example, from a level one to a level two response according to the triggers which are in our plan, and what official roles then transition through those hospitals.

We are committed to increasing the information we share with all our staff across those environments, and very keen to get feedback from the ANMF and HACSU. For example, I chaired 'What Was' during the outbreak, a weekly meeting with each of our key medical workforce stakeholders - and the minister is part of that meeting - to call for their information and feedback about what we can do better to improve the health service, and what is coming out from the ground in terms of the issues. We had some key learnings through that environment, which we were able to quickly act on and get information out to staff. Certainly, those are continuing to occur.

Mr O'BYRNE - That jars with the evidence we received from both the nurses union and Health and Community Services Union. How do you account for them saying it? They are not saying it because they want to say it. It is legitimate, based on the kind of evidence they provided.

Ms FORREST - It is particularly around the closure of the North West Regional Hospital.

Mr O'BYRNE - That was in terms of the nurses union, but also in terms of the situation now. From their perspective, their level of communication and information is very low, and their understanding of what would happen in the circumstance of a positive case is very low. That is the evidence we have received. How do you rationalise those two comments?

Ms COURTNEY - Can I make a comment before Kath goes into the detail of some of the communication? We have worked really hard to establish strong relationships with all the health stakeholder groups. Some of those are obviously employee representatives, but also the non-THS ones in the community, such as Primary Health Tasmania, The Pharmacy Guild and others. As Kath said, we have facilitated, through my office, regular meetings with them so they can raise concerns, and we have worked hard to follow those up, indeed, the most recent one was last night.

We are continuing to work hard because having strong communication lines is critical, for both dissemination of information, and also getting feedback from people. One of our strengths throughout the response as a state has been the collaboration that we have seen across different stakeholder groups. We have done a really good job of working as a single team with a strong common objective. I look at other jurisdictions, and that is one of the things we have done well, and one of the things, as a health system, we will be able to take going forward.

In relation to the North West, Kath will talk about the detail of the communication that was provided. The overarching comment I make is that we have implemented the

recommendations of the North West review. We have a process in place to ensure that those learnings are continuing to be implemented, because we want them embedded in our system.

The situation in the north-west evolved very quickly and we had to use the information portals that were available, given how quickly the situation changed.

Mr O'BYRNE - I completely understand that. My question was not necessarily about the north-west, although there were some reflections and we understand it was a difficult moment. The evidence we have received is that, as at today, the level of communication and information around understanding what to do in response to a case is not clear to people.

I have heard this through more than the sources of evidence here today. I have also heard it anecdotally. Constituents have contacted me from the Health department, Public Health servants, and I have encouraged them to come back through the chain of command. You could say they were middle-level management people in large hospitals saying, 'We are unclear, I have not been consulted, I do not know what to do, the borders are opening.' That is the source of my question.

This is the evidence we have received from the unions, and I have received that information from constituents as well.

Ms MORGAN-WICKS - Through the minister, I cannot comment on evidence that I actually have not heard today, but I am very happy to have a look at *Hansard* if it is provided to me to look at the particular instances. I cannot comment as to the current view. We invited both the ANMF and HACSU last night to the meeting, but they were unable to attend.

Regarding communication to staff, it will depend on various types of teams of staff, so I would like to know from which areas and which hospital we are getting concerns. I don't need to know in terms of identifying anyone, but trying to work out if there is a particular training need in a particular area.

We have regional health and emergency management staff who are trained and know, in terms of the triggers, how to convert a hospital and respond once a COVID-19 positive case is received, and working as to the triggers.

In terms of the staff then following the command, for example, of middle management, or the regional health emergency management team coordinator, or our Tasmanian Health Service Emergency Operations Centre leads, and we have leads in each of our hospitals, they are issuing them instructions in relation to the management. It's whether you're trained in terms of personal protective equipment. It's whether you're an ED team that's ready and able and coping now and handling respiratory symptoms as they arriving in EDs. It's whether an ICU or critical care nurse that's ready in terms of ventilating a COVID-19-positive patient and those requirements. Training has been conducted throughout each of our hospital settings. I am confident that they have that training in being able to deal with COVID-19 positive patients and they have dealt with them. They've dealt with the surges of the patients.

In terms of communications, it's a continuing challenge in the health system to make sure we can get the right information out to the right people as quickly as we can, often trying to beat social media in getting that information out. For example, in April we sent a daily email to staff which was a 'What's new COVID'. We did have daily changes at one point in the

CDNA definitions of testing criteria, or we had to share other information. Our emails, for example, in late-April were getting 16 000 opens which is indicating we are getting that penetration through in terms of the information.

I will have to write to the ward managers to say please print this out, please talk to your staff at handover to make sure that this information is actually coming through. We do have to try various ways of communicating with our staff. But we are always happy to take the feedback and seek to improve.

Mr O'BYRNE - As an extension of that, aged care facilities are critical assets where if there is a positive case the risk is still large but the consequences are even larger in terms of the impact on Tasmania. Are you considering, now that the borders are sort of reopening again, putting in an extra layer of testing and temperature testing in health facilities as a matter of course to protect those sorts of institutions? Is that something you are considering doing?

Ms MORGAN-WICKS - We already screen our staff and visitors who enter our hospital environment. That has not stopped in terms of the requirement to answer - and I answered them last week as I entered, for example, the LGH in terms of -

Mr O'BYRNE - Including the Royal?

Ms MORGAN-WICKS - Yes, including the Royal.

Mr O'BYRNE - So all staff, every time they enter the facility, are temperature tested?

Ms MORGAN-WICKS - No, I didn't say they were temperature tested. I said that they were health screened and they answer questions in relation to their symptoms.

Mr O'BYRNE - Are you considering temperature testing?

Ms MORGAN-WICKS - We did employ temperature testing at a stage through the first wave of COVID-19 and as we were developing our health screening tools. On the advice of the THS Emergency Operations Centres that are responsible for the hospital environments we have ceased temperature testing in the hospitals.

Mr O'BYRNE - Now the borders are opening again and the risk is potentially increasing, are you considering putting that back in? A number of health professionals have contacted us saying it would be good to have those quick tests as a quick barrier to potentially get some baseline information. Is that something you are considering as well?

Ms MORGAN-WICKS - We have rapid test kits which are available in our hospital environments and we've used them. We continue to evaluate health screening depending on the circumstances that are applying in the state on a regular basis.

Mr O'BYRNE - Given there's always that two-week lag, is it being considered now that there's more movement potentially that that will be reinstituted in some key assets like our hospitals or aged care facilities or -

Dr VEITCH - It's very important that there's a culture of not going into any of these settings when you're ill. The prompt of asking whether you are you well, or do you have

symptoms, as you enter is the critical thing. Temperature testing really provides - some would say none but at very best marginal - additional benefit. It may in fact provide false reassurance. There's quite substantial evidence about screening people in what we have to say is a very low risk environment, even with the borders open - it's not zero risk - the evidence for additional measures such as temperature screening in going into businesses is not there. I wouldn't encourage that.

I would certainly support a culture of not attending, not visiting and if the prompt with a series of questions when you enter helps reinforce that then that's a good thing. The most important thing is to prevent people from entering into an environment when they may be ill with flu or anything really.

Mr O'BYRNE - What about the concept of rapid testing for health professionals in Tasmania? Is that something you would consider?

Dr VEITCH - There's good national advice being produced by the Public Health Laboratory Network and Communicable Diseases Network Australia. Rapid testing is not useful in a low prevalence environment, particularly in a very low prevalence environment, because no test is 100 per cent perfect. It misses some; it gets false positives. If you're using a test that's less perfect - and those rapid tests are less perfect - in an environment of very low prevalence it's not going to help you. It's going to cause more problems with false positives and false reassurances. It's a bit like temperature testing.

While we're operating in a low prevalence environment, we should use the very best tests we have, which is the PCR laboratory-based test. This takes a little bit longer to get back but it gives us an almost completely reliable test result.

Mr O'BYRNE - I am mindful that the impact of closing the North West was significant and you have to protect these assets. It's almost like the Western Front, really, it's the different front lines you have. If there was a positive case in the community would you then, as a part of your plan, reinstitute a number of these protective barriers around these sensitive facilities?

Dr VEITCH - Yes, certainly the aged care group is considered in particular if we had a small number or a larger number or even one case near or far. If there was a case in the south, would you worry about the north? If you had a case in the south, how would you respond to nursing homes in the south? What sort of measures should we put in place if that risk level increases even a small amount? There's some work being done to look at what should be done.

Mr O'BYRNE - Wouldn't it be of benefit to make these escalation plans public?

Ms FORREST - We've asked for those to be provided.

Mr O'BYRNE - Yes, that's to us. In terms of broader communication, the community has a whole range of questions about what happens and how you respond and if there's an articulated plan that builds confidence that the system is ready. Is it in the public interest for these escalations to be shared publicly?

Ms COURTNEY - Many of the supporting documents are available on the internet and some of them are available on the THS intranet so that staff can access all the escalation strategies within the THS. It's making sure that they are read in the right context. The THS

ones have been done in collaboration with a lot of the staff. Many, as I said, are living documents.

As we look across other settings, documentation that's developed is done so in collaboration with the stakeholders that are necessary and then disseminated appropriately and often quite widely with them. If we're looking at the EOC we have for aged care at the moment and the work that's -

Mr O'BYRNE - EOC? I know it. For people reading this.

Ms COURTNEY - the Emergency Operations Centre is continuing to do a lot of positive work with a range of external stakeholders.

We have worked hard to ensure that information is disseminated appropriately. A lot of these things are a living document. It is important that when people are referring to them they are also referring to the most current version.

Ms MORGAN-WICKS - They're an internal operating document. I'm not going to expect a member of the public to come in and reconfigure our EDs. It's an internal working document for our THS teams to make sure that they are setting up, in terms of the restrictions, the screening, the configuration and the even the movement of resources, whether it's going to trigger different patient transfer protocols, whether it's going to trigger various working between health asset protocols which are being developed following the outbreak.

CHAIR -I am hoping we can draw this to a conclusion shortly.

Ms FORREST - It's interesting entering facilities. We ask all members of the public who come into this building to answer those questions. We don't do it for ourselves. It is just a thought.

Ms MORGAN-WICKS - We do it for the staff of the THS.

Ms FORREST - We heard from the ANMF - particularly when they presented to the committee a little while ago - about the ongoing mental health issues for staff. I am wondering what has been done to assess staff mental health and wellbeing, and whether there has been any formal assessment of that, and what is being done to support staff? Obviously, there are ongoing challenges in this space.

Ms COURTNEY - I will make a comment while Kath is cogitating. We have done a lot of work, particularly with regard to the north-west. It was a difficult time for not just the staff but the broader community, and it is something I am conscious of. I have had conversations with the ANMF about that, as well as the chief executive of those hospitals. The wellbeing of the staff is incredibly important to me, and I know it has been a difficult time. We have worked hard to ensure that, above and beyond what we have done more broadly with the THS, we have put appropriate additional resources there, and continue to do so to support them. I will get Kath to talk through the detail, but it is an important area of focus.

Ms MORGAN-WICKS - Thank you, minister. I don't have the numbers for our current expenditure in 2020-21, but in 2019-20 we spent over $330 000 on mental health support for healthcare workers as part of our pandemic response.

The largest program cost $228 000, for approximately 1200 workers across the north-west, particularly given their requirement to quarantine following the outbreak, together with their households. That program is ongoing and includes online self-care, a resilience and wellbeing program, a weekly support. We have run that for a minimum of six months, but are certainly talking to the management about an extension of that. Establishment of a peer support network with training, support and mentoring. We have had virtual workshops and support to help individuals to develop their own self-care plans during quarantine, and to ensure their own safe and sustainable return to work following the north-west outbreak.

This is in addition to our existing employee assistance programs - so our EAP, which is available for all of our employees. That service is delivered by a team of qualified support workers, psychologists and social workers, and utilises a range of approaches to support different individual needs.

We have engaged other more specific services, based on skill set or identified need. We have had different targeted strategies, which we have piloted across the hospitals. At the LGH, we have had a dedicated social worker to develop ward-specific plans and strategies, including developing peer support programs. For example, in the THS South, we've had a staff initiative which has been developed and led by our allied health team. The initiative is called COSI[?] and is based on early intervention and self-care, with specific tools developed as resources.

Another example is Ambulance Tasmania, where we employ a health and wellbeing consultant who oversees a critical peer support program.

Ms FORREST - The ambulance one would have been there before, wouldn't it?

Ms MORGAN-WICKS - Yes, but this is specific to COVID-19.

Ms FORREST - I see. You are increasing the support and resources in that area?

Ms MORGAN-WICKS - They changed their prioritisation with the program they are developing and implementing with the team, particularly with COVID-19 in terms of that support and self-care, but we have also found the peer support networks have been quite critical for our healthcare workers.

Ms FORREST - This may be one you want to take on notice. COVID-19 taught us a whole heap of things. It probably helped us see where some of the failings were in the system more broadly - and this is perhaps a question for you, minister, to contemplate as well.

There are positive outcomes that come out of some of this, despite some of the difficulties that it also presented. Are there areas of learnings that should rightly be brought forward into the future, regardless of whether it an ongoing challenge with COVID-19, or another potential infectious disease down the track - which there will be at some stage - or just in general terms of delivering health care? Obviously, it is a very rapid shift, and we hope it does not need to happen too often. Are there learnings in all of this, that would see measures taken that would actually be appropriate to carry forward?

This may be a question for next week, but in terms of the budgetary requirements to meet the needs of the health system, has this exposed where the real gaps are?

Ms COURTNEY - I might start at a high level. Yes, I agree we have had lots of learnings that are really good to be able to implement. It also helped us expedite things that are going to be helpful for our health system more broadly.

The easy one to go to, because it is easily understood, is the telehealth example and the benefits that has had for patients, in particular those in regional areas. We have seen a broad suite of those types of things that COVID-19 has brought forward incredibly, and there is going to be a lot of benefit from that.

One of the other big benefits that we have seen, in response to one of Mr O'Byrne's questions earlier, was the degree of collaboration and the pathways of communication across our health system that have been embedded. A number of people have commented to me that the relationships that have been established, not just within the THS but more broadly, are going to strengthen our healthcare system Tasmania-wide. With the healthcare system it is easy to think of it being just our hospitals, but as members would be aware, there is an enormous amount delivered through GPs, through community facilities, through pharmacies and through allied health. The collaboration we are seeing across those pathways has been hugely beneficial. As a Health minister I look at our health system, and one of the things that will be one of our greatest benefits going forward is that ability for us to be able to distil some common goals and work towards that.

In terms of some of the COVID-specific things - and Kath might be able to add to this - mental health was one we talked about. In the recommendations we had from the north-west review, one was around the staff wellbeing program, as well as communications. They have always been recognised as being important, but there has been renewed focus.

The important thing is that we roll out, across the systems, the learnings that we have in one single area - so we don't just go, 'we have learnt that in this hospital' and leave it there. We look at how we can actually embed these learnings across different areas of our healthcare system, noting how decentralised a lot of our workforce is.

It has highlighted some areas where we can perhaps improve, but we have worked really hard to take on board those things in a positive way and look at solutions.

Ms FORREST - Have you actually done a staff wellbeing assessment? I know you have the supports in the units, but have they actually done that?

Ms MORGAN-WICKS - We had a State Service survey, but that was actually conducted right at the beginning of the first wave of COVID-19.

Ms FORREST - Was that in relation to the review of the State Service Act?

Ms MORGAN-WICKS - No, that was the general State Service survey, which has some questions in relation to wellbeing or feelings of safety within workplaces, et cetera.

We have not done a COVID-specific. For example, there is a study being led by one of our very good Public Health staff members in relation to staff experiences. I am not sure if it is touching on public experiences during the north-west outbreak, more in the range of their symptoms or their later effects or antibodies, but I won't seek to describe that survey.

Certainly that is something we can look at in terms of a touch-in with our staff, but we have been trying to do that on-the-ground support and really looking at our emergency management teams, getting out and trying to support our staff on the ground - a lot of which has been around the information training and supports which, where you don't have that

We have been trying to do on-the-ground support, and really looking at our emergency management teams, a lot of which though has been around the information, training and supports which, when you don't have that information, can cause anxiety in the workplace. So we're really trying to tackle that type of communication.

If I can reflect in terms of learnings, certainly the Health department, at the same time remembering that we are in a response phase for the pandemic, we are participating very actively in regard to several reviews which are on-foot in relation to COVID-19, particularly the Mellick Review in relation to the north-west outbreak.

We have had a review of hotel quarantine, nationally led, and a national review in relation to contact tracing and outbreak management under Professor Alan Finkel. A review has now been announced in relation to national PPE stockpile arrangements in the various states and territories' jurisdictions and requests for information from the Auditor-General or even the ANAO, the National Audit Office in relation to various parts of our COVID-19 response.

Each time in which we are preparing that information or appearing and providing evidence in terms of learnings and receiving those recommendations and acting upon them and the importance of that interjurisdictional comparison so we are learning from the experiences in the other states and territories are demonstrating. It is evolving over that time.

Ms FORREST - As you highlighted some of the areas where under-investment has been an issue or where you need to focus more, Public Health probably needs to have more people working in it in the short to medium term, but there is always going to be something.

Ms MORGAN-WICKS - We discuss at Budget Estimates every single year the prioritisation of our resources across various units within Health, including Public Health or elective surgery or critical care or our community nursing or primary health provision. It is a balance and one that we have respected and flexed and managed throughout the COVID-19 environment and certainly not just using health resources but also our interoperability, which has been a fantastic assistance in pulling resources from other agencies, but noting at the time, we are pulling down some of our business-as-usual activities in order to support what is an extraordinary situation of a pandemic.

We are making sure that we are doing all that we can to shore up our equipment and our capability, our facilities. We have tweaked and improved along the way but it is also going to guide our future view of what might be a longer-term capital infrastructure plan or a longer-term technology-ICT in terms of the systems needed to support.

What it all comes back down to is the resilience of our healthcare workers and our team of staff in a very, very long-term pandemic scenario which really, in relation to historical testing or preparation or training for that, certainly hadn't been countenanced for this length of time or proceeding into two or several years. We are doing our best to flex to that development.

Ms FORREST - I understand all of that, Kath. But unless you have some redundancy in the system, you have not got that flex up and down. One of the criticisms we have heard is that there are rosters with gaps in them when they are set and situations like that. You do not have that redundancy; you have nurses working double shifts and pulling in staff from other areas, which is not sustainable over the long term. If you don't get that right when you don't have an extra burden of something like coronavirus over the top, then we are always playing catch-up.

Ms MORGAN-WICKS - Yes. We are closely watching and monitoring our overtime and double-shift information. From a statewide perspective, we are not seeing an increase in overtime or double shifts. If, for example, I am looking into the north-west where we have experience COVID-positives within our healthcare workers, that is where we are feeling strain and are attempting to support them in that environment.

Ms FORREST - With additional staff?

Ms MORGAN-WICKS - Yes, and surge capacity. The efforts have gone into develop a health surge workforce, which is close to some 700 recently retired or other members of the public who have been able to demonstrate their recent professional registration for example. We have engaged over 180 of those already to assist our management of the pandemic.

CHAIR - Thank you. I thank you for staying on for a longer period and appreciate that very much. Thank you for the way that you allowed us to question, minister, I appreciate that. It's helped us to properly expedite it and move forward fairly quickly. So, thank you all very much.

Ms COURTNEY - It's a pleasure.

THE WITNESSES WITHDREW.