PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE OF PUBLIC ACCOUNTS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON FRIDAY, 24 JUNE 2022

TASMANIAN GOVERNMENT'S CONTINUING RESPONSE TO THE COVID-19 PANDEMIC

Mr JEREMY ROCKLIFF, PREMIER AND MINISTER FOR HEALTH, WAS CALLED. **Ms KATHRINE MORGAN-WICKS,** SECRETARY, **Ms LISA HOWES,** DIRECTOR, OFFICE OF THE SECRETARY, **Mr DALE WEBSTER,** DEPUTY SECRETARY, MENTAL HEALTH AND WELLBEING, **Dr MARK VEITCH,** DIRECTOR OF PUBLIC HEALTH, **Dr TONY LAWLER**, CHIEF MEDICAL OFFICER AND DEPUTY SECRETARY, CLINICAL QUALITY, REGULATION AND ACCREDITATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome.

Mr ROCKLIFF - Thank you, Chair. We welcome the opportunity to provide further information today to the Public Accounts Committee, building on our Government's written submission. Our submission highlights how Tasmania established one of the strongest vaccination rates and entered 2022 with one of the strongest economies in Australia. The submission details financial measures designed to support Tasmanians in anticipation of the borders reopening, outlines instances where the Tasmanian response exceeded standards and targets set as part of the national cabinet process, and highlights areas where support was extended to ensure the health and financial security of Tasmanians.

Of course, the Government's priority has been protecting the health and safety of Tasmanians, and we also continue to support economic outcomes during this very challenging time.

The reopening of Tasmania's border through the Reconnecting Tasmania Plan was carefully planned to strike a balance between protecting public health, while supporting economic recovery. Reopening borders on 15 December 2021 was based on detailed modelling prepared specifically for Tasmania, the Kirby Institute modelling, public health advice developed at both state and national level, the strong uptake of vaccinations by Tasmanians and the aim of 90 per cent vaccination rate, as well as the social benefits of opening our borders.

Our decision-making was guided by decisions and advice at the national level, including national cabinet decisions on the national plan to transition Australia's national COVID-19 response, and regular advice from the Australian Health Protection Principal Committee (AHPPC). However, it took into account local needs and local conditions, based on the state's specific modelling, and advice to balance the national approach.

We were deliberately slower and more careful in reopening our borders, ensuring we had safety nets in place to keep on top of COVID-19 during the initial phases. Additional measures were put in place at our borders to help minimise the risk, including requiring people entering Tasmania to be fully vaccinated, and providing a negative COVID-19 test if coming from certain locations.

Our Government has communicated extensively with the Tasmanian public and specific stakeholder groups to ensure people were aware of the changes being made, why they were being made and where to get that information and support. The Government ensured we had in place the necessary health, social and economic measures to minimise the impacts of opening our borders. The Government has adjusted restrictions and support mechanisms to reflect changing public health advice, and provide proportionate measures to the health risks as they change.

The response to the COVID-19 pandemic has demonstrated the resilience of the Tasmanian community and the strong partnerships that exist within our communities. The ability of the Tasmanian state service to effectively engage with a range of stakeholders ensured that opportunities have been seized to improve the lives of Tasmanians through reinvestment in health, education and local infrastructure.

Learning from the outcomes and actions of governments in other states and territories ensured Tasmania avoided the extended lockdowns experienced in all other Australian jurisdictions.

Tasmania has nation-leading COVID-19 vaccination rates. As at 21 June 2022, over 99 per cent of people aged 12 years and over have had their second dose, and we are leading the states with vaccination rates of 5-11-year-olds. That has been consistent.

We also established community case management facilities to support COVID-19 patients unable to isolate at home. As I have said publicly many times, any death is an absolute tragedy. Tasmania currently has the second-lowest COVID-19 death rate per capita, behind only Western Australia. Tasmania was the last jurisdiction in Australia to apply elective surgery restrictions and the first to lift those restrictions.

Importantly, elective surgeries have continued at all of our major hospitals since the Omicron outbreak after borders opened on 15 December last year. While the wait list increased in January with a high number of hospital staff furloughed due to contracting COVID-19 or being a close contact, the wait list reduced in February, and again in March and April. Despite these challenges, only 52 fewer procedures were delivered in January 2022 compared to January last year.

Tasmania's extensive planning and strength in emergency management enhanced our ability to be flexible and responsive. We rolled out the rapid antigen test distribution model to facilitate getting RATs to where they are needed, getting them into the communities well ahead of other states.

The Government notes that the committee's previous inquiry on the economic response to COVID-19 concluded that the Government's response was timely and effective in controlling and preventing the spread of COVID-19. The committee acknowledged that the Government and our departments demonstrated an ability to be responsive and agile as demands in situations rapidly changed. Where policy and operational decisions had traditionally made in silos, many of these barriers were removed, resulting in greater collaboration between departments.

The committee also noted that the state was well prepared, as practices and processes were well established and could be quickly adapted to meet the situation. Since reopening

Tasmania's borders, the Government has continued to focus on preparation and planning, balancing the interests of public health and social and economic need. Ongoing review of public health measures and adjustment of various settings ensure that a flexible approach can be taken that will allow us to respond to issues in a timely manner. We will continue to review public health advice and adjust our approach to suit Tasmanian's needs.

The Tasmanian Government planned thoroughly. We worked together to prepare our essential services within Government and across the broader community. We listened to the needs of those likely to be affected by opening our borders, and we responded to those needs. We showed we could quickly adapt and respond as circumstances and advice changed, to provide the best support for our state.

We successfully managed the difficult task of opening our borders and reconnecting Tasmania, and for that I give my thanks to our entire public service, across the whole of government, for the enormous effort, work and commitment - not only since the border reopened and leading up to that, but since the commencement of the pandemic early in 2020. For that, I am eternally grateful.

CHAIR - Thank you, Premier. I would like to go back to the decision on opening the border and the modelling that was done - the Kirby modelling and some Doherty modelling. As I understand it, they were both undertaken with Delta being the predominant strain of the coronavirus at the time. We know that immediately upon reopening, and even slightly before, Omicron was the most likely variant to enter the State - and it was.

I want to understand what re-evaluation assessments were done on the basis that a much more infectious - though in the majority of cases less virulant - strain was going to enter the state. The modelling relating to impact on ICUs and hospitals generally was on the basis of a less infectious strain. I would like to understand how it was reconsidered in light of a new variant.

Mr ROCKLIFF - Dr Veitch may be able to detail that. You are right, the Kirby Institute modelling reflected the Delta strain which, at that time, if memory serves me correctly, was more transmissible than previous ones, but also more concerningly, a much more serious illness. Omicron hit around the time the border reopened, and we had to be very flexible in our approach to dealing with those matters. A lot of decisions were made quickly at a national level, which we adapted to a state level as well.

I want to put on record, Chair, that our modelling did not take into account the variability presented by new strains that have emerged, such as Omicron. It also does not account for the inclusion of a vaccine for 5- to-11-years old which was being discussed and planned at the same as the modelling was being developed. We knew that we might see a different result than what the modelling told us.

Modelling is a hypothetical exploration of different outcomes based on what we know at the time. It was a rapidly changing environment at the time. Models do not predict the future, but they do help us inform plans based on different scenarios.

We were very clear in our approach at the time to get to that 90 per cent vaccination rate. Other states led a little earlier to that 80 percent mark. I believe that waiting and all the work

that was done to get our vaccination rate up to 90 per cent has helped us since that reopening stage commenced.

Dr VEITCH - Thank you, Premier. I don't have a great deal that I can add to illuminate this from what the Premier has already said.

The initial modelling was based on the transmissibility of the Delta strain. We knew that the first Omicron strain that came along was substantially more transmissible than the Delta strain. The subsequent Omicron strains are incrementally more transmissible than the original Omicron strain. The modelling that we considered looked at a range of inputs that were estimates based on the available information at the time. It gave us a range of outputs. We received dozens of different outputs from the modelling, so there was no single model answer.

CHAIR - My question was more about, was any modeling redone in light of a more transmissible variant? I understand what you are saying about how it was developed. My question is, was it updated?

Dr VEITCH - We had further discussions with the Kirby Group. I think they did some modelling in the early months of the year, but we were informed by the understanding that if you have a more transmissible virus you are going to see more cases. The measures you need to have in place would need to be more vigorous to contain a virus.

Even without extensive formal further modelling, we were in a position to understand what the implications of the new strain were based to some extent on the Delta modelling. We knew the situation would be more problematic and more difficult to manage.

There were many people doing modelling around the nation. There was modelling shared with the Australian Health Protection Principal Committee and National Cabinet that was conducted by the Doherty Institute. In many ways that has been the most useful modelling that we have had to guide us, because it was a form of forecasting or nearcasting that looks at what's been happening in the very recent past and projects moderately into the future.

It doesn't try to do what the Kirby Institute modelling did, which was to try to project the whole experience over a number of months of the new strain. The Doherty Institute gave us a fairly realistic projection of what case numbers would look like over the early months of the Omicron wave.

They continue to produce forecasts that tell us how many cases we can expect in the coming weeks and how that will translate into pressure on hospital and intensive care beds.

CHAIR - Minister, we started with the Omicron variant BA.1. We are up to BA.5, as I understand it. What I read, and it is not academic papers, so it may well not be true, is that BA.4 and BA.5 are having more respiratory symptoms for people, which may increase the burden on our health system. What is the current situation with the most apparent variant in the State? What are we seeing in the symptoms of the people who are experiencing it?

Dr VEITCH - We have seen the emergence of BA.4 and BA.5 Omicron variants around the world and around Australia over the last month. BA.5, and to a lesser extent BA.4, is emerging in Tasmania. It has been present in Tasmania for about a month, often in small numbers, but it is probably going to become the predominant strain of the SARS-2-COVID

virus in Tasmania within the next four to six weeks. I believe the most recent laboratory report has about 10 or 15 per cent of isolates being BA.4 or BA.5. I expect that will probably double week-on-week for the next few weeks. That is the way it behaves.

The experience is that even though it is more transmissible than BA.2, it is not as much of an increase in transmissibility that Omicron was over Delta. It is a marginal increase in transmissibility. The evidence to date is that it, like the earlier strains of Omicron, can infect people despite prior infection with one or another strain of COVID-19 or after vaccination. The evidence that I am aware of to date is not that it causes more severe illness or a greater case fatality rate. Exactly how it will play out in Tasmania or Australia we don't know because it is going to be a complex mix of the virus versus the vaccination immunity that we have and our population immunity as a result of fairly recent exposure to BA.2. It's hard to predict how quickly or high case numbers will go, or how long the wave of BA.5 will last.

CHAIR - You didn't say a lot about the symptoms that people are experiencing with BA.4 and BA.5. I have seen data that I have not had the time to drill down into that suggests there are more respiratory symptoms with it. Is that the case or do we still do not know? These are the things that put pressure on our health system?

Mr ROCKLIFF - I understand the line of questioning, Chair, which is fair enough. We can talk about health system preparedness further on.

CHAIR - I want to understand this first. We can come back to that if we might, minister.

Dr VEITCH - I have not reviewed in detail the comparison of the data on these strains. When a new disease comes along, what people almost always do is pick up and pay attention and report the more serious consequences of that disease, whether it is a new disease or a new strain. As a general principle I recommend caution in interpreting initial clinical accounts around a strain of infection until we have more time to see the spectrum of illness that it causes, and whether the spectrum of illness it causes is substantially different from the earlier strains.

CHAIR - Are there other strains around the world that we are seeing, minister, that may cause concern beyond Omicron BA.5?

Dr VEITCH - There is extensive global surveillance. Australia is very well-networked into that, as is Tasmania through our laboratory network to identify new strains and to get important intelligence about the severity of it. I have not received any advice through AHPPC that flags particularly severe strains of COVID-19 being common anywhere.

Mr ROCKLIFF - Dr Veitch mentioned the laboratory, which I visited yesterday, with huge investment in recent times in new equipment. We have a more detailed weekly surveillance report that drills down on a number of matters pertaining to the variant and Omicron. It is very detailed information that is easily accessible for the public as well. Ms Morgan-Wicks, would you like to make a comment?

Ms MORGAN-WICKS - In relation to whether we are seeing different symptomology of variants four or five, nothing has been reported through our THS Emergency Operations Centre, which continues to meet very regularly to discuss the load of COVID in the hospital and our management of it.

In today's figures, 47 are currently hospitalised with COVID, but 16 due to COVID, and that has remained fairly steady over recent months. We receive a report each week on the national rate of hospitalisations, and Tasmania has still remained incredibly low.

Ms WEBB - With the BA.5 strain coming through, is there any early indication about people getting COVID more than once, and people who have had Omicron potentially now getting the BA.5 variant? Do we have an indication about whether it is more likely, less likely, or absolutely the same risk to get this next strain, whether or not you've had an earlier strain?

Dr VEITCH - I don't think we're in a position to provide a completely precise answer to the latter part of your question about the likelihood. However, people are capable of being reinfected with BA.5 after the other strains.

At the moment, our surveillance for variants is done on a proportion of the cases that are diagnosed by PCR, which is the test that happens in the laboratory; they have a sample with the virus. About 15 per cent of Tasmanian diagnoses are made on that basis. We hope the people who are getting the PCRs tend to be people more prone to serious illness, or people connected with outbreaks. Then there's a sample of around 100 of those cases tested every week that have the genetic makeup of the virus looked at, so we get a sample of it.

Our understanding of reinfection and symptom severity is probably going to come first from national and international data rather than Tasmanian data, simply because of the number of cases.

Ms WEBB - My question encompassed whether we have we learnt - do we know anything from those other jurisdictions that might have had this variant circulating longer than we have?

Dr VEITCH - There are people who have had the original Omicron strain, and have then had the BA.2 strain, so we would expect that BA.5 will occur among people who have had the previous infections, as well as people who haven't had any previous infections - so it's expected to occur among the whole population. For example, we have seen hundreds of cases of reinfection during this most recent wave, but we do have to remember that there's been 170 000 or 180 000 infections in the course of the last six months, so it's only a relatively small proportion of all the infections.

The other thing to bear in mind is a lot of the infections that are occurring at the moment are being transmitted between people who have been vaccinated, who have had infection as well, so the strains do tend to evade natural immunity, and they do tend to evade vaccination.

What is holding up reliably is the protection against severe disease that we achieve from our vaccination strategy, even with these highly transmissible strains. Even when we can't hold the virus back at the door, we are able to reduce the more severe harm as a result of infection.

Ms WEBB - Are we capturing reinfection data in a reliable way and reporting on this in our normal infection data, so we can understand what proportion of cases coming through are reinfection?

Dr VEITCH - There is national work to try to get a standardised approach to reinfection. The difficulty is that most people who get reinfected are people who are diagnosing themselves

with a RAT, so we don't know whether they're getting the same strain or a different strain. There is work being done to understand what is useful to collect. It is interesting to know whether someone has been reinfected, but we need to focus our surveillance on what's actually useful and makes a difference.

Ms WEBB - Presumably, when people report an infection, whether they had it before or not, that is collectible data, without having to know what strain it is. Is that level of data collected through our system?

Dr VEITCH - It is collected, but people are not classed as a new infection or a reinfection if they test positive within 12 weeks after their first infection. That is because you can pick up evidence of a first infection for quite a few weeks.

CHAIR - With a PCR?

Dr VEITCH - With a PCR, and probably with a RAT too, fairly early on, or at least from time to time.

So, the surveillance is not being focused on picking up infections that occur within a relatively short aftermath of an initial infection. The focus of the surveillance would be looking at people who had a bit of a lag after the first infection, and then get re-infected.

The national approach to surveillance is constantly evolving and it is developed by the Communicable Diseases Network of Australia, which we are of course represented on. A consistent approach has not yet been invented, but that is something people are working on.

Ms WEBB - And our intention would be to align with that national approach, once it is determined?

Dr VEITCH - We do our best to align with national surveillance throughout.

Mr WILLIE - Premier, what do we understand about long COVID with re-infection? I can speak from personal experience here. I still have a cough from my COVID-19 experience in April, and speaking to other people it is quite common that they have some persistent symptoms. I guess the concern here is, with different strains, is there a cumulative effect of COVID-19, and is that going to contribute to long COVID suffering in the community?

Mr ROCKLIFF - Thanks, Mr Willie, that is a good question. I still have a persistent dry cough from my experience in April as well.

The understanding internationally and nationally of long COVID is still evolving. It is a syndrome that may affect a variety of body systems to varying degrees, as I discussed briefly in the budget Estimates hearings. The symptoms of long COVID, as you highlighted as well, are highly variable from individual to individual. The dominant strain of COVID-19, as we have been speaking about, is the Omicron variant, and the current view is that the presence of long COVID associated with the Omicron variant is less severe.

To date, there has been no definitive diagnosis of long COVID in Tasmanian hospitals, but that is not to say it is not prevalent within our community. The Department of Health is aware of the potential for long COVID, and of course we will monitor its prevalence.

On 6 June we announced an investment of $400 000 to establish a statewide navigation and referral service specialising in long COVID. That service is expected to be operational in September this year. I met some people on the north-west coast, particularly with that first experience of COVID-19 when it was only in the north-west, and talked to them about their experience, and the long COVID implications as well for them. So, it is evolving. We are hoping our announcement will give us some more data to support people with long COVID. We are also working with Primary Health Tasmania (PHT) as well, which is assisting us with this.

Ms MORGAN-WICKS - As the Premier noted, a long COVID clinic is being established, and we hope to launch that in September. I know that meetings are ongoing to make sure the referral pathways are all set up. PHT has also been working through a long COVID referral pathway to make sure GPs are cognisant of the potential to monitor for symptoms following, or sometimes occurring weeks after, COVID-19 infection, and to determine the specialist they could refer to in the THS.

Establishing a long COVID outpatient service then brings all of those specialist pathways together into one clinic. That avoids one-hundred-and-something GPs across the state referring to different types of specialists that may provide different types of treatment to the patients.

We are hoping to get it all into one outpatients clinic so we can assist the patients, collect the data and determine if any other actions are required. We will also tap in through our chief medical officers and directors of public health international networks to see if there's any further learnings that can be applied in Tasmania.

Mr ROCKLIFF - The World Health Organization has activated two emergency diagnose codes to use when a condition is directly attributable to COVID-19. That's the diagnosis of long COVID-19 requires that the person no longer has COVID-19 and that the presenting symptoms are causally related to COVID-19. Some of those symptoms of long COVID-19 are extreme tiredness, shortness of breath, chest pain or tightness, problems with memory or concentration, difficulty sleeping, dizziness, pins and needles, joint pain, depression and anxiety. There are others: feeling sick, stomach ache, loss of appetite.

Ms MORGAN-WICKS - We still have patients accessing COVID@home. So, if you're still continuing to experience symptoms or are concerned or unable to get into a GP to discuss that, our COVID@home service is still available for those patients. They have the number if they've opted in for the service during their infection. Otherwise they're entitled to speak to the nursing team and doctors that are available in the COVID@home service.

Mr WILLIE - It is good to hear that there is a clinic and that work has been taking place, but to simplify my question, is any work being done on the cumulative impact of reinfection? If you have COVID-19 multiple times is that going to contribute to a greater chance of long COVID-19, or are we leaving that to international experts to do that work?

Mr ROCKLIFF - I would leave it to the experts, locally, nationally and internationally. Dr Veitch, do you have any information or has this been discussed at AHPPC, for example?

Dr VEITCH - Not in detail, Premier. The information about the consequences of second infections is that it's going to come from bigger places than Tasmania that are going to have more experience to see more of those cases. That will come out in the literature. There's never

been a disease in human history that's been as investigated as intensely over a short period of time as COVID-19. That is good on one hand but it's also problematic because every day you can probably find papers that contradict each other. It's important that we look for that information but probably the critical appraisal of the various pieces of information that come out internationally and elsewhere in Australia is going to be the thing that gives us the best intelligence about the consequences of multiple infections and long COVID-19 in general.

Mr WILLIE - Following the North West Regional Hospital situation, when health workers were infected with Delta, my understanding is that some of them suffered from long COVID-19. Are they still being supported and are they still suffering from those conditions?

Mr ROCKLIFF - We will get more detail for the answer. The people I was referring to in my initial comments to your question were the people you were referring to. I have met them on a couple of occasions, Mr Willie. As to the status now, I'll ask the health commander to speak?

Ms MORGAN-WICKS - We're trying to see if we have up-to-date information on our workers compensation cases and whether they still include cases of long COVID-19 from the North West Regional Hospital. A few months ago we were still supporting staff members who had long COVID-19 and they were still part of our workers compensation as a long-term support. I don't have it up-to-date today. We will try to get that information.

Mr WILLIE - It's a follow up questions from our previous inquiry.

CHAIR - Do you want to put that on notice?

Along the same lines but in a slightly different area, I am interested in the use of antivirals and when they're used in treating COVID-19. Is there any evidence the use of them would help prevent long COVID-19 or serious infection and when is it used?

Dr VEITCH - Antivirals are a very important part of our armamentarium to deal with COVID-19. The focus of the use of antivirals is on people who are at risk of more severe illness. It is typically people aged over 65 with a couple of chronic medical conditions, or people with significant immune-suppression, particularly people who may not be completely vaccinated and boosted. The benefits we are looking to and which the efficacy of antivirals is measured against is not getting sick enough to require hospitalisation, intensive care or death.

The use is fairly targeted but it is quite a wide target. There are a lot of people who can benefit from antivirals. I am unaware of any data that looks at their use for preventing long COVID-19. In a sense, there are a number of long-term sequelae of COVID-19. The Premier has outlined the cluster of symptoms that's beginning to become recognised as a feature of some people in the aftermath of COVID-19. We have experienced similar sequelae after a range of other infections historically, things like Epstein-Barr virus or glandular fever, CNV and bacterial Q fever. There is substantial knowledge about how to manage people with those post-viral or post-bacterial sequelae. It is going to be important to build on that intelligence when addressing people with those forms of long COVID-19.

The other thing that can happen with people who have severe illness is they can have chronic sequelae of a severe bout and disruption of their lungs or heart. People may have

chronic coughs because of slowly resolving of inflammatory processes in their lungs. Some people can even have permanent damage to their lungs, for example, after intensive care spells.

We can reduce long-term outcomes from COVID-19 with antivirals. That is probably where the greatest gains are going to be. Stopping those more significant pathophysiological harms as a result of COVID-19 is probably the main benefit of antiviral treatment. The extent to which it influences the other, mostly milder, but in times disabling symptoms, is not clear.

CHAIR - Premier, I want some data or information about how antivirals are delivered. I understand it is in hospital settings. It is not something that is delivered in communities by GPs. With a lot of antiviral treatments it is really important to get it early. People are encouraged to avoid health settings so they do not pass on the virus but the only way to get antivirals is if you are in a category that would benefit from it, as I understand it, is to get it early. If I am wrong about that feel free to tell me.

Mr ROCKLIFF - My information is that antivirals are the most effective when taken early after symptom onset.

CHAIR - How do we manage all the competing interests there?

Mr ROCKLIFF - They are available in pharmacies as well.

CHAIR - Is there a cost to patients in pharmacies?

Mr ROCKLIFF - I will take that on notice for the exact cost to people.

CHAIR - The reason I ask is that if we are trying to encourage people not to access our acute health services unless there is a real need, even though they may be in the category that may make them more vulnerable, they go to the pharmacy and it is quite an expensive medication. A lot of people I represent couldn't afford it.

Mr ROCKLIFF - I understand they are PBS listed. Some are available on prescription through participating community pharmacies. They are on the PBS as of May. Is that right?

Ms MORGAN-WICKS - Yes. Paxlovid and Molnopiravir have recently been PBS-listed, I believe in May 2022, and are now in community pharmacies. We have also established a COVID@home pharmacy service, so if you test positive for COVID and opt into our COVID@home service, we have a pharmacy service to deliver appropriate antivirals to you at home.

I think early on in the outbreak we were delivering treatments - you are right, Ms Forrest - in terms of hospitals. We were identifying patients through our COVID@home triaging and bringing them into hospital, for example for day treatment, or sometimes overnight admission if their symptoms worsened. Now we are seeing more widespread availability of the antivirals, but still prescribed either via a doctor in COVID@home to a particular patient, or if a patient is attending their own GP.

CHAIR - In the course of the illness, what is the optimal time for administration of the antivirals?

Mr ROCKLIFF - Very early after symptom onset, is the information I have.

Dr VEITCH - The use of antivirals has evolved over time, as we have heard. We started off with some drugs that had to be provided in hospital, which was a bit complex because you had to get the person to hospital and manage them. Over the last six months or so, clinical practice in relation to antivirals has changed, as has their regulation and availability. It has been a bit of a balancing act, balancing the risk of side effects from some of the early treatments against establishing the safety of the agents that we are using now, when used in the right context.

The recommendation is that people who are most likely to benefit from antivirals - people who are over 65, have a couple of chronic diseases or are immunocompromised - get a diagnosis as soon as possible, preferably a PCR with a quick turnaround or, failing that, a RAT test, and then expect to be assessed by their general practitioner or whoever they are dealing with for their care to contemplate the use of an antiviral agent and either decided for or against. The sooner, the better.

CHAIR - This would be a very good reason to ensure that telehealth is still funded. You do not want those people to go into a doctor's surgery.

Mr ROCKLIFF - I agree with telehealth. I am advised that as of 23 May, we have 1333 courses of Paxlovid in Tasmanian hospitals. On average, our hospitals are providing courses to 11 Tasmanian patients per week. We have done a bit of research on the Commonwealth website as to the cost, which comes to $6.80 with a concession card, or $42.50 without. Aged care have been pre-positioned as well, so it is available in our residential aged care facilities.

CHAIR - I do not know if this is available publicly, but are we able to know which pharmacies actually stock it - is it all pharmacies?

Mr ROCKLIFF - All pharmacies, as I indicated earlier.

CHAIR - So, all community pharmacies would have this available?

Ms MORGAN-WICKS - We have had feedback from the guild and society early on in relation to the cost of the stockholding, and their ability to actually get it and then get it back out the door. It was a significant cost, so I believe that a buy-back or guarantee scheme was provided to pharmacies to take that risk.

CHAIR - Through the Commonwealth?

Ms MORGAN-WICKS - Yes, that is my understanding, but assisted from the state, so we are making sure the antiviral stock can move around the state as required.

CHAIR - I am not sure if you know whether all pharmacies have it, such as the pharmacy in Queenstown, the one that is occasionally open in Rosebery and Stanley, places like that, and down the east coast where it is more difficult for people to get to GPs.

Mr ROCKLIFF - Yes, I understand the reason for your questioning its accessibility in rural and regional areas. I do not have that information with me, but we can ask the Pharmacy Guild.

CHAIR - We will write to you and see what can find out about the availability, and the cost.

Mr WILLIE - Premier, it's still very concerning that the vaccination double-dose rate in 5- to 11-year-olds - I've just looked it up - is 51.11 per cent. It seems to have stagnated for some time. Do you think there's a problem with the Government messaging? Some parents I speak to who haven't vaccinated their children often repeat the line that has been repeated by government: it's mild in children; I'm not going to worry about it. Shouldn't the message be that we need to prevent the spread in schools, because education is important, and we need to stop the virus coming home to vulnerable family members? Do you see a problem with the Government messaging contributing to that?

Mr ROCKLIFF - Not necessarily. I believe our Government messaging has always been encouraging parents to vaccinate their children between the ages of 5 and 11.

I can get the latest figures for you, Mr Willie. The first dose in 5 to 11s is 63.23 per cent, and as you've identified, the second dose 51.11 per cent. We are consistently above the national average, and that has been consistent - around 10-12 per cent, I believe, for the whole of population. There is some resistance in parents, we accept that. We can only reinforce the message that the number one defence is vaccination.

We have said many times in our public commentary that we'd be open to suggestions to cut through further with our parents on that matter. Dr Veitch has indicated he would like to comment on that.

Dr VEITCH - Thanks, Premier. It is definitely a challenge to lift the vaccination rates in 5- to 11-year-olds above 60 per cent or so. Tasmania saw quite a quick uptake when we pushed it along, but the plateau seems to have been fairly common across a lot of states, at half or a bit over half of that cohort.

You're correct that the observation that the illness is relatively mild among those children is a bit of a discouragement for parents if they have any hesitancy about vaccination. There have been really excellent groups of researchers and practitioners on vaccination who had a couple of forums to see whether they could think of some messaging that would encourage parents to increase vaccination, and we've participated in those forums and seen the outputs, but it really suggested much of what we were doing.

One point I probably should make is that the message that it will reduce transmission in schools is probably not a message that we should promote, because it probably doesn't. The vaccination of young children will not have much effect on the rate of transmission in schools.

The very rare but awful experience of children getting seriously ill or dying is something that we've been fortunate not to experience. There has only been I think eight children of school age admitted to hospital because of COVID this year, so it's a very rare event. For example, in influenza season there are more children of that age admitted to hospital than there are from

COVID, so it is a difficult message to sell, taking on the vaccine to prevent very rare but serious side effects.

Mr WILLIE - Is the Government surveying parents, trying to understand the core reasons for the vaccination rates not continuing?

Mr ROCKLIFF - No, I don't believe we're surveying parents. We have looked at other national campaigns and we're very mindful of any other ways that we can get that very important message through.

My advice here is that nationally, when it comes to second dose, it's 39.37 per cent as opposed to our 51.11 per cent. Notwithstanding that, I agree that we need to do more to lift those vaccination rates where possible. We can't rest on our laurels and say we're above the national average. It is important to get those figures up a lot higher.

Mr WILLIE - It's good to hear that serious illness is very low, but it has been incredibly disruptive to education and the system. You're about to remove masks in schools. Is there an expectation that cases will increase in schools from that measure being removed?

Mr ROCKLIFF - I acknowledge that it has been very disruptive, as you would be well aware. Mr Jaensch has been at the Public Accounts Committee and all of these matters were canvassed then. I will refer to Dr Veitch regarding expectations around mask removal.

Dr VEITCH - The vaccination will have a modest effect on attenuating spread in schools. Very limited, as I have just said. Children mix in a whole range of circumstances inside and outside of schools. I'm sure that when masks come off there will be transmission within schools. When masks were on there was transmission within schools. In the course of the first and second term, about 45 percent of school-age children were notified with COVID-19. Even with masks in place, you are still seeing cases among school children. Whether they caught it in school, outside school, or in the home we do not know. There will be instances of transmission when masks come off in schools.

Mr WILLIE - The question, Premier, is whether we are going to see an increase in transmission? Is the Government expecting that?

CHAIR - If I can elaborate on that question. Has there been modelling done to specifically look at the impact of masks in these sorts of settings?

Mr ROCKLIFF - Lifting the mask mandate is not an order to not wear masks. People are encouraged to wear masks in certain settings, and for very good reasons. We will be encouraging people to continue to wear masks where appropriate. In lifting the mask mandates, I will still encourage people to wear masks in certain settings. It is not an order to not wear masks. What would you say to that, Dr Veitch?

Dr VEITCH - The first thing I would say is the most useful information we will get will probably not be from modelling but it will be from monitoring the incidence of reported cases in school-age children.

Since the peak of transmission among that age group, which was during first term, when the more senior students were wearing masks, the rates dropped right down to about a quarter

of what it was during the start of term one, and through towards the end of that term. We will continue to monitor the trends in the incidence of COVID-19 in school children. We will continue to provide support to schools that identify a problem in their schoolroom with a greater than expected number of cases.

In the discussions with schools, we have talked about the prospect that there may be particular circumstances and particular times, they might be doing a particular activity that brings a large number of students together, maybe occurring at a time when there is more COVID-19 in Tasmania in general, or in their particular community and in those circumstances they may make requirements or a strong recommendation that their students wear masks.

It is almost impossible to stamp out the mask-off meme that comes through the community. It is not masks-off. It is no longer a public health mandate to wear masks, but the ongoing recommendation is to wear masks if people want to, or if there are circumstances they cannot socially distance, or the risk appears to be greater, or the setting in which they are requires them or recommends them to do so.

CHAIR - On vaccinations more broadly, the evidence seems to suggest that after about four months from the vaccination, immunity wanes. For the majority of people who aren't over 65 or are not immuno-compromised they're getting into that period, health workers and others, where the last vaccine was more than four months ago. What is the current thinking around this? It is a concern for a lot of people, particularly health workers who are at the front line.

Mr ROCKLIFF - Thanks for the question. These matters have been discussed at ATAGI. Correct, Dr Veitch?

Dr VEITCH - When we think about vaccination, it's important to think about what we're expecting to achieve with vaccination. The two things that people want to achieve with vaccination are protecting people from getting severely ill, and reducing the transmission of disease.

The evidence is that the protection against the disease, particularly among people who are at a greater risk of severe disease, holds up pretty well. It's true that it probably does diminish as you get four or six months and beyond, but it still provides a substantial level of protection against severe illness in those people.

Some of the studies have looked at antibody levels. That is only part of our immune response. There are increasingly sophisticated ways of looking at our immune memory to see whether that kicks in many months after vaccination. There's increasing evidence that that holds up pretty well in people who are at risk of severe disease.

Unfortunately, by that time the protective level that you have against catching it in the first place, or spreading it, is long gone. That does not last more than a couple of months. We don't have the vaccines available to us that prevent infection, the way measles vaccine prevents infection.

There is increasing evidence that with multiple, multiple doses of largely the same vaccine you get diminishing returns. As we move to an era with increasingly diverse strains, we may end up having several strains of COVID-19 co-circulating in the community in the years to come. It is going to be important that vaccines cover the diversity of strains. It probably

means there will be some diversity in the vaccines. They'll target a specific group of viruses, rather than the last one that came through.

CHAIR - A bit like the flu vaccine.

Dr VEITCH - It is. When I read about it it did seem broadly analogous to how we approach flu each year, where we try to get the best match.

People are trying to develop a universal flu vaccine. That's a holy grail. I'm sure they're working on a similar idea for COVID-19. I'm not sure where that basic research is up to.

Mr ROCKLIFF - Chair, I have some information in relation to questions by yourself and Mr Willie.

The department received 49 workers compensation claims relating to positive COVID- 19 results from the north west outbreak in 2020. Of these, 48 employees are located in the north west and one is located in the north. Of the 49 workers compensation claims, 16 remain active. All of those are based on the north west coast, as of 3 June.

I have the cost associated with the vaccination rollout, which might be of interest to the committee. The total cost for the 2021-22 state clinic vaccination rollout forecast is $28.6 million. This comprises a forecast $15.7 million for salaries and wages and $12.9 million of other costs. It is estimated that the commonwealth will contribute $11 million to the total cost based on the number of doses delivered in the last financial year. This leaves $17.6 million as the state-funded component. These are early numbers and subject to the National Health Funding Body reconciliation process. That gives an indication of the costs associated with the rollout.

Mr WILLIE - How is the state Government managing the impact of flu and COVID together through this winter? Are we seeing increased rates of hospitalisation? Are there people who are carrying both the flu virus and COVID virus?

Mr ROCKLIFF - Having visited the laboratory yesterday, I've asked a number of these questions, including whether people are carrying both the flu and the COVID virus. From my information, it is possible. Dr Veitch?

Dr VEITCH - Yes.

Mr ROCKLIFF - I can point you to our winter flu strategy, and once again the state Government's investment into free vaccinations for the community across the board. Some of those are part of the national NIP program, and our own state investment as well. To date, that has been relatively successful in terms of uptake and vaccination status. That free vaccination program lasts until 6 July this year. We'll monitor that and see if it needs any extensions.

Mr WILLIE - That was my next question; are you going to extend it?

Mr ROCKLIFF - I will come to that, absolutely. Currently, 227 803 Tasmanians - or 41.5 per cent - have had a flu vaccination: 44 per cent in the south, 40 per cent in the north, and almost 37 per cent in the north-west.

CHAIR - Do you have the costs of those to the Government?

Mr ROCKLIFF - We could break those costs down. From memory, our commitment initially was $1.5 million, and then another $1.5 million. We will get the figures for you, Chair.

The 6 July question came up over forums every three weeks with key stakeholders across the health system, including the ANMF, AMA, HACSU and other key stakeholders. We used to meet weekly for a long period of time, and then fortnightly, and now every three weeks around these matters, and that was discussed. As you can appreciate, we had the monthly period from 6 June to 6 July for people to access free flu vaccinations. We'll evaluate its success and decide on that time. One reason we had that narrow period of a month is to encourage people to not wait for the flu vaccination.

Ms MORGAN-WICKS - In relation to hospitalisations for influenza, at the moment we have two hospitalised in the south, we have seven in the northwest - four at the North West Regional and three at the Mersey - and we have seven at the LGH, with one in the emergency department with suspected influenza. That adds up to the exact same numbers hospitalised with COVID at the moment. For our health system, both influenza and COVID in equal measure are of concern in our winter period, and we are prepared for both.

Mr ROCKLIFF - To Mr Willie's question, because it's winter, we have a heightened response to these matters. This will include increased COVID and influenza vaccination rates across the Tasmanian population; testing to detect influenza and COVID and ensure timely and accurate treatment; increased hospital avoidance and primary care support - for example, we now have COVID@homeplus for all respiratory illnesses; maintaining additional COVID bed capacity in our hospitals; continuing to build and maintain COVID/influenza treatment stockpiles, and increase their availability, including through pre-positioning.

The Tasmanian Government is providing free flu vaccines to the public through state-run community clinics, and is offering GPs and pharmacists a reimbursement payment of $21.50 for all flu vaccinations reported to the Australian Immunisation Register between 6 June and 6 July. This will assist access to flu vaccination for all Tasmanians, to reduce the risk of serious illness and the need for hospitalisation associated with influenza, which we know from 2019 is a very serious issue.

CHAIR - You can argue that the Commonwealth should be assisting the pharmacies and the GPs in covering the cost of vaccines?

Mr ROCKLIFF - I would always argue that the Commonwealth should do more.

CHAIR - Have you had an argument about that with them?

Mr ROCKLIFF - We've had an argument or discussion about funding more broadly, but all premiers have to stay united in these matters, and were very pleased to see a three-month extension in the National Partnership Agreement in sharing a 50 per cent cost. With COVID-19, that now extends to 31 December.

CHAIR - Premier, isn't a fact that the Commonwealth is responsible for primary health care and vaccinations in their National Immunisation Program?

Mr ROCKLIFF - The NIP, yes.

CHAIR - Why are we not seeing the Commonwealth stump up here? Perhaps that's not a question you can answer. It's a little frustrating that the state has to fund all this, when there is a responsibility elsewhere.

Mr ROCKLIFF - I'll take up your question on the primary care part. There was a lot of discussion at national cabinet about this very matter and, pleasingly, a willingness from the Commonwealth to engage with states, particularly on that intersect between primary health care and our queue care system, which we are responsible for, and a very willing and collaborative discussion around the need for national reform in this area. It was a pleasing first national cabinet meeting. My first, the Prime Minister's first. We can only hope that reform and voter support and investment in primary health care is not too far away from the Commonwealth.

CHAIR - Premier, I'd like to go to the testing capacity and its cost.

Mr ROCKLIFF - Can I add that the Commonwealth is providing 205 000 NIP doses of the flu vaccination.

CHAIR - They are funding that, did you say?

Mr ROCKLIFF - Yes, under the NIP, as you highlighted.

CHAIR - They're the ones through pharmacies and GPs?

Mr ROCKLIFF - Yes.

CHAIR - Are you still topping it up, Premier? Am I correct in understanding that?

Mr ROCKLIFF - Correct.

CHAIR - We still have testing stations, like the one in Burnie - that one is outsourced to the private sector - that did have a number of challenges at the outset and failed to deliver according to their contract. What happened there, Premier, and how are things going now? What is the future of the offsite or standalone testing centres, and the cost to date of the north-west one and the other standalone ones that aren't inside our queue care system?

Mr ROCKLIFF - You mentioned the testing clinic at Burnie. It is not outsourced any further; it is our responsibility.

CHAIR - It's back in now?

Mr ROCKLIFF - Yes, it has been for several months.

CHAIR - Where is that geographically located?

Ms MORGAN-WICKS - Still the same site.

CHAIR - But it was always funded by the state, and now it's completely operated by the THS staff?.

Ms MORGAN-WICKS - Yes. We're managing that outsourcing contract. Some difficulties were experienced and that contract was brought back into the state, so it is part of our state testing network.

CHAIR - Premier, with these standalone clinics, we know that testing is done when a patient comes into an acute setting, if they haven't already had a test. Can you explain the cost of those centres and the future of them?

Mr ROCKLIFF - I will ask our CFO, Craig Jeffery, to come to the table.

Mr CRAIG JEFFERY, CHIEF FINANCIAL OFFICER, DEPARTMENT OF HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr JEFFERY - Total cost estimated for 2021-22 is $20.297 million. That comprises $10.417 million relating to the Department of Health and $9.88 million relating to other agencies, which is the Department of State Growth for message boarding and things like that. The state Government component of that is $10.173 million. The Australian Government component of that is $10.134 million. I have a lot more detail if you want, but that is the high level.

CHAIR - Related to those matters?

Mr JEFFERY - Related to what comprises the testing clinic costs, yes.

Mr ROCKLIFF - We are moderating and adjusting the demand of the testing clinics, in terms of the hours of operation. I am advised they will continue for the foreseeable future.

Mr JEFFERY - Those numbers are as of 8 June, including actuals to 31 May and forecasts for June. The actuals to May still could change as costs may be journalled backwards and forwards. The component relating to the Department of State Growth, the message boarding, and traffic control, is $9.88 million, testing clinics salaries and wages are $6.732 million, testing clinics cleaning and waste removal are $427 000, testing clinics communications $523 000, testing clinics external contractors, some of the outsourcing, $878 000, testing clinics freight $358 000, operational costs at the testing clinics $544 000, testing clinics rent and property-related costs $772 000, security at testing clinics $133 000. That's it.

CHAIR - Do we have a cost of posting out RATs? There was demand in the north-west, and probably other parts of the state that are quite remote.

Mr ROCKLIFF - We can ask that. I can confirm that there was huge demand.

Ms MORGAN-WICKS - While Craig has a look to see if he has the postage cost number, in the past week we have seen our RAT distribution move from around 1000 a day, and that had been pretty constant over several months, to 2000 a day. There is still continued demand for RATs. I understand we have about 2.5 million rapid antigen tests still within our

stockholding. We have daily monitoring right across all of our sites, we have collection and we have the Australia Post contract to distribute those.

CHAIR - There are still some being picked up at clinics. You can register to pick up a free RAT. Do the figures include them?

Ms MORGAN-WICKS - That is correct. The cost our CFO, Craig Jeffery, just read out for testing clinics does not include the cost of running the laboratories to do the second pass.

CHAIR - It is just the clinics?

Ms MORGAN-WICKS - Yes, in terms of our Royal Hobart Hospital laboratory.

Mr WILLIE - Other agencies would have stock holdings too, wouldn't they? The Department of Education distributing RATs. The 2.5 million is just the Health department.

Ms MORGAN-WICKS - I am not aware of the Department of Education's stockholding, just the ones available for Health distribution.

CHAIR - There is a separate stockholding.

Ms GALE - We would need to get the current information but previously the Department of Education RATs were being distributed through the Health distribution mechanism.

CHAIR - They are not still?

Ms GALE - We would need to confirm whether that is still happening or not.

Mr WILLIE - It is probably a question for State Growth, but $9.8 million for traffic control and signage seems like an extraordinary cost.

Mr ROCKLIFF - Including personnel. That is my advice, yes.

Mr WILLIE - There was a separate figure for wages.

Ms MORGAN-WICKS - The separate figure for wages are wages paid by the state Government. The outsourced traffic controllers are quite a significant presence, as probably anyone who has turned up to a PCR and been guided through by the meeting personnel will know. They are often the unthanked component of our staff but they have been integral to the smooth operation of our testing clinics.

CHAIR - Particularly when they were busy. Do we have the postage costs from Mr Jeffery?

Mr JEFFERY - Rapid antigen tests freight was $149 000 and external contractors rapid antigen test distribution $27 000.

CHAIR - It is interesting that the demand has increased. It is not going to get any less over the short period.

Mr ROCKLIFF - I'm not aware of any other state that is posting rapid antigen tests out to individuals.

CHAIR - I do recognise that, Premier, and the fact that it has been a real assistance to many Tasmanians.

Mr ROCKLIFF - Thank you, Chair. For school term two, one bulk distribution of RATs was made to all sites during week one to cover the first four weeks of term. Schools will continue to distribute to families as requested and are able to contact the central facility services within the Department of Education should additional RATs be required. Supply and demand will continue to be monitored throughout the term and the Department of Education will continue to support the supply of RATs to independent schools. Catholic Education will manage this directly with the Department of Health, I am advised.

CHAIR - Early education and care centres? Are you sending them there?

Ms GALE - Our understanding is they are included in the school distribution.

Mr WILLIE - Is there an expectation that the demand for RATs will increase? A lot of people are coming out of that 12-week window from the first wave and they will be testing again.

Mr ROCKLIFF - If demand increases, we have ample RATs in stock for the winter period.

CHAIR - Are there supply issues? You need to maintain the stockpile too.

Mr ROCKLIFF - I'm advised the supply chain has stabilised so there are no immediate concerns with supply.

Mr TUCKER - Premier, regarding COVID@home, how successful has that been at keeping people out of hospital?

Mr ROCKLIFF - I would say, very successful, Mr Tucker. We are moving in to COVID@homeplus through the winter for all respiratory illnesses. COVID@home coincided with a policy in our health system of seeing where we can support people in the community, outside the acute care system - particularly with innovations such as the Community Rapid Response Service (ComRRS), Hospital in the Home, Hospital in the Home Mental Health. A mental health example would be the Police, Ambulance and Clinician Early Response (PACER) initiative, and the secondary triage in our ambulance service.

COVID@home brings together that acute community and primary care support to provide a safe and effective in-home healthcare setting for those diagnosed with COVID-19, to ensure people diagnosed with COVID-19 are clinically safe and cared for at home. In our view, the program has been a significant contributor to Tasmania having the lowest rate of hospital admission - just a proportion of active cases compared to other states that have opened their borders. COVID@home has contributed to less people turning up to our emergency department as well, with lower numbers of emergency department presentations for COVID@home-enrolled patients.

For your interest, I have some data here. Between 15 December 2021 and 11 May 2022, 15 302 people have chosen to participate in COVID@home. As of 17 June, 18 244 people have participated in a COVID@home program - with 499 yesterday currently enrolled in the service as well. So, it has been very successful. We are pleased to see how COVID@homeplus rolls out and supports people.

Ms WEBB - With the two pathways that people can come into the COVID@home program - through self-referral, or being referred by their healthcare provider - what was the mix generally?

Mr ROCKLIFF - Good question.

Ms MORGAN-WICKS - I do not have the exact number, but from anecdotal conversations, for example with the nurse unit manager of COVID@home, a significant proportion are coming through just the individual opt-in-service.

Every single person receiving a positive test result from PCR, or who reported a positive RAT test, was sent a text message asking if they would like to opt in. We have also had a support line for GPs run by COVID@home. I estimate around 10 per cent is probably the likelihood, but we can check the number of calls coming in from GPs referring.

The COVID@homeplus program is going to be through GP referral, but also through emergency department and Ambulance Tasmania referrals. Our paramedics, for example, are in secondary triage. If they visit a home and do not think a patient needs to be brought in to hospital or for admission, they may offer the COVID@home program, and they actually carry the kits in the ambulance vehicles. If our EDs do not believe a patient needs admission, they may offer the virtual monitoring service in case there is a deterioration in their respiratory symptoms. They will also offer a kit, so patients can leave the ED with that and be enrolled in the COVID@homeplus.

We are going to monitor the numbers that are coming through from GPs, EDs and also Ambulance Tasmania.

Ms WEBB - Do we have an average or typical length of time that people are being supported within the program?

Ms MORGAN-WICKS - We have the seven days isolation period, where people are asked by COVID@home every single day to answer questions as to their symptoms. If there are continuing symptoms, they remain enrolled in the COVID@home service. There is no time line.

Ms WEBB - I am not wondering about when we cut them off or anything like that. I am asking, from the data so far, what is the average time that people are staying supported in the program?

Ms MORGAN-WICKS - We are currently undertaking a program review of the first 150 days of COVID@home. I think we will be able to publish the outcomes of that review and include data as to the length of stay in COVID@home.

CHAIR - Do you have any numbers about people who have been diverted from our acute service, who don't end up going to ED because they're supported through COVID@home, but would normally have turned up? Do you have that sort of data? Not all the people who registered would have needed hospital care.

Ms MORGAN-WICKS - Not all people who register for COVID@home need hospital level care, that is absolutely correct. I don't know when this number was collected, but of 381 people enrolled in COVID@home, 2.8 per cent were escalated to hospital; that might have been for a day treatment for an antiviral intravenous as it was during the first period of this year. I'd prefer to wait until we've undertaken a full program review and can get that data, if the Premier is happy to share that information.

CHAIR - When are we likely to have that data? Did you say you're doing it now?

Ms MORGAN-WICKS - The review is currently being undertaken.

CHAIR - Have you any indication of the time frame for completion?

Ms MORGAN-WICKS - I don't have an indication as yet.

Mr ROCKLIFF - We could provide that as a follow-up answer, if you like.

CHAIR - If it's going to be months -

Ms MORGAN-WICKS - I imagine it's in the next few weeks, but I just don't know.

Mr ROCKLIFF - I am advised in the next few weeks. Let's say maybe 1 August.

CHAIR - We will add it to the list of questions so you can provide it when it's available. If it's going to be months, there's no point holding out for it; we can call you back another time.

Mr WILLIE - Can we get some figures on COVID@home too? Costs for the kits and the monitoring and everything else that went into it.

Mr ROCKLIFF - We do have those, Mr Willie, including the actual number of kits. We initially indicated 2500, from memory. Is that right?

Mr JEFFREY - The estimated cost of the COVID@home program is $6.981 million. I have sub-components, if you're interested.

Mr WILLIE - Yes.

Mr JEFFREY - Salaries and wages, $1.096 million. Licensing, $214 000. Communications, $3.384 million. External contractors, $208 000. Freight, $124 000. Operational costs, $390 000.

CHAIR - Is there a supplies and consumables line somewhere that would cover the kits?

Mr WILLIE - We can put that on notice if you want to clarify that.

Mr ROCKLIFF - We ordered above the 2500 kits. I'm just getting some clarification on the final figures.

CHAIR - If Mr Jeffrey finds it, we can come back to it.

Mr WILLIE - My last question probably is a follow-up from previous questioning. Potentially there'd be tens of millions of dollars in hospital admissions saved through the COVID@home program. Is there some sort of understanding of that?

Mr ROCKLIFF - I am not sure of the data, but it would indicate savings, but more importantly saving the congestion in our hospital system and the positive impact on access and flow through the hospital, avoiding bed-block and ensuring that people who need to access our acute care system for other reasons are able to do so in a timely manner.

I am advised that for the first 150 days of operation, people who were enrolled in the COVID@home program had a 49 per cent reduced chance of attending the ED, than the general population of Tasmania.

Ms WEBB - I was going to move on to the community case management facilities.

CHAIR - Mr Deputy can come back with that figure when he finds it. We'll move on.

Ms WEBB - I was going to ask for a similar update on the community case management facilities. In a similar way to COVID@home, are you reviewing that program to provide a full picture of an evaluation?

Mr ROCKLIFF - I might soon refer to Ms Morgan-Wicks. We've maintained our community case management facilities throughout the pandemic to accommodate COVID-19-positive patients who do not need to be hospitalised but do require a higher level of clinical supervision and support than is provided by COVID@home and government-managed accommodation facilities. To 20 June, 202 people were accommodated at the Coach House, 299 at Fountainside. The community case management beds at Sunrise Hotel in Devonport have not been required. They adopted a model of care supported by medical governance and facility management provided by local hospitals. The nurse-lead model of care is on-site, operational service 24 hours, 7 days a week. Staffing includes a nurse unit manager who reports to the regional THS nursing director pandemic response. The nurse-led model of care includes the health screening assessment management, early intervention, client advocacy and infection prevention and control oversight. People are referred to the community case management facilities by Public Health, COVID@home or a THS hospital.

Ms MORGAN-WICKS - We have been closely monitoring the volumes that are currently being managed through our community case management facilities and our government-managed accommodation facilities. We have currently three COVID-19-positive people in the CCMFs. We have had very low volumes over recent times in those facilities. In January they were full. We were looking for capacity in all the regions, but with the success, I think, of COVID@home and the ability to manage people within their own residences and take appropriate isolation precautions, the need for the CCMFs has lessened.

We are reviewing our CCMF strategy and our government-managed accommodation facilities, noting that the government-managed accommodation facility function has moved

from Communities to Health in the last two months. That has been consolidated. We will have more to say about that future management. I note the lower volumes that are currently being managed in those facilities.

Ms WEBB - Do you have a profile of the costs of the community case management facilities?

Mr ROCKLIFF - Mr Jeffery is looking at the figures there. I'm advised that the ongoing management cost of the three government-managed hotels from 21 March 2022 until 30 September this year, so six months, will be $8.9 million.

Mr JEFFERY - The estimated cost for community case management facilities is $2.479 million. I have more detail. Estimated rent $1.479 million, security $508 000, contract staff $216 000, operational costs $153 000. They're the main components.

CHAIR - Regarding hospital capacity, the secretary said earlier that the numbers of people being hospitalised for COVID-19, as opposed to with COVID-19 has remained pretty stable. We are still seeing significant wait times for things like elective surgery and access to outpatient. I assume the capacity that has been put in place has not just been held there in case we need it and has been utilised. How has this worked? It seems we are not catching up, despite your earlier comments about the rates of elective surgery in January and February.

Mr ROCKLIFF - Yes. Estimates covered decreasing waiting lists. We recognise the outpatient waiting list, while it has decreased marginally, is still way too high. We have the outpatients program addressing that very complex issue. We brought forward the opening of a number of beds to prepare for the borders re-opening. You would have seen in the forward Estimates that will continue. Ward 3D at the LGH is an example of that. Even though it was a preparation for the borders opening and the impact of the pandemic and those with COVID- 19, those beds have been well-utilised.

Work to prepare for COVID-19 has included increasing bed capacity across the system, with 146 additional beds opening since July, 2021. This comprises 66 beds at the Royal Hobart Hospital, 33 beds at the LGH, and six beds at the North West Regional Hospital, but also up to 41 beds in private hospitals as part of that private-public partnership arrangement.

CHAIR - Regarding beds, you need staff to staff them. There is the challenge of COVID-19 but also influenza and other illnesses keep staff home from work. How often are those beds fully staffed, acknowledging the challenges of sick leave?

Mr ROCKLIFF - My understanding is that we have opened the beds in alignment with when we can safely staff the beds and not before. That has been a key factor in that.

Ms MORGAN-WICKS - The Premier has noted the opening of the beds, and Ms Forrest has also rightly noted that keeping them open means the safe staffing. This is evaluated every single day across all of our wards in the hospitals, according to staff who are themselves calling in sick or on carers leave et cetera, to manage that on the wards.

We have had the significant impact of COVID-19 illness and infection, but also the rules relating to close contact management, particularly in the first three months of this calendar year with COVID-19 cases coming in and widespread community transmission. That will have an

impact on the availability of beds across our hospitals, which is why it was so important to maintain that virtual COVID-19@home service.

We have managed, and I believe all hospitals at the moment are at level two COVID escalation, in terms of their configuration, the way we're managing COVID-19 cases in particular wards, and whether that's affecting the availability of surgical beds - for example, for elective surgery - on any one day and also the flow of patients coming from the ED.

CHAIR - So it does have an effect on that when you're at level two?

Ms MORGAN-WICKS - Yes, the different levels of the hospitals will affect availability, depending on whether we are going to cohort all of our COVID-19 patients together. Now, for example, it's influenza - are we cohorting all of our respiratory patients together, and does that affect the availability of other beds for surgery?

We are very pleased that we haven't had a significant impact on our ICUs. We have maintained a very low rate of between one to four patients in our ICUs, which has then meant that general surgery can also continue, noting that we need to have that availability of ICU beds post-surgery should a complication occur, or just for the first few days of recovery.

Elective surgeries have maintained very strong throughput, according to the first year of the four-year plan for elective surgery, despite COVID-19. They are absolutely to be commended for their efforts, noting that they've had to manage their own teams of surgeons, anaesthetists, theatre nurses and support staff through COVID-19 infection and close contact management.

CHAIR - Premier, do you have any indication of how often full bed capacity has not been available? I accept the explanation provided, and fully understand that. When you say we've got 146 beds, but if that capacity is only able to operate fully staffed half the time, then it's not giving a true picture. I am seeking some information about how often that full capacity has been able to be utilised.

Mr ROCKLIFF - We can certainly take that on notice and provide the data.

Ms MORGAN-WICKS - The number of beds that are open and available every day across all of our health services is an incredibly complex data issue. We do measure through the bed census, but that is a manual process that involves effort right across the hospital system, which consolidates at the same time across all services and then provides that information through to RoGS, so we can do state and territory comparisons, for example.

Through the digital health investment, we are absolutely hoping to increase the level of daily available real-time data on bed numbers. We do have a bed dashboard where we can see the number of beds opening, closing, dirty, cleaning, et cetera, but there's not necessarily a report that says at this hour this is the exact number that are open right across our services. It is monitored through our integrated operation centres who are moving patients not only within a hospital, but between hospitals and out to regions.

CHAIR - It will be good when this new system is in place. It will be much easier to report on these sorts of things, as we were told in Estimates in answer to a number of questions about this sort of data.

Are we normally able to operate close to full capacity with all beds open? Is it 50 per cent of the time? I am not asking for specific data, I am just trying to get a picture of how often we are fully staffed.

Ms MORGAN-WICKS - If I can rely on anecdotal data, the chief executives text me about their quotas on a nearly daily basis. For example, this week I was informed of six beds being unavailable at the Royal Hobart Hospital. In those text exchanges or checks through our executive, which also monitor it on a weekly basis, I have never heard anything above 10. With the large number of beds that were brought on in preparation for COVID-19, we had minor reports of bed closures for the safe management of those wards, as directed by the nurse unit manager, that they have this amount of staff available for the day and can safely operate this number of beds.

If we fall below a particular level, we do put the call out to our private hospitals to make sure the beds we have contracted there are full and are flying through.

CHAIR - We will take a break at 11.00 a.m. for 15 minutes. You have provided some information on the PPE availability. We assume that continues to not be an issue anymore - availability, access, stockpiles and those sorts of things?

Mr ROCKLIFF - I can provide some information on all of this - masks, gowns, goggles, gloves, et cetera. I am advised that the following expenditure is above and beyond the normal Department of Health PPE supply chain arrangements, as you would appreciate. As at 31 May 2022, the department has spent $17.94 million for the 2021-22 financial year to date, with a full-year forecast of $22.21 million.

For the 2020-21 financial year, the department spent $24.5 million. The previous financial year, we spent $43.2 million. Since the start of the pandemic to 31 May this year, the department spent $85.7 million on PPE. The total forecast expenditure to 30 June this year is $89.9 million. Under the national partnership for COVID-19 response, the Australian Government will fund 50 per cent of the PPE costs incurred by the department in response to the pandemic.

As of 17 June this year, we had 4.08 million surgical masks; 3.2 million P2N95 respirator masks; 41 161 litres of hand sanitiser; 2.25 million gowns; 20.26 million gloves; 968 079 goggles and eye protection; and 2.19 million face shields. I also have some corresponding figures on order above the normal supply.

CHAIR - The figures you gave initially, they were above and beyond the normal supply, weren't they? Just to clarify.

Mr ROCKLIFF - The first figures were quantity and on order above normal supply.

CHAIR - Those were the figures you gave us.

Mr ROCKLIFF - No, the figures I gave you were what we have on stock, on hand. I can give you some figures on order above normal supply if you would like.

CHAIR - That would be helpful. I assume that is mostly related to COVID-19, and maybe influenza to a degree.

Mr ROCKLIFF - That is what I am advised. I guess we could say respiratory illnesses.

Perhaps I will do those figures again. Surgical masks, 4.08 million, on order above normal supply 837 000. Respirators, that is the P2N95, 3.2 million, on order above normal supply 2.6 million, gowns 2.25 million, on order above normal supply 500 000, eye protection and goggles 968 079, on order above normal supply 260 400, and face shields 2.19 million, on order above normal supply 762 300.

CHAIR - That provides a better picture of the COVID-19 impact.

Mr ROCKLIFF - Mr Jeffery has some costs of COVID @ Home kits.

Mr JEFFERY - The COVID@home program is supported by an ICT platform called MyCareManager. The estimated costs of the related hardware for 2021-22 is $1.517 million.

Mr ROCKLIFF - You might recall leading up to the border opening we detailed how many bed numbers, surge capacity, testing, and our COVID@home kits. That figure was 2500. I can advise the committee that we have 4500 COVID@home Plus kits, 4200 for adults and 300 paediatric, totalling 4500.

CHAIR - I might go to the staff, public and key stakeholder communications section that you referred to in your submission to the committee. During our previous inquiry there were concerns regarding communication with staff in the north west during the outbreak, with some staff not hearing in a timely manner about changes. It is a much different situation now. I'm interested in the Department of Health internal reach platform you've referred to, through which updates are provided to the DoH workforce. How is that working? Are staff able to have input? I assume it's a two-way thing?

Ms MORGAN-WICKS - It is an app on a mobile phone. It's the Reach app and it sends notifications. I have had significant volumes of staff signing up for Reach. We continue to promote it to them. Prior to having this app, it was difficult to get a message out to all staff within a health service, whether they're on in a hospital, off on nightshift, dayshift, et cetera.

We had all-staff email we had to send to nurse unit managers for wards to print out messages to place on staff notice boards, we would do walkarounds, we would do road shows to try to get messages out to staff. In a COVID pandemic where people are not being brought into rooms, with social distancing issues, we had to look at communications to notify staff instantaneously.

In August 2021 we launched Reach, which is, I understand, connected to the Microsoft platform we use within the department. A range of staff are able to publish articles on there. Any staff member can publish comments on each of the articles or ask questions of the author. We have had just over 1400 articles published since the launch. We have the ability to put something right at the front so that the first thing you open and see is one of the high strategic operational alerts. Then you can just sign in and say you would like all of the news of the North West Regional Hospital or your particular hospital, or Oral Health Tasmania, for example. Like Facebook or Instagram, it can channel the news to you as a recipient.

We've had fantastic feedback from staff. It's a huge improvement compared to April 2020, when we basically had to send a geographic bomb text to make sure that we could get to all of our 1700 staff, so via SMS, but a geographic one for the region of Burnie.

CHAIR - I assume it is moderated in some form. Who actually manages it? Is there an opportunity to have something taken down if it was not an appropriate article, for example?

Ms MORGAN-WICKS - In terms of the social medium itself, we trust staff to use it in a proper way. We do not attempt to moderate all articles being published on Reach. People are trained in its use. They're advised in the proper way in which to communicate with staff. People are able to freely comment. In relation to an Easter message I sent out to staff that might have referred to chocolate, I got an interesting response from some who do not necessarily support the eating of Easter eggs. We'd look for any inflammatory or defamatory content and apply our social media policy to that moderation. If there was bullying or harassment in a comment, for example, we'd keep an eye on that.

CHAIR - Do you have someone dedicated to that task? Is there someone that monitors that? Harm could be done quite quickly if there were some defamatory or inappropriate comments being made. I am not suggesting that the staff generally do that, but there is the capacity when there is so many people potentially engaging with it.

Ms MORGAN-WICKS - Yes, the comments are watched. If there are any concerns being reported, we immediately take the messages down, or otherwise speak to the author of the comments. It is one thing to be constantly monitoring and removing messages, but if there is a particular issue playing out in the comments, there may be something greater at play, so arranging to have a chat to the staff member to see if they have a problem and find out why they are raising it in that open forum.

CHAIR - It can help you to alert people who are feeling disenfranchised or unheard about their genuine concerns.

Ms MORGAN-WICKS - We have had no significant issues raised to date through Reach. Staff are really embracing it. For example, last night when I hopped on to check the news of the day there was the news of the launch of the Women in Ambulance Tasmania steering committee. You could see the really positive comments that were flying through, particularly for women in AT commenting on that Reach article. It is increasing the morale and the general communication between groups. Often people in health work in very dedicated silos. They are now able to see some of the great work that is happening in different areas of the department.

Ms WEBB - I have a series of questions about communication and interaction with stakeholder groups. Maybe we can come back after the break.

CHAIR - We might come back to that. Premier, we will take a 15-minute break. We will come back and continue the communication issue and then go to the re-opening with Josh.

Committee suspended from 10.59am to 11.18am.

CHAIR - Over to you, Meg, to follow-up.

Ms WEBB - I am interested in hearing more about the interactions with key external stakeholders about planning the reopening, and since the reopening time what that has looked like in a structured way.

Mr ROCKLIFF - Sure. I can give a view on how I have interacted with stakeholders. There would also be an internal view leading up to those meetings.

I became Health minister in May 2021. I had been Minister for Mental Health and Wellbeing for a couple of years. Before then, we started our regular meetings with COVID-19 stakeholders. They were on-line meetings with between 15 and 25 stakeholders.

Every couple of weeks, but then leading up to the opening every week until February. Then it went to a couple of weeks and now three-weekly. It would back to weekly if that was ever required. The stakeholders included people from the Australian Medical Association, the Pharmacy Guild, the Pharmacy Society, the Community and Public Service Union, HACSU, the ANMF, the Antarctic Division and GP colleges. It was quite a number of people who could raise issues surrounding the borders re-opening, or particular issues at any particular time. It was chaired by the Health Commander, and questions could be put to either myself, Ms Morgan-Wicks, Dr Veitch, Professor Tony Lawler, and others who were able to provide some good information to questions.

That was the stakeholder interaction I had. There were outside meetings I would have with individual organisations and often COVID-19 was raised. Internally, there was at some point almost daily meetings with key stakeholders leading up to the border re-opening. At an operational sense, I'll ask Ms Morgan-Wicks to provide more detail on that.

Ms MORGAN-WICKS - At the highest level the Premier's described the health stakeholders teleconference. This included Primary Health Tasmania. Regarding the management of staff infection and close contact management through the hospitals, we did for a period hold daily meetings with the key health unions: AMA, ANMF, HACSU, CPSU. Each change, for example, the escalation level of the hospital, or a new protocol that was being introduced, was consulted through those meetings with the union groups.

Ms WEBB - Has there been any review or assessment of how well those communication channels with external key stakeholders functioned? Were lessons learnt from that?

Mr ROCKLIFF - From my point of view, we do, as a group decide the frequency of meetings depending on matters that need attention at the time. We are still meeting once every three weeks. I think our next meeting is scheduled in July. Had the last one this week.

We will gauge it from there. It is a very good information session when you here about from, say, the Pharmacy Guild or the Pharmacy Society and their particular challenges or comments that may be relevant to other areas of primary health care. They are very productive and informative meetings. They will continue, even though the health emergency finishes on 30 June. It is important to continue to monitor and to see what is happening.

From your point of view, Kath -

Ms MORGAN-WICKS - Regarding that external stakeholder conference, we regularly check in with them to determine how often they want to have it. We had comments back from

the Pharmacy Guild and the Pharmacy Society that they feel very lucky because they also attend national meetings on their own organisations and had reported that no other state has been holding such regular and all-encompassing stakeholder view on COVID-19. They have been providing information we were sharing back to their national colleagues.

In addition to meeting and discussing with stakeholders, a lot of information is contained on our external website - coronavirus.tas.gov.au. There is our public health hotline, which we're constantly mining for information on calls that are coming in and information that needs to be pushed out for stakeholders. Regular media conference or COVID conference updates have also been provided to the public. We probably receive COVID media enquiries on a daily basis, and we're pushing out information that way as well.

If I could just finish by saying that in our emergency management structures, we have a dedicated stakeholder emergency operations centre (EOC) - for example for aged care, for disability, and also for vaccination. They have been meeting with their key stakeholders, together with Premier and Cabinet, about managing the RACF peaks, and making sure we have that flow of information and that needs are met. For example, every single day the aged care EOC is reaching out to the RACFs that are reporting a first positive case, or an outbreak, and managing that, and then sharing the information to the other RACFs.

We really do regard the aged care EOC in particular as a tremendous success in preparing the RACFs for the opening on 15 December, but also stepping into the shoes of the Commonwealth in the early days between Christmas and New Year's Day when we just couldn't get supply. We were then able to get state supplies through to the RACFs for critical PPE, helping them with staffing and also antivirals. In a small state like Tasmania, having that close connection to the stakeholders meant we knew on the day if there was a problem.

Mr ROCKLIFF - I understand our Department of Premier and Cabinet secretary had meetings with a couple of business enterprises, their own companies and other state authorities, and DPAC also. She also had meetings with various stakeholders, which fed into the regional recovery committee conversation as well. Just by way of interest, probably from July to January or February or further, I would have had weekly meetings with all the state and territory health ministers, as well as the federal health minister.

Ms WEBB - I am interested to hear how vulnerable stakeholder groups in our community and their representatives were engaged in regular interaction leading into our border opening, and then since opening. I'd like to hear if there was a structured approach taken and what that looked like, as well as hearing about individual instances.

Ms MORGAN-WICKS - It was structured through each of our emergency operations centres, because they had a particular portfolio in terms of the health preparedness. For example, our vaccination EOC certainly had significant interaction to drive up vaccination rates in vulnerable groups. Their interaction with disability groups was also assisted by Communities Tasmania, for example with MCOT reaching out groups in the community who did not have English as their first language, and with their assistance we ran a 'train the trainer' vaccination promotion to try to get members of those particular community groups to go out and promote vaccination, or to run and be there at hosted vaccination clinics, where those groups might not have interacted with a state-run clinic at PW1, for example.

Because we were monitoring and trying to lift Tasmania up to as high as possible, we were looking at individual areas or groups where we saw lower vaccination rates, and we employed strategies through direct stakeholder interaction to encourage those parts of the community to vaccinate.

Ms WEBB - That sounds really positive. I know our overall vaccination rates compare very favourably with other jurisdictions in Australia. Within our vulnerable cohort groups, how do our vaccination rates compare, after the effort that was put in to make those connections?

Mr ROCKLIFF - I'm advised that from 9 June this year, NDIS registered providers reported that 99.5 per cent of disability workers required to be vaccinated had received their first dose, and 97.3 per cent have had two doses. At 26 May this year, over 87.1 per cent of NDIS participants aged 16 and over had received one dose, and over 85.1 per cent have had two doses.

Ms WEBB - Do we know how that compares to other jurisdictions?

Mr ROCKLIFF - I have some figures on a percentage of NDIS participants aged 16 and above who are fully vaccinated.

- The ACT, 87.9 per cent.
- New South Wales, 86.1 per cent.
- Northern Territory, 75.8 per cent.
- Queensland, 83.7 per cent.
- South Australia, 82.8 per cent.
- Tasmania, 85.2 per cent.
- Victoria, 86.7 per cent.
- Western Australia, 86.5 per cent.

The national average is 85.4 per cent. This is data as at 16 June.

Ms WEBB - Thank you. Was there a program of engagement with various vulnerable cohort groups or representatives on other aspects of the reopening, leading into and then afterwards?

Mr ROCKLIFF - I'm advised TasCOSS met with Public Health in November last year and held a monthly forum with the community support industry. Communities Tasmania are also engaged with TasCOSS through membership of the Community Services COVID-response project steering committee. Communities Tasmania engaged in regular discussions with funded organisations through regular scheduled meetings to monitor progress against agreed grant outcomes, as well as unscheduled meetings and informal discussions.

Forums were held with business peaks and State Growth, Public Health and WorkSafe to discuss settings during the transition. A series of guidelines and other communications have

been prepared to clarify applications on specific work contexts, including not-for-profit community service organisations, et cetera.

I also have some information that looks at impacts on community wellbeing.

Ms GALE - TasCOSS is still holding those forums for their member groups online. They're held monthly, I believe. Government representatives are still attending those, depending on the nature of the discussions.

Ms WEBB - In terms of engagement with Aboriginal Tasmanians, as a vulnerable cohort group?

Mr ROCKLIFF - I can seek that information for you.

Ms WEBB - You may have vaccination statistics for me, that's fine. We could probably find them on the website, I imagine.

I would like to hear about engagement with the community leading into and going out of the reopening, if there was any, for that more holistic preparation, not just vaccination rates?

Mr ROCKLIFF - Most certainly. Perhaps we will take that on notice and get that advice to you.

Ms WEBB - Thank you.

Mr WILLIE - Premier, I'm trying to get an understanding of what happened with the reopening plan. Once the borders opened we saw a number of changes happen quite quickly. I'd like to work through a few of them. There were business hotspots and businesses were listed on a Government website as being a place where the infection had been detected. That was quickly abandoned. What was the reason for that? Was it unworkable? Was it impacting the business trade? What were some of the reasons that plan changed so quickly?

Mr ROCKLIFF - A number of discussions would have been handed at National Cabinet level of which I was not involved. Dr Veitch was part of AHPPC discussions. You have raised some matters regarding changes. The Omicron variant's high transmissibility no doubt had implications for contact tracing, where it became impractical in many respects. I will hand over to Dr Veitch to talk further about some of those matters.

Dr VEITCH - Most of the planning we did was built around the prospects of a strain that had more or less the transmission dynamics of the Delta strain. We had seen our colleagues on the mainland managing outbreaks of Delta with extensive use of check-in aps and alerts about hotspots. This is really a scaled-up way of doing traditional contact tracing and case management with some additional technological supports. That worked reasonably well for the most part on the mainland.

Tasmania was fortunate during 2020-21 that we had almost no incursions so we never got to practice that response to cases in an environment with Delta as the predominant strain. Nevertheless, as we just heard, we were doing a lot of things to be ready for whatever strain emerged. As it turned out it was Omicron almost from the start. We had a few Delta cases but it was the effectively the highly transmissible Omicron strain. We were in an okay position to

face a reasonably large case load because we had deferred border opening until we had as high a possible level of vaccination and everyone had a chance to get vaccinated if they were eligible. That is important in protecting us from severe outcomes.

As the case numbers mounted very quickly with Omicron it became clear that to ask people where they had been when they were potentially infectious turned out to be Tasmania as a whole. There were very few places where you could confidently say no one was at risk. It would have been misleading to the public to be overly specific when we needed a really general precautionary approach and awareness that you could get crook with COVID-19 any day. With that rapid transition to a widespread infection, it wasn't feasible to be listing specific sites.

What we did do at that stage was focus our public health management on most 'at risk' settings. Where there were more vulnerable people where there were outbreaks. This is where some of the work Ms Webb just prompted us to discuss turned out to be very useful. One of the really important bits of work that public health and our colleagues across government did in the middle months of 2020 was to identify a whole group of settings where there were higher risks. It was things like aged care, disability care, corrections, industry, education, homeless people, Aboriginal Tasmanians, remote islands.

We established relationships with those people. We built a lot of our discussions around outbreak planning with those groups of people, so that these people had an outbreak plan, they knew what they could face when COVID-19 arrived. Some of this work then evolved into separate, semi-independent but related emergency operation centres such as aged care and disability. Those relationships are being maintained until now, so people who are in those sectors always know who to call up and talk with. Various bits of tailored advice has been developed for those people.

When we moved from a situation where we could almost manage case and contact groups one after the other because that was not possible, we focused on working in those settings where there were higher risks. We established relationships with those people because we knew it was a higher risk and ensured they were confident in managing the consequences of COVID-19 in their circumstances.

Mr WILLIE - What date did the Government abandon that intensive contact tracing approach?

Mr ROCKLIFF - I will have to think back and get that information for you, Mr Willie.

Mr WILLIE - There were changes to close contact rules as well.

Dr VEITCH - Close contact rules evolved throughout the pandemic. We moved away from declaring, for example, a hospitality site as a close contact site, and then subsequently confined it to the family and the household.

Mr WILLIE - I am happy for you to take this on notice, but if we could get a timeline of the contact tracing changes, the close contact protocols.

Mr ROCKLIFF - I think Dr Veitch has a timeline?

Dr VEITCH - I have just been provided it by the secretary. The restriction of the close contact definition to people who lived in the same premises occurred on 30 December, 2021, a couple of weeks after we opened our borders. The changes that came through nationally were only partly influenced by the Tasmanian circumstances because they were national changes that we were looking at. We also applied our Tasmanian lens to national advice to make sure that what we were doing was okay for Tasmania.

Mr ROCKLIFF - We have a timeline that we could build on, Mr Willie, if you were wanting to take that on notice in terms of particular changes that were made at particular times. Some of that aligned with national decisions, some would have been made within a state context.

Mr WILLIE - It would be useful for the committee in our reporting to have that timeline, and any check-in app changes too. From memory, we were still checking into a lot of businesses. I think people thought the Government was not using that data towards the end there either.

Mr ROCKLIFF - The check-in app was introduced 1 December, 2020. It was a key resource in pursuing the elimination containment strategy for COVID-19. It ceased being used in all settings on Monday 2 May this year.

Mr WILLIE - If the data was used up until that point, was that for those higher risk settings and not identifying close contacts in those settings and trying to trace the sequence?

Dr VEITCH - We kept it in place in certain high-risk settings and events. It was a just-in-case mechanism in case we needed to deal with a large outbreak in those settings. It's use, as the Premier just mentioned, as an aggressive containment strategy to identify anyone in the setting where a case could have been, became futile once Omicron became widespread.

Mr WILLIE - We saw long queues for testing. With the Omicron variant, obviously the Government did not anticipate the large numbers. What was the response to increase services for that demand? I heard stories of people waiting for four or five hours in their car.

Mr ROCKLIFF - If you watched television screens at that time, there were pictures of long queues in every state of Australia, from memory, for a long time.

Ms MORGAN-WICKS - From a Tasmanian perspective, unfortunately the brunt was really felt in the hardest week of the year to staff any service, which was between Christmas Day and New Year's Day. We had certainly prepared to be able to conduct thousands of tests in that time, and we threw in every available staff member, including bringing staff back from leave, to operate the polymerase chain reaction (PCR) tests, as it then was.

What we did experience was being experienced in every single state and territory in Australia - and to a worse extent, I think, in New South Wales and Victoria, with people reporting waiting for days, or not getting a PCR test result back for weeks, given that their laboratories were also overwhelmed. Some states had a significant reliance on private pathology to also support their testing, which we had to a more limited extent.

Talking to the public and getting feedback, what we probably experienced was some confusion between the state testing clinics and private pathology services that also popped up and opened in that period - where, for example, private pathology might open only for three hours, nine to 12 at the showgrounds, and be quickly overwhelmed in that time.

What we focused on was bringing forward the rapid antigen testing, which was a much more widely available test for the public. My understanding is that both the Australian Health Protection Principal Committee (AHPPC) and national cabinet considered that it could basically replace the PCR test as the more readily available testing mechanism.

In that time, Premier and Cabinet worked incredibly hard to source large volumes of rapid antigen tests for Tasmania. We then set up distribution mechanisms to make RATs available statewide. I think that was brought on prior to the Commonwealth also making them available to concession-card holders in pharmacies.

Mr WILLIE - Premier, if we do see a variant of concern, are we likely to see the return of any measures such as the check-in app, or going back to old contact-tracing methods - or will it be a continuation of the status quo?

Mr ROCKLIFF - We will be always guided by Dr Veitch and the team at Public Health, which have carried us in very good stead to this point. All the matters and measures we have had in place previously, such as Check in TAS, can be reinstated if necessary.

Mr WILLIE - With that time line, can we get the information for the testing too, and the change to the RATs, those sorts of things? It is probably publicly available. I could look it up, but if you have it there.

CHAIR - It would be helpful to get a time line to date, even close to the end of the public health emergency. I think it is a request to end it.

Mr ROCKLIFF - We will provide a time line up to the public health emergency.

CHAIR - From re-opening. The decision-making process around that.

Mr WILLIE - The point being that the re-opening plan set out how things would be done, and it changed very quickly.

Mr ROCKLIFF - It did, because of the high transmissibility of the Omicron variant, which the nation had challenges with. But I think the decision-makers at the time - people within and across departments, people on the ground - were incredibly adaptable to what was - as I recall as health minister over that Christmas - clearly a very challenging time.

As Ms Morgan-Wicks has said, that real challenge peaked at a time when people were on holiday, between Christmas and New Year. We managed as best as we possibly could at the time, and it was supported by some very dedicated people across our whole of government.

Mr WILLIE - Through that two or three-week period from the borders reopening, did the Government notice any change in the population's behaviour? There was talk of a shadow lockdown where people were staying at home through that time. We know businesses were impacted. We saw stories where trade dried up. Were you monitoring the behaviour of the

population? Were there any key data that showed a change in behaviour? Potentially, did it help with the case numbers and transmission if people were being overly cautious?

Mr ROCKLIFF - Probably, anecdotally, naturally cautious. At the time, the severity of the Omicron variant was probably still a little unclear in many people's minds and so there was some self-isolation, if I can put it that way, through those times.

Obviously the Department of Health was monitoring positive cases and the like at that time. I made the point earlier about the adaptability through that period, and the flexibility of people as result of very sudden and quick policy changes at a national level. In many respects, that adaptability and flexibility has been a case in point ever since the pandemic started, the whole way through. The reopening was no exception in terms of that need to be flexible.

Mr WILLIE - The question was whether the Government was collecting any sort of data on population movement and behaviour change through that time.

Mr ROCKLIFF - We only have anecdotal information. We were not collecting anything in particular, I am advised.

Dr VEITCH - Throughout the pandemic, national surveys were conducted asking people two questions: how many contacts they have inside and outside the household, and how well they think they are doing keeping their distance from other people.

The first question is about macro-distancing, so it is about how much mixing you have; the other one is really about the distance you keep from people. This data is not in the public domain, but it is shared with the AHPPC in confidence, and is done at a statewide level. What it showed in Tasmania around December was a drop in macro-distancing - the number of interactions that people reported they had every day.

You often see that around public holidays, because people tend to stay at home and confine their interactions to people. So, in December there was a drop in the number of reported interactions people had with each other, but they did not report that they were keeping the distance much more.

CHAIR - They were still hugging their family.

Dr VEITCH - You could put it that way. These data go into the forecasting methodology institute models about where the pandemic is tracking over the short term.

Mr WILLIE - Is the Committee able to have that data?

Dr VEITCH - I do not think so. Release of data from AHPPC papers needs to proceed through an Australian Government request for information process. I am happy to speak to someone.

CHAIR - It is important to recognise that contact tracing does still continue. It is not like it stopped, is it?

Dr VEITCH - In the community when a case is notified, they are asked to advised their contacts to find and advise the people who live in the household with them that they are close

contact, and the implications; where they can get information that will explain their obligations. I think most of the public is now aware of the obligations and what you have to do -

CHAIR - You just put it on Facebook and you are done, really.

Dr VEITCH - Once people broadcast that is sometimes can cause more disruption than is actually necessary. But where there are cases in vulnerable settings, such as residential aged care, hospitals and the like, there will be support. Usually it is for the organisation themselves to work out who is at risk and to manage those contacts.

Mr WILLIE - In terms of the data you have there, Dr Veitch, is there an average mixing figure that was used? Are we able to understand what the drop was in that December period?

Dr VEITCH - Tasmanians were reporting on average 12 or so contacts per person outside the household per day. At the time we opened the borders it dropped briefly down to about eight. Then it picked up quite quickly again.

Mr WILLIE - In January?

Dr VEITCH - It would be in January to a similar level. It's very hard to maintain sustained behavioural change in people. The thing that may do it is not necessarily concern about COVID-19, but because it was Christmas. The shops were shut, less sport, and so on.

Mr WILLIE - I hate to think what our contacts would be some days.

CHAIR - Going back to when you get a positive test, you're required to notify your close contacts yourself. Is there any monitoring of that done to see whether people do that? Do you just take people at their word?

Dr VEITCH - We have taken people at their word throughout the pandemic. We have tried to communicate why people should limit their movements, support them to do so, for example with the provision of RATs and social supports if necessary. There hasn't been an interrogation or check-up. There was last year when we were more actively managing cases, but with a shift towards self-regulated management of one's behaviour as a contact, we haven't intruded to either monitor or enforce in most instances.

Ms MORGAN-WICKS - In vulnerable settings we have been checking. For example, in hospitals where a positive case is detected on a ward, we then check all of our screenings. That's why we maintain screening to see who has come into the hospital, who has nominated that ward as a visitation point, we go to staff logs and work out every single staff member who has worked on that particular ward, and then we do sweep testing through a ward for all of the patients, including discharged patients, visitors and staff. In vulnerable settings such as aged care, disability or hospital where we are closely managing outbreaks, that does continue.

CHAIR - Regarding the requirement to isolate if you're a positive case, there was great concern when we weren't vaccinated if someone breached their quarantine - it was for longer at the time. Is that monitored at all, or are we just relying on people to do the right thing?

Dr VEITCH - For the most part we are relying on people to do the right thing. The period of isolation has diminished, the requirements of people in isolation has eased a little bit

in terms of testing. We still think that the appropriate strategy is to require people to isolate for a week, but as we progress through the coming months the national expert committee, CDNA, AHPPC, will look at whether the approach we're taking to isolation remains proportionate.

CHAIR - How often is that reviewed?

Dr VEITCH - These various committees meet once or twice a week. There's constant monitoring. The pace of change of guidelines has slowed a little bit. There were about 30 or 40 different national guideline revisions that occurred up until late last year. We've probably only had three or four revisions of the guidelines this year. It means that substantial changes are not likely to occur more often than every couple of months.

Mr WILLIE - Does the Government have any understanding of the prevalence of people not testing so they don't have to quarantine? There is that discussion in the community that people go about doing that, I don't know why, because it's a public health directive.

CHAIR - Some of them get it, stay at home anyway and don't test.

Mr WILLIE - Yes, or it might be economic security too. They might be a casual worker and think they're going to miss out on employment. Do you have any understanding of how prevalent that is?

Dr VEITCH - We know that as of recently about one-third of Tasmanians have been diagnosed with COVID-19 in the first few months of this year. That many people have definitely fessed up. Tested and fessed up.

There was a period when people doing the modelling estimated that we missed about half the cases. I think we probably do better than that. We will inevitably miss some illnesses that are really mild. People don't realise that they've been infected. I think it is probably useful to conceptualise it, knowing about one-third of the population's been infected but probably a bit over half of the population actually has been infected. What does that mean? You might be missing 20 per cent or even 30 per cent of cases as a consequence of either mild illness or people not proceeding down the pathway of testing. We're hearing about the majority of cases.

We will eventually move to a set of circumstances where we are less actively diagnosing every case.

Mr WILLIE - Compared with flu?

Dr VEITCH - Compared with flu, for example, we would be diagnosing in a typical year, probably under 10 per cent of cases.

Mr WILLIE - I know because my boys recently went to the respiratory clinic and their doctor said that they had influenza, but she wasn't going to test them.

Dr VEITCH - This year we are trying to do better with diagnosing influenza. We are trying to understand better how much influenza's out there and manage it more actively. We want to reduce the pressure on the health system. We don't want people who could have severe illness from influenza averted. We don't want them to miss that opportunity.

Not necessarily this year, but not too far off, we will probably move to a situation where our testing practices are largely focused on the people who are most likely to have severe symptoms from their illness. Other people we will ask to be responsible with a respiratory illness, to stay at home until symptoms resolve. Don't go to work while they're sick. We will want to keep the focus on diagnosing people who are more at risk. That's a testing surveillance swerve, but I don't think we're likely to do that in the short terms. It is on the horizon.

Mr ROCKLIFF - Chair, Ms Gale has some information on Ms Webb's question with our Tasmanian Aboriginal community.

Ms GALE - Through you, Premier. The Office of Aboriginal Affairs, including Mel Gray, who leads that team, was in constant contact with Flinders and Cape Barren islands. They were leveraging contacts in other agencies, for example, State Growth, in relation to business support. Leadership and liaison through the pandemic was led by the Tasmanian Aboriginal Health Reference Group. Aboriginal organisations were members of that group.

Ms WEBB - Did that continue into the reopening time and then after reopening?

Ms GALE - I was only asked the question in relation to the lead up to reopening. I assume so, but we would need to get the information for you.

Ms WEBB - Thank you. I wanted to have the picture leading in and leading out. I wanted to ask some follow-up questions on the check-in app. You mentioned 2 May as the date it officially stopped operating. Given we're now past the 28-day period that required deletion of data, can you confirm that we're no longer retaining any data from the Check-in Tas app?

Ms MORGAN-WICKS - That is my understanding. That was a programmed feature of the application.

Ms WEBB - Thank you.

Dr VEITCH - in vulnerable settings such as residential aged care, hospitals and the like, there will be support, usually for the organisation to work out who is at risk and to manage those contacts.

Mr WILLIE - In terms of the data you have there, Dr Veitch, is there an average mixing figure that was used? Are we able to understand what the drop was in that December period?

Dr VEITCH - Tasmanians were reporting on average 12 or so contacts per person outside the household per day. At the time we opened the borders it dropped briefly down to about eight. Then it picked up quite quickly again.

Mr WILLIE - In January?

Dr VEITCH - It would be in January to a similar level. It's very hard to maintain sustained behavioural change in people. The thing that may do it is not necessarily concern about COVID-19, but because it was Christmas. The shops were shut, less sport, and so on.

Mr WILLIE - I hate to think what our contacts would be some days.

CHAIR - Going back to when you get a positive test, you're required to notify your close contacts yourself. Is there any monitoring of that done to see whether people do that? Do you just take people at their word?

Dr VEITCH - We have taken people at their word throughout the pandemic. We have tried to communicate why people should limit their movements, support them to do so, for example with the provision of RATs and social supports if necessary. There hasn't been an interrogation or check-up. There was last year when we were more actively managing cases, but with a shift towards self-regulated management of one's behaviour as a contact, we haven't intruded to either monitor or enforce in most instances.

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Ms MORGAN-WICKS - That is my understanding. That was a programmed feature of the application.

Ms WEBB - Thank you. **Ms WEBB** - There were particular circumstances described in legislation where data could be shared from the Check in TAS app to other agencies - for example, the police. Across the period of time the app was operating and data was available, were there any instances where there were requests for sharing of data from the app by other agencies such as the Police?

Ms MORGAN-WICKS - I am not aware of any instance in which data was provided to Police from the Check in TAS app.

Ms WEBB - Were there any requests made for data from the Check in TAS app?

Ms MORGAN-WICKS - My understanding was that there had been one early request, which was declined.

Ms WEBB - Was that from Police?

Ms MORGAN-WICKS - From Tasmania Police, yes; but noting the terms and conditions in which the application was launched and which all of the information available to the public, it was for Public Health use only.

In relation to the data there were a couple of instances where Check in TAS information may have assisted in outbreak management where people would have been contacted and those contacts would have been recorded in other public health systems. For example, our Maven system, Maven would retain that data in terms of the management of that particular outbreak, I cannot dispel that, but not in the form of data held within the Check in TAS app.

In response to your follow-on question, yes, that group is still operating and still discussing COVID-19 matters.

CHAIR - Regarding the vaccination roll out and public health advice about that, in the submission, on page 41, you talk about monitoring and evaluation stating that 'throughout the vaccine roll out public health advice informed the development and interpretation of the weekly COVID-19 vaccine coverage report for Tasmania'. It goes on to say, 'the Department of Health also established an adverse event on the immunisation surveillance system'. What data about adverse events was collected through that system?

Mr ROCKLIFF - I will have to refer to Dr Veitch.

Dr VEITCH - Monitoring adverse events after vaccination is tremendously important in terms of identifying signals of potential harm from vaccines, but also in providing public confidence about the safety of vaccination roll out. In a campaign as extensive as the

COVID-19 vaccine campaign with a new vaccine, it was very important. We established a register which received reports from the general public, from vaccination providers across the range - particularly from people who reported back through to vaccination clinics - and compiled those data. We also report them into the national data set for adverse events surveillance.

Reports are regularly produced that give us a profile of the occurrence of side effects. In most instances they are mild and local, but we have also captured those occasional rare - and very rare, but tragically fatal - side effects due to clotting disorders that were particularly associated with the AstraZeneca vaccine earlier on. That mechanism is also linked to clinical providers now, who can provide guidance to people who had an adverse event in the past about whether it is safe to proceed with further doses or how to switch vaccines, if necessary, to try to avoid a side effect that might have been previously experienced. It is a real asset for Tasmania to have that established. It will gradually morph into a system that provides enhanced adverse event surveillance for vaccines across the spectrum.

CHAIR - From Dr Veitch's last comment, I think he was saying was that the surveillance system now is more robust, because of the scale of that. Every time I have a flu vaccine, I get the text message a couple of days later asking for reporting of side-effects. Is the system now more robust, in terms of picking up side effects? We still have a degree of vaccine hesitancy, particularly with the parents of younger children, as we talked about earlier. Is this data that could be used to encourage those who remain concerned or hesitant?

Dr VEITCH - There is always more reporting of side effects soon after you establish an adverse events program or when a new vaccine comes out, and then enthusiasm for reporting side effects - particularly the mild ones - tends to dwindle. There can be additional mechanisms such as you described, Ms Forrest, where people have been prompted to provide response, a more active elicitation of adverse events. Our Communicable Disease Unit, which is responsible for community vaccination, as I mentioned, has always had a vaccination adverse events reporting mechanism; but this offers morphing into a more comprehensive one which could provide that advice out to the public.

Again, a little bit like the research, with the information about adverse events it is probably best to look at the national picture to get a more comprehensive overview of what the risks and the occasional adverse events of vaccines are like. That is probably where we would turn to for communication for the public, because it is a bigger data set.

CHAIR - Minister, particularly with the new vaccine, people will likely report every possible impact, including a sore arm or feeling a bit tired. you can feel tired. As we become more accustomed to those less serious side effects, are we likely just to see more reported serious side effects or adverse events as a result of vaccines that may skew the picture?

Dr VEITCH - A short answer would be 'yes.' We do want to know about the more serious side effects. When more serious side-effects are reported, there is a mechanism for considering them locally or reporting them nationally. If necessary, an expert panel can be convened. It involves both national and local experts to look at perhaps a new, serious side-effect and decide if that is related to the vaccine; is it a coincidence; what is the causal mechanism?

So, there is a process in place to tease those sorts of things out. That's really important, so that if you have a very rare event, you do not get into a question about is it truly related to the vaccine? We really need to be able to thoroughly interrogate the data on those things so we don't give false impressions of risk; or if there is risk, to work out what the scale is and how we manage it.

CHAIR - This is the basis for which a lot of the misinformation is circulated in the community. I think that misinformation has slowed down; but, through social media particularly, people were talking about these 'high rates of adverse events', which may mostly have been sore arms, for example, creating an impression that the vaccines were not safe because so many people got a sore arm.

Hopefully that will maybe alleviate people's fears, if the rate of adverse reactions reported slows down a bit, if that is what it relates to. That was more a comment than a question; but have you seen a reduction in that anxiety about vaccines? We go back to the point that we have better than other states, but still quite low overall rates of vaccination rates for young children aged five to 12 years old.

Mr ROCKLIFF - I can only go on what I can pick up in the community. Anecdotally, there is less vaccine hesitancy than my impression earlier on. People are becoming more confident in the information, and know where to access correct information as well. However, if you look at social media - and I don't tend to - there is a lot of information on social media that is complete and utter rubbish, as you know.

CHAIR - It seems to have slowed down though, from my observation. If you don't watch, you can't comment on that, I suppose.

Mr ROCKLIFF - Not really; but on a passing glance, I'd say, well, one would hope so.

Dr VEITCH - Being honest with people: you might get a sore arm after you've had the vaccine. Then, the people who don't are happy about it - they probably don't talk about it. It's really important to be frank that this could happen, and then, when it does happen, people don't talk about it so much. I think that frankness about even mild side-effects is beneficial in terms of setting expectations and not having people kick up a social media storm over an unexpected - for them - but perhaps predictable, minor side effect.

CHAIR - It's how you use the data, isn't it?

Mr ELLIS - I might just ask one of the Premier about state-wide hospital pharmacy, if that's okay?

CHAIR - Yes.

Mr ELLIS - Premier, could you outline the role of the statewide hospital pharmacy, particularly with preparation and management of the state's COVID-19 response over this period?

Mr ROCKLIFF - Thanks, Mr Ellis. The statewide hospital pharmacy has been responsible for the distribution of COVID-19 vaccines by the Government. In total, around 99 734 vials of vaccine, representing a potential 640 644 doses of vaccine was held in inventory

during the last financial year. To ensure that hospital outpatients can continue to receive their public hospital medications without needing to attend hospital premises, home medication delivery service has been provided free of charge to patients, and this service has provided up to 14 450 patients during the last financial year.

Our hospital pharmacies are responsible for the majority of our COVID-19 medications available in Tasmania from the national medicines stockpile. These medications have only become available in the last nine months and reduce hospitalisation and death from COVID-19. Last financial year, 912 courses of treatment were provided and some medications are now listed on the PBS and are available from community pharmacies - as we've discussed already.

Hospital pharmacies are providing support for COVID@home, ensuring our patients can continue to access their ongoing medications as well as COVID-19 treatments during their isolation. To buffer against the disrupted global pharmaceutical supply chain, our Government hospitals now hold over $15.2 million in pharmaceuticals, nearly triple the value of pre-pandemic stock holdings - for your interest. As a Government, we've established a secure, ring-fenced stockholding of medications specifically to treat and ventilate patients with acute COVID-19 illness. That stock is valued at $1.25 million, I'm advised.

My thanks to everyone working in the statewide hospital pharmacy program.

CHAIR - I know we've talked about this in Estimates and other forums, but I'd like to get the information on the record for this committee about the impact of the vaccine mandate for healthcare workers. How many staff were stood down as a result of that?

That's the first part of the question. I understand from talking to some of these people that the concern was particularly about the mRNA vaccines. Since the Novavax vaccines have become available, have some of these people been able to be vaccinated and either re-employed, or come off extended leave or some other arrangement, through that process?

Ms MORGAN-WICKS - As at 21 June 2022, a total of 120 employees have had their employment terminated, which equates to less than 1 per cent of the department's workforce. In terms of the availability of different types of vaccine, certainly, for each employee that we were working with who had yet to provide evidence of their vaccination - noting that this is a day-to-day process as employees return from long leave, such as maternity leave - we have talked to them about the availability of different types of vaccines, and particularly, where they expressed their concern in relation to mRNA vaccines.

Regarding Novavax, we did put employees in contact with a GP or pharmacist that were supplying that type of vaccination. I am aware of at least one employee that did go and was vaccinated with Novavax. I don't have the numbers of exactly how many were vaccinated with Novavax; given that I don't believe we ask the actual vaccine that people received, just evidence that they have received it.

Mr WILLIE - In the private system, is there a mandate for vaccines? It's not like the school system?

Ms MORGAN-WICKS - Yes, there was a public health direction that applied to age care, disability workers and health workers.

CHAIR - Acknowledging that some people would have medical exemption, what's the current rate of vaccination among the health workforce?

Ms MORGAN-WICKS - In terms of the state health workforce, we currently have 100 per cent vaccination rate for first and second dose of COVID-19 vaccine in our workplaces. In terms of workers that are outside of our workplaces, I don't have that current rate, but we are monitoring them.

CHAIR - In terms of private hospitals?

Ms MORGAN-WICKS - This is state public; I don't have the numbers in relation to private hospitals.

Mr ROCKLIFF - Novavax figures, you might be interested in. As of early June, I'm advised that approximately 1432 [?] doses of Novavax have already been administered in Tasmania.

CHAIR - That is a two-dose vaccine too, isn't it?

Dr VEITCH - That's my impression, but I'd have to check.

Mr ROCKLIFF - Novavax is two doses as well.

CHAIR - How far apart? Do we know?

Mr ROCKLIFF - I'm advised that it's at least three weeks apart.

CHAIR - Most people who might have had it, would have had the opportunity for both by now, you'd think.

Ms MORGAN-WICKS - Yes.

Ms WEBB - I have some questions related to page 3 of your submission - the financial measures that were outlined there, particularly the ones towards the bottom of that page about support to individuals and communities since the borders re-opened. There is a list there, including the Salvation Army, TasCOSS, and various others. I was interested to hear about how it was determined that those particular supports were required, and were required at that level?

Mr ROCKLIFF - Perhaps Mr Limkin can comment on that more.

Mr LIMKIN - The State Recovery Committee, which includes representatives from each agency, met regularly during that period of time, and debated and discussed the needs from the community.

There was a needs assessment process through our recovery partner framework, where matters were identified, brought forward and then determined going on that. Based on that, recommendations were made to government and the Government made decisions on funding requirements.

Ms WEBB - Each of those that are listed in the dot point list here in the submission, have they been fully expended and utilised?

Mr LIMKIN - I would have to take that one on notice, and check whether they have been fully expended, because a number of the programs ran over a period of time and they are still in process.

Ms WEBB - Can I also ask then how will it be reported on in terms of the utilisation and the impact of those amounts provided?

Mr LIMKIN - Each grant deed or mechanism where we have signed up with these organisations has reporting back to the Government, so that we can make sure we get the outcomes and outputs as we wanted.

Most of these are focused on outputs, given the time and the quickness that we had to put these in. Normally, we would look at outcomes for the community, but it was a decision we made because of the speed that we had to act.

Mr WILLIE - I am interested in the impact on the ambulance service, which we have not spoken about, in transporting COVID-19 positive patients, but also, managing the ambulance service workforce. No doubt they have been impacted by COVID-19. We know that there is significant pressures on that service. What impact has COVID-19 had on the ambulance service? You touched on it briefly in your submission, but some more information on the impact to the workforce and how that was all managed would be good.

Mr ROCKLIFF - The Ambulance Tasmania Emergency Operation Centre liaises with the Department of Health Emergency Co-ordination Centre to provide that operational interface, as you could appreciate. AT has developed a whole-of-service plan to strengthen organisational preparedness in direct response to the COVID-19 pandemic, with the Ambulance Tasmania Emergency Operation Centre maintainging and implementing these plans.

The ATEOC is committed to providing an ongoing safe working environment for the staff of Ambulance Tasmania, while responding to the COVID-19 community transmission.

Maintaining sufficient personal protective equipment and training remains a critical focus of AT for the safety of staff, patients and the wider community. Since the commencement of the COVID-19 pandemic, AT has increased its paramedic workforce and other support, resourcing to meet potential increased demand to COVID-19 and better service in rural and remote areas of the state.

It has continued to recruit volunteers to areas of the state where volunteer numbers were impacted by the COVID-19 pandemic. Contracting the use of the Bell 412 helicopter continues to provide additional aeromedical capability and capacity, particularly in servicing the medical emergency and inter-facility transport need of the north-west region and Bass Strait islands.

AT has established additional single and double branch stations to better service rural and remote areas. In April this year, we announced funding to Huonville and Sorell, which is a broader need, and contemporary national COVID-19 infection prevention and control advice is rapidly incorporated into all operational areas within AT.

Ambulance Tasmania paramedics conduct rapid antigen tests on all patients being transported to Tasmania Health Service facilities and emergency departments to facilitate more rapid triage and to reduce the risk of disease transmission.

EOC is developing protocols around the provision of MyCare devices to be provided to COVID-19 positive patients, for both paramedics in rural settings to in home care of patients with COVID@homeplus assistance as well.

Since the commencement of the COVID-19 pandemic there has been significant growth in the operational workforce. We have an additional 12 intensive care paramedics forming a critical response unit in the north-west, 24 paramedic positions increasing to 24-hour crew coverage in Burnie and Devonport and more scalable workforce capacity with the employment of casual paramedic and non-emergency patient transport officers.

In the last financial year, 12 paramedics have been employed in both Launceston and Hobart and 24 paramedic positions have been established in rural and remote areas across the state. We have also seen the development of a community paramedic role with an increased primary health focus to direct lower acuity patients to alternate service providers to meet their medical needs. The establishment of a secondary triage service in February last year - which I've mentioned already in relation to that community care outside of the acute care settings - and regional operations have increased their operational support with the introduction of operational support officer positions focusing on COVID-19 impacts. Ambulance Tasmania EOC has developed and implemented return to work procedures for staff identified as close contacts as well.

Mr WILLIE - In your submission, Premier, I note there hasn't been a confirmed case of a case of COVID-19 being transferred from patient to paramedic because of the infection controls. However, paramedics would have been catching COVID-19 through that time. You talked about an increase in some positions. Was there any increase in overtime payments through that time, or staff having to work extra shifts?

Ms MORGAN-WICKS - I can comment in my role as Commissioner of Ambulance Tasmania, our AT crews and workforce are to be commended in their infection prevention and control. I think out of all of our workforces, we were probably seeing lower rates of reported COVID-19 infection in paramedics than perhaps generally across hospital staff.

For example, as part of the ending of Public Health directions in relation to masks we are looking at what masks are to be applied in health settings, and the feedback from AT is that their preference is for N95 masks to continue to be utilised when there is a patient within an ambulance vehicle or they're involved in any direct patient care within the home or transferring a patient. They have certainly maintained the highest rigour, not criticising my hospital staff but certainly the paramedics have been right on top of it. Our AT EOC has been managing that. That meant that we had that lower need for replacement staff due to significant levels of infection.

I am not saying that there wasn't any overtime in that period, I would need to check the numbers on overtime for AT. We made the decision in the approach to 15 December border reopening to bring forward all recruitment that we had in the wings for AT, even where commitments had been made for various numbers of paramedics to be brought on over years, that was all brought forward prior to 15 December. We did that in the knowledge that we had

very good fields of paramedics or graduate paramedics applying for those positions. That's why we made the decisions to put them in the regions, as the Premier has just outlined, and to bring on additional roles such as the community paramedic to try to support.

We also retained vehicles. We've replaced up to 30 vehicles with 30 brand new ambulance vehicles in the last financial year but we kept the old on standby and fully stocked. I've seen those in our stock depots in Devonport, ready and on standby if needed in the regions for COVID-19 transfer.

Mr WILLIE - There is a variety of vehicles now too, isn't there? My understanding is they might dispatch one paramedic and then the other one will catch up, for different specialisations and things.

Ms MORGAN-WICKS - My team has just pulled up a budget Estimates brief on overtime in relation to ambulance, which has actually decreased. At 2021-22 as at 31 March, overtime FTE as a percentage of paid FTE for ambulance is 7.79 per cent, compared to previous years, for example 2018-19 9.61 per cent, 2019-20 9.8 per cent, 2020-21 7.99 per cent.

CHAIR - That may be attributable to the additional staff being brought on. Have all the positions that you brought forward been filled or are there vacancies around the state still?

Ms MORGAN-WICKS - Yes, it is my understanding that we were very successful in filling those positions. I note in things like advertising new roles like a community paramedic, for example, or where we have introduced additional management positions, it might have been a backfill process where someone has been successful in applying for another role or in another post or region and that we continue to backfill. Recruitment remains ongoing in Ambulance Tasmania, every day.

Mr ROCKLIFF - Since 2019-20, there has been a 17 per cent increase in Ambulance Tasmania staff.

CHAIR - As we have heard of this impact inquiry in relation to Ambulance Tasmania or to general review that was really just keeping up with the demand. The question is now, where there is additional staff the fall in overtime may well indicate that you are actually getting on top of it now. Do you feel fairly confident that you actually are on top of it now? If demand grows, more staff will be needed, but where are we at now?

Mr ROCKLIFF - We are doing our clinical services planning in each region of Tasmania, which will include Ambulance Tasmania statewide. This will inform us further with respect to that. From memory, when we committed to the 48 additional paramedics in the 2021 election, which have almost all been filled now, at the time where we would also do another workforce scan as well to see what is required to cater for that increasing demand, as you have said.

Ms MORGAN-WICKS - The clinical services planning will look at all of the call data to also determine levels of geographic demand in different regions. It will inform us as to the necessity to either upgrade existing stations, so from single-branch to double-branch, or whether new stations are required, for example, like the Bridport presence that we have recently

announced. That work is currently underway and we are hoping to have that information by the end of the year.

CHAIR - Do you want to add anything?

Mr ROCKLIFF - We could talk about the COVID-safe vehicle?

Ms MORGAN-WICKS - Oh, the Barbie bus.

Mr ROCKLIFF - Yes, the Barbie bus.

Ms MORGAN-WICKS - We are probably being light-hearted in relation to the vehicle that we actually saw in the north-west region when the Premier and I last toured there. In terms of its additional capacity and technology for Ambulance Tasmania, we referred to it as being like a Barbie bus because it was very high and large, so a paramedic has the ability to stand, treat a patient and to maintain social distancing. That larger space within a vehicle enables them to safely attend to patients, particularly in relation to COVID-19 transfers.

In addition to that type of vehicle, we are also aided by the Bell 412 helicopter, which was a contract that the Premier mentioned. I recall we brought it on in April 2020. It can transport more than one patient, so two patients at a time in that larger helicopter and for longer distances without refuelling, for example, if a patient with COVID-19 required transfer from the North West Regional Hospital to an ICU at the Royal.

Mr ROCKLIFF - We should have our 30 new vehicles - which we have committed to at a cost of about $9 million - mostly or all on the road very soon.

CHAIR - How many of those qualify as 'Barbie buses'?

Mr ROCKLIFF - Only one, nation-leading design, I understand. They are north-west supply as well.

Ms MORGAN-WICKS - We have only witnessed one. They are very keen to get more through the north-west.

CHAIR - Are they fitted out in the north-west as well? The same as the other ones are in Penguin?

Mr ROCKLIFF - Yes.

CHAIR - Excellent. If COVID-19 is going to be with us for a long time, wouldn't it be appropriate to prioritise some of those larger buses or trucks so that patients and the paramedics can be more distanced. Is that the plan? Or is it just like a prototype?

Ms MORGAN-WICKS - We have been in recent possession of that new addition to the fleet. We will evaluate the success of that or not in reliability, speed, ease of use, social distancing et cetera and comfort for the paramedics. We will get that feedback directly from the users.

CHAIR - One assumes it handles on the road okay being so high?

Ms MORGAN-WICKS - I think we are getting into a level of detail in which I have no expertise.

Mr WILLIE - The question there is, if you have had excellent success with infection control, is there a need for these buses if you have not had any COVID-19 transfer from a patient to a paramedic?

Mr ROCKLIFF - I imagine that would be part of the evaluation.

Ms MORGAN-WICKS - To be fair, although we can be quite light-hearted about it now, in the preparations for 15 December we were witnessing, for example, the outbreaks in India in particular and the numbers of our fleet. We were quite concerned as to the number of ambulance vehicles that would be required to conduct inter-hospital transfers or patient home to hospital transfers.

Certainly, every step was taken to try to get available fleet, noting that we were also competing with every other state and territory in relation to this resource. That is why we brought on the 30 new vehicles as quickly as we could but also retained all vehicles that had been assessed as safe to retain in the fleet.

We leased large warehouse facilities to house those vehicles and also all of the stock, electronic Stryker stretchers, for example, that would also have to be installed. Our thanks to our suppliers in Penguin, I think it is Mader, for their work because I know they were working around the clock in supplying those vehicles to us.

CHAIR - Thank you, Premier. Thank you for appearing and for the lengthy submission which was very informative and helpful as well. We have a few questions on notice, most of them you have been able to answer during the session and we appreciate that. We will report in due course, acknowledging that there was the one report that you were going to provide to us that might take some time.

Mr ROCKLIFF - Thank you very much, Chair, and thank you members for your questions and interest. Thank you to our team across the Department of Premier and Cabinet and our team at the Department of Health and Public Health also for their contributions today.

CHAIR - We appreciate all the work you do.

THE WITNESSES WITHDREW.