T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

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

Melbourne—Wednesday, 18 November 2020

(via videoconference)

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WITNESSES

Ms Felicity Topp, Chief Executive Officer, and

Dr Shyaman Menon, Executive Director of Medical Services and Clinical Governance, Peninsula Health.

The CHAIR: Hello, everyone, and welcome back. I am very pleased to be joined by Ms Felicity Topp, the CEO of medical services at Peninsula Health, and Dr Shyaman Menon, the Executive Director of Medical Services and Clinical Governance at Peninsula Health. My name is Fiona Patten. I am the Chair. I am joined today by Dr Tien Kieu, the Deputy Chair; Ms Kaushaliya Vaghela, Ms Melina Bath, Dr Catherine Cumming, Ms Georgie Crozier, Ms Wendy Lovell, Mr Enver Erdogan, Ms Tania Maxwell and Dr Matthew Bach.

I have just got a couple of formal words to speak to before I open it up. All evidence taken at this hearing is protected by parliamentary privilege. That is provided by our constitution and the standing orders of the Legislative Council. This means that any statements you make today are protected by law. However, any comments repeated outside the hearing may not have the same protection. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament. This session and hearing are being recorded, as you would be aware. We will provide you with a proof transcript of today's session. I encourage you to have a look at that to make sure that we have not in any way misrepresented you. It will ultimately make its way to our website. I appreciate that, Felicity, you might have some opening statements for us. Dr Menon, do you also have a statement?

Dr MENON: No, Ms Topp will be providing the statement for Peninsula Health.

The CHAIR: Thank you. If you would like to make your statement, then we will open it up for a committee discussion.

Ms TOPP: Thank you, and thank you, panel members. I am very grateful for the opportunity to participate in this important inquiry this afternoon. I would like to firstly acknowledge that I am talking to you from the land of the Bunurong, or Boon Wurrung, people and pay my respects to all Aboriginal and Torres Strait Islander people. I would also like to introduce our Executive Director of Medical Services and Clinical Governance, Dr Shyaman Menon. Shyaman has been an integral part of our clinical COVID response team this year, and I thank him for being here with me today.

This has been an extraordinarily difficult year for all Victorians, and I would like to say how proud I am to be working in the Victorian public healthcare system and leading an incredible organisation. I would also like to acknowledge the commitment, expertise and dedication of the staff working at Peninsula Health. I have 35 years experience of working in the public health system, spending many of my years as a critical care nurse. In all my years I have never encountered anything close to COVID-19. Intensive care is not an easy place to work. As a critical care nurse I navigated many complex situations, but nothing comes close to what we have had to address in 2020 with COVID-19.

Early in March Peninsula Health stood up an incident command team made up of executive and senior staff specialised in areas such as infectious diseases, infection prevention and control, logistics, staff wellbeing and workforce planning. We established our first COVID-19 testing clinic by the second week of March, and during the second wave commissioned a drive-through clinic, three mobile services and testing sites at Frankston Hospital and Rosebud Hospital. During this time we have undertaken over 98 000 COVID tests, cared for 93 COVID-positive patients and thousands of patients presenting to our emergency departments suspected of having COVID-19. Our community health and mental health team services have supported vulnerable communities and local residential aged-care services and have worked with multiple community agencies to ensure people are provided with access to testing and care. Throughout this time we had a strong focus on education, training our people in infection prevention and control measures, the use of PPE and cross-skilled significant cohorts of doctors, nurses and allied health to be ready for redeployment into areas such as intensive care. All the while we listened to our clinical experts and took advice delivered through the Department of Health and Human Services and adjusted our internal policies and guidance accordingly.

When the second wave emerged in July, I was confident that the health service was well prepared for an increase in COVID-positive cases. We were prepared for a surge of patients and had concentrated on preparing

for a surge in acute care and a need for intensive care capacity. However, this wave brought hospitals a vastly different patient cohort with the influx of older people from residential aged care. The difference in needs for the care of these older, frail community members with COVID immediately presented us with challenges. The outbreak at Frankston Hospital occurred very quickly, indicative of the aggressive nature of this virus. Importantly, the outbreak was contained, and I am very proud of the way our staff responded to what was a difficult, confronting and challenging time, demanding much of our people and our community.

There are a number of key learnings from this experience. As the outbreak at Frankston Hospital was escalating it was clear to me we needed to call on the Department of Health and Human Services for support to ensure we contained the spread of the virus and to ensure the safety of everyone involved. I was able to call in additional clinical experts and support from Monash Health and Safer Care Victoria. This support gave us a greater capability across key areas such as increasing our contact-tracing team's experience and expertise. In particular due to the fast nature of the outbreak we required an immediate increase in the number of contact tracers and people on the ground to support our teams. The Department of Health and Human Services and Monash Health assisted in mobilising these resources to support the outbreak. Secondly, we took a very conservative and cautious approach to furloughing staff. This was very difficult for our service broadly and for every single staff member impacted, but it was a matter of caution. We made the decision to furlough more than 600 staff during the height of the outbreak. We also instigated asymptomatic testing for all staff for a period of time to ensure we were catching any possible staff who may have been infected with the virus and were not showing any signs and symptoms. These measures were effective and meant that we were able to get on top of the outbreak quickly. Ultimately it was down to the clinical experts advising and guiding our response, including the team from Monash Health and the Department of Health and Human Services and support from our incredible community partners, including the south-east primary healthcare network, general practitioners, Ambulance Victoria, our private hospital partners and the Frankston City Council, and most of all the Peninsula Health staff listening to the advice, adapting quickly to the changes required and working exceptionally hard together as a team to bring the outbreak under control and continue to care for patients.

Returning to the second purpose of this inquiry, we stood up the COVID screening and testing clinics where they were most needed by our community. These were developed in collaboration with our local community services, the ADF and the Department of Health and Human Services. The screening clinics continued to work incredibly well. There is no doubt, however, that the time it took for test results to be available caused difficulties during the height of the pandemic. It caused operational issues within our services, clinical challenges and quite often anxiety in staff, patients and the community. There have been significant improvements in the testing processes over the last two months. Test results are now being made available in under 24 hours, and this improvement is making a significant difference in our efforts to stop any further spread of the virus as well as greatly improving the experiences of people coming forward to be tested.

As many of us on the floor can relate to, 2020 is a year that I will not forget. We are learning new things about this virus all the time, almost every day, and we are making cautious and considered changes to our approach as we understand more about COVID-19. Many improvements have been made and are being made and we are constantly reviewing and evolving our approach, and we will continue to work with the Department of Health and Human Services and the sick to ensure that we stay ahead of this virus. Thank you again for inviting me to appear before this inquiry today and for listening to my statement.

The CHAIR: Thank you, and thank you for the time, and I certainly would like to pass on our appreciation to the staff down there because I fully imagine just how hard they were working at an incredibly difficult time. Sometimes I think that we forget to acknowledge that while there is a lot of criticism going on, there are lots of people just working so hard to look after people and to effect change.

I suppose I open this question to both of you: given it felt like quite a significant outbreak, particularly in the fact that it really affected about 600 staff, I think, in that area, what do you think were the key factors and the key learnings from that and the key changes that have been made within Peninsula Health so that that will not happen again, or if it does, it will happen differently?

Ms TOPP: Look, there have been incredible learnings throughout the whole pandemic cycle and certainly wave one gave us a taste, I suppose, of the pandemic, and allowed us to test a lot of our systems and processes. The key learnings for me were the importance of the environment and where we were caring for patients who were coming into the organisation. Like I said in my statement, we were thinking and preparing for a lot of

acutely unwell people who might require intensive care and that was not what happened in the second wave, and the care of older people coming in from residential aged care really did require a very different skill set with staff. I have to acknowledge how difficult it is for staff who are caring for older people with COVID with full PPE on. The way you nurse people is by touch, you know, and it is by empathy, with your face, and our nurses have masks and shields and gowns and gloves—and so that was incredibly difficult. So the nurses really had to adapt to how they were caring for these people and the environment that they were caring in. We needed to do things like move tearooms out of these clinical environments. We needed to include new positions, such as safety spotters, to assist staff putting on and taking off their PPE. And it is not because they did not know how to do that; it was just a safety check that we added in for all our staff. The experience of our staff when they talked to us about caring for people in PPE is that fatigue played a very big role, we believe, in people, in staff, being infected. So it really is creating lots of breaks—making sure that staff can get out of the clinical environment. So that would be from an outbreak point of view. How we managed the outbreak, I am sure we can get through that—with regard to contact tracing et cetera, we can explore that further.

The CHAIR: Yes. Thank you. I expect that we will. Thank you. I will hand to my Deputy Chair, Tien Kieu.

Dr KIEU: Thank you, Chair. Thank you, Felicity, and before I have some questions I would like also to express our appreciation and commendation for all your hard work and also to all the frontline health workers for their dedication and the risks that they have to face—and obviously this has been realised in some of the very high numbers of infections among healthcare workers. I have two related questions. The first one is: could you please share with us the experience and the lessons that you have learned from helping the homeless people—because they do not have a fixed abode, address—and how to help them? You have a mobile unit, so could you share with us the experience? And the second question, related more or less, is: now we are in a very good position, being on the 19th day of no fatalities and no new infections, so what steps and what preparations do you have in your part of the world in preparation for a COVID normal returning in the near future?

Ms TOPP: Okay. Thank you. I might take the first part of the question and, Shyaman, I might hand over to you for the second part of the question. Is that okay? So the first part of the question is about how we are caring for our vulnerable community members. Peninsula Health is really lucky. We have got a fabulous community health team as part of our service, and we also have a very strong community mental health team. Those teams are very much integrated within our community. They know where the rough sleepers are; they know where the families are who are struggling; they are connected into families that might be experiencing family violence. They have worked incredibly hard with all our community agencies to ensure that we made the testing available. And we have used some of our own initiative and technology. The team looked at what postcodes were not actually coming for testing, and we would think about who was not coming for testing and then take the mobile sites out to those areas. The community was telling us, 'You know, look, it's a bit too far to drive to Frankston to be tested. I don't have a car and I don't have public transport, so we can't get to testing'. So we made sure that we were able to take the testing out to those sites. We have also got a number of vulnerable communities that are living in shared accommodation—our disability services et cetera—so we actually took our mobile sites to them so they could undertake testing. Shyaman might now talk about the sorts of changes—the looking-ahead changes.

Dr MENON: Thanks, Felicity. So part of our preparation is really sort of consolidating the learnings that we have had with this outbreak and building it into a plan, and certainly we actually do have a stepwise approach to moving towards what we are envisaging as COVID normal. While we are doing that we certainly are doing a lot of monitoring of the data, so really looking at—at the moment, as you mentioned, it is really good and we are 18 days in with zero and zero—where our community prevalence sits and what our approach is going to be should we actually get a positive result. How are we going to respond? And that is both responding sort of locally and within the health service. What changes do we need to do to our processes within the hospital in terms of testing of patients when they are coming through? Where would we nurse patients? Which wards would we put patients in? What level of PPE do we need? All that is actually built into very much a stepwise program.

We have actually used the traffic light system where we have gone, 'Green is COVID normal'—scaled up to where we have got a black response where we are in a major catastrophe. So we have built that all into our program, and it is being agile to be able to move and understand and it is daily monitoring. We have got an incident management team which is currently meeting twice a week, where we go through the data to make sure that all the steps and all the preparations are in there. It is also preparing for an element—maintaining what

we have actually learned, so just moving away from understanding the COVID fatigue, which might come through, and having some preps to make sure that we are on top of it, that we have got ongoing training occurring as well.

The CHAIR: Thank you. Georgie Crozier.

Ms CROZIER: Thank you very much, Chair, and thank you, Dr Menon and Ms Topp, for being before us this afternoon. Forgive me if I am repeating some of what you said. It was a little bit faint when your audio was not working properly. To go to the point of the Chair's comments around the 600 of your healthcare workers who were infected or furloughed, which was a significant amount of your workforce, could you provide to us the follow-up from the department in relation to the contact tracing and the support that you received at that time because there were such large numbers? Obviously it was quite a worrying time for your community but more generally. I am interested to know in terms of the issues that you experienced with that follow-up contact tracing and how you managed that.

Ms TOPP: Okay. Thank you for the question. Just a correction on the figures: Peninsula Health has had a total of 66 healthcare workers infected over the entirety of the pandemic, and during the outbreak here at Frankston Hospital, yes, we furloughed over 600 staff. Now, as I said in my statement, we took a very low bar to making the decision to furlough staff, and that is based on understanding who may have been in contact with the virus. So when we talk about contacts it is primary contacts and then it is also contacts of contacts, and in our situation we were also concerned about the environment, so we furloughed people who had even been in the environment but had perhaps not had direct contact with a patient or a known contact. I would say that decision, going hard on the furloughing, is what allowed us to turn our outbreak around very, very quickly. And that occurred because when I and when the incident command team noticed that we were having an escalation in the outbreak, we asked for support through the Department of Health and Human Services and Monash Health, and together we set up an incident management team, command management team, which was led by the chief executive of Monash Health, Andrew Stripp, who I would really like to acknowledge, who was a tremendous support through this process. We were also able to access resources from Monash, additional expertise to help us as the outbreak was occurring. It was clear that the number of contact tracers that we had and we had been managing with was not going to be enough to be able to do the contact—

Ms CROZIER: Sorry, were they your in-house contract tracers?

Ms TOPP: Yes. In health services we have infection prevention control people who are able to do contact tracing. Our responsibility during outbreaks is to concentrate on outbreaks inside the hospital. Our contact tracers do not have anything to do with the community outbreaks. That is the responsibility of the Department of Health and Human Services.

Ms CROZIER: And how many were in that team, if I could?

Ms TOPP: We started off very early on with four, up to eight, and at the height of the outbreak we had 25 people in the organisation to deal with contact tracing.

Ms CROZIER: Thank you.

The CHAIR: Thank you. Kaushaliya Vaghela.

Ms VAGHELA: Thanks, Chair. Thanks, Felicity, and thanks, Dr Menon, for your submission, for your presentation and for the great work that you do at Peninsula Health. During the pandemic we have seen COVID-19 cases in many high-risk industries and we have also seen a high number of infections among the healthcare workers. So one of the changes that was brought in over the course of the pandemic was the introduction of mandatory surveillance testing in health services. Can you tell us about how this change has helped to prevent the spread of COVID-19 and keep healthcare workers and their patients safe?

Ms TOPP: Shyaman, I might ask you to answer that if that is okay.

Dr MENON: Yes, I am very happy to, Felicity. Thank you very much for that question. I think mandatory testing of at-risk workers, whether that is healthcare workers or any population at risk, is a significant part of a response. It certainly was part of our response, as Ms Topp had mentioned in the submission, where we actually

did a couple of cycles of asymptomatic testing of our staff and our patients to actually ensure that it is not just the people but the environment. We did not have any surprises around this. So certainly we would be very, very supportive, and we are very supportive, and we have implemented the mandatory testing of asymptomatic staff who are working in high-risk environments.

Ms VAGHELA: We have had someone else from another industry. We just wanted to know: now that, as Dr Kieu mentioned, we have not had a coronavirus case for the past however many days and there have not been any fatalities, do you think it should be a best practice to continue doing the surveillance testing?

Dr MENON: I actually think, yes. I will need to go to the advice of the experts, but certainly I think if there are minimal symptoms you need to test. My personal view is asymptomatic testing has got a place where the community prevalence is low. I think we want to know where it is, and certainly as the prevalence increases the threshold where you would actually institute that testing will need to be set, but certainly it has a role in maintaining where we are.

Ms VAGHELA: Thanks.

The CHAIR: Team, I am just conscious that we are behind the clock again. Wendy Lovell.

Ms LOVELL: No, I am fine. I do not need a question.

The CHAIR: Lovely. Thank you. Enver Erdogan.

Mr ERDOGAN: I am fine as well for this.

The CHAIR: Thank you. Melina Bath.

Ms BATH: Thank you. And thank you, Felicity. A family member of mine actually works in your fabulous institution, Peninsula Health, and I can certainly attest to the lengths that you went to in terms of multilayered, I guess, safety and protection for staff and patient care. So I think they certainly know how to spot anything and they know how to put on and take off PPE with their eyes closed. I guess I am just interested in relation to resources. You have touched on it a little bit, but could you help me understand. Resources can be both personnel and funding and actually equipment in terms of testing resources and PPE. Could you paint us that picture? Has it all been rosy or have there been some gaps, and would you like if you were doing it again to have some better support in terms of resources?

Ms TOPP: Look, I think at the beginning there was a bit of anxiety regarding the availability of PPE. I think the system that was set up in centralising that supply to hospitals and making information available to hospitals of what was available was initially difficult but it was resolved very quickly. I have not had any struggle in being able to get the resources that have been required at all. I think contact tracing is not something that you do every day in a hospital, and we do have some staff who are trained in contact tracing. We had to increase that significantly and probably underestimated what was required for an outbreak, but in saying that, the mobilisation of resources from the department of health and the involvement of Monash Health was able to mobilise those resources very quickly. And I think the public health units and the establishment of the public health units to support contact tracing is going to be another improvement in those processes. Staffing resources were a little bit difficult when we had the 600 staff off, but again the sector—which is why I acknowledged our private partners and other health services and the department—they all supported us. And I think that is an important lesson. You cannot do this on your own. It is about teamwork. It is about working together. It is about putting up your hand and saying, 'Hey, I need a hand', and I think that worked incredibly well.

Ms BATH: Chair, could I borrow Ms Lovell's question?

The CHAIR: You can borrow a little bit of time. As you are aware, we are chasing the clock.

Ms BATH: Thank you. I appreciate that. Felicity, my electorate is in Eastern Victoria Region, and Gippsland is a large patch, and of course we have a number of health centres and hospitals across the way. And I know that they have tried to work very collaboratively and shift services. You know, there were deliveries at one hospital and aged care at the other. Have you been able to provide some support for them, or are there some learnings that regional Victoria can take out of your incidents or the COVID experience that you have had?

Ms TOPP: It is a really, really good question. Look, I think all the lessons learned we have been sharing with regional Victoria. I think if there were any outbreaks down in regional Victoria, then we would all mobilise around those areas, as people came and mobilised and supported us during our outbreak. I think a key lesson here is that the outbreaks pop up and you need to be able to get people down to support all those areas. The regional hospitals have been engaged at a lot of the chief executive meetings, and at a lot of the meetings that I have been involved in we have been sharing information. And I know the department of health have also been actively involved in supporting those organisations. And I must say, they have done a fantastic job. They are doing things with much less resources than what we have, and they have done a tremendous job.

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

Dr BACH: Nothing from me, Chair.

The CHAIR: Thank you. Dr Catherine Cumming.

Dr CUMMING: Thank you, Felicity. And I guess my question is around what are the gaps between your health service, the GPs and DHS. Are there any gaps that could be filled so that we are better prepared once we go into the colder months of May, June and July? And obviously, as I understand it, your service would have done some of the outreach, in your hospital service doing a bit of outreach. Are there lessons to be learned that we can actually fill while we have got this time now and the learnings that we have gone through? Are there any recommendations you could make to make it better, your communications with DHS? Your facility is just not a silo facility, so we have got all those community connections and council connections as well.

Ms TOPP: No, you are exactly right; we are not siloed. I might do a bit of this, Shyaman, and then I will get you to jump in on how they have got results over to the GPs. We have had great GPs working with us. We have had GPs come in and form part of our contact-tracing team, and our community teams have been working with the GPs in supporting the residential aged-care services. So we have got those things, and we have had multiple conversations with GPs. I would also say that we have had tremendous engagement with South Eastern Melbourne Primary Health Network, and they have linked us with all our GPs in our areas. I might talk to Shyaman. Shyaman, you might want to talk a bit about how we are working on getting the test results, because I think that has probably been one of the biggest frustrations for GPs—getting the test results—and we have been working with our GPs on that. Shyaman, do you just want to jump in there?

Dr MENON: Yes, thanks Felicity. So we certainly have identified that there are areas that we could actually improve on and we can learn, particularly here if we do get another outbreak. We engage with our GPs really well, and we have developed a system currently where results are going to GPs. It is not just the results; the GPs work together with our community team, providing a more unsiloed response, really, where we are not just doing the results, but we are tracking a patient throughout. The majority of patients so far have been actually managed within the community, and it is actually having a seamless progression of care between acute, community and the GPs. So we have got all the teams together, working really well together, and the data is actually visible to all to be able to track, and that data is actually linked in with the department of health as well, so we know that they will know that if there is any of our community who are actually positive, that response now will be taken over by the peninsula team, and that is Peninsula Health, along with our GPs in the area, to build a response that we are tracking a patient, we are maintaining that continuity of care for a patient, and we are keeping the GPs very close by in relation to the progress of a patient. So that system has been built in. I am hoping that we do not have to test it, but we have actually got a system in here, which we are really proud of.

The CHAIR: Fantastic. Thank you. That is actually a very good note to end this session on. Thank you, again. Yes, you really seem to have overcome quite a challenge there. We very much appreciate the work that you do, but also providing the time to us today. As I mentioned, a proof transcript will be sent to you. Please have a look at it, as it will eventually go up on the website and may well form part of the report that we present to Parliament in a few weeks. Thank you, everyone. We will take 2 minutes to reset.

Ms TOPP: Thank you.

Witnesses withdrew.

WITNESSES

Adjunct Professor Russell Harrison, Chief Executive Officer, and

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

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

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

Adjunct Prof. HARRISON: Just from me, Chair.

The CHAIR: Great, thank you.

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

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

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

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