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 Fiona Brew, Chief Executive, Colac Area Health, and

Associate Professor Daniel O'Brien, Deputy Director, Department of Infectious Diseases, Barwon Health.

The CHAIR: Good afternoon. Welcome back. This afternoon we are now joined by Ms Fiona Brew, who is the Chief Executive of Colac Area Health, and Associate Professor Daniel O'Brien, who is the Deputy Director of the Department of Infectious Diseases at Barwon Health. Thank you both very much for joining us this afternoon. On the committee today we have Deputy Chair Dr Tien Kieu, Ms Georgie Crozier, Ms Kaushaliya Vaghela, Dr Matthew Bach and, as I mentioned, I am Fiona Patten, the Chair of the committee.

I will just let you know that all evidence taken at this hearing is protected by parliamentary privilege, and that is provided by our *Constitution Act* but also by the standing orders of the Legislative Council. This means that any information that you provide during this hearing is 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 could be considered contempt of Parliament. As you are aware, this is being broadcast, but it is also being recorded. We will be sending you a proof transcript of today, and I will encourage you two to check that when you have time to make sure that we have not misrepresented you. We welcome you to make some making remarks. Fiona, I believe you have a presentation to start us off with.

Ms BREW: Thank you, Chair and committee, for the opportunity of actually participating in the public hearing today.

Visual presentation.

The CHAIR: Thanks, Fiona.

Ms BREW: I am just checking that you can see that.

The CHAIR: Indeed we can. Thank you.

Ms BREW: Fantastic. I am going to start and just talk about our preparedness, which commenced in January of this year. Typically we had a health service response in preparing ourselves internally. But being a rural hospital, we also work very closely with our GPs, and in fact they are the predominance of our workforce. So in liaison with our general practitioners—and we have two predominant practices here—it was identified fairly early that they did not have the capacity to assist with testing, and part of that was because of their own comorbidities and also from infrastructure. So indeed we actually set up a clinic in February sometime. The other thing that we did was really value community engagement, and that is probably not a surprise when you think about the size of our organisation and our town being somewhat 12 000 to 13 000 people.

In March of this year I was actually approached by a CEO of a major national business here and we did convene a meeting at the local football oval, and a number of community leaders actually attended. We also had local media involved in that, being both radio and print. At that meeting we really decided that we needed to have a health promotion approach or public health messaging. We actually developed a campaign, and our campaign slogan was Keep Colac Safe. Everything hung off that in our communication with business leaders and with our community so people could actually identify with it. We also had a communication strategy, and I will not open that link, but that is included for members to open offline. Part of that communication strategy was recognising that not people of authority but people of influence were participating in vignettes and key messages to the community. Also when we did have our outbreak we changed our messaging, and our campaign became Let's Get Back to None. We changed our messaging at different times. One of the other things is that we had Father's Day and we said, 'The best gift you can give your father is to stay at home'. So we were responsive to what was happening within the community at the time.

From a COVID service response our primary role was testing, and we had a very agile testing model. We worked with Barwon Health, but they indeed led the contact tracing as the public health unit, and monitoring was in collaboration with Barwon Health. So although the majority of that role was with Barwon Health, we certainly had input into that process. And accommodation and social support was provided through Colac, but in the early days it was in partnership with Timboon hospital.

Assoc. Prof. O'BRIEN: I am just going to take over here and describe the actual outbreaks just so you can familiarise yourselves a little bit with them. Thanks again to the Chair and committee members for allowing me to present to the parliamentary inquiry.

Colac was affected by two major outbreaks. The first one was in mid-July. It occurred coincidentally at about the same time that the Barwon Health contact tracing, management and monitoring unit was set up. It involved quite a number of cases in the end, with 104 confirmed cases that were contact traced and monitored, 335 primary close contacts and also quite a number of secondary household and workplace contacts. It predominantly involved the abattoir in Colac, the Australian Lamb Company abattoir, and in the end there were 67 cases in staff and 15 cases in household contacts of staff. It was quite a complex outbreak, however. Firstly, it involved a very high-risk setting. We know that abattoirs are a high-risk setting. There is a huge risk for amplification and spread of the virus very rapidly in these settings, and by the time the outbreak was detected it had already spread across multiple production lines, shifts and different areas in the facility.

But it also involved many challenges, which included a culturally and linguistically diverse workforce, many of whom shared accommodation, and being a large employer in the town it really had an impact on many other parts of the town, including local schools, early learning centres and such things as gyms and other community services. Finally, the other thing that complicated it was that by the time the outbreak was detected there was already evidence of unlinked community transmissions, so it had actually spread outside the workplace and those close contacts. In the end there were 23 non-ALC staff or contact cases, indicating further transmission outside ALC. But despite the of complexity of the outbreak, the size of the outbreak and the fact that it was reasonably established once detected, it was still completely controlled within four weeks and no further cases were detected after that.

Just to give you an idea of how, I think, effective this was, if you look at the estimated risk of the number of cases that a person transmits to, it is thought to be about 2½ per person. If you look at the 67 cases in the ALC company, you would have expected maybe 160 or 170 household contacts or other contacts infected, and in fact only 15 were. That is probably a more than 80 per cent reduction in the estimated potential number of cases, so I think considering the significant complexity and size of the outbreak that that was an excellent outcome. Now, that outcome was not only through all the great management of the local and Barwon Health teams, as well as Colac, and also DHHS but I think the Colac community performed an amazing role in really addressing what needed to be done and really taking on this outbreak and doing something about it. So I think it was a great effort by the community.

But despite all that effort, within really another six weeks unfortunately they were faced with another outbreak. This was imported from metropolitan Melbourne, so it had no relationship at all to the first outbreak. And it ended up involving 39 confirmed cases that required again contact tracing and monitoring, 576 primary close contacts but also as well further secondary and household contacts. Once again it was really very complex and involved at least five workplaces, an early learning centre and some very complex households and had spread into social networks. So it was certainly a major threat to the Colac community, but once again with the response of the management teams and the Colac community there was in fact no unlinked community transmission at all detected from this outbreak, and within two weeks the outbreak was under control with no further cases—so, once again, I think a really excellent outcome.

Ms BREW: For the outbreak management Colac Area Health had an incident management team, and that was actually stood up in January of this year. Obviously the frequency it met changed over time and on what the needs were. We were also part of the emergency management team that was established in Colac, and my role was as a member of that team. In terms of contact tracing and outbreak management I have already suggested contact tracing was led by Barwon Health and monitoring was done in collaboration with ourselves. So when there was a need for escalation or for people to be seen, we provided that function through hospital in the home.

We also provided advice. Isolation and quarantine was done with the Department of Health and Human Services and Barwon Health, and we managed that accommodation for some period. There was also oversight of testing protocols through Barwon Health, and we also provided infection prevention and control support to businesses, aged-care facilities and indeed the hotels. Other community supports were our communications, and I touched on that before. We were also responsible for notifying results of all testing and clinical escalation. The social support was extremely important, and in fact we established a community support line, a

1800 number, that was very well utilised throughout that time. At one stage we were also responsible for purchase and distribution of food. I have already mentioned accommodation, and compliance and follow-up was provided by the ADF and the Department of Health and Human Services. And follow-up testing again came through to Colac Area Health's responsibility. I just want to touch on the key learnings. I will hand over to Daniel, and I will pick up halfway through.

Assoc. Prof. O'BRIEN: Thanks again, Fiona. I think that we really learned a lot throughout the two outbreaks. It was certainly some learning as you go, but there are some really important things that we felt are worth sharing. First of all, to me it was absolutely critical that the local community who are affected by the virus have a knowledge of and a trust in the local health services who are providing the actual response. The fact that they know the health service and they trust them really leads to an openness around contact tracing, which is, as you would know, vital. If you do not find out the information, it is very hard to track and stop the virus. But also it leads to a willingness to comply and to adhere to the instructions and the requirements around isolation and quarantine, so I think that really played a major role in the success of the outbreak.

Of course it is really important to be rapid. The virus moves very quickly, so if you cannot get in front of the virus, you are not going to be able to stop it. There are a lot of components that really are important, but what we saw was that ability to provide same-day provision of onsite testing for all the workplace outbreaks was really important, but also having laboratory capacity to actually achieve rapid turnaround times for results within 24 hours makes a massive difference. Of course being notified and being able to perform the contact tracing within hours of notification was possible, and that made a big difference. But also the fact that, once again, it was a clinician-led team which really had that trust and confidence I believe of the community really helped to make it more effective. But another thing that we enacted that I think made a big difference as far as being rapid was with the close contacts not - waiting until they had become symptomatic to find out that they were infected, but to actually test them straight up. So that if you find out they are positive, you can actually start your contact tracing immediately, and that would actually allow you to get ahead of the transmission train, rather than waiting until they become symptomatic or until day 11 testing, so I think that had a big impact.

It was also clear that as much as people try and isolate in a home with a family or other household contacts, it is really hard to stop the transmission and many people get infected. Therefore access to accommodation was vital, so being able to get either the cases or the contacts out into accommodation and therefore no longer isolating together really was important as far as interrupting transmission. But also we instituted very early on this idea again that because there is a high risk of secondary contacts being infected and that by the time you find out that they are infected they have already been out in the community, it is best to actually isolate them up-front. Therefore we instituted the third ring really quite early on as far as households but also people who worked in at-risk or high-risk settings.

Ms BREW: And just in terms of testing, I think scalable testing is absolutely critical, and I have heard other people mention it. Our experience was that the only way we could actually achieve that was through the drive-through model, and we adopted that on many occasions. Obviously we established the community leaders group, but also being able to respond and rely and communicate very quickly with that group was critical in messaging. One of the big challenges, and I have heard it said before, was around up-to-date employee contact information. When we were looking at getting results out for our culturally and linguistically diverse, there were some people, six or seven people, giving the same mobile number and we did not find that out until we were actually trying to contact them. Obviously the ability to address the culturally and linguistically diverse community through interpreters and community leaders and written material and infographics was absolutely critical. So there were diverse requirements in that phase because communication was critical at all levels.

The CHAIR: Terrific. I suspect Colac is going to be on the international stage soon as best practice. That really looked incredible. Congratulations.

Ms BREW: Can I actually say we already are.

The CHAIR: Of course you are. Well, it is well deserved. I think from my point of interest here around that, that really rapid testing that you were able to do, or I guess being able to provide those results very quickly, then getting onto the close contacts, getting them to be tested very quickly and this being a clinician-led process, the way you did it, do you think this is something that could be scaled up or is this something that is quite specific to more localised communities like Colac?

Ms BREW: Dan, I might start, if that is all right. From our experience, we felt that we needed to understand what the size of the problem was and the only way to do that was through testing. So I think that is a transferable learning. And the other thing is that taking it to the worksites, we found, was the most efficient way of actually doing it. So from our perspective I think it is transferable, I think it is easy to do, and it is all about preparation, so anybody can do that accordingly.

The CHAIR: Yes. Can I just step through it? I know I have not got much time. So you might go and set up at a drive-in site at a business, you do the testing and within 24 hours you have got the result of that test back. Have you got a contact-tracing team that that information—

Ms BREW: So how the process worked—and I am sorry to interrupt you—in the early days it was not 24 hours, but we did get the tests done very quickly. We worked with two pathology providers and understood what the capacity was at any given time to maximise the turnaround times. Once those results were known the contact-tracing unit were given those within the hour—and I mean within the hour; that was our individual KPI we had at the health service—and the contact-tracing unit immediately swung into action from there.

The CHAIR: So it was the contact-tracing unit that would have provided the results to the individual?

Ms BREW: No, that was our responsibility to anybody that was tested. So we let the contact-tracing unit know but also the people know as well. So as soon as we received a positive test through the director of medical services at Colac Area Health they were actually notified and at the same time the contact-tracing unit were told as well. So there were no time delays.

The CHAIR: Yes, so almost within 2 hours that—

Ms BREW: Within an hour.

The CHAIR: Within an hour that positive person would have received notice of their positive test and a contact tracer calling them.

Ms BREW: Yes.

The CHAIR: Terrific. Thank you. Dr Tien Kieu.

Dr KIEU: Thank you, Chair. Thank you, Fiona and Daniel, for the contribution today, and congratulations to you for the very successful management. Deservedly it should be a model and well known. I am also very much impressed with the preparedness, with the engagement not only with the community but also with the medical profession as well as local council, and then the response, and on top of that the support to follow through with people who are in need. I would just like to move on in the interests of time. Now we are moving into local health, public health, and apart from six of them in metro there are a few also established or being established regionally. So what challenges do you see for those locals in being established and what measures would be needed? Also, just following on from that, we are moving out hopefully with the vaccine that will be coming soon, hopefully maybe in six months or eight months time. Is there any plan for vaccination as well? How prepared are you?

Ms BREW: Daniel, do you want to answer that question?

Assoc. Prof. O'BRIEN: Yes. Thanks for that question. It is a good question. Look, I think one of the challenges now for the new units setting up—and I have been involved in helping the metro units—is the regional units are really quite well established now, but it is a fact that in fact a lot of the learning is learning as you go. I mean, it is on-the-job training, in other words. There is no substitute for experience. So I guess one of the challenges for them is, though it is a great thing the cases have gone, they do not have the cases to train with, so we are trying to do it through protocols and through mock cases. We may get some real-life training through South Australia right at the current time, but I guess that is the challenge, to build the experience in the units, because I think experience is really critical. Every case is different and every setting is different, and you really need to understand it well to work your way through it.

I guess the other thing when the cases are low is just maintaining the workforce as well, because you need to have that ability to surge and reduce your workforce, because if there are not a lot of cases around there is not a lot to do. So I think that is a challenge. There is also the data management that needs to be worked through to

make sure that it is all well understood and appropriate and across the board uniform, so that is also another challenge. But I think at the end of the day the main point from me is that when you have got teams that are based in the community, whether they be in a tertiary or secondary health service or a community service or a GP service, they really understand the community, they understand the settings that they are involved with, the community know and trust them, and it really makes for a very effective response. Therefore, although there needs to be a lot of capacity built and training, I really think it is definitely the way to go and should hopefully make a big difference in our ability to respond should we have further cases in the future.

The CHAIR: Great. Thank you. Georgie Crozier.

Ms CROZIER: Thank you very much, Chair. Professor O'Brien and Ms Brew, thank you so much for your presentation to us this afternoon, and congratulations on all of your efforts. What you have been able to provide for your community is a terrific model that I think we will be looking at very closely. I have been impressed. I have been following the issues in Colac from 17 July. I just would like to understand some of those challenges. But before I do go to that, could I just ask: Colac health, obviously, which is a part of Barwon—

Ms BREW: No.

Ms CROZIER: No. Sorry. But you are partnering with Barwon.

Ms BREW: Yes. So we are in the same region.

Ms CROZIER: Correct. Sorry, I meant that in terms of this area. But my question is: it is Colac Area Health that really led that local response in the first place, isn't it, in terms of getting that community engagement on board, whether it was the leaders, the schools, the businesses, ALC? I am correct in saying that?

Ms BREW: Yes, you are.

Ms CROZIER: Yes. And to go to Professor O'Brien's point about that being embedded into the local community for the trust, getting that result that you got within four weeks for the first outbreak and two weeks controlled in the second outbreak is very impressive. I want to understand. I think what we want to understand is those frustrations that you were able to work through. Because it was reported at the time the testing results were not coming through—that you actually had not been contacted by DHHS. Could you explain to the committee some of those delays in notification from testing and how long it took for you to be notified by DHHS?

Ms BREW: So the first index case—because it was a routine screen through our clinic, that result actually came back to us, so we knew firsthand. That was with both clusters. In terms of from a response perspective, obviously it was an immediate response but there were delays in getting testing results back.

Ms CROZIER: How long were the delays?

Ms BREW: Look, it was a couple of days, and then it was a challenge to get some of those results out to people because people were not answering their phone or we had wrong contact details. So there were often delays from that as well, and that is why the 1800 community support line was so important so we had a loop back into the service. The other thing I would say is day 11 testing, because it is planned, and particularly when you are talking about the volumes we were testing—700 or 800 people—we were absolutely able to plan for that in terms of testing pathology building in that time. So our day 11 testing was a very quick turnaround. On both occasions it was 24 hours. But that was in the planned purpose because we worked with pathology services to make sure that could happen. The turnaround time in general improved over time. There is no doubt about it. But it was absolutely challenging in that first couple of instances, or first few days, and that was reflective of what was happening statewide.

Ms CROZIER: Have I got any time left, Chair?

The CHAIR: Yes, go ahead.

Ms CROZIER: Just quickly, I am interested that when you said, 'Look, there were issues with contacting people after they tested positive' and you set up that 1800 number. How did that work?

Ms BREW: Yes. In terms of the positives, they were a phone call. We did not just leave messages or anything like that. So we hunted down until we could contact them. In terms of the negative tests, remembering we did about 5000 tests during that time, that was via text and other modalities, but the positives were always a discussion with the person. Now, because a lot of these people obviously had frequented our services before—that local knowledge—you knew who were families or who was in businesses and things like that, and from payroll data we could go back to the companies and they were liaising with their employees directly, so we could get the most accurate information.

Ms CROZIER: Thank you. We heard from Dr Haikerwal similarly in terms of really understanding the local communities and families and how that is so important—

Ms BREW: Critical.

Ms CROZIER: in some of these areas. Thank you for that.

The CHAIR: That GP connection. Kaushaliya Vaghela.

Ms VAGHELA: Thank you, Chair. Thanks, Fiona and Daniel, for your submission, your presentation today and the great work that you have done in handling the outbreak during the pandemic. You have highlighted the key learnings in the presentation that you showed today, and I understand you may have used some or all of those key learnings while handling the outbreaks. I just wanted to know how much guidance and support you received from the department while handling those outbreaks.

Ms BREW: From a Colac Area Health perspective, Barwon Health were actually designated contact tracing on the same day as our first outbreak. So our relationship was very much with Dan's team as the contact-tracing unit because central office was not involved in that contact tracing for Australian Lamb Company. So it was a close relationship. There were already relationships built, because from the regional perspective—not that I knew Dan before—they knew us and we knew them, and that goes back to that local response as well.

Assoc. Prof. O'BRIEN: I should say that I had a direct contact with a colleague in DHHS, Professor Paul Johnson, who was appointed to basically support the regional team. So I had very close contact with him, and he very much helped me to work with the central levels to check, I guess, that the protocols were right and to discuss strategy, and that made a really big difference. So we felt very well supported. Having said that, we also were able to have our own autonomy and independence to run the outbreak ourselves. So I very much think that the connection with DHHS was good and worked well.

Ms VAGHELA: And just a quick one: how easy or difficult do you think it would be to replicate the learnings that you have had in other outbreaks? You were very efficient in handling this. Do you think it would be easy to replicate those learnings in future outbreaks?

Ms BREW: Look, I think we have seen that around the state, and we have all heard the regional learnings. I think some of those regional learnings have come from this outbreak, because it was the biggest regional outbreak. That rapid response is always what we have maintained as a key objective, and we are certainly seeing that now. We saw that in Shepparton and other outbreaks as well.

The CHAIR: Great. Thank you. I will go to Dr Matthew Bach. I see that Wendy Lovell, Sheena Watt and Melina have been able to join us now, but Matthew.

Dr BACH: Thank you, Chair. And a big thankyou to you, Ms Brew, and also to Professor O'Brien for being with us today. It is wonderful to hear from you and to seek to learn from you, given that you did such an extraordinary job in your community. It is interesting for me to note as you talk some of the huge differences between what we have heard today and also on Monday about DHHS-led responses and the way in which you handled things in your community. Ms Brew, earlier on you talked about the real need for speed and to turn tests around very quickly. Just earlier today we heard about not only huge delays but many people in other parts of the state never being contacted at all, even when they were known to be COVID positive. We heard about many other people being contacted by multiple contact tracers with multiple different messages, conflicting messages. We heard about a lack of communication to GPs and to other relevant health professionals. So I might direct my question initially to you, Professor O'Brien, if I may. If my notes are correct, earlier on you were talking, sir, about how important it was in your community to test asymptomatic contacts. Earlier today

we heard from an eminent doctor that currently GPs are actually banned from testing asymptomatic close contacts of COVID-positive patients. So because of that I wonder if you could talk us through why it is, sir, you feel doing that in your community was so pivotal to dealing with the outbreak.

Assoc. Prof. O'BRIEN: I think the thing is that people are infectious for two days before they develop symptoms and probably sometimes even more. So the thing is that they can be already infectious but have no symptoms, that is, they are in the pre-symptomatic period. Now, when you are dealing with a contact who, for instance, works in an early learning centre or works in an aged-care facility or works in a school, you need to know as quickly as possible when you take that person out of that context and into isolation whether or not they were infectious at the time that they were last exposed to that place, because if you wait the next two days until they get symptomatic and are diagnosed as a case, by the time you have done that you have lost 48 hours and we know the virus moves so quickly that you have already missed another chain of transmission. So it just allows you to more quickly catch up and then get ahead of the outbreak. So why did we do that? I guess it just made sense when we were doing it. It helped us also with our resources, because if the person has been at school but they are negative on their last contact, well then you do not have to close the school and do all the contact tracing in the school because you actually know they were not positive there. So it is really a different situation to just saying, 'Let's test all asymptomatic people'. It is actually people at very high risk who may well be presymptomatic, and you are trying to find them in that window. So that is basically where the idea came from.

Dr BACH: All right. That is excellent. Thank you very much.

The CHAIR: Terrific. Thank you. The next question would go to Sheena Watt, but she has ceded her question to Deputy Chair Tien Kieu.

Dr KIEU: Thank you, Chair. I am interested in your view on mandatory testing for certain identified at-risk cohorts, and also the other question that is very much of interest for us is the communication with the CALD communities, not just only in languages but sometimes people in those communities can speak the language but it is very hard for them to understand the written even in their mother tongue, in their mother language. So could you take us to what you have done? Because there has been a problem in the north-west and elsewhere in the state—and not just in Victoria but also throughout the nation, and in America as well that has been a big problem.

Ms BREW: Dan, if I can take the cultural diversity, and I will leave the testing question for you. From our perspective, if I talk about Australian Lamb Company, their head of people and culture we have also worked closely with, and the languages we were talking about were about 80 per cent Mandarin, Dinka and Farsi. We used those resources and intelligence to also translate, and some of it was written material, some of it was infographics. I think one of the key learnings is 'Keep it short, keep it simple', and we actually used a red card and a green card methodology at one stage that I know has been used in other parts of the state, so it was very clear what people needed to do and infographics actually facilitated that as well. In terms of when we were texting, the actual employees told us, 'If you text us that will be better, because at our end it will be translated into our language', and that was working not only with employees of those companies but it was working with the employer as well. So that sort of thing really helped and hastened things, which we were not aware of before. And I will pass over to Dan.

Dr KIEU: For certain communities being tested positive could be a big stigma. Is there any pushback on that?

Ms BREW: Sorry, could you repeat?

Dr KIEU: Sorry. For certain communities or for certain individuals being tested positive could be a big stigma. So is there any way to overcome that or to reassure people?

Ms BREW: Yes, and that was a consideration. That was also one of the reasons why we decided to do it onsite in the first instance—because we felt the employees would be comfortable in their work environment rather than coming to another environment. And when we did Central Reserve testing on day 11 it was closed to everybody else, and we had actually management there as well. So actually the employees saw people they were familiar with, and there were not other people around. So part of that was that sort of consideration that we did.

Assoc. Prof. O'BRIEN: Look, I was just going to add that, you know, I think the point is a good one. There is absolutely stigma around this infection, and therefore it is something that really needs to be kept in mind and addressed, because people have a real fear of being diagnosed because it has significantly negative impacts on them, not just from a financial or social perspective but from the way other people treat them if they have or have had the illness. So it is very important to consider those in your processes.

The CHAIR: Thank you. And I think certainly that red and green card is less confusing than positive-negative as well. That is a great idea. Wendy Lovell. Hello.

Ms BREW: Hello.

Ms LOVELL: Hi, Fiona, how are you? Sorry, Fiona, I did send you a message to say if you got to me, go back to Georgie. Coming in halfway through makes it a bit hard when you have not heard.

The CHAIR: Thank you. Georgie.

Ms CROZIER: Thank you. I will take the opportunity, thank you very much. I just want to follow up on that issue. You have got ALC, so it is a high-risk industry that is in your community, and the testing. And we know that the government announces testing rates every day. The vast majority are from industry through the mandatory testing that is required. So I am just wondering for the general community, is the testing ongoing within your community to keep abreast of everything that you have achieved so you do not go and have a further outbreak?

Ms BREW: Yes. So in terms of ALC, the surveillance testing is happening there now and we did participate in that when they first opened, but that is ongoing. In terms of the clinic, yes, it is, but with our testing clinics we have always flexed it up and flexed it down, and at the moment it is flexed down. We have run from seven days a week to three days a week. At the moment we are three days a week.

Ms CROZIER: Is that enough for the community?

Ms BREW: It is at the moment for the numbers that we are seeing, but we can change that on a daily basis. Because we work so closely with the media, we actually can have direct access to our community, and we also use social media. We continue to meet with the practice managers from each of the GP practices as well, so we are getting that local intelligence from our doctors. At the moment it appears we are getting low numbers down, but it is something we monitor on a daily basis to actually understand what that looks like and we respond accordingly, and we have done that since January.

Ms CROZIER: Thank you.

The CHAIR: We will quickly go to Kaushaliya, and then we will go back to Georgie because I understand Melina has ceded her question to you, Georgie.

Ms VAGHELA: Thanks, Chair. Either of you can answer, Fiona and Daniel. Now that Victoria is opening up we are going to restaurants for lunches and dinners and we are giving our first name and second name and using the QR code, so can you tell the committee what contact-tracing processes are currently integrated across your health service? So if there is an outbreak, how is that going to work now?

Ms BREW: From our perspective, we have already got the processes and procedures to escalate and we have a workforce trained, and we have got different tiers within our workforce that can step up. We are incorporating this as part of our business as usual, I will be honest, and we also are aware because of where we sit in the state of Victoria, with the Great Ocean Road, there are a lot of people coming this way. We are not just looking at it as Colac Area Health, we are looking at a systems approach so our partners as well have testing capability and we complement each other. Indeed, during the outbreak our partners also helped—other services helped us as well from the staff actually doing some of that on site here so our workforce could be rested as well.

The CHAIR: Terrific. Thank you so much. That really was great and, as we now know, world-class. Once you are able to no doubt you will be travelling far and wide to share this really great story of how you were able to jump on this creatively and, most importantly, effectively. We will send you a transcript shortly. Please do

have a look at it. Make sure that we have got things correct. No doubt you have sent those slides, Fiona, but if you have not, could you?

Ms BREW: They have been forwarded.

The CHAIR: Great, thank you. Thank you, Fiona, and thank you, Daniel, so much for today and for all the work that you have been doing over 2020 and before.

Dr KIEU: Are you ready for the influx of visitors this summer?

Ms BREW: Yes, we are.

Assoc. Prof. O'BRIEN: I think they are here already.

The CHAIR: They came on the weekend. Thank you.

Witnesses withdrew.