TRANSCRIPT

PANDEMIC DECLARATION ACCOUNTABILITY AND OVERSIGHT COMMITTEE

Review of Hospitals and Care Facilities Pandemic Order

Melbourne—Friday, 4 March 2022

MEMBERS

Ms Suzanna Sheed (Chair)
Mr Jeff Bourman (Deputy Chair)
Mr Josh Bull
Ms Georgie Crozier
Mr Enver Erdogan
Ms Emma Kealy
Ms Harriet Shing
Ms Vicki Ward
Mr Kim Wells

WITNESSES

Professor Euan Wallace, Secretary,

Ms Jacinda de Witts, Deputy Secretary and General Counsel, Regulatory, Risk, Integrity and Legal,

Mr Jeroen Weimar, Commander, COVID-19 Response,

Ms Nicole Brady, Deputy Secretary, Public Health Policy and Strategy, and

Ms Jodie Geissler, Deputy Secretary, Commissioning and System Improvement, Department of Health.

The CHAIR: I declare open this hearing of the Pandemic Declaration Accountability and Oversight Committee. The Pandemic Declaration Accountability and Oversight Committee is a joint investigatory committee established under the *Parliamentary Committees Act 2003* and the *Public Health and Wellbeing Act 2008*. Its powers include the ability to review pandemic orders made under the *Public Health and Wellbeing Act* and report to each house of Parliament on these orders.

I would like to begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting. We pay our respects to them, their culture, their elders past, present and future and elders from other communities who may be here today.

All phones on silent, please.

I would like to first of all welcome all our witnesses here today: Jeroen Weimar, Jodie Geissler, Professor Euan Wallace, Nicole Brady and Jacinda de Witts. Thank you very much for your attendance today.

I am Suzanna Sheed, the Chair of this committee. We have Mr Jeff Bourman, who is the Deputy Chair; Mr Josh Bull; Ms Georgie Crozier; Ms Emma Kealy; Ms Harriet Shing; and online we have Mr Enver Erdogan and Ms Vicki Ward will be joining us in a little while.

All evidence taken by the committee is protected by parliamentary privilege. Comments repeated outside this hearing, including on social media, may not be protected by this privilege.

All evidence given today is being recorded by Hansard. You will be provided with a proof version of the transcript to check. Verified transcripts, presentations and handouts will be placed on the committee's website as soon as possible.

I welcome all of our witnesses and invite you, presumably, Professor Wallace, to make no more than a 5-minute statement, and then we will be following up with questions from the members. Thank you.

Prof. WALLACE: Thanks, Chair. Good morning, everyone. And again, thank you for the opportunity to be here with you and share the department's work since the pandemic orders came into place. I have just three slides. I am not sure if they are going to be shown on the screen or if you have got them in your pack.

The CHAIR: I do not think we have seen them.

Prof. WALLACE: No?

The CHAIR: We do not have them. Perhaps you can talk to them.

Prof. WALLACE: Yes, I will just talk to them. Let me also begin by acknowledging this is Wurundjeri land and pay my respects on behalf of our department to their elders past and present and any First Nations people joining this hearing this morning.

I think the first thing to say is that clearly this most recent wave of the pandemic, the so-called omicron wave, began in the weeks preceding the pandemic orders in mid-December, and the planning for the early phase of December–January–March had been made really on the previous wave, which was the delta wave. It became evident to us from overseas experiences in early December, ahead of the pandemic orders coming in, that there was this new variant that had some key features, and we may get to those this morning, that were very different

to the previous variant that was dominant in Victoria and Australia. And the key feature at that time was that it was far more transmissible, and so rapidly through December and into January our modelling and planning adjusted as we gained experience.

If we recall that in 2020 we had about 20 000 cases in total in the pandemic, and we peaked out in this wave in January at around 50 000 cases a day and just over 1200 cases in hospital a day on 17 January, they are extraordinary numbers. There have been something like just shy of 17 000 hospital admissions across the most recent phases of the pandemic. So it was against that rapidly changing background that the planning the department made—in collaboration obviously with the Chief Health Officer, our public health division—and of course the decisions ultimately the minister made through the pandemic orders were shaped.

In terms of visiting hospitals and care facilities, it was about three things really. One was keeping either inpatients or residents as safe as possible, mindful that 650 of the 800 deaths were in aged care in 2020—the most vulnerable population—and it was very important that the decisions that were made in respect to that acknowledged that increased risk. The second thing was to keep staff safe. It was evident to us from early experience overseas, mostly from the UK, that very large numbers of healthcare worker and aged care worker staffing would be knocked out by this wave if we did not manage that carefully. And then of course the third was just about maintaining capacity in our health system to be able to respond to what we were anticipating as that modelling changed very quickly, very rapidly over December and into early January when—we may get to this later—we were modelling somewhere between 2500 and 4000 hospital admissions at any given time.

So I think the pandemic orders that the minister put in place were around maintaining visitation rights, if you like, for both hospital patients and aged care residents that also acknowledged some of those risks. In terms of the third component, that maintaining capacity, we had to make changes, as you know, on 6 January—very significant changes—to elective surgery to cancel or pause all non-urgent surgery. And again that was about reducing workforce strain in our public hospitals. Our public hospitals, it is fair to acknowledge, have carried almost the entire burden of the COVID response across the last two years, very much in partnership with our private sector, who have provided staff and bed capacity to do some of our category 1 urgent elective surgery, allowing bed capacity and staff capacity in our hospitals. That response in January, really driven and overseen by Jodie Geissler's division, always had a very precise management structure that allowed us to resume elective surgery as soon as we felt it was safe for meeting those key three things. Chair, I might just leave it there as a backdrop—opening comments—and welcome questions from the committee.

The CHAIR: Thank you very much. Perhaps I will start. The committee has heard that in some instances health services have imposed greater restrictions, such as requirements and limitations on visitors which are in excess of the pandemic orders themselves. Dr Matthews, the CEO of the Royal Women's Hospital, on Thursday, 17 February, said:

> As you know, health services are obligated to comply with the hospital visitor pandemic orders; however, the orders relating to visitor restrictions do allow hospitals to set their own additional requirements, conditions or restrictions provided they are not more lenient than the orders.

So I am just wondering whether the department has had concerns about the greater level of restrictions that hospitals have imposed—and we heard more about that—and if so, what steps were taken to try and manage that within the hospital settings?

Prof. WALLACE: Thank you. I think there are two things to say probably. One is that the restrictions, the measures that were put in place as part of the orders around visitor restrictions really since the orders came in have always balanced the human rights aspects, so the proportionality in what the measures were trying to do and how we could most effectively do that without infringing human rights, acknowledging that inpatient admissions and in particular inpatient admissions in our hospitals are scary times for those patients and their families. So the measures that were put in place as part of the suite of the pandemic orders were always balancing that.

We have some 80 health services in the state, as you know, that are independent organisations with their own governance structures and their own boards and, as employing authorities, their own responsibilities under OH&S legislation to look after the staff and to look after of course their patients. We have always been mindful of the need for uniformity and equity wherever possible, mindful that some families are visiting family members in different hospitals and it makes no sense to them and it is confusing when one hospital has different

rules to another. But we have always worked with and respected the need for local application of the orders. And there have been some hospitals we are aware of that have had slightly tighter regulations than the pandemic orders, and mostly that is because of some of the capital constraints—so shared rooms rather than single rooms. In our most modern facilities the rooms are ready to manage airflow challenges that we require for a pandemic. In some of our older hospitals they are just not built for that, and again the health services themselves had very deep experience across the last two years—2020, 2021—when we and they learned what worked and what did not work in terms of managing transmission risks. So where there were very overt differences and seemingly differences that we did not understand, we would always reach out with those services.

Ms Geissler might want to summarise just the levels of engagement we have had with hospitals across the whole pandemic but particularly since the pandemic orders. We are meeting with services daily at operating officer level, at CEO level and so on. Jodie, I do not know if you want to summarise that.

Ms GEISSLER: Very, very happy to, Euan. So we have got numerous ways we engage and communicate with the sector to inform the pandemic response, and visitor restrictions have come up in numerous conversations with the CEOs over time. We provide and share information through—and I think some of the CEOs did speak about this—our standardised broadcasts and bulletins, but we have lots of engagement forums where we are interacting on really critical issues such as these. So we have operational matters arise in our regular meetings with the chief operating officers, and particularly during peaks that was daily with our health service operations team, our deputy controller health service operations and more recently the health service response centre. We also meet regularly with the CEOs, as you have heard. Sometimes that is specific to LPHUs, and Jeroen convenes those meetings. Often it is relevant to hospital operations, and they meet several times through the course of any week. We have specific CEO groups that are brought together to inform the emergency response. They can be about emergency demand. They might be time limited in nature about the streaming model or longer term, but regardless, there are multiple forums and ways we engage with the sector. And most recently we have stood up a health service operations management and COVID-19 working group with CEOs, which just came together on 11 February, which will work through a whole range of different considerations as we move into the next phase of the pandemic. So, look, it is a very intensive engagement program, and I think the CEOs have spoken—

The CHAIR: I wonder: could you move to the same issue in relation to aged care and the level of consultation and engagement you have had with aged care, both state and federally funded aged care, in Victoria?

Prof. WALLACE: Yes. Obviously the public aged care facilities are governed by our health service mostly, and exactly the same engagement opportunities and processes were in place for those. You will recall that in 2020 the commonwealth in collaboration with us set up the Victorian collaborative aged care response centre, and in terms of engagements with the broader residential aged care sector the communications and engagement were done in association with VACRC and through VACRC and through the commonwealth. So our engagement with private residential aged care has been principally through VACRC. Now, we have a dedicated aged care team both in Ms Geissler's division and also in Mr Weimar's division, so we have our aged care and COVID response team, and they are the key liaison between us and VACRC, the commonwealth's response centre. Engagement with private aged care was principally through VACRC but also our area of operations teams. This is the regional structure that Jeroen set up. I do not know, Jeroen, if you want to talk about it.

The CHAIR: Could I just sort of break in there and say one of our witnesses described what an incredible challenge it was for them dealing with the commonwealth and the orders and directions coming from there, the state orders and then the local public health units, and the interpretation and the difficulty trying to manage all of those. The witness suggested that there should be just one body taking care of aged care. I just wonder whether you have a view on that, Professor Wallace.

Prof. WALLACE: Yes, I think that is the purpose of VACRC, and the commonwealth established VACRC for that purpose—for us to feed in our public health insights and advice, the case numbers and changing epidemiology that we see in our aged care sector to then inform both our public health actions through our local health units since they were established in July 2020. But in terms of communications and broader policy settings and an application of those, an oversight of those, for the private sector that has been a commonwealth function.

The CHAIR: Challenging?

Prof. WALLACE: I think the whole thing has been challenging for everybody. Whether it is in the public or private sector, it has been really challenging. And again, mindful of the events in 2020, I think it is not unreasonable that aged care providers themselves have been wanting to err on the side of caution. I understand that.

The other thing I would say is that our team, led by Ms Brady and me, have been meeting with the commissioner for older persons regularly throughout to get feedback from the sector—not just the public aged care sector but also the private sector—to hear what they are saying. And I think you will have seen the evolution of visiting settings for aged care has differed from that of hospitals, and that reflects in part Gerard's feedback from his sector, what has been most challenging for the sector and what could be done to try and address some of those challenges. But they are also mindful and respectful that these are people's homes, and we are always comparing the measures that we have for what is someone's home with what applies to our own homes, our own private homes.

So for previous witnesses to say it is challenging I completely agree with and understand—very challenging—but in terms of those communication channels and challenges and integration, that really was why we were really keen with the commonwealth to set up the response centre, mindful that as a state we just do not have governance and jurisdiction over the private sector.

The CHAIR: Yes, okay. So my 10 minutes are up. Will I keep going?

Mr BOURMAN: Keep going.

The CHAIR: Yes, thank you.

Mr BOURMAN: I am going to give the Chair my extra 10 minutes.

The CHAIR: Thank you. In instances where health and aged care facilities are found to have been non-compliant in relation to pandemic orders, if that has occurred, I am just wondering what steps the department takes to assist those organisations in mitigating what could be significant risks from their failure to do so.

Prof. WALLACE: I am not aware of any of our hospitals being non-compliant with our orders. In fact our hospitals, again mindful of risks to both patients and staff, have put in place very appropriate measures around attestation, around check-in facilities for staff, visitors et cetera. I am not aware of our hospitals being non-compliant with our orders.

As for aged care facilities again, really for private through VACRC and for public through our own health service providers, where we were aware of a facility struggling we would reach out, usually through the local public health unit, because that is one of the key functions, to try and support them and ensure that they had clarity about what the pandemic orders meant for them, how to interpret them and how to apply them. Chair, it has always been one of seeking to provide them clarity, certainty and support so that they can do what they need to do, which is look after their residents and patients as best they can.

The CHAIR: Furloughing, of course, of hospital staff was a huge issue—and aged care, presumably—and being from Shepparton I am well aware of some of the impacts that that had on regional health services. I just wonder what the policies are around furloughing but also what level of support the department was able to give regional areas which may have been struggling at a particular point in time.

Prof. WALLACE: Yes, so there are three bits to that. It is a really important question, and what I might do is ask Ms Brady to talk to some of the furloughing exemptions and why we brought those in, and then maybe Mr Weimar might address some of the local responses that we put in place. Particularly I am thinking of work we did in your own electorate, Chair, in Shepparton but also in Mildura, because our regional cities can get overwhelmed very quickly, as you know. I think we learned a lot from the delta wave, and actually most of those lessons were from Shepparton and our outer western suburbs, Western Health and Goulburn Valley Health, where the impact on health services was not from infection per se in their hospitals but infections in their schools and their communities, which were knocking out nursing staff, medical staff, allied health staff, admin staff. We learned a lot in the delta wave, so when we saw what was coming in omicron, so since

15 December, when we saw what was coming in late December, we started modelling that and anticipating that somewhere between 10 and 20 per cent of the workforce could be knocked out by our furloughing rules. Again, remember that the furloughing rules were around trying to reduce infection transmission in some very high-risk environments, aged care and hospitals. So we began to anticipate from what was going on in South Africa and in London what this could mean for our critical healthcare workforces—aged care and hospitals—and did some modelling. Hence why we got to the furloughing exemptions. Nicole might take us through the furloughing exemptions as a specific response and then Jeroen might talk to how we supported particularly our regional cities that were getting overwhelmed by those staff knockouts.

Ms BRADY: Thanks so much, Euan. And yes, as Euan has referred to, based on that understanding of what was going to come, work was done to have a 'broad class furlough exemption' as it was called for healthcare workers. That was put up in January, which then meant that healthcare workers who were exposed people, which means that they lived with somebody who has COVID, providing that they let their employer know that they were intending to come to work despite the fact that they were living with someone who had COVID they were allowed to come to work with the agreement of both the worker and the employer with certain conditions based on them attending the workplace. So, for example, they needed to wear an N95 mask, they were not allowed to attend meal break areas and things like that that helped manage the risk while still providing that really critical provision of services. As we moved through January there were other critical workforces. As you would have known, there were problems with food supply and some of the other really critical infrastructure roles that we have across the state, so the role of the class furlough exemption was broadened to make sure that we were going to ameliorate against those other issues that we were facing as a state as a consequence of the omicron wave.

Prof. WALLACE: Chair, I think in about mid-January, 14 or 15 January, we had almost 6000 healthcare workers out of the system because they were either a case or a close contact, and at that time it was about 50-50. So about half of that 6000 were cases themselves and the other half were close contacts. Hence the response that the CHO and public health team came up with as a recommendation for a change to the orders for the minister. Actually very quickly then over the following week or so we saw that 6000 more than halve.

But in terms of the specific responses, clearly our regional cities, particularly those far away and on the border, Shep and Mildura, were enormously challenged.

Mr WEIMAR: Yes. Thank you, Euan. G'day, committee. Back in September on the back of really the delta wave picking up and on the back of the Shepparton incidents during August where we saw 10 to 15 per cent of the town essentially in isolation and quarantine because of exposures through the very large schools, that contact of contacts approach that got us so well through the bulk of last year and the previous year really found its limit at that point. So we established in early September the nine areas of operations modelled on our local public health unit areas—so six across regional Victoria, three in metro Victoria. The purpose of those teams—really they were based on the emergency management framework using well-established emergency management principles, working with local councils, emergency services and health services, including primary health—was to ensure we managed that relief and support effort: so ensuring that people could effectively isolate safely, that there was culturally appropriate provision being made in terms of the food relief and other relief that was necessary, and that was a real challenge in some of those early outbreaks we saw prior to September, but also we could start to manage and protect key public services and functions, so making sure the food supply chains continued to operate even with large numbers of people being forced into a quarantine-type environment, making sure emergency services could work and health services could work. So it was a really proactive approach in all the corners of the state and particularly important in Mildura, in Gippsland and in Wodonga, where we had significant rural and community outbreaks and real tensions not just in the general community but also in our Aboriginal communities, really ensuring we had that proactive approach to particularly more diverse and sensitive communities where we needed to ensure that their needs were being met.

That approach worked well through the back end of delta in September, October, the early part of November, and then as we saw omicron come in it really, really engaged again to really provide us with that surge capacity. I think it was critical to ensure that we kept councils engaged and communities engaged through that real peak of omicron in early January. It was a very anxious time. Nobody quite knew how this was going to play out, and as Euan said, the introduction of the critical worker quarantine exemption back in the first, second week of January provided that relief, that safe relief, to ensure that we could maintain those public services.

The CHAIR: Thank you. I had better stop at that, because I will be pulling up other members if they go over time. Ms Shing.

Ms SHING: I have no doubt that was probably a salutary warning to me, Chair; thank you very much for that. Thank you, everybody, for not just attending today but also for the work that you have been putting in as part of the recovery and response.

I would like to pick up on a number of things that the Chair has identified in her initial questions which go to perhaps, Professor Wallace, some of the things you talked about with the extension of the pandemic declaration tabled on 8 February and the way in which the risk profile has changed as a consequence of omicron and the sorts of measures that have been required to contain the virus to the best extent possible in line with that heightened risk profile on the one hand. And then I would like to take you to a principle which we have heard a lot in the context of not just delta but omicron, being the precautionary principle, and the way in which that operates.

One of the challenges that we have as a committee is to understand and to report on the way in which the response has been proportionate in relation to limitations on movement and other measures which have changed the way in which we live, work and connect on the one hand with the proportionality associated with maintenance of human rights, which is something that you have talked about, Professor Wallace. You have said it was always about balancing those two priorities. So I would like to understand how that fits in terms of the changed public health risk not just within the hospital system but also more broadly within aged care. Please feel free to open the floor to other witnesses. And I have got a couple more questions after that, so—I have not led by example—the pithier the better. Thank you.

Prof. WALLACE: Thanks, Ms Shing. This is when you wish you had brought your CHO with you. I said in my introductory comments that planning for early December at that time for the introduction of the pandemic orders was based on the experience of 2021 and most notably the delta wave. But in the early weeks of December we watched what was happening overseas, and it was just a matter of time before omicron was here. It was really just in the week or so before Christmas that omicron became apparent, and obviously the pandemic orders were already in place. So as it became clear that omicron was going to wash over us, as it had done in Europe and elsewhere in the world, we were asking really two questions, and as State Controller, Health, I was asking my public health team and my CHOs, 'What does this mean in terms of not just case numbers but also severity?' and 'How many hospital beds are we going to need? How many of these Victorians who get omicron do we expect to be admitted to hospital and do we expect to be admitted to our ICU and do we expect to be seriously sick?'.

So there are two bits to that in terms of the virus itself and the virus variant itself. One is its transmissibility. It was glaringly obvious from South Africa and from the UK and from Western Europe that this was a profoundly more transmissible variant than either the very first variants or delta. What was not so clear—and you might recall that South Africa quite early on was saying, 'This looks less severe'. Now, we were treating that with some caution because the population in South Africa that were getting infected at that time were significantly younger than the Victorian population who were infected, so the proportion distribution was markedly different. So we had to interpret those in light of 'Well, of course, if there are only younger Victorians getting it, then of course they're going to be less sick'. However, as it washed over Western Europe and then progressively over us it did appear that it was less severe—still significant, and I will come back to that in a moment because I do not want anyone to walk away thinking omicron is a fine virus to get, because it is not. But it was less severe, and we now know, having been through our significant wave in January and February, that it is about 15 per cent as severe as delta—so 85 per cent less severe. So we were asking our public health team and our CHOs to interrogate the information that was coming from overseas and interrogate both our experience and New South Wales's experience in lock step. It was obviously done through bodies like AHPPC around sharing experience across the jurisdictions, asking the question, 'How many beds do I have to plan for in the system? So how many infections? How many Victorians do I expect to get infected per day? How many hospitalisations?'. So again, we were planning for somewhere between 2500 and 4000, 4500 admissions.

Ms SHING: Was there modelling that supported that?

Prof. WALLACE: Yes. We have been working with the Burnet Institute here in town throughout the pandemic, and they have been providing regular modelling to us. We will pivot questions to them about what

the impact of omicron is on case numbers and on hospitalisations. And then obviously, as it became apparent that the severity of omicron was mitigated compared to delta, we would ask them to remodel. We would ask them, 'If we get differing uptake of vaccines in different bits of our population, what are the impacts? What are the impacts of masks? What are the impacts of restrictions?'. And so on and so forth, constantly. So our modelling was suggesting that we should be preparing for somewhere between 2500 and 4000, 4500 admissions and somewhere around 50 000 cases a day, which is where we got to—

Ms SHING: Do you mean 2500 to 4000 in toto or—

Prof. WALLACE: At any given time. So we needed beds for 2500 to 4000, 4500, and ICU admissions of somewhere between 300 and 500 were included in that number. So really that is what we were planning for.

The cadence of these meetings has changed across the whole pandemic, depending on what status we are in, but since December I have had three times a week State Controller, Health, meetings. They are broad meetings and they are first thing in the morning, and two of those are focused on the pandemic per se—the epidemiology, the outbreaks, where we are seeing particular surges in numbers or not, again, to help pivot C comm's actions, so the COVID response division, Mr Weimar's division's actions. And one of those three was focused on a deep dive on hospital systems and hospital capacity. All three meetings talked about how many new cases today, how many hospitalisations, how many staff we have got furloughed, how many aged care outbreaks we have, when our schools are open, how many cases we have in schools et cetera. But two of them were deep dives into the outbreak and one of them a deep dive into the system.

Actually that is what has really driven the accelerated use of COVID-positive pathways and hospital-in-the home pathways. The out-of-hospital care pathways, knowing that if we are going to get 50 000 cases a day then we are going to have a quarter of a million to 300 000 active cases at any given time—all of these people need access to health care. Where are they going to get the health care?

Ms SHING: I might invite you to wrap that point up just now if you can because I do want to ask about visitor context and settings for aged care and what that looks like.

Prof. WALLACE: I can wrap up there. Really, that planning and that interrogation of what was going on overseas and what was going on here was fundamental to anticipating what our needs were going to be. Ms Wainer, who is our head of public health, and Jodie—together their divisions built our COVID-positive pathways.

Ms SHING: So again, just to move from COVID-positive pathways through to prevention and through to the settings that applied as they changed on visitor rules and regulations within the aged care and hospital system. I would like to understand a little bit more around the importance of visitors and contact: how the reduction of the challenges that come for people without contact over prolonged periods of time was balanced against the prevention component on the one hand, risk management on the one hand, and human rights on the other, as far as connection is concerned—if there are any witnesses here who would like to quickly address that point.

The CHAIR: With about 1 minute to answer.

Ms SHING: Yes, quickly address that point.

Prof. WALLACE: Well, look, I can say that the human rights aspect and the possibility of causing harm were always considered by the CHO in the development of his advice to the minister.

Ms SHING: What do you mean by 'harm', just quickly?

Prof. WALLACE: Well, recognising that having visitor restrictions, whether at the hospitals or aged care, is harmful, because at a time of ill-health that is the very time that you want your loved ones around you, and if we have limited those numbers then it is going to have unintended consequences, so always mindful of that. There was—I mean, I think you can see it in the corrections of some of the orders—some very rapid pivoting around clarification, for example, for pregnant women to be allowed to have their partner there who is a case, who is a positive case. It was never an intent to prevent women being with their partners at a time of need when they are in hospital having their baby, so there were some very agile changes in response, acknowledging or

recognising that balance between human rights and also protecting other patients, staff and the community at large.

Ms SHING: Thanks, Professor Wallace. Thank you, everybody. Thanks, Chair.

The CHAIR: Thank you. Ms Crozier.

Ms CROZIER: Thank you, Chair, and good morning, everyone. Thank you very much for being before the committee this morning. Professor Wallace, you mentioned the pausing and cessation of elective surgery that started on 6 January and then obviously we went into the code brown on 19 January. We have heard from various witnesses throughout this committee about the elective surgery waitlist numbers, so as of the end of February what are the elective surgery waitlist numbers in Victoria?

Prof. WALLACE: The total number is about 80 000.

Ms CROZIER: 80 000. We have also heard evidence from various witnesses that there are outstanding category 1s that are not within the recommended time frames, so how many category 1s have not met the time frames of being able to be seen?

Prof. WALLACE: I do not have that number this morning, Ms Crozier, but I can certainly provide it to you. I mean, throughout the pandemic, as you know, our hospitals have strived to deliver category 1s, and really throughout December and January there were no breaches of category 1. The category 1 wait time, as you know, is 30 days, and there were no breaches. I mean, there has been the individual patient here or there, but in terms of big breaches of category 1s, that has not been a feature of the pandemic. But I will, on notice if I can, provide you with the number that are over time.

Ms CROZIER: Thank you. That is all right. So are you saying that the code brown had no impact, because 81 000 were on the elective surgery waitlist to the end of December 2021, and you are saying it is 80 000. But we have had a code brown. We know that surgery was suspended for five weeks through that code brown, so how have the numbers gone backwards?

Prof. WALLACE: No, the numbers have not gone backwards. Our elective surgery waiting list continues to grow, given the recent cessation. Maybe I will just separate the code brown from the elective surgery. So the elective surgery pause was a decision made, as you say, on 6 January. The code brown was more than that, so of course it was overseeing the elective surgery pause, but it was overseeing much more than that.

Ms CROZIER: I understand that, but the impacts to the elective surgery waitlist were significant for those five-odd weeks that the code brown was in place. So I am curious that we have gone backwards, if you are saying that the elective surgery numbers are 80 000 at the end of February, when we had the suspension from almost the end of those figures at the end of December. So my question is from the end of February.

Prof. WALLACE: Okay. I did say about 80 000, but Jodie might have the precise numbers.

Ms GEISSLER: I only have the late December numbers with me here today as well, but you are correct, they are around 81 000.

Ms CROZIER: Yes, but I find that stunning, because when I have asked this question of every health service, they have been able to provide to me those numbers that they have, and you are telling me you cannot tell the committee how many Victorians are on the elective surgery waitlist.

Prof. WALLACE: We will provide you that number.

Ms CROZIER: Thank you. Well, just before I do go to that, how long do you think in terms of months or possibly years will it take to get through those numbers?

Prof. WALLACE: Our elective surgery list, as you know, normally runs around 30 000, 35 000. To return to that will take a number of years.

Ms CROZIER: How many?

Prof. WALLACE: We have work underway to accelerate elective surgery, so it is going to take a lot of—

Ms CROZIER: One, two, five years?

Prof. WALLACE: I cannot give you a number this morning. It will be dependent on the effectiveness of the measures that we will now put in place, both short-term measures and medium and longer term measures. Our intent is to have no Victorians over time waiting for surgery—as soon as possible.

Ms CROZIER: I can say that there were 289 category 1s from Central Gippsland, from their evidence. So we would be very interested in getting that information, if you would not mind.

I am also interested in just asking you about some of the evidence that was provided by Dr Sutton. You have mentioned that they were matters for you. Dr Sutton in his evidence said that the suspension and resumption of elective surgery and IVF was your decision. But he also said the social licence and social considerations for the cap in crowds—but nobody has been able to tell this committee who was on the exemption panel to allow the tennis player Novak Djokovic to come into the state. I think it is important the public understand: was there a panel within the Department of Health or not?

Mr J BULL: Sorry, Chair, just a point of order. Is that in scope, Chair?

Ms CROZIER: Well, it is evidence.

The CHAIR: Just on the point of order, would you like to speak to the point of Mr Bull?

Ms CROZIER: No, I will move on. I am not going to have my time wasted. Again, I think it demonstrates the secrecy of this government and the unwillingness to say who was on that panel that made that decision. If I could go on to some of the issues you raised about planning, you spoke about cases, the furloughing of staff, but in answers to questions of this committee the department has provided you cannot provide to us how many staff have been stood down due to vaccine mandates. You say the department is unable to provide that information. So to go to the planning and understand when you are talking about whether it is within health, whether it is in the supply chain, surely the department must have that information.

Prof. WALLACE: Again, to understand our health system, as you know, the health services are the employing authority, and the responsibility for making decisions about the need to stand down staff for not meeting a vaccine requirement—two or three doses—is the responsibility of individual health services. We understand from our health services that very small numbers of staff have been stood down because of the two-dose mandate.

Ms CROZIER: Across the workforce, though?

Prof. WALLACE: Yes, across the whole state.

Ms CROZIER: Great. That is good to know—that you do actually have those numbers. If I could just go to some of the issues around the pathology testing, obviously there were 100 000 tests that were thrown out in early January, so the numbers of people that actually had omicron—but before I get to the pathology test question, if I may, what was the date that omicron arrived in Victoria?

Prof. WALLACE: We first started seeing omicron in very early December.

Ms CROZIER: That is what I think you told the committee in the briefing. Thank you—8 December, was that the correct date?

Prof. WALLACE: I would have to take that on notice. Jeroen, I do not know if you know the precise date with omicron?

Mr WEIMAR: I do not have it with me, but the first or second week of December.

Ms CROZIER: I think that is what you said. My point is: 1 December there were 74 000 that were being tested; 11 December, 84 000 Victorians were being tested; 22 December, 92 000 Victorians were being tested. Professor Sutton said the maximum test capacity in December was for 50 000, so well over those numbers were

being tested. What advice for the increasing testing capacity was given, and when did the ordering of rapid antigen tests kits actually happen?

Prof. WALLACE: I might ask Jeroen to talk about the rapid antigen tests. Again, it is important to understand the challenges facing our testing system, both public and private testing laboratories, at that time. Very large numbers of tests were being done, as you say—70 000-plus tests. And I should put on the public record the extraordinary effort that our laboratories have delivered this state over the course of the pandemic. So how the laboratories handled those tests when we had a test positivity rate of around 1 per cent—so back in October, November, early December we had very small numbers of PCR tests being done that were positive; 1, 2 per cent—was they would so-called bundle the tests. So they would run 10 samples at the same time, which meant they could get through 10 times the volume of samples. Once your test positivity rate starts to rise—and we have seen test positivity rates of around 20, 25 per cent—you can no longer bundle, because every bundle is positive. So they then have to do every test individually, which means in effect they are doing 10 times the number of tests for the same number of tests.

Ms CROZIER: The point is that Dr Sutton told the committee that it was 50 000; that was the capacity. So my question is: when we had these big numbers coming through in early December, the government had been told in late September, early October—well, the country was told—that rapid antigen test home kits would be available from 1 November. We have evidence from the committee—a letter from the CHO to the minister on 23 December. So when did the government order the rapid antigen test kits?

Mr WEIMAR: So to the rapid antigen testing kits, ATAGI made the decision on 1 November that authorised some rapid antigen test kits for at-home use. Before 1 November, uniquely here in Australia, we could not use rapid antigen tests for home use; they had to be used under medical supervision. We ordered relatively small numbers, hundreds of thousands of rapid antigen kits, during November and December for use within the healthcare system.

Ms CROZIER: How many?

Mr WEIMAR: Hundreds of thousands.

Ms CROZIER: How many hundreds? Is that 100 000, 200 000?

Mr WEIMAR: I can get you the exact number on notice, but relatively small numbers for use within the healthcare system. So we had stock of around 200 000, 300 000 during the early part of December. The significant order on rapid antigen test kits was made right before Christmas. On 24 December we made the first significant order—

Ms CROZIER: The 24th of December—Christmas Eve.

Mr WEIMAR: Correct—of a significant number of tests. We were the first—

Ms CROZIER: How many did you order on Christmas Eve?

Mr WEIMAR: The first order for around I believe 20 million tests was put in on 24 December.

Ms CROZIER: And when did they arrive?

Mr WEIMAR: They started arriving, from memory, from 7 or 8 January. They started to arrive—

Ms CROZIER: The whole 20 million arrived? Did they all arrive?

Mr WEIMAR: No, they arrived in batches. So we put orders in with a number of suppliers. And can I just say I would welcome a bit of time to answer the question, if you do not mind.

Ms CROZIER: It is all right. My time is running out, so I apologise.

Mr WEIMAR: I appreciate that. I am sure we can come back to it. So the important thing to notice here is that we were the first jurisdiction in Australia to order significant volumes of rapid antigen tests—number one. Secondly, we were the first to receive significant numbers coming in on 7 or 8 January.

Ms CROZIER: But it was too late, and 100 000 PCR tests were thrown out.

Prof. WALLACE: I think the other thing, Ms Crozier, is that because of the large numbers we had to pivot—

Ms CROZIER: It was Christmas time—Christmas time, 24 December.

Prof. WALLACE: the testing strategy. Yes, so we had a PCR-based—

Ms SHING: The commonwealth did not order until the middle of January.

Ms CROZIER: I will come back in my next time.

The CHAIR: Time is up. We will move to Mr Bull.

Mr J BULL: Thank you, Chair. Thank you, Secretary Wallace, Deputy Secretary and General Counsel Ms de Witts, COVID Commander Weimar, who has been a regular feature of our home viewing over the last couple of years, Deputy Secretary Brady and Deputy Secretary Geissler. Thank you very much for being here today, for presenting to the committee and particularly for all the work that you have done over this very tough and challenging time. It would also be appreciated if you could pass on our thanks to staff in your very big teams for all of the work that has been done and the impact that that has had on their families. So thank you.

Secretary, I did want to go to you if I can and ask: under the new pandemic management part of the *Public Health and Wellbeing Act*, the way in which those pandemic orders are made is different to what the arrangements were under previous arrangements, and you spoke about this a little earlier on. Can you summarise for the committee the process that is undertaken for the minister to consider and make those pandemic orders, please?

Prof. WALLACE: Yes, of course. Thank you. I will describe the process in sort of high-level terms, and if you want further details about the various steps then Ms Brady, I am sure, will be pleased to answer. So under the Act the first is that the minister seeks advice from the Chief Health Officer and then considers that advice along with advice and feedback from other stakeholders. And he would, if it was a decision relating to health system capacity—elective surgery, for example—seek my advice and the department's advice in my role as state controller for health. Based on the CHO advice, other stakeholder advice, other consultations that the minister is free to seek, he then instructs the department to draft pandemic orders, and the broader orders consist of the orders themselves, the minister's statement of reasons and then a record of the Chief Health Officer's advice or anyone else's advice. So if I was providing advice, as State Controller, Health, a record of that advice. And then those draft orders are considered against the charter of human rights, and Ms Brady maybe can fill us in on how that is done. And then once the minister has considered the draft orders, how they are balanced, you know, consideration of the charter of human rights, and the orders reflect his intent, then the order pack is signed and published. And that process is followed regardless of the urgency or the planned nature of the orders, and clearly stepping down of orders is usually done in a more planned manner than stepping up of orders that are in response to some urgent thing like the emergence of omicron.

Nicole, I do not know if you want to fill in any further details about that.

Ms BRADY: Yes, thanks very much, Secretary, and thank you. It also goes to the question that Ms Shing asked earlier, really, in regard to guiding principles that both the Chief Health Officer in the advice that is provided and the minister must use in his decision-making really, and they are really critical principles. They pick up on some of the questions previously. Evidence-based decision-making is one of them. The precautionary principle, so we do not wait for the best evidence if we do not have it as it emerges is another. Omicron was a really good example of that, because it was emerging very rapidly around the world. The precautionary principle, so being careful as opposed to taking dangerous action or waiting too long rather than being precautionary; and the primacy principle of prevention, accountability, and then proportionality and collaboration, those guide the way that the team works and the Chief Health Officer provides advice on the basis of. So in regard to the collaboration principle, that goes to when the public health team is working up advice very closely with the Chief Health Officer. We are collaborating and working really closely with other teams across the department who have those really key stakeholder relationships, and Jodie spoke about them earlier in regard to the work that her area does in relation to speaking to the chief executives of health services

across Victoria. As well, we work with other agencies and other departments to make sure that advice that is worked up does accord with those principles in working with the Chief Health Officer and providing advice to the minister.

Mr J BULL: Great. Thank you. So just in relation to that proportionality and the collaboration that you just touched on, can you just explain perhaps in more practical terms how those relationships occur, whether it be with hospital CEOs, industry, the workforce. Just step us through the process and how that might look.

Ms BRADY: Aged care visitors is a good example, just making sure that it is proportionate to the risk, and noting the burden that is borne by people in aged care and their families, so making sure that the ability of people to have the connections with their families is proportionate to risk. So we are balancing the risk to services and to staff and being able to manage, as CEOs have spoken to you about, not wanting to have outbreaks through their facilities, but being proportionate in regard to the final advice that has stood us in stead throughout December and January and February. For aged care that it is up to five visitors at a time, but we would recommend that people have a rapid antigen test before they attend. So that is proportionate to what services have advised us they can manage, but then it is also helping them to balance the risk. Clearly some of them have taken further steps, and we are working with them in regard to how we can continue on with that approach. And in regard to collaboration, as Euan referred to, we met very, very regularly with the commissioner for senior Victorians, and he then has become a very powerful, steady and clear advocate on behalf of agencies such as COTA and elderly Victorians, Dementia Australia, and just making sure that their voices are heard as recommendations are framed up for the Chief Health Officer to send through to the minister in advice. That is another example, really, of informing us about what is proportionate and collaborating to make sure that we have restrictions or orders that meet the needs of balancing the risk with also making sure that people can continue on to have the care of their loved ones at times of great stress, as we acknowledge January especially has been across Victoria.

Mr J BULL: Excellent. Thank you. It is fair to say that the nation, through states and territories, has been considerably tested over the past couple of years, particularly with variations across various restrictions in different states and different territories and each state and territory facing their own set of circumstances and the challenge that they present. I think here in Victoria we are acutely aware of that. Can you outline for the committee how the pandemic order process can support a move to a more nationally consistent approach, whether that be around mask rules, testing, isolation, visitor restrictions to facilities or the like?

Ms BRADY: I think if you reflect on that question and the situation we are in now, as we entered the latter part of last year, which also coincided with us moving to the new legal framework that we are working within, in the key states—and let us hold up Victoria and New South Wales—our risks became the same. We had previously been working in different situations with different risks, and so therefore, based on that as well as the new framework and following the leadership through national cabinet, there has been an ability to have a shared approach in regard to orders in terms of people speaking together at that level and then use the AHPPC and other meetings between the key states and between the key chief health officers and other leading members of the government in terms of working together to have alignment, because we know that that supports community understanding. Also you have to bear in mind what the impact has been on people living in the border communities and how that has been challenging for them, and we have heard that in terms of having different rules in different parts of the states as they interact with each other. So we are working as much as we can so that the settings remain as consistent as possible for those reasons.

Mr J BULL: The committee—done?

The CHAIR: Done. Well, 22 seconds.

Mr J BULL: Twenty-two seconds. That is fine; I will waive my right. Thank you again, and thanks, everyone, for all the work that you have done.

The CHAIR: Thank you, Mr Bull. And moving to Ms Kealy.

Ms KEALY: Thank you very much. Thank you for presenting today. I would like to ask about mental health data, in particular some data on the number of phone calls to Beyond Blue, Lifeline and Kids Helpline that was requested on notice, Professor Wallace, at the last hearing. And you said that was not available to you;

you could not provide it to the committee. Are you not providing that data internally as part of your routine reporting process any longer?

Prof. WALLACE: That data is held I think at a commonwealth level, because these are—

Ms KEALY: Professor, I realise that. My question was: do you still provide those reports at a state level to the minister and amongst your colleagues?

Prof. WALLACE: We do see cuts of those data internally, yes.

Ms KEALY: Why was that not provided to the committee?

Prof. WALLACE: Again, because we are not custodians of the data—

Ms KEALY: There is a lot of data that has been provided to date that has not been from the custodian. There has been a lot of commentary around the aged care sector, for example, which is sometimes dismissed as being a commonwealth issue and sometimes owned as a political football by the state. I would like to know: why wasn't that data provided to the committee?

Prof. WALLACE: The data is available to the committee through—

Ms KEALY: No, it was not. We asked for it, and it was not provided to the committee. I would like to remind you, Professor Wallace, that acts or omissions—

The CHAIR: Let us not badger the witness. Let us give him an opportunity to answer the question.

Prof. WALLACE: My department is not trying to be obstructive.

Ms KEALY: Can you then on notice—there are a number of questions that were put on notice the last time you provided evidence to this committee—please provide that evidence to the committee in a fulsome way, because otherwise it does appear that there is a cover-up and that there is a lack of transparency for the Victorian community in as much as it prevents the committee from doing their job.

The evidence that was provided to the committee was that emergency department presentations for those with mental health related symptoms have increased dramatically over the past 12 months. In fact we look at the increase in presentations: all ED presentations for mental health related matters have increased by 407 per cent to February last year, and a further 40.2 per cent—1856 people—presented in that rolling data to 21 January at our emergency departments because of mental health related issues. Do you concede that you got the balance wrong between looking after people's mental health and keeping them safe and controlling the spread of omicron?

Prof. WALLACE: No. There are two bits to the question. Did we consider and weigh up the potential mental health burden of social restrictions? Of course we did. Of course the CHO did during the time that the process was under his directions, and the minister of course under now the pandemic orders takes into consideration the CHO's advice in weighing up potential mental health impacts of restrictions. Apologies, because my computer has just died on me, but mental health presentations to ED are lower now than they were last year.

Ms KEALY: Well, that is not actually the data that we have received. The emergency department data that we have received from you has been there were 1856 presentations for mental health related reasons in the data up to 21 January this year. In February 2021 it was 1324, and in June 2020 it was 261. That is a massive increase, from 261 people in the early days of the pandemic to 1856. That data is further replicated through what we see through our kids, so youth presentations for mental health reasons. For zero- to 17-year-olds it was 34 people from June 2020, went up 438 per cent to February 2021 to 183, on a rolling four-week average, and to 21 January 2022, as provided by you, was 241. That is a further increase of 31.7 per cent. How can you say that this is anything short of complete negligence, or how would you describe it?

Prof. WALLACE: Well, it is certainly not negligence. Let me take you to the real numbers, so let me just walk through them. Since the pandemic orders came into place, week 1, as of 17 December, there were 2061 ED presentations that were mental health related. In the same week in 2021 it was 2219. In the same week

in 2019–20 it was 2259, so about 10 per cent lower in the week of 17 December last year, the first week of the pandemic orders. That is true compared to both 2020 and 2019. That is true for week 2; 1763 mental health ED-related—

Ms KEALY: Professor Wallace, if you can provide that on notice—

Prof. WALLACE: Please, you have thrown numbers of—

Ms KEALY: You have provided that data.

Ms CROZIER: So are we getting the wrong data?

Prof. WALLACE: No, we have provided the—

Mr J BULL: On a point of order, Chair, the Secretary has to be able to answer the question if the question continues to be thrown at the Secretary.

The CHAIR: I agree. The witness should not be badgered. He has been given the data, he is interpreting the data and he is giving an answer. You either want to hear it or you do not, so let him finish.

Ms KEALY: I am asking questions about the detail of the data.

Mr J BULL: It is a ruling from the Chair. The Chair has ruled.

Ms Ward interjected.

Ms KEALY: You will have your time, Member for Eltham; I am sure it will be riveting.

I am very concerned that the devastating impacts on mental health, particularly for our youth, have not been appropriately dealt with or prioritised by the government, and I would like to know, in your role heading up the Department of Health, what advice you have provided about concerns of the impact on the public health system that the orders were having on the mental health of Victorians, including our kids.

Prof. WALLACE: We have provided advice throughout, and I think you would recall from previous budgets, plural, that the government has invested heavily in mental health both in 2020–21 and this year specifically to address the anticipated impacts of COVID and social restrictions. I refer you to budget paper 3 for both 2020–21 and 2021–22; the mental health investments are there.

Ms KEALY: It is about the orders. The orders are the things that are causing the harm. It is not the budget—

Ms SHING: The pandemic causes harm, not the orders.

Ms KEALY: No, it is the orders causing the harm, and there is a lot of respected research that they are doing that.

The CHAIR: I would like to just bring you back to asking questions of the witness.

Members interjecting.

Ms KEALY: Can I please just hear the answers? It would be most helpful.

The CHAIR: I think you need to remember that we also have the minister coming and that there are certain questions suitable for Professor Wallace and probably some more well suited to the minister because they relate to government policy. But here we are dealing with the hospital and aged care facility orders. I think mental health is a genuine issue in relation to them, but try and stay on the issue. Professor Wallace was giving us some answers by going to the data.

Ms KEALY: I will move on. Thank you, Chair. Will the data make all health advice public in relation to the state government's COVID-19 orders as it relates to mental health considerations? So will the mental health advice please be provided in relation to how orders have been created?

Prof. WALLACE: All of the advice to inform the minister to make decisions about the pandemic orders is published, and I have described the process.

Ms KEALY: We have been told through this committee that the Chief Health Officer does not provide that mental health advice—that other areas do. That is not published, and so I ask for that information to be published.

Prof. WALLACE: Again, the advice that the minister uses to determine the pandemic orders is published.

Ms KEALY: We have heard in this committee that the Chief Health Officer does not provide the advice around the mental health elements of that and the impacts on mental health; we have heard that comes from other areas.

The CHAIR: I think if you are quoting other evidence that has been given, you should go to the source just to make sure that the witness is confident that you are referring to accurate evidence.

Ms KEALY: Well, perhaps I will go back and say that, if the witness is saying that there is no other input provided for the minister to provide mental health advice around pandemic orders, maybe that mental health advice is not available if it has not been published, because it is certainly not available—

Members interjecting.

Ms KEALY: Can we go back to pathology testing, please? Modelling in late December showed that there was an increased number of cases from 1 December. Professor Sutton has reported to this committee that the maximum testing protocol was 50 000 tests per day. You have given advice earlier that the department started to order tests for the public health system in November. Why weren't more tests ordered in November? Why did you wait until 24 December, when there had been a cascading backlog of pathology tests, which then resulted in 100 000 tests being thrown out in the first week of January?

Mr WEIMAR: Thank you for the question. Let me just put a few things out there. We were running at a cadence of 60 000 to 70 000 tests a day from September of last year and the turnaround time never fell below 90 per cent within the next day. So we have seen sustained high levels of PCR testing all the way through last year—as I said, 60 000 to 70 000 through September, October, November and into December. Between 6 December and 16 January we processed 3 million PCR tests—just under; 2.9 million—

Ms KEALY: Mr Weimar, if I can, I am referring—

The CHAIR: Just wait. You are over time. Just let the witness finish the question and we will move to the next committee member.

Mr WEIMAR: Thank you, Chair. So that is 70 000 tests a day processed and turned around to the public. We maintained a turnaround time of over 80 per cent coming in the next day until 21 December. That is when the backlog started to build for the reasons that the Secretary has given; I will not repeat that in the interests of time. Our turnaround time dropped to 18 per cent—the next-day turnaround time of course—on 7 January. Within two weeks we had recovered to 80 per cent. To the question around rapid antigen test ordering, we were the first jurisdiction in the country to order a high volume of rapid antigen tests, on 24 December. We had not decided to pivot towards rapid antigen testing until we saw the sheer impact of the scale of the numbers, partly because of the pooling issue and partly because of the high volume of tests we were being required to do for people going interstate. Thank you, Chair.

The CHAIR: Thank you, Mr Weimar. We will move now to Mr Erdogan.

Mr ERDOGAN: Thank you, Chair, and thank you to all our witnesses for coming in today. It has been an informative discussion so far. I want to actually turn to a bit of a discussion about vaccines because there is continued significant public interest around this issue. Obviously at the beginning of the pandemic it was presented as our ticket out of the pandemic—high rates of vaccination—and obviously the Victorian community responded. We have one of the highest vaccination rates globally, and the Victorian community came forward in record numbers. Can maybe the Secretary or Deputy Secretary just outline for the committee the likely impact of high vaccination rates, including third doses, on hospitalisation rates and how these projections have provided comfort in easing restrictions, such as on elective surgery and mask requirements?

Prof. WALLACE: Thank you. The underlying premise and the assumption is that as you increase vaccination rates across the population but particularly those most at risk of severe outcomes—so the people over 70, over 80 et cetera—you both reduce the transmission rates, so reduce the number of cases, and reduce the severity for those who still get infected. One of the key challenges of the wave that we have had since the pandemic orders came in has been omicron, because we have learned, both locally and overseas, that the omicron variant is subject to so-called 'vaccine escape' to a degree that the previous waves—delta and so on—were not. That is in part because the mRNA vaccines were based on previous variants. So the whole point about vaccinating the community, as it is for any infectious disease, is to protect them as an individual but also to reduce transmission risks and protect other individuals who either are not yet vaccinated or have inadequate vaccination. So, again, through our planning we have planned the potential impact of various vaccine uptake rates not on just cases but on hospitalisations, on ICU admits, and continue to adjust the measures that we have taken based on that planning. So again I go back: with omicron we were anticipating hospital admissions of 2500 to 4000–4500, ICU admits between 300 and 500, and as third-dose vaccinations then came on board and were particularly focused on older Victorians, we could then adjust some of that modelling.

So there are obviously some fundamental assumptions of 30 per cent uptake of third doses, 40 per cent, 50 per cent, 60 per cent and so on, and as we do that we can then project forward to say, 'Well, we're now on a trajectory', and as of today—and Jeroen will have the up-to-date figures—I think something like 70 per cent or 80 per cent of Victorians over 70 who are eligible have had a third dose. That has a profound impact on, 'Well, if you get omicron, how likely are you to fall really sick and require a hospital bed?'. And so as those vaccine numbers and coverage, particularly for third doses—it is really stressed for omicron; it is the third dose that is really critical—especially for older Victorians who, like myself, got AZ the first time round, so they got two doses of AZ and are now getting an mRNA vaccine, Pfizer or Moderna. So as that coverage increases, we can project, 'Actually, we think then the hospitalisation impact is going to be lower, so we can begin to then plan easings, not just social restrictions but easings on surgery'. As you know, as of this week there are no restrictions on elective surgery, and that is made possible not just by the actuals, those 250-odd Victorians in hospital today with COVID and about 30 in ICU, a small number—I think five or six—with active COVID and the residual recovering from COVID in ICU, but it is not just the absolute numbers today that allow us to ease restrictions on surgery. It is also the projected numbers that we think we are going to have out through March, April, May, given the anticipated coverage of third doses across the whole population but particularly those at risk.

Mr ERDOGAN: Thank you for that. That is very informative, but vaccine mandates still do remain an issue of public contention, and we have seen obviously they are in place now across all Australian jurisdictions, but globally it is still an issue that is discussed in the United States, in Canada, across Europe, so it is still very topical and still important. Can you just outline for the committee what consultation the department undertook before putting in place third-dose vaccination requirements for workers in healthcare settings and also in other care settings as well?

Prof. WALLACE: Yes, thank you. It is useful, I think, just to stand back for a second. So Australia at large and Victoria especially have among the highest whole-of-population vaccination rates in the world. Now, we did not get there by accident. We got there by a very purposeful, strategic, coordinated vaccine program led by Jeroen Weimar and Naomi Bromley in the vaccine program here in Victoria. And the other stand-out thing about the Victorian vaccine program is—and the commonwealth have done this and reported across all jurisdictions—when you look at measures of equity. So if you take SEIFA codes and vaccine uptake, it is completely flat in Victoria. It does not matter who you are or where you live, the uptake of vaccines in your community is the same as everybody else, and we have driven very hard in our disability communities and our First Nations communities to ensure that we have got maximum uptake. It is really important, because they are among the most vulnerable communities. In terms of then extending the vaccine mandate from two to three doses for key workforces, you asked about healthcare workforces and aged care workforces—

Mr ERDOGAN: Yes, particularly healthcare—

Prof. WALLACE: Yes. So why did we do that? We did that because of course the patient and the resident have no choice about who looks after them, and again hospital inpatients and aged care residents are among the most vulnerable in our community to fall sick and die from COVID. It was about ensuring that who was looking after them protected themselves and reduced transmission.

What engagement did we have? We had deep engagement with our health services—our CEOs, our COOs, with our CRAFT group leaders, with all of our unions—and actually pretty much universally everyone said extending from two to three doses was critical, and they were supportive. I think of all industries, of course, they can see the data; they can see the vaccine escape from omicron for two doses and the profound impact of three doses. So there was overwhelming support for extending the mandate. That is not to say it is not challenging. It is challenging for the workforces, particularly as very large numbers of healthcare workers themselves got omicron in December, January and February and so they had to recover from omicron before they could have the third dose a month later or so. So deep engagement—and, look, it has been throughout. I think the department has been so grateful to the healthcare industry, employers and key stakeholders and unions, for their engagement, for their wise counsel and for their advice about how to do things and how to ensure that their representative workforces are kept safe. So, yes, deep engagement with the industry broadly and pretty much universal support for extension to a third dose.

Mr ERDOGAN: Thank you. Our Chair in her earlier question—one of the first questions—was talking about how many of the care providers have taken a more restrictive approach or have been risk averse, broadly speaking. When considering measures to put in place the minister is required to look at the least restrictive measures before considering more restrictive options, broadly speaking, especially in relation to vaccines. Can you talk through what less restrictive measures were considered by the public health team before recommending these third-dose requirements be put in place?

Prof. WALLACE: Absolutely. Throughout the pandemic I think the key character of what were CHO directions and now are ministerial pandemic orders is just that approach: balancing the measures against human rights and always seeking—always seeking—the least restrictive option. In terms of vaccine mandates it is about engagement, it is about education, it is about consultation and discussion about 'What other things could we put in place?'. Now, remember, both in aged and in health care—hospital staff—this is a workforce that for two years now has been pretty much in full PPE. As a surgeon in a past life who wore a surgical mask for 8 hours a day, I cannot imagine how it must be for our healthcare workers, and particularly aged care workers, who are so not used to masking up and putting on visors and full PPE—just how hard it must be to work in all of that gear for this time in very challenging conditions. Again, by maximising vaccine uptake by reducing community transmission, by reducing in-hospital transmission and by changing how our staff have worked—we heard earlier about tearooms and so on—by ensuring that staff at risk are not putting other staff at risk, those are sort of the less restrictive measures. But I think we have to acknowledge that none of these measures have been unrestrictive. Our healthcare workforce has done an extraordinary job—

The CHAIR: Professor, I will have to get you to wind up.

Prof. WALLACE: Sorry. Yes. Fundamentally it is about consultation, it is about education, it is about explanation about why we think these measures are important or other things that can be done, and then consideration of 'Well, actually this is the need to go to a third-dose mandate'.

The CHAIR: Thank you. And thank you, Mr Erdogan.

Mr ERDOGAN: Thank you, Chair.

The CHAIR: In the absence of Mr Wells, I will go back to Ms Crozier.

Ms CROZIER: Thank you very much, Chair. If I can just again pick up from where Ms Kealy spoke about the important issue around mental health. So far we have had 372 pages tabled in the Parliament on the pandemic orders. There have been 10 mentions of mental health, none relating to the mental health impact of orders. Do you still stand by your advice to the committee that all mental health advice has been published?

Prof. WALLACE: All advice provided to the minister on which he bases a decision regarding pandemic orders is published. That is a requirement under the Act.

Ms CROZIER: Okay. Thank you.

Ms BRADY: Could I add for you, though, if you go to the minister's statement of reasons from 15 December, it talks about who he consulted with under the principle of collaboration, and there is a list of a

number—I am just scrolling to find it now. But certainly the chief psychiatrist and a number of senior psychiatric leaders across Victoria were consulted by him as part of that first wave.

Ms CROZIER: If we could have that.

Ms BRADY: It is published. It is on the pandemic orders register.

Ms CROZIER: Thank you, Ms Brady. Could I just go to again the issue—I mean it is in relation to some of the questions we asked and the response we have received. The number of calls that were answered by Beyond Blue's COVID-19 telephone counselling service, the number of visits to Beyond Blue's COVID-19 website et cetera—but the response through the department via you, Professor Wallace, is reporting on crisis and support helpline services, including Beyond Blue, Lifeline and Kids Helpline is a matter for the commonwealth government not state and territory governments. However, it is the Victorian Agency for Health Information, with the Victorian state government's logo on it, that actually has these reporting figures, and that is why—Beyond Blue telephone counselling services, there is reference to it—we are asking about this important issue around the advice you are receiving, the advice that is being made public and the actual data and figures, because what we are being given and told is not actually what appears to be in the public domain all the time. So whether that has changed and if that weekly reporting is not done, then I think Victorians would want to know why that reporting is not done—if that is the case. But I make that point because these are important issues, and I think we need to have some clarity around that initial question that Ms Kealy asked around mental health. If I could also just go to—

Ms SHING: Was that a question?

Ms CROZIER: Well, no. It was just making that point about the advice that was coming through based on what I had said, Ms Shing.

If I could go again to the issue around rapid antigen testing, does the department have an estimate on how many positive/negative RAT results were not reported to the department from Victorians and therefore the potential numbers of COVID that were possibly within the community?

Prof. WALLACE: No, we do not. So we do not have visibility, of course. Because it is an end-user test we do not have visibility of the so-called denominator. We know how many tests we have distributed, and we know how many positive results have been reported in. And of course our engagement with the community at large is all about, 'Please report, because it then triggers a COVID-positive pathway and care for you. So we don't want you sitting with a positive test and not telling everyone—and because there's care provided'. But just by the nature of the end-user test we do not have the denominator. I think Jeroen wants to—

Ms CROZIER: In terms of the data you were getting from the spread and the collection of where it was and obviously the nature of the virus and how it was moving—and because of the 100 000 PCRs that were discarded—there were possibly many more cases than were publicly reported. Is that fair to say?

Mr WEIMAR: Look, I think what we would say is we were the first jurisdiction in Australia to open up rapid antigen test positive result reporting on 8 January. We ordered 52 million rapid antigen tests by 23 December, if I can correct the record from my earlier evidence. I think the availability and access we provided, of testing, and the sheer volume of testing that has been going on since the beginning of January through the rapid antigen testing platform that we introduced—are there likely to have been people who did not avail themselves of that? Absolutely. We have always seen through the entire pandemic a proportion of the community who do not come forward for testing. That is why we push it so hard.

Ms CROZIER: But you do not really have a clue of the totals. That is okay. I will move on. Thank you.

Mr WEIMAR: No, we have no access to that. Beyond the survey data that we do, we do not have any—

Ms CROZIER: Yes. Thank you very much. So, Professor Wallace, was it your advice to government to stop IVF treatments?

Prof. WALLACE: As part of the elective surgery cessation on 6 January, yes.

Ms CROZIER: And your advice to resume the IVF treatments?

Prof. WALLACE: Yes.

Ms CROZIER: You know this issue very well.

Prof. WALLACE: I do.

Ms CROZIER: You know, it is your background. You understand that cessation of treatments for women at this critical time is vital, and yet there was, soon after the public outcry from tens of thousands of women across the state, that reversal. So why was that? Was it a mistake in the first place to put IVF into that elective surgery suspension?

Prof. WALLACE: No. There is two bits to it. One is: clearly the need to suspend non-urgent elective surgery was really important. We have been through that evidence already about creating the capacity in the system to respond to what we thought was going to be 50 000 cases a day—

Ms CROZIER: But the IVF clinics were not—

Prof. WALLACE: Well, I will come to that. So, remember that on 6 January when non-urgent elective surgery—and I know there has been lots of commentary around the use of 'elective surgery' as if it is a choice; it is not a choice, it is just the phrase that we use—women who had already commenced their cycle continued through the cycle, so there was no interruption for existing egg stimulation cycles already underway. And typically, as you know, with those cycles there would be women who would be somewhere within a two- to three-week window of that cycle for ovulation induction and egg retrieval. We then had engagement with the sector to say, 'Look, the intent of the elective surgery'—and the elective surgery cessation on 6 January was essentially the same approach that we took last year and a bit before—actually the resources that you free up from—

Ms CROZIER: So were those resources that were freed up used in the public health system? And to go to my next question—I am sorry to butt in—because I think it is really important—

Ms Shing interjected.

Ms CROZIER: Well, I have got as much as I probably need, but you have just said the resources being used in the system. How many were used? When I have asked the likes of Professor Way this question, they were not moved across to the Alfred, so how many staff from the private system actually worked within the public health system?

Prof. WALLACE: So, specifically to the IVF, I think we responded very agilely. The sector said to us—

Ms CROZIER: Well, I had clinicians just screaming at me, saying, 'Do something!'.

Prof. WALLACE: So again, the sector said to us, 'Look, the nurses that we have in our IVF clinics are not nurses that are going to your ICU and ED', so we responded, and we restarted I think on 25 January. So the number of women whose—no women's existing cycles were interrupted. There will have been women—and we are not deaf; we hear the angst that it causes, we know the angst it causes. There are a lot of clinicians in the department; we understand that.

Ms CROZIER: Were there any staff that were moved?

Prof. WALLACE: I do not have precise numbers for that. But I can say that somewhere around 80 000 public patients have been cared for in the private sector across the pandemic because of the surgical orders.

Ms CROZIER: I understand that. What I want to know is how many staff from the private system as we have heard from evidence in this committee that none came across. So I want to understand how many. I know patients were shipped out into the private system; that is a different question. Were any staff from the private system utilised outside of vaccination or testing?

Ms GEISSLER: Yes. There were in aged care

Ms CROZIER: How many?

Ms GEISSLER: From 2020 they covered about 3000 shifts.

Ms CROZIER: No, I just want in the recent—

Ms GEISSLER: Yes, so from 1 October 2021—

Ms CROZIER: No, the recent—from the code brown.

Ms GEISSLER: I would have to come back to you with that data, other data.

Ms CROZIER: Thank you—you have got that data. Can I go to Ms de Witts, if I may, but it might be a question also for you, Ms Geissler. With regard to the use of the critical instrument procurement policy as a result of implementing pandemic orders over the past three months, how many times has the CIP policy been used by the health department?

Ms de WITTS: Ms Crozier, I would have to take that on notice. I am not the chief procurement officer, but we can come back.

Ms CROZIER: Okay, if you could, and if we could have a list of those procurement contracts. Thank you very much.

The CHAIR: Thank you, Ms Crozier. We will go now to Ms Ward, who is on Zoom.

Ms WARD: I am. Thank you. And apologies for coming in a little bit late and being on Zoom; I had something in my community this morning. Firstly, I want to thank you all for all the work that you have done over the last few years, and I want you to know that an overwhelming part of our community is very grateful for and respectful of the work that you have done. I can only imagine how exhausted you all are and how difficult it has been for you and how difficult it has been for your families because so much of your life has been caught up with managing this pandemic as best you can. I want to thank you for that.

We have heard earlier this week from witnesses who were talking through the challenges and the effects of the visitor restrictions that both hospitals and care facilities have experienced, and I had this myself with my own family. My mother-in-law had motor neurone and passed away at the Austin. It was very difficult not being able to get to see her, but towards the end of her life we were able to, and I am very grateful for the care that the hospital gave to her because it was exceptional. A key theme that emerged from the evidence that we heard was the way that the health services and care facilities have chosen to apply the restrictions. So can you please talk us through why it has been important or why it is needed to enable local facilities to make decisions based on their communities, based on what is happening around them, when it comes to visitors in hospital and care facilities?

Prof. WALLACE: Thank you. I think, as we discussed earlier, the pandemic orders themselves lay a foundation piece based on evidence and advice from the CHO about a number of measures, in this case visitor restrictions, so what is the intent of visitor restrictions? Why would you consider them? And what is the potential negative impact—we have discussed this in another context—particularly on the mental health of residents? So the broad backdrop is around these restrictions are reasonable and appropriate, and they have changed across the pandemic for obvious reasons, because the pandemic itself has changed. The intent is to have as consistent and clear directions or orders as possible for the sector, and we are very mindful that the directions and then orders have changed a lot, necessarily, in response to a very rapidly changing pandemic. So there is uniformity across the sector.

Ordinarily we have got staff working in multiple facilities, so all the more important. Now, one of the key features of the pandemic has been a restriction on that over time that has now been changed really so that we have reduced risks of staff taking infection from one facility to another. But the overarching principle is about having a balanced set of orders, restrictions, that have a very precise intent. You know, why would you restrict numbers of visitors to aged care facilities to five? Why would you want them to be vaccinated? Why would you want them to have a RAT et cetera? It is all about reducing risks of infection to the residents. Now, again, the local situation varies enormously between facilities, and I think it is right and proper that facilities themselves say, 'Well, for these reasons we may add to the orders'. So not lesser than the orders but, 'We may

add to the orders'. Where we become aware of that, then through our aged care team or through our local public health units, our Deputy CHOs, we would reach out to the facility—and we have done this many, many times—to understand what is it about your environment, your staff, your infrastructure, your residents that you have taken a slightly more restrictive approach than the orders, and then work with them. And sometimes it is very understandable or appropriate and in others they say, 'Oh, I understand that now' and they will relax. And whether it is an aged care facility, whether it is a hospital, I think it is really important to acknowledge and respect the autonomy of the facility to recognise that it understands its own situation, but where it would appear on first inspection that a facility is being more restrictive than they need be, we would reach out and have conversations, discuss their intent and other less restrictive means of getting there.

Ms WARD: Thank you. So what support and what advice has the department given to local services to help them understand the orders and how they can work with them?

Prof. WALLACE: Aged care facilities or health services, or both?

Ms WARD: Both.

Prof. WALLACE: Both. So the health services, obviously we are having very regular meetings with health services. There is a dedicated meeting for chief operating officers. Through the peak of the pandemic, this latter wave, that has been happening daily. We have a so-called streaming meeting, so a meeting with our streaming sites, so our hospitals that have been identified as streaming sites. We have a regular meeting with those and with our health service partnerships, so the overarching partnership for a region, the three here in the city and then our five regional partnerships. Then we have a CEO bulletin, so we have a bulletin that goes out when orders change—the orders themselves go out, but then an interpretation, a Q and A and a summary and a plain language statement goes out to health services in a manner that health service can either share directly—

Ms WARD: I am glad to hear about the plain language.

Prof. WALLACE: Yes. They can either share it with their staff directly or they can reformat it with their own organisational header et cetera. So it is a deep engagement with health services. Public health care facilities—many, not all but most—are caught up as part of those communication channels because of course they are governed by a health service. Then for private health services principally the communication channels are through the Victorian Aged Care Response Centre, VACRC, that we share with the commonwealth. There are highly effective communication channels through VACRC working with private aged care facilities, and from time to time, particularly where there is an outbreak or where there is a particular problem, the local public health unit, the PHU, who is responsible for helping manage outbreaks regionally and locally, would reach in to a facility to share information. It may well be that they need our infection control team to visit et cetera, et cetera. In the same way the PHUs have been reaching into schools and local industries, meatworks et cetera, really trying to work in partnership with whichever bit of the sector it is to understand what their needs are and provide them.

Ms WARD: Thank you. Chair, have I got much more time?

The CHAIR: You have got a minute.

Ms WARD: Okay. Thank you. Just quickly then, hospital visitations have changed since the new pandemic orders came in in December and they have continued to be refined. Can you please quickly talk us through them and how the hospitals are managing those?

Prof. WALLACE: Yes. I will do. I might just ask Ms Brady to do that for us as very quickly.

Ms BRADY: Sure. Happy to. I think in essence the key thing to know is that since 15 December when the first orders came in there has been a maximum of two visitors per patient in hospital, but when we began on 15 December—noting we were coming out of the delta wave—there were permitted purposes, which really means that the most vulnerable and at-need patients were still able to have someone visit them to provide care and support; for example, for their physical and emotional wellbeing. There are other reasons, such as children were allowed to have their parents, someone who had a mental illness or dementia was able to have a visitor to support them, interpreters and other key supports that were permitted the entire time.

Those clauses remain within the directions—or the orders as they are called now—at the moment. We actually had a really good meeting yesterday that I referred to previously with the commissioner for senior Victorians about how we can build some of those essential visitor provisions into things such as our outbreak management guidelines so that if a hospital, or really this applies mostly to an aged care facility, is needing to close down due to having an outbreak we can still make sure that there is an ability for these essential visitors to attend. So we are working through those, and it goes to that principle of collaboration we were talking about before just to make sure that the support is provided where it is most needed.

Ms WARD: That is great to hear. Thank you very much.

The CHAIR: Thank you. Just one final question on the human rights issue: we heard from a regional health service that when a disgruntled, unhappy family member is unable to visit in the circumstance they may like to, an executive doctor and nurse within the system would look at that and make a decision. Is there anything beyond that—a process within the department—that an individual can go to to have a decision at that level reviewed, or is it something that they might take to the Ombudsman, for instance?

Prof. WALLACE: They might take it to the health complaints commissioner if it was about a hospital and a specific complaint about a health service. We do have a function within Safer Care Victoria, a patient complaints facility. It is a small facility but a capacity, a capability, a function to deal with direct patient complaints that have not navigated to the health complaints commissioner per se. Again, Chair, we have confidence in the executives in our hospitals to make the right decisions. Pre pandemic they were making, as you know, very difficult decisions almost on a daily basis about all sorts of family needs and trying to meet those. In closing I would say I would hope that if a health service was struggling with a particular issue that they would reach out to us, and they certainly have done that. The team, whether it is the CHO or public health or indeed Jodie's division, have worked with health services on all sorts of issues that they have been struggling with. I guess if a family have tried to escalate something internally with a health service and the health service executives have made decisions that have not met the needs of the family, the next course of action probably would be the health complaints commissioner.

The CHAIR: Thank you. Thank you all very much for attending today and giving evidence. It is much appreciated, and I know you have all gone to extraordinary lengths over the last couple of years to do the work you do. We are all very grateful for that, and we are also mindful of the fact that we have got 100 to 200 Victorians a week dying in Victoria and that unfortunately we are not out of it all yet.

But thank you for your contributions today. I will just say that you will receive a copy of the transcript of the hearing within the next week to review, including a list of questions may have been put to you on notice.

Witnesses withdrew.