REPORT ON PROCEEDINGS BEFORE

PUBLIC ACCOUNTABILITY COMMITTEE

NSW GOVERNMENT'S MANAGEMENT OF THE COVID-19 PANDEMIC

CORRECTED

Virtual hearing via videoconference on Thursday 30 September 2021

The Committee met at 2:00.

PRESENT

Mr David Shoebridge (Chair)

Ms Cate Faehrmann

The Hon. Scott Farlow

The Hon. John Graham

The Hon. Courtney Houssos

The Hon. Trevor Khan

The Hon. Peter Poulos

The Hon. Penny Sharpe

The CHAIR: Welcome to the virtual hearing of the Public Accountability Committee's inquiry into the New South Wales Government's handling of the COVID-19 pandemic. Before I commence I would like to acknowledge the Gadigal people, who are the traditional owners of the land upon which the Parliament sits. I pay our collective respects to the Elders past, present and emerging, and pay those respects to any First Nations peoples participating in the hearing and also joining us through the webcast.

Today's hearing is, again, to be a fully virtual hearing, which enables the work of the Committee to continue during the COVID-19 pandemic without compromising the health and safety of witnesses, members and staff. I would ask for everyone's patience if we have any glitches or difficulties with the technology. If participants do lose their connection, please rejoin by the link that was sent to you by the secretariat. Today's hearing will continue the Committee's focus on the New South Wales Government's plan and roadmap out of lockdown. We will hear evidence from the Chief Health Officer, Dr Kerry Chant; Ms Susan Pearce, the controller of the State Health Emergency Operator; and Dr Nigel Lyons, the Deputy Secretary of Health System Strategy and Planning for NSW Health.

Before we commence, I would like to make some brief comments about today's hearing. While parliamentary privilege applies to what is said in the hearing, it does not apply to comments that are made outside of the hearing. I ask members and witnesses to bear that in mind. Committee hearings are not intended as a platform to provide adverse reflections on individuals. I ask all participants to stick to the issues, rather than the personalities. All witnesses have a right to procedural fairness. It is a matter this Committee takes seriously, and it is also consistent with the resolution of the House. If any witness feels they cannot answer a question, but would benefit from having access to other documents to assist, they are entitled to take a question on notice and provide a response within 21 days. Of course, it is of great assistance to the Committee if information can be given during the course of the hearing. Today's proceedings are being broadcast live by the Parliament's website and a recording will be uploaded to the Parliament's YouTube channel. As always, a professional written transcript will be provided by Hansard.

I have a few notes, if I could, on virtual hearing etiquette. I ask committee members to identify who questions are directed to and that everybody—witnesses and members—to state their name when they begin speaking. Members should also use the raise hand function if they wish to take a point of order, and can everybody please refrain from speaking over each other, if at all possible. I remind witnesses and members that before you speak it is always preferable to take yourself off mute and it is preferable to place yourself on mute at the end of a contribution as well. Also to assist Hansard, may I remind members and witnesses wherever possible to speak directly into the microphone.

KERRY CHANT, Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Health, on former oath

SUSAN PEARCE, Controller, State Health Emergency Operations Centre, NSW Health, on former oath

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning, NSW Health, on former oath

The CHAIR: I formally welcome all three of our witnesses. Thank you very much for attending today. Thank you also for the countless hours you have been devoting to the people of New South Wales in your work within NSW Health. I am sure I speak on behalf of the entire Committee when we pass on our collective gratitude to all of the employees in NSW Health—the people working the administration, the nurses, the doctors and the other attendants at our hospitals and in the health service. We owe you a great debt of gratitude and we are deeply thankful for the work you do. There is now an opportunity for any of the three witnesses, if you wish, to make a brief opening statement.

Ms PEARCE: No, thank you, Mr Shoebridge.

Dr LYONS: No, thanks, Mr Shoebridge.

The CHAIR: With that, I will hand over to the Opposition to commence questioning.

The Hon. PENNY SHARPE: Thank you. My question is to Dr Chant. We are looking at 70 per cent double vaccination around Monday 11 October—a day that we are all very much looking forward to. Can I just ask you, in terms of the 80 per cent double dose, are you projecting that to be on or around 25 October?

Dr CHANT: Obviously there are multiple factors that will influence when we get to that 80 per cent, but we are looking that the 80 per cent second dose will occur very shortly, probably within two weeks of us reaching the 70 per cent threshold, and maybe even sooner. We have been very pleased with the incredible response of the community.

The Hon. PENNY SHARPE: Thank you for that. My questions really just go to, I suppose, where the Doherty modelling is at between the 70 per cent and 80 per cent and what that is going to mean in practice around test, trace and isolate. Are you going to revise what a close contact is and when will that occur?

Dr CHANT: We are currently formulating what test, trace and isolate looks like at 70 per cent and 80 per cent. I would like to assure the community that the work that we have put in place during this period will translate to the approach we will take. Some of the ways in which we will scale contact tracing are that the community can expect to get an SMS text message when they are positive and then there will be advice provided. We will be assessing people's high-risk exposure during that time and a lot of the detail about how that might work differently. The key elements of contact tracing in terms of the prioritisation of household contacts, complex settings and high-risk settings will continue to be a feature. We have taken significant steps to automate and use technology wisely as we prepare for a setting where we will see higher case burden, but potentially a time when we have not got the same impacts on the health system because of the vaccinations. We are expecting cases in vaccinated individuals, but we are expecting them to be less severe because of the effects of the vaccine.

The Hon. PENNY SHARPE: Does that mean, in practical terms, that if someone comes in contact with a case and they are considered a close contact, they would be treated differently if they were vaccinated or unvaccinated?

Dr CHANT: We are looking currently at the evidence around the risk of transmission. Clearly, the vaccination status of both the person with COVID and the person that they are exposed to will all be influenced by that. Some of the evidence is evolving. But, certainly, your risk of acquiring COVID is very greatly reduced if you have been fully vaccinated.

The Hon. PENNY SHARPE: Just to be clear, I am particularly interested in the difference in those two weeks between 70 per cent and 80 per cent, but I am also interested in post-80 per cent. When the pubs are opening up and someone comes into contact with a positive case within a pub, will their isolation requirements be different if they are vaccinated or unvaccinated? Is that something that is being contemplated?

Dr CHANT: We are working through these issues now. I think it is important to understand the other controls that are in place at the time when we get to 70 per cent. At 70 per cent, workers in a hotel or a café, as your example, will be fully vaccinated. They will be wearing masks at all times, alcohol will be served in seated arrangements and people will be seated. There will be strict COVID safety plans and there will be bookings limited to a smaller number of booking size. All of this means that your chances of coming into contact with someone who is COVID-positive as you eat a meal at a café will be greatly reduced and your risk of transmitting it will be

greatly reduced as well because all of the people—apart from children of vaccinated adults in those settings—will be protected significantly through being vaccinated.

The Hon. PENNY SHARPE: Thank you for that. I understand all of those things; they are obviously the public health orders and social distancing measures. I am really asking about what the impact is on people around the biggest impact on their lives, which is whether they have to isolate or not and whether there is likely to be a difference in terms of—leaving aside whether they are a close contact or not, whether there are going to be differential isolating requirements for people whether they are vaccinated or unvaccinated.

Dr CHANT: We are currently finalising that advice to Government, but I can say that vaccination status—the fact that people are wearing masks and the fact that people have got other controls, like COVID safety plans, reduces your chance of being a close contact because if you have not come in contact with someone within that [disorder]—

The Hon. PENNY SHARPE: I understand that and I appreciate—

Dr CHANT: We are currently providing that advice to government. We are currently drawing the best available evidence to support an appropriate way for contact tracing both at 70 per cent and 80 per cent and contemplating beyond that as well.

The Hon. PENNY SHARPE: Sure. But, just to be clear, are you contemplating different isolation requirements for people whether they are vaccinated or unvaccinated? It is a very specific question.

Dr CHANT: We are open to the evidence factoring in the likelihood of you acquiring the infection being differential if you are vaccinated or not vaccinated and factoring that into our considerations. Currently those considerations are going to government. I can strongly support the fact that if you are vaccinated and you have received your two doses and you are two weeks to three weeks past that time, you have significantly reduced your risk of acquiring the infection.

The Hon. PENNY SHARPE: I will turn to the contact tracing now. The contact tracing is essentially going to be far more automated. Is that correct?

Dr CHANT: We have taken this opportunity as we have had to, to some extent, learn and modify. We are going to be focusing very much on high risk areas. We see the household as particularly high risk and so we will have a strong focus on making sure that household contacts are aware and that they are appropriately quarantining and that they are tested. We have also learnt a lot about workplaces and we are working with industry on a range of measures in workplaces, including things like rapid antigen testing. We have also provided advice to industry around things like tearooms and other sites where transmission is occurring to really reduce the risk of transmission in workplaces.

We will continue to refine our guidance about what risks exist in workplaces and how to minimise those and what actions to take. Every workplace is different and the risk of transmission in different workplaces is different. We have acquired a lot of that information and are working proactively with industry. We have done a lot of work with construction and a lot of work with supermarkets to understand the nature of that risk. I should say that we are learning that a lot of the transmission risks actually is not necessarily public-facing risk; it is risk more around the workplace and work colleagues and the fact that people tend to let their guard down when they are in settings like tearooms or social settings and interactions. We will have to keep on reinforcing that as we make this transition, but they have been some of the key learnings for us.

The Hon. PENNY SHARPE: I suspect you are going to have to take this on notice, but I am interested in how many contact tracing staff there are currently, how many there were at the peak and how many you are expecting to have post-11 October.

Dr CHANT: Could I just say, a lot. But I will take that on notice in terms of giving you the numbers. I think it is important to say that we are also ensuring that—we are very pleased that currently, you know, when we are texting messages out to people and we have got embedded questions, it is pleasing to see that about 40 per cent to 50 per cent of respondents are using that technology. We are also looking at questionnaires that will facilitate our scale-up. Through this period contact tracing has not been fixed; we have had to evolve contact tracing and learn what it looks like at scale using technology. We are grateful to the community who have worked with us. There have been some bumpy bits. I am not saying it has all been perfect; it has been far from that at some points. But what has been important is we are bedding the system down for that higher case load in the context of a highly vaccinated population.

The Hon. PENNY SHARPE: How does that work with the QR codes? The Government has basically indicated that the QR codes are going to be voluntary from December. I assume they have been extremely important, having had to have a test myself as a result of being in a shop where they obviously picked up someone

with a case. How comfortable are you with the change in the arrangements around the QR codes and contact tracing and your ability to let people know when they have been in contact with a case as we open up?

Dr CHANT: Progressively, as we come to have COVID as an endemic disease, part of what we have to recognise is that the threat always exists. There will be a little bit more individual responsibility in assessing your own comfort level in certain environments. I think that we are still looking at how the QR code system is there and I think that will be discovered in due course. I think one of the things to say is the roadmap has been the roadmap, but obviously we continue to learn as we have done through the pandemic. I am very reluctant to say one thing or the other about the QR codes. They have been very useful and we will continue to look at how we will use them at 70 per cent and 80 per cent and then we will keep an open mind as we progress through that period.

The Hon. JOHN GRAHAM: Dr Chant, you have given us a date for 70 per cent and a rough date for 80 per cent, and you have indicated that you would like to see vaccination go above 90. I thought your comments on that were really encouraging for the community. When do you expect we will reach 90 per cent?

Dr CHANT: I have seen some projections. Again this is very rubbery, as all things. But I would be really very keen that—we believe we will get first dose 90 per cent by the end of next week.

The Hon. JOHN GRAHAM: And second dose 90 per cent?

Dr CHANT: The second dose 90 per cent should follow within a period of four to five weeks or six weeks after that, given the interval. Most people have an interval of three weeks for the Pfizer, four weeks for the Moderna, and if anyone has received AstraZeneca our guidance is somewhere between four to six weeks. So rapidly, once you get that first dose into people you then get the second dose. Whilst I am pleased we get to 90 per cent I do not want to stop there, as you have indicated. I think I want to see it go above 92, 93 per cent double dose. Can I just add how pleased I am with the uptake in the 12- to 15-year-olds. We have got around 50 per cent of 12- to 15-year-olds that have had one dose of the vaccine. I am anticipating that again will convert to at least 50 per cent double dose in three to four weeks' time, given the interval and that they will both be getting Pfizer and Moderna. I am confident that rate of growth in the 12- to 15-year-olds has been growing quite significantly every day. Again I am very optimistic that we will have incredibly high coverage in that age group as well.

The Hon. JOHN GRAHAM: As my colleague was asking, Minister Dominello has been very upfront that once we hit that 90 per cent he would like to see the QR codes, the check-in, turned off. What is the exact date that is envisaged for that? Is it as we hit December or as we hit 90 per cent, which might be just slightly after that 1 December date?

Dr CHANT: My understanding is that Government has made the decision, which is clear on the road map, that we are doing 70 per cent, some more slight easing at 80 per cent and then we hold to watch the effect. I am very pleased about that because we do need a long enough period to see any effect on numbers. And during that time I am hoping that immunisation rates continue to climb and that we have taken the opportunity to continue the intensive work that is going on to make sure that there is no disparity of vaccination in homeless people, social housing recipients [disorder].

The Hon. JOHN GRAHAM: No, exactly.

Dr CHANT: For me, my understanding is that we are not going to be changing anything until we get to 1 December. We are having the 70 per cent, the 80 per cent and then the road map says we hold things until 1 December.

The Hon. JOHN GRAHAM: So when Minister Dominello said that—switching off the check-ins—that is really his view; that is yet to be agreed?

Dr CHANT: I could not comment on—I am sorry, I just am not familiar with Minister Dominello's statement, the context, how that was used. As I said, my understanding is that we have got 70 per cent, the 80 per cent and then we are reasonably holding our settings constant for a long enough period so that we really understand that impact. I think that is incredibly important. The other message to the community is to try and lift our immunisation coverage even further during that period.

The Hon. JOHN GRAHAM: Just staying on that theme for one final question: If those codes go off, though, it is a real change to the way we have contact tracing in New South Wales, isn't it? Are you comfortable with losing that capacity out of the health system if we shift to that voluntary approach? That would be a very different environment.

Dr CHANT: I really cannot comment on Minister Dominello's comments, then. But I think suffice to say that we will need to evolve what we do as COVID becomes more commonplace and as immunisation becomes high and assess the utility of all our actions and the steps we take. As I said, there are a range of other controls such as mask wearing and distancing, and so I think this is going to be a continual process for us to reassess and look at what things we need to have in place at certain points in time.

The Hon. JOHN GRAHAM: You referred to vulnerable communities and we are seeing some of those pressures at the moment. Indigenous vaccination rates are still very, very low. There is clearly some Federal responsibility here, although there is some crossover. But it is New South Wales that is making the decision to open up and, as the Premier says, to let cases go through the roof. Are you comfortable that when that happens the Indigenous communities of New South Wales, in the city or in the bush, will be safe

Dr CHANT: There are a couple of things that I would like to comment on and I think it is important that this is understood. When we get to the opening date, which is projected to be 11 October and the 70 per cent double dose—at that time many regional communities will have stricter settings than they have currently got. So the only people that will be permitted to be working in hotels or cafes or hairdressers will be vaccinated staff. The only clients that will be able to attend those premises is vaccinated clients. That will be in existence. There may be areas of the State that are currently open to everyone. At that point it is clear that when we switch over to that 11 October, those settings that apply will apply across the State.

The Hon. JOHN GRAHAM: Yes, understood. Although some of those things will start to relax as we get 80 per cent.

Dr CHANT: No, the requirement about vaccination generally stays in.

The Hon. JOHN GRAHAM: Yes, I understand.

Dr CHANT: I would like to say—

The Hon. JOHN GRAHAM: My point is vaccination has been so important to our strategy. These communities are not vaccinated. How concerned are you about that as cases rise?

Dr CHANT: I would just like to say that I am very keen that our Indigenous communities have the highest possible protection. For me it is essential that they see vaccination uniformly above 90 per cent in those communities. I would just like to acknowledge and ask Susan Pearce to provide the Committee with some examples of the intensive work that is being done to rapidly ensure that Aboriginal people and Indigenous communities have the highest vaccination coverage possible.

Ms PEARCE: Thanks, Dr Chant. Mr Graham, the Aboriginal vaccination rates are also high on our agenda, so thank you for asking that question. What we are doing, as Dr Chant has said, is putting a lot of intensive effort into getting vaccination to our Aboriginal communities, both in the city and in the bush, and working very closely with the Commonwealth Government in doing so, as well as primary care providers. What is pleasing—still not good enough for us and we have got some really significant stretch targets around this—is that over the last month 13 of our 15 local health districts have seen an increase in first dose rates in their Aboriginal populations of 20 percentage points or more and six of the 15 local health districts have seen an increase of 25 percentage points, all in the last four weeks. So New South Wales is, as I said, very focused on this. Out of the large States we are leading the Aboriginal vaccination rates in the country, second only to the Australian Capital Territory.

The Hon. JOHN GRAHAM: I might just ask, then, could you tell us this—

The CHAIR: Sorry, John, the Opposition round has expired.

The Hon. JOHN GRAHAM: Very good.

The CHAIR: We just might let Ms Pearce finish, and then will hand over to Ms Faehrmann. Had you finished your response?

Ms PEARCE: Yes, thank you.

Ms CATE FAEHRMANN: Dr Chant, what advice are you providing to cancer patients and other immunocompromised patients, as well as people living with a disability, about what to do come 1 December?

Dr CHANT: I will answer that question in a slightly—start off with the fact that I am aware that the Australian Technical Advisory Group on Immunisation [ATAGI] issued a statement to indicate that they were looking at the recommendations in relation to booster doses for their patients that are severely immunocompromised. I believe that ATAGI has that under active consideration and that updated advice will be released. It would not be a surprise that they may well recommend booster shots to those very immunocompromised, and that would clearly fit into patients that were actively undergoing chemotherapy or

patients who had kidney transplants or other transplants, as an example. We would obviously work as a health system to support our GPs and others in implementing those recommendations very promptly, as soon as the recommendations are made by ATAGI. All through this we have followed the ATAGI advice.

In terms of the advice in December, I will be hoping that there would be clarity, that they would have followed any updated advice—that transplant patients or any more vulnerable members of our community would follow any advice of ATAGI in relation to additional protection that needed to be achieved through vaccination. I think it is always important that individuals speak to their doctors about their particular circumstance. If they are highly immunocompromised at a particular point in time the doctors may give them specific advice about things to avoid, but that would apply to avoiding busy, crowded settings or settings that might place them at risk of other infectious diseases as well. So I really would support people that are in the position of being significantly immunocompromised to always discuss that with their doctors. I am hoping that ATAGI will give clarity in relation to booster doses for those that might be in that particular severely immunocompromised area.

Ms CATE FAEHRMANN: I am glad you clarified around booster doses as well because that was going to be one of my next questions. There are other things to consider, aren't there—not just booster doses for those people? Of course some of them cannot get vaccinated as well. Also, did you take their situation into consideration when the advice was given in relation to removing the requirement for people to wear masks indoors?

Dr CHANT: I think it is important to say that the road map outlines a way forward. At every point I think I have been clear that mask wearing is a good protection indoors. There may be specific advice that we give to specific groups about mask wearing if case numbers are high or there are other situations; we obviously continually revise. December is a long way away and I think throughout this we need to be flexible, pragmatic. I would want to say that individuals that are in situations that are at higher risk—we will certainly ensure that there is advice that is tailored to them when that situation arises as well.

Ms CATE FAEHRMANN: Dr Chant, do you support the lifting of the provision around indoor mask wearing on 1 December?

Dr CHANT: I think I would hold my advice depending on what case numbers are or what we are seeing and what we have seen is the pattern of transmission. At those points we will see what transmission is like, what the impact is occurring and provide advice to individuals about how to mitigate and what is appropriate for the circumstances.

Ms CATE FAEHRMANN: You are suggesting that depending on where case numbers are, advice may change from 1 December in relation to indoor mask wearing?

Dr CHANT: I think the point I am trying to make is that for certain individuals we always say that—and I think we will continue to do that—once COVID is endemic with us we will continue to say that everyone has to act in accordance with being at risk. Even if people are vaccinated we know that age in itself is a significant risk factor regardless of vaccination status, even though they are very effective vaccines. We will be empowering individuals with information which goes into the fact that these are the steps that you can take to minimise your risk. Partly that will be individual. At times, if case numbers are very high in particular settings or we are seeing transmission, we will issue public health advice around those settings. It is important to understand that everyone, particularly vulnerable people, people who are immunocompromised and people who are elderly, can still experience quite severe disease even if they are vaccinated, although vaccines are very effective. It will be important that everyone takes individual decisions as well about the settings that they are choosing to interact with depending on the level of COVID transmission in the community, as they would with the level of influenza transmission in the community and other infectious diseases in the community.

Ms CATE FAEHRMANN: I have had quite a few people contact me, very concerned about the removal of the requirement to wear masks indoors from 1 December—people, for example, who live in apartments who are immunocompromised. They, of course, may need to get into lifts with people who are unvaccinated and who are not wearing masks. Dr Chant, don't you think it is too soon to remove the requirement entirely for people to wear masks indoors on 1 December? What would you say to people like that who are really expressing quite a bit of concern and fear about what it means to them to be circulating in their place of residence, in their apartment block, and trying to move around with people who are not wearing masks, on 1 December: What do you say to those people?

Dr CHANT: I would just have to say that we assess the situation on 1 December. Although we are looking forward and the road map is 1 December we will assess—in providing that public health advice I will always look to the areas, the level of infection, the risk and we will provide advice. Some of it may be public health orders and some of it may be in advisories. I will continue to monitor the situation as we go forward. What I would suggest, if people are genuinely concerned about their situation they need to, as I said, engage in advice

about boosters. But also there is ways that we can encourage communities, and stratas and others, to encourage mask wearing in indoor settings depending on what situation we find ourselves in at that time. I am just saying that the mask wearing is being laid out as a road map, but nothing is set in concrete in terms of my public health advice until we get to the situation of 1 December. It is a long way off and we need to give a clear outline but I may still be saying the most appropriate thing to protect yourself is to wear a mask.

Ms CATE FAEHRMANN: I just wanted to turn to a slightly different area. This is around mental health wards and rehab wards being closed down in particular hospitals to make way for temporary COVID wards. There has been a particular incident raised with me in relation to the closure of the mental health rehab ward at Prince of Wales Hospital in Wollongong. Some of the patients there were sent to other places such as, for example, a men's refuge. What is happening to those patients and do you have any idea when the mental health rehab ward will be reinstated at the Prince of Wales?

Ms PEARCE: Sorry, Ms Faehrmann. Go ahead, Dr Lyons.

Dr LYONS: I might take that question, Ms Faehrmann. There have been from time to time changes to the service profile of many of our services, including mental health. There have been changes to the configuration of our facilities to enable the appropriate care of COVID patients in a range of different environments. We have had some challenges in mental health with the incursion of the COVID virus into inpatient settings; and we have had those at a couple of sites, as you are probably aware. There have been assessments made across all of our mental health facilities about how to make them safer for clients who are admitted or cared for in those services, as well as for the staff, while we work through these transition periods. There have been some changes made to some of those services to make them able to separate if there is a COVID patient in the service, that there is enough space to create safe zones for the patients who are not positive as well.

That has led to changes in the configuration in a range of different services that we offer. Those changes will only be in place while they are required to be in place to ensure that we can deliver care in a way that is safe for everybody. As soon as we get to a point where the community transmission of COVID or the vaccination rates are at a level that enables us to reconfigure our services, we will do that to make sure that there is less impact on those who have had the service changes apply to them. This has happened in a range of different settings: in outpatients, it has happened in relation to some of our aged-care facilities, and it has happened in a number of cases where we have had to make service changes to reflect the need to deliver care differently. We will only do that where it is required to be done for the amount of time that we need to, and then we will reinstate those services to the usual configuration.

The CHAIR: Thanks, Dr Lyons. Dr Chant, three days ago the Premier, the Deputy Premier and the health Minister issued a joint release that said from 1 December further changes will be introduced, including all the venues moving to the two square metre rule; masks will not be required indoors at offices; indoor pools and nightclubs can reopen; and unvaccinated people will have greater freedoms. Is it your understanding that that is subject to a review of how things progress up to 1 December—that it is subject to the progression of COVID in the community?

Dr CHANT: I cannot speak on behalf of the Government. I would like to say that in a pandemic we are drawing upon the best evidence. We know the vaccines are highly effective, we understand and review the Doherty modelling, we are looking at international experience and we would understand that having very high vaccine coverage—in the order of 90-plus double dose, and that would cover 12-pluses as well—will afford us a great deal of protection. But I think the Premier—all I could say is that we will continually review how we are tracking and what disease burden we are seeing. We continually provide updated advice. We can draw on all of that international experience, our understanding of vaccine effectiveness and the modelling, but ultimately we need to see how we progress over these times. And that is why I am very pleased that we have got a period of stability between that 80 per cent and 1 December to really see what impact those changes that we have made at 70 and 80 per cent have, and to see where we are going into December.

The CHAIR: Dr Chant, there is no reference to any qualification from the Premier or any review of the data; it is an unqualified statement from the Premier and the Deputy Premier and others. Do you support that unqualified statement that those restrictions were left on 1 December? That is really what I am asking you.

Dr CHANT: I cannot speak for the Government. I think you have seen that every time during the pandemic we have had to respond to changing and new information. I am very confident, from everything I have reviewed internationally, that achieving high vaccination coverage and ensuring that we have that equally distributed across all socio-economic groups and we have targeted our vulnerable communities, that will afford us the greatest protection. We will need still to modify the way we go about things. We will still need to isolate when we have got disease. We will still need to be taking some preventative public health measures at that point,

clearly. And I think that for me I will be looking closely week to week on how the situation unfolds, and what else we can learn internationally in informing government.

The CHAIR: Dr Chant, you would know that a number of regional communities have very real concerns because of the relatively scarce public health resources, particularly intensive care units. You would be aware of those concerns in regional New South Wales in particular?

Dr CHANT: I am clearly cognisant of the challenges that regional communities have. But I would also defer to my colleagues to describe the fact that we have a very integrated system, and a system that supports escalation of care where people need it through a very sophisticated system. Ms Pearce, do you want to address those issues?

Ms PEARCE: [Disorder].

The CHAIR: No, I do not require any further detail on that right now. Dr Lyons, maybe if you are on mute if you are not speaking, as we seem to be getting a bit of feedback.

Dr LYONS: I am on mute.

The CHAIR: Excellent. Dr Chant, is it envisaged that there will continue to be movement restrictions into parts of regional New South Wales until those parts of regional New South Wales themselves have sufficient vaccination rates—either 70 per cent or 80 per cent—or are you looking at statewide changes, looking at the average across the State, particularly when it comes to regional travel?

Dr CHANT: In terms of the regional travel, visitors to regions are not going to be permitted until 80 per cent. Then I will defer to Ms Pearce, who can talk about the efforts that have been put in regionally to achieve those high coverage rates uniformly across our regions, which is a correct point you make. It is important that we get that uniformity of coverage.

The CHAIR: Before we go to Ms Pearce, Dr Chant, when you say 80 per cent [audio malfunction]. I am sorry, can you hear me again? That was an unusual glitch on my Surface Pro. I am sorry. Dr Chant, when you say 80 per cent, do you mean 80 per cent in each LGA across regional New South Wales or do you mean 80 per cent on average across the State?

Dr CHANT: The Government road map is related to 80 per cent double dose across the State. It has been pleasing to see that whilst greater metropolitan Sydney has a slightly higher vaccination coverage, the regions are catching up very quickly with increased access to both Pfizer and Moderna, and some of our regional communities have some of the highest vaccination coverage that we have got. Obviously some of the second dose coverage lags but that should pick up quite quickly over coming weeks. Also, visitors to the regions have to be vaccinated; unvaccinated people cannot travel to the regions.

The CHAIR: Dr Chant, it is not much comfort to somebody, say, in Bourke if they have double dose vaccination rates at 60 per cent, if there is a statewide average of 80 per cent. How is that going to protect people, for example, in Bourke if there is such a disparity?

Ms PEARCE: Mr Shoebridge, I am happy to comment with respect to rural vaccination rates because it is something that we have been heavily invested in and very focused on. The last data that we have, rural and regional LHDs—this is as at the end of last week—are currently at 82.2 per cent first dose compared to metropolitan areas of 84.7. There is a 2.5 per cent difference in the first dose rates. They are catching up very quickly with respect to that and in fact, as Dr Chant has said, we see some parts of regional New South Wales with first dose rates above 90 per cent. There has been a significant amount of work that has gone into places like Bourke and Brewarrina et cetera, who have seen exceptional increases in their vaccination rates. And noting that we have been administering Pfizer in those communities, for which we provided increased supply, we will see that convert to second doses quite quickly because they have a three-week time interval. The rural vaccination rates—in fact, presently there are only four LGAs currently below a 70 per cent first dose rate, with two of them in the high sixties, and all of those have got intensive efforts going into them. The rural vaccination rates and any suggestion that they are being left behind is not correct.

The CHAIR: Ms Lyons, I am not asking about averages, because an average does not protect somebody if they are in a local government area which has a lower than average rate. I am asking again: Is it envisaged that there will be unlimited travel to regional New South Wales for vaccinated people, including into LGAs that have double dose vaccination rates of less than 80 per cent? Is that the policy?

Ms PEARCE: Just for the record, Mr Shoebridge, my surname is Pearce.

The CHAIR: Sorry, Ms Pearce.

Ms PEARCE: That is quite alright. I appreciate what you are saying with respect to LGA data and we understand that. What we do is we look at postcode data. We dig beneath the LGA level so that we are focused very heavily on not just dealing with that but really throwing our effort and energy into ensuring that any town who requires the intensive efforts—noting that we are not the only people vaccinating in New South Wales. Our Commonwealth partners are out there, the pharmacists, the GPs, the Royal Flying Doctor Service, and we have had support from the Australian Defence Force, which is why New South Wales has the highest vaccination rate of any large State in Australia. We are very, very focused on regional New South Wales and I think Dr Chant can respond to the question in terms of travel, but she has already noted that the vaccinated nature of people travelling into regional New South Wales is obviously on our agenda, and by the time that changes I would expect to see the rural areas of our State have a very high vaccination rate indeed.

The CHAIR: What is the current double dose vaccination rate for Aboriginal and Torres Strait Islander people in New South Wales?

Ms PEARCE: I will just have a look for that. I just might say, while I am looking for that, the Aboriginal communities—again it is not just in rural New South Wales but right across the State—are an area of increased and ongoing focus for us, with the Commonwealth. So at the moment there are about 60 per cent first dose for our Aboriginal population. As I noted earlier, Mr Shoebridge, in the last four weeks—

The CHAIR: Ms Lyons, my question was just a data point. It was what is the current double dose rate for Aboriginal and Torres Strait Islander people in New South Wales?

Ms PEARCE: It is sitting around 40 per cent.

The CHAIR: And how does that compare with the State average?

Ms PEARCE: I will have to look for that, Mr Shoebridge. I do not have it right in front of me.

The CHAIR: [Disorder] Dr Chant, across the State the double dose rate is above 62 per cent?

Dr CHANT: The double dose rate across—

Ms PEARCE: It is around 62 per cent.

The CHAIR: I am going to ask a final question in this round. Dr Chant, given such a proportion of Aboriginal and Torres Strait Islander people live in the regions of New South Wales, with such a disparity on double dose rates, is it your health advice that there can be unrestricted travel to those regions—particularly regions with high proportions of Aboriginal and Torres Strait Islander people who are unvaccinated people—once there is a State average of 80 per cent double dose? Is that your public health advice?

Dr CHANT: The protections that are in place at that point are that only vaccinated people can travel. We will look at all the circumstances involved, remembering at that time as well that the only people in venues such as gyms, pubs and clubs, cafes et cetera will be vaccinated people. I think it is clear that there is a priority for Aboriginal communities, and we are very keen to work on Aboriginal communities. But as you also understand, Mr Shoebridge, the Aboriginal communities are very connected and there is still a lot of movement usually around households because of the close connectivity within Aboriginal communities. What we have seen emerge is really the movement of people within the Aboriginal communities as well that we really need to address, from a public health perspective.

We need to work in partnership with those communities. We need to work in partnership with our Aboriginal community control and in partnership with our primary health networks to ensure that everyone has access to the vaccine. Also concerns that we should support those communities—there has been also some misinformation in some of those communities and so we need to redouble our efforts to ensure that everyone is afforded the opportunity and we really support and work in partnership with the communities to get them vaccinated. We are strongly aware that we need to put in a range of public health measures, including working with those communities, to prevent incursions into the Aboriginal communities.

The CHAIR: Thank you, Dr Chant. I will hand back to the Opposition. I am sorry, Ms Pearce, for misidentifying you. I truly did not mean a discourtesy and I apologise. Dr Chant and Ms Pearce, could you please commence your answers by putting your name on the record to assist Hansard: "Ms Pearce here" or "Dr Chant here" at the commencement of your answers. I hand over to the Opposition.

The Hon. COURTNEY HOUSSOS: Thank you, Mr Chair. Dr Chant, today is the last day for health workers to receive their first vaccination [inaudible] requirements kick in. What is the figure as at today's date of health workers who remain unvaccinated?

Ms PEARCE: Ms Pearce here. I am sorry; we just had a little bit of trouble hearing you then.

The Hon. COURTNEY HOUSSOS: Sorry. Can you hear me now?

Ms PEARCE: That is a bit better, yes.

The Hon. COURTNEY HOUSSOS: Today is the last day for health workers to be vaccinated as part of the mandatory requirement. What is the figure as at today's date of healthcare workers who are unvaccinated?

Ms PEARCE: It is just over 2½ per cent.

The Hon. COURTNEY HOUSSOS: And how many actual workers is that?

Ms PEARCE: I would have to take that on notice, Ms Houssos.

The Hon. COURTNEY HOUSSOS: Are you able to provide any information about a breakdown of where those workers are—geographically where they are?

Ms PEARCE: Ms Pearce here. Again, we would have to take that on notice. I do not have that information in front of me at the moment.

The Hon. COURTNEY HOUSSOS: What planning have you done to ensure that those 2.5 per cent of positions are able to be filled going forward?

Ms PEARCE: There has been extensive work done by my colleagues in Workforce here at the ministry to work with all of our local health districts to understand any areas of impact. We believe that at present the impact will be minimal and the discussions with our local health districts are ongoing, obviously to ensure that any risk associated with that is managed.

The Hon. COURTNEY HOUSSOS: Are you able to provide us with any general insights about where specifically you are looking at those gaps?

Ms PEARCE: Again, I am sorry, Ms Houssos; I will have to take that one on notice.

The Hon. COURTNEY HOUSSOS: Is it correct that all of those workers will be stood down as of this evening if they have not been vaccinated?

Ms PEARCE: Look, there are a range of options in place. Obviously, unpaid leave is certainly factored into this issue. The system is looking and reviewing appropriate applications for leave—paid leave, that is, if people have entitlements. But, again, they have to be appropriate and not used in a way to avoid this situation. I think that it goes without saying that clearly this is an issue that the system takes very seriously. There are a range of other vaccinations that are mandatory in our system and have been for many, many years. I think that on balance this is the right thing for our health system, which is why the decision has been taken.

The Hon. COURTNEY HOUSSOS: Perhaps you can provide on notice how many applications for paid and unpaid leave have been received at this stage and how many have been approved?

Ms PEARCE: Thank you.

The Hon. COURTNEY HOUSSOS: That is a pretty significant jump. We have seen 3 per cent since Tuesday. What specific efforts have been involved to increase that level of vaccination?

Ms PEARCE: As you would be aware, since the commencement of the vaccination rollout healthcare workers—not just our own healthcare workers in NSW Health but, indeed, any healthcare worker in New South Wales, and from quite early on in the vaccine rollout, has been welcomed to NSW Health clinics. We have made vaccination for our staff as easy as humanly possible, which is why we have got a rate of over 97.3 per cent of a very large workforce vaccinated. So that result is pleasing. Our message to our workforce, of course, is that it is never too late. Please come forward and get vaccinated, along with your colleagues that have done so in such large numbers. Our job is to look after our workers and on this occasion that includes offering them vaccination. It is a very important measure for their own safety, as well as the safety of those around them.

The Hon. COURTNEY HOUSSOS: Do you have figures on how many teachers will be vaccinated on 18 October?

Ms PEARCE: No, I do not. However, we certainly have again welcomed teachers into the NSW Health vaccination centres. You would be aware with our initial LGAs of concern we did some very specific work for teachers in those LGAs, but I do not know the figure. That would be a question perhaps for the Department of Education.

The Hon. COURTNEY HOUSSOS: So you are not tracking those figures?

The CHAIR: Ms Houssos, I am sorry to interrupt. Ms Pearce and Dr Chant, I have had another request from Hansard: If you could commence your answers by saying "Ms Pearce" or "Dr Chant", it would really assist them. I know that it is somewhat iterative but it would assist Hansard.

Ms PEARCE: Certainly.

The Hon. COURTNEY HOUSSOS: Ms Pearce, you are not collating that data? That is the Department of Education that is collating that data?

Ms PEARCE: Dr Chant has something to add there, Ms Houssos.

Dr CHANT: [Inaudible] the Department of Education is monitoring that situation closely because it does link to their return-to-school plans and the requirement around only vaccinated teachers being present at the return to school.

The Hon. COURTNEY HOUSSOS: Dr Chant, in terms of the requirement, when students do return to school on 18 November what will the requirements be for schools to close and isolate if there is a case at a school?

Dr CHANT: We are currently working through an updated incident action plan. As you are probably aware, schools have been operational throughout for those students that cannot be cared for otherwise or schooled from home, because of either essential workers or for other reasons. We have been responding to cases in schools throughout. I think some of the factors that will change our approach has been the rapid and pleasing uptake in our 12- to 15-year-olds. I was reviewing some of the data today by local government area and it is just amazing that some of our regional communities—there was one community, I think, that had 129 of their 133 12- to 15-year-olds vaccinated. Obviously that school that those students attend will be in a very different position than if you have a very low vaccine coverage.

At the moment we are working through what our approach to high school is. But we see high school as very different because we have had such fantastic vaccine uptake. We know that our year 11s, our 16 and overs, have also got a high vaccine coverage. We are just working on our incident action plans for both high schools and primary schools, and there will be a different approach, noting the differential benefit of vaccination. I should also say that the vaccination status of the community more broadly is also likely to be taken into account, because clearly the risks are much lower if you have very high parent population. We would be encouraging anyone—we are encouraging everyone, but it is particularly important that parents and grandparents around children are vaccinated, because that will reduce the risk. Most children are actually infected through the adults they come in contact with.

The Hon. COURTNEY HOUSSOS: Dr Chant, do your comments mean, then, that there may be different approaches in different schools? If there is an area where there is a case at a school with a lower vaccination rate in the broader community, there might be different requirements on them to close or for people to isolate than if there was a school that had a case in a higher vaccinated community?

Dr CHANT: All I am saying is at the moment we are working through to finalise our protocols. Clearly, I think you have seen—and to be perfectly frank, it surprised me—that we got to 50.5 per cent of our children 12 to 15 have been vaccinated. That is a pretty outstanding result. We still have many weeks before school is open. That is one dose but they will get their second dose quite quickly. We will just be factoring some of those factors into account because it may be that you have got everyone in a classroom totally vaccinated. We will also be taking into account the application of COVID-safe plans. Education has very clear plans around mask wearing, using outdoor spaces, segregating classes, and all of that will be have to be factored into our assessment of whether you fall into a close contact or what your risk is. It is just a new piece of the puzzle that we will have to put in place and consider how vaccination has changed the risk to people. We know that these young people will respond generally very well to the vaccination and after two doses are likely to be highly protected.

The Hon. COURTNEY HOUSSOS: Dr Chant, what is the latest data, then, on the rates of transmission, given that there are going to be so many unvaccinated children in primary schools? What is the latest information on transmission in vaccinated versus unvaccinated people?

Dr CHANT: The issue is that we have got some data—and I probably can just provide that to you on notice in answer to the question. Clearly vaccination—I am just trying to quote the latest—it does vary by vaccine so probably I need to subset it by AstraZeneca, Pfizer and Moderna. But all of the vaccines have a significant effect in stopping transmission by both stopping symptomatic disease and potentially less likely to spread if you have a breakthrough infection. I am probably best to collate that for you, so that I do not make any inaccuracies with that. But that is the mechanism [disorder].

The CHAIR: Dr Chant, if you have the documents to hand [disorder] if you could just email them to the secretariat.

Dr CHANT: I am just trying to find the vaccine effectiveness assumptions.

The Hon. COURTNEY HOUSSOS: That's fine. I am happy for you to take that on notice, Dr Chant.

Dr CHANT: In terms of the vaccine effectiveness against overall asymptomatic and symptomatic infections, SARS-CoV Delta variant, based on [inaudible] 2021: AstraZeneca had effective of asymptomatic and symptomatic infection. After two doses it is around 60 per cent for AstraZeneca; and for Pfizer it is about 79 per cent. Onward transmission to household members after dose one: AstraZeneca has about a 48 per cent; Pfizer has 46 per cent after one dose and after two doses 65 and 66 per cent; and combined vaccine effectiveness assumptions on transmission—the calculated overall reduction in transmission for one dose of AstraZeneca is 57 per cent, from AstraZeneca dose two is 86 per cent, from Pfizer dose one is 62 per cent and Pfizer dose two is 93 per cent.

The Hon. COURTNEY HOUSSOS: Thank you, Dr Chant. Can I just ask a question to Ms Pearce. In terms of the 2.5 per cent of health workers who are unvaccinated as at today's date, how many resignations have been received from those workers?

Ms PEARCE: Again, I would have to take that on notice, Ms Houssos.

The Hon. COURTNEY HOUSSOS: I will hand back to my colleague Ms Sharpe.

The Hon. PENNY SHARPE: Just two quick follow-ups from my previous questioning. In relation to the QR code and the mandatory nature of that, have you provided any advice to the Government for support or otherwise in relation to changing that after December?

Dr CHANT: As I indicated, we are looking currently at providing advice about what test, trace, isolate and quarantine [TTIQ] looks like at 70 per cent and 80 per cent vaccination status and we have not finalised that yet.

The Hon. PENNY SHARPE: Just to clarify, there has been no advice provided to Government about the removal of mandatory QR codes. That is what I am checking. My second question is this: When you were talking before about the TTIQ, you used the words there is an evolution in the way that we do contact tracing and the way that that operates. Is that factored in to the New South Wales modelling around Doherty or is this a New South Wales innovation?

Dr CHANT: It is very clear that the Doherty accepts that as you get higher case numbers, you are doing a modified contact tracing—that you are doing partial TTIQ—and that is factored into the Doherty considerations when you get higher case burden. Also the Doherty modelling in terms of opening up does not assume that you have segregated vaccinated from unvaccinated. So that is another feature that is different. But we would know that having only vaccinated people together does reduce the risk, given what I indicated the vaccine effectiveness is previously.

The Hon. PENNY SHARPE: So, essentially, New South Wales is trialling different things in this space that are not necessarily set out in the modelling but, you would argue, are consistent with the TTIQ and the Doherty modelling. Is that what you are saying to me?

Dr CHANT: Potentially the step to only have vaccinated people gives us an added assurance as well as the work we are doing to get vaccine coverage up as quickly as we can. There are many factors that play into these considerations. As I said, having that four- to six-week period after we get to the 80 per cent will be really important for us to see the impact flow through in terms of case numbers and, in fact, on hospitalisations.

The Hon. PENNY SHARPE: Just to clarify, given that we are one week away from 70 per cent, does that mean you are not really expecting any changes to TTIQ before then, and that we are really looking at 80 per cent before those changes take place?

Dr CHANT: As I said, we are currently putting advice to Government about being very clear about what TTIQ looks at at 70 per cent. I just want to reflect that we have had to evolve contact tracing quite rapidly over this period. We have learned what is the main—I should just stress that we have had to apply close contact tracing to the groups that we know are likely to contribute most to transmission onward and what we know is that is going to be households. Currently most of the high-risk premises are actually not open [disorder]—

The Hon. PENNY SHARPE: Thank you, Dr Chant. The clock is ticking and I know that my colleague Mr Graham has a couple of questions so I might just cut you off there. I appreciate that and I am sorry to be so rude.

The Hon. JOHN GRAHAM: I might just pick up on that last point. Given the potential changes which might happen to TTIQ or tracing in particular—automation, move to an SMS. A focus on staff rather than customers was one of the things you have touched on today and referred to yesterday. What protections will be in place for businesses and for workers to avoid what we have seen overseas—that "ping-demic" phenomenon?

Dr CHANT: Could you just clarify what phenomenon you are referring to?

The Hon. JOHN GRAHAM: I am referring in particular to the UK "ping-demic" phenomenon, which saw automated notifications, particularly to UK staff and businesses facing staff shortages, as people were notified and then had to immediately isolate. What protections will be in place as you automate the system here to avoid that?

Dr CHANT: Can I just say the system has actually been automated and, as I said, this has been an evolving system. For many months now we have actually been texting people. We get the notification coming in from the laboratories and we text people. Where there is a disconnect in number, we try to trace back to get a reliable number for the SMS text. We indicated that we have been embedding a few key questions in that initial SMS text to allow us to get to the highest priority individuals—people that may have been working whilst they have been infectious that might be working in high-risk industries like health care. I am grateful that a large proportion of the community has been embracing and responding to those SMS texts. A lot of the ways we will be doing things in the future builds on some of the work we have put in place as we have had to respond to a high case load environment. I think the important thing is that we know that households are the greatest risk of transmission—

The Hon. JOHN GRAHAM: Dr Chant, I think what you are saying is that we are building on where we were and we will not see major changes to that as a result. That is really the message to those businesses.

Dr CHANT: That is correct, although progressively we have been factoring in the fact that business has really stepped up and embraced additional technology, such as some businesses have embraced rapid antigen tests, other businesses have even further strengthened their COVID-safety plans and other businesses have extremely high rates of vaccination. All of those factors will help us calibrate and be proportionate in terms of our response in those settings. We will have to adjust our risk matrix or how we define things taking those factors into account. This is going to be a work in progress as we learn. But the highest feature is to make sure we prevent as much transmission as we can to keep the transmission in the community as low as possible. But individuals have a key role in that and we will be continuing to urge individuals with symptoms to get tested and to isolate, not just soldier on. Some of those behaviours that we had perhaps before the COVID pandemic I hope to put to bed once and for all going forward.

The CHAIR: If you have finished that line of questioning, I will hand over to Ms Faehrmann.

Ms CATE FAEHRMANN: Dr Chant, or maybe even Ms Pearce, what is the current percentage of cases in children—basically people under 20—roughly?

Dr CHANT: It is a high proportion. I will just call up the data for you because I have it. I will just have to calculate it but I can say that in the naught to nine age group—would you like that on the last 14 days or since the outbreak began?

Ms CATE FAEHRMANN: The last 14 days is fine.

Dr CHANT: In the last 14 days in the naught to nine age group—and this is data as of 8.00 p.m. on 29 September—we have 2,346 cases. In the 10- to 19-year-old age group we have 2,176 cases.

Ms CATE FAEHRMANN: Of those, in terms of in hospitals, do you have that as well?

Dr CHANT: It will just take me a moment call that up if that is okay with you?

Ms CATE FAEHRMANN: Sure. Just while you are finding that, I have a general question around why the current ICU numbers do not include paediatric intensive care unit [PICU] or neonatal intensive care unit [NICU]. Is there a reason for that?

Dr CHANT: My understanding is that they do include those, but if you have any different information I am happy to pursue that.

Ms CATE FAEHRMANN: I have the COVID-19 Risk Monitoring Dashboard printout from the 28 September 2021 and under "healthcare settings" it does say that the current ICU number does not include PICU or NICU.

Dr CHANT: I would probably have to take that on notice. We are very transparent with our data. I was not aware of that. I cannot confirm that, but let us take that on notice. I think we have clearly reported when we

have children in ICU and it is an important piece of information for the public. Could I also just indicate—and I know this was asked in the previous inquiry and I apologise that it has been delayed—that the National Centre for Immunisation Research and Surveillance has done a frequently asked questions on the disease, vaccines and schooling and that is now uploaded on the NCIRS website. I will get someone to provide that to you because I know you had a keen interest in the evidence around children, transmission, vaccines and other aspects, and that document is there for consumers.

Ms CATE FAEHRMANN: Thank you. Did we get those numbers in terms of hospitalisation?

Dr CHANT: I will just have to go to the—apologies, I will just be a moment for that. It will just take me a moment because I have to go to the Excel spreadsheet and pull that off.

Ms CATE FAEHRMANN: Are we close?

Dr CHANT: Perhaps if you ask a different question and I will keep trying to find the ICU rate.

Ms CATE FAEHRMANN: I did try to do that then I realised it is also distracting so I thought I would give you a moment. I think I will go then into the school setting. I know some questions have been asked about this quite a bit before but I did want to check on NSW Health's involvement in the audit of classrooms for ventilation and where that is up to.

Dr CHANT: The Department of Education is undertaking that ventilation audit, so that is run by them and I understand they are seeking expert ventilation advice as well in relation to those audits.

Ms CATE FAEHRMANN: Have you provided them any recent information about high-efficiency particulate absorbing [HEPA] filters or any type of filters or air purifiers for those classrooms?

Dr CHANT: No, we have not provided any specific advice about that. We have clearly indicated that ventilation is a key component and it is one of the risk mitigation strategies, alongside other strategies. It is very important that there is not one silver bullet; it is really a multi-layered approach. They have done the audit and are seeking their own expert advice on the things they need to put in place to enhance ventilation.

Ms CATE FAEHRMANN: Dr Chant, you are aware that with the New South Wales Parliament looking at sitting hopefully in a COVID-safe way over the next few weeks, a key part of that was to ensure that there was appropriate ventilation in the Legislative Council particularly—obviously the Legislative Assembly as well—to make sure that there were eight fresh changes of air within every hour. In terms of safety we essentially had to make sure that that was operating to be deemed COVID-safe. Why are we not getting the same sort of advice for other key public buildings, including schools?

Dr CHANT: I am not saying that that is not the case—that schools do not understand the importance of air. Our Department of Education colleagues are leading that work and they very much appreciate the importance of air exchange and taking steps to undertake an audit, so I think those questions are best directed at them. I have no question that they do not understand the importance of ventilation as one of the hierarchies of control and are auditing all of the spaces in schools. That is due to be completed very shortly and they will take the lead on what steps need to be taken in relation to that factor.

Ms CATE FAEHRMANN: If parliamentarians or politicians are being told that to return to work in a COVID-safe way, part of that is to ensure that we have sufficient ventilation in the buildings that we are going to be sitting in in the Chamber, what type of advice have you provided to other departments in relation to ventilation, particularly in terms of workspaces? Education was a question I asked before but what about workplaces?

Dr CHANT: Certainly we have provided clear advice—and SafeWork has a key role in this—is that ventilation is key and we have embedded a section on ventilation in all of our COVID safety plans and have updated that information highlighting the importance of ventilation. I believe that there is World Health Organization guidance and I can find out what additional information SafeWork have provided in relation to ventilation. I would expect people have due regard to the guidance that is being issued in terms of air exchanges and it is a matter for expert ventilation and occupational health physicians about how that is achieved most effectively in those workplaces, including in schools. The Department of Education is across all the evidence. We have been to many joint meetings with experts in ventilation and people have discussed that so I am confident that Education understands the importance of achieving adequate ventilation in schools and is taking steps to do that. It is a matter for them to comment on the specifics of the findings of their audit, which I do not know has concluded yet.

Ms CATE FAEHRMANN: Back to the schools and children, you were saying that in the previous fortnight in zero to nine-year-olds we have had 2,346 cases of COVID and in 10 years to 19 we have had 2,176 cases of COVID. When we reopen and, to quote the Premier, "cases go through the roof", what proportion of the

cases that go through the roof do we expect to be within the under-20s, and particularly within the under-12s, considering that they will not be vaccinated?

Dr CHANT: I suppose, to answer your question, with the 12- to 19-year-olds I am hoping that we see a rapid decline in the case numbers post-vaccination, given the efficacy of the vaccine in that population, given the evidence that it has high immunogenicity. In relation to children, we will see cases in children that are attending primary school so there will be cases in the community and children attending primary school will have the subsequent diagnosis. That will be reduced if we can reduce the community transmission risk associated with COVID and the consequences of that will also be reduced if we can ensure parents and grandparents around those children are vaccinated.

Ms CATE FAEHRMANN: Yes, but, Dr Chant, at the moment with the restrictions in place now we have had 2,346 cases of COVID up until the age of nine. When we open up that is the age group where cases will go through the roof, particularly, as we have said, with people not wearing masks indoors. That is a concern.

Dr CHANT: The groups that are going to be at risk of transmission are young children. We do not know in terms of the overall burden of transmission they do not contribute as much as say, for instance, the 16- to 39-year-old age group in terms of the transmission risk, but they do contribute and they will be able to acquire it. The best way—I mean, the majority of these children have acquired the disease from other adults. There will be some children who have acquired it from other children—with delta, we certainly see that—but the best way to protect our zero to nine-year-olds is to make sure that we are well vaccinated around our younger children, our under-12s.

The CHAIR: Dr Chant, could you remind me again the proportion of 12- to 15-year-olds who have had a single dose and what proportion have had a double dose of vaccination?

Dr CHANT: In the 12- to 15-year-olds we have had 50.5 per cent that have, as of yesterday, been vaccinated.

The CHAIR: That is one dose?

Dr CHANT: Yes, one dose. They will be completing their two doses quite quickly because they have been predominantly Pfizer, which is a three-week dose interval. Some would have got Moderna, which is a four-week dose interval, so will see very rapid completion of the two doses. I think it is—

The CHAIR: [Disorder]. Sorry, Dr Chant, education—

Dr CHANT: I think it is still important that whilst we cannot underestimate the seriousness of COVID in children—and I do not want to be seen in any way to walk away from that—it is important that we put it in perspective around the severity. I would commend the frequently asked questions on the disease, vaccines and schooling [disorder]—

The CHAIR: Thank you, we have that, Dr Chant. You would be aware that parents across the State of students aged 12 to 15, as soon as it became possible to vaccinate, organised appointments to get the double vaccination in time for their children to return to school with the benefit of being doubly vaccinated. You would be aware that that had happened.

Dr CHANT: Yes. I am very pleased to see the uptake that we had in vaccination.

The CHAIR: Now, midway through, they have been told that the return date has been advanced by a week and that—I have had many, many parents contact me anxious about this because their child will not have the protection that they expected because the return date has been advanced by a week. What is your advice to those parents and their children?

Dr CHANT: I would encourage those parents to talk through their concerns, read the document that I indicated and make the decisions for them and seek some advice from their general practitioners as well. It is pleasing to see the high uptake of one dose and it is likely that one dose alone will also have some significant protection, given the low rate of illness even in the 12- to 15-year-olds. I would be optimistic that a high proportion, given that we have 50 per cent now, by the time we go back to school—remembering that school is going back in a phased way—will have completed their second dose.

The CHAIR: Dr Chant, did you give advice to the New South Wales Government to support the advancing of a week of return to school, knowing, as you do, that parents had been booking in vaccinations so their children would be protected in accordance with the initial time frame? Did you give advice supporting the Government's decision to advance the return to school by a week?

Dr CHANT: I cannot comment that I knew that parents were booking in to get that completed, but I am very pleased to hear that has been the case—

The CHAIR: Of course they were.

Dr CHANT: The reality is that schools are an important and essential component but I do encourage parents to appraise themselves of the evidence and to make informed decisions about their children.

The CHAIR: Dr Chant, I am trying to assist parents in making informed decisions by getting your opinion, your advice, as the Chief Health Officer about what parents should do if they are in the process of having their children double-vaccinated. But it will not be completed by the time that their child is returning to school because of the advance return. Should parents be waiting the extra week so that their children are protected or should they be returning kids to school?

Dr CHANT: I would encourage children to attend school because of the importance of school, but I respect there may be circumstances that parents are particularly concerned and should discuss that with their health professional if there are underlying health conditions or other reasons why they have concerns. I would also suggest that parents are aware of the disease in the community and the risks associated with that. I am very trusting that if we give parents information, they can make those decisions in an informed way but I also acknowledge the other important mental health impacts of engaging with education, the educational outcomes. So this is not only about balancing COVID risks and I [disorder]—

The CHAIR: Dr Chant, you do not need to persuade me about the benefits of children going back to school. I can assure you we have had a test case of that in my own household about how important school is. But, Dr Chant, did you give advice, did you support the Government's decision to advance the return to school by a week, given these factors? It is a simple question: Did you support it?

Dr CHANT: I cannot comment on conversations of Crisis Cabinet. I can just basically say that vaccination is a risk mitigant. The fact that so many children have actually got one dose of vaccine is very pleasing—

The CHAIR: Dr Chant, if you are not going to answer the question, that is okay. We will move on to the next question. My next question is this: Initially, the New South Wales education department said that the advice from NSW Health was that schools would not return where there was a level of disease in the community that meant the CDC definition of pandemic, which I think is some 50 cases per 100,000 over a fortnight period. Is it still the position of NSW Health that schools should not be returning to face-to-face learning if that definition has been met?

Dr CHANT: We are currently providing updated advice to Government on what would be the context and how to also factor in vaccination stays in that and how to factor in other risk mitigants, including RAT testing. Currently that is a work in progress and we urgently progressing that. We hope to be able to update the community on that shortly.

The CHAIR: Dr Chant, this was the position of NSW Health and the New South Wales education department as recently as a week ago. Are you saying that that is now under review, are you saying the position has changed or are you saying that the position as it was stated by the Minister and New South Wales education officials a week ago do not understand?

Dr CHANT: I am saying that we are looking at that threshold and other factors, particularly in the context of secondary schools, because we now have the added benefit of high uptake of vaccination which will then reflect on our considerations in terms of our approach to schools and return to school. At the moment, as you would expect us to do, we are looking at the data [disorder]—

The CHAIR: Okay. Dr Chant, in the most recent outbreak since June there have been more than 60,000 COVID cases. Is that right?

Dr CHANT: Yes, the updated data as of 29 September is 56,500.

The CHAIR: Of those 56,000 cases, is it true that they will have to wait six months until they have access to vaccination—six months from testing negative?

Dr CHANT: What we have provided to individuals is, in accordance with ATAGI advice, that natural infection affords protection for six months. But we are clear that there will be certain groups within that that can have vaccine at an earlier stage. But the reason we gave that communication as part of the stock standard—noting that a medical practitioner can make individual assessments earlier than that—was to ensure that people were able to go about their business if their advice from their practitioner was not to have a vaccine earlier, given the mandatory vaccination requirements. But in some circumstances, doctors will advise that they get vaccinated, say,

two months after that or three months. That advice is what we have done in places like Wilcannia and other places where, notwithstanding natural infection, we have clearly advised that it would be more prudent to be vaccinated because we know vaccine will afford good protection.

The CHAIR: So those 56,000 people who have had COVID, many of them in western and south-western Sydney, who have been advised not to be vaccinated, will they have the same rights under the roadmap as vaccinated people?

Dr CHANT: Yes, they are treated as immune. Can I just be clear that when you have a natural infection, the guidance—and this is not us advising, this is the ATAGI advice that says you do not vaccinate them again immediately when you have just had COVID. What you do is vaccinate them into the future to give them more long-lasting protection. What we have said is that, yes, it is up to six months but, within that period, there is always room for that clinical decision-making. The letter that was provided to them allows them to be not prevented from going to those venues and other things in this period because, in essence, they are immune because they have had a naturally acquired infection.

The CHAIR: So it is your understanding that if they wish to be out and about they will have to carry that letter with them? Is that the current arrangement?

Dr CHANT: That is the current arrangement that that letter would serve. It could be saved as a photo on their device but the concept is that they would have to produce—if you look at our medical exemption form, which is on our website, you will see that that has a temporary contraindication box on it. Having had recent COVID would be a temporary contraindication to be immediately vaccinated because, obviously, clinicians would want them to recover and make a decision about what is the appropriate time for revaccination. I would encourage everyone who has recently had COVID to engage their doctors in a discussion about when is the right time for them in their circumstance to get vaccinated.

The CHAIR: Dr Chant, unfortunately my time has expired. I will hand you back to the Opposition.

The Hon. COURTNEY HOUSSOS: Thank you, Chair. Of the healthcare workers who are unvaccinated, do any of those fall into the criteria that Mr Shoebridge was outlining—because they have had COVID they are not required to be vaccinated?

Ms PEARCE: I do not know that we have the specifics on that, Ms Houssos, but they would be treated as would anybody else. Should they have had COVID then they would be treated in the same way as the general population in respect of that.

The Hon. COURTNEY HOUSSOS: Okay, if you could provide that to us on notice that would be quite helpful.

Ms PEARCE: That is fine, thank you.

The Hon. COURTNEY HOUSSOS: Dr Chant, I wanted to come back to the questions about ventilation in schools. When you said that the Department of Education is receiving expert advice on ventilation, that advice is not coming from NSW Health, is that correct?

Dr CHANT: NSW Health does not have particular expertise in the many elements of—whilst we have engineers in our health infrastructure and other bits that can provide advice internally, I understand that the education department is engaging their own ventilation experts around what solutions are best in the settings if they find there are issues with ventilation. So that is really very much an engineering expertise, given the parameters of air exchange and other things are set up. That is the way that I understand that is progressing.

The Hon. COURTNEY HOUSSOS: I wanted to ask about a couple of other issues. How many extra health staff have been recruited back from retirement?

Dr CHANT: I would have to defer to my colleagues but we might have to take that question. Can we take that question on notice, if that is okay?

Ms PEARCE: Unless Dr Lyons can comment?

Dr LYONS: I think we will have to take that on notice.

The Hon. COURTNEY HOUSSOS: Okay. Do you have an update as to when you believe the peak in COVID cases requiring hospitalisation and intensive care treatment will occur?

Ms PEARCE: With respect to the modelling information on that, as you know, we publicly released our modelling with respect to the peak some weeks ago. Pleasingly, at the moment, there is a decline in cases. We are not running it routinely in terms of use because at the moment what we have done is run the model and planned

for the worst-case scenario as was predicted at that particular point in time. It stands to reason that with declining cases, given that case numbers are a very significant input into our model, you could see the number coming down. What we can say is that the actual hospitalisation numbers versus the predicted are substantially lower and the number of actual ICU cases now are lower than was predicted in the model that we publicly released a number of weeks ago. So it is very pleasing to see. Because of our very high vaccination rates, we are confident about where we are at the moment in regard to that. We are watching it very carefully and we watch our ICU bed numbers, as you would appreciate, around the clock. The number of COVID cases in ICU is coming down and that is why the actual line is starting to depart away from the predicted. That is very pleasing to see at the moment.

The Hon. COURTNEY HOUSSOS: That is excellent news for everybody. Can I ask you about the mass vaccination centre at Wollongong? What is the current capacity that it is operating at? How many vaccines is that doing a day?

Ms PEARCE: I have not got the figures on a daily basis, Ms Houssos. Certainly what I can say, though, is that we have provided and have been providing the Illawarra Shoalhaven Local Health District with some additional vaccine in the most recent last couple of weeks. We are obviously very focused on ensuring that they are vaccinating particularly vulnerable groups of people in the Illawarra, and we have made arrangements for additional vaccine to go to them just as late as last Friday. So that is good news for them as well.

The Hon. COURTNEY HOUSSOS: Do you have an average of how many vaccinations are being done per day?

Ms PEARCE: Not in front of me at the moment. I could certainly take that on notice and provide that information to you.

The Hon. COURTNEY HOUSSOS: My understanding is that when it was opened it said it would be doing 2,500 a day. Would that be accurate? Is it doing roughly that at the moment?

Ms PEARCE: I believe that it was around that number, yes, when it was opening. They have been doing a lot of work down there, obviously, offering the vaccine. You will note that supply of vaccine is a significant factor in terms of what our system is capable of doing. As we have demonstrated when we have had supply of vaccine we have been able to deliver very, very large amounts of vaccine through our hubs, and the Illawarra is no different to that.

The Hon. COURTNEY HOUSSOS: But, Ms Pearce, you are not able to give us any insight into an average number?

Ms PEARCE: Not at the moment, I am sorry; I do not have it in front of me right now.

The Hon. COURTNEY HOUSSOS: I just have one final question. Dr Chant, obviously sewage testing across regional communities has been really important in detecting where there might be cases undetected. How many regional communities—is it being conducted in all regional communities across New South Wales now? And how long will that be continued for?

Dr CHANT: I can provide a list of the communities in which it is done and I think we released the sewage testing data publicly. I am happy to provide that to the Committee. Again, like all things, we will have to review the utility of the sewage surveillance. Once the disease becomes more endemic then the utility of that sewage surveillance may change or how we use it may change. For instance, it might give us an idea if we are seeing escalated case numbers in a community so we may still have sentinel towns where we are monitoring for increases in the sewage viral load, which will give us an idea if we are seeing more unrecognised disease transmission. We are going to have to evolve how we use the sewage surveillance. As you know, we switched the sewage surveillance from Sydney to metropolitan to rural and regional to enable us to have that early warning. Again, we will have to change how we use it again, and to some extent that will take us a bit of time to work through what is the best way and how sewage surveillance can inform both our public messaging and public action around testing, promotion or other things. We have some thoughts but we will have to again bring those experts together to best have them fit. I am really pleased at the scale of the regional sewage detection we have in place at the moment.

The CHAIR: Ms Faehrmann.

Ms CATE FAEHRMANN: Dr Chant, do you keep statistics in relation to the number of people living with disabilities who are vaccinated? Is that information being collected?

Dr CHANT: The Commonwealth website has data on the number of people in—I would have to refresh my memory but they have data on disability workers and people in disability settings. I am not sure that that covers everyone with a disability but that is probably a subset, which is important data. I know that there is a lot

of work underway to improve the coverage and there are current gaps in the levels of vaccination in those with a disability. That is certainly another focus area that we want to work alongside the Commonwealth in addressing.

Ms CATE FAEHRMANN: They were originally going to be part of the priority group, is that right? Then that slipped down the level of priority for people with disabilities.

Dr CHANT: My understanding was that the Commonwealth had prioritised disability alongside aged care so that is probably a matter for the Commonwealth. It has certainly been a priority for NSW Health to do all we can to vaccinate people with a disability—and when I say disability I mean a broad set of people with differing needs and different approaches to get vaccinated.

Ms CATE FAEHRMANN: I am aware that there have been some outbreaks in supported housing. I have a tweet in front of me where somebody has said that—this is on 25 September—"of the 11 dead yesterday there were eight of us who were in this supported housing where there were cluster-style homes with communal areas". They said, "We are dying like flies in our homes. These are group homes." Do you know about that situation?

Dr CHANT: I am really distressed by that and if you could provide perhaps the details we will immediately get the district to follow them up. I am aware that there are some complex situations being dealt with in the Illawarra, Shoalhaven and Wollongong area. I know that we have had challenges in others but that does not resonate with something that I know about at the moment. I am really distressed that you have that so could you please provide that immediately after this hearing so we can respond to those needs?

Ms CATE FAEHRMANN: Yes, I would love to do that. Do you have vaccination rates for places like supported housing? Has there been additional effort that is going into areas like supported housing?

Dr CHANT: There has been incredible effort been done and just to let you know we are also monitoring our vaccination rates across many indices to ensure that we have reached the most vulnerable. We have also done an analysis by the Socio-Economic Indexes for Areas—from one, being the most disadvantaged, to five, being the most advantaged—to make sure that we have even spread and high rates across all of those. All of our districts have done well in minimising disparity but some have actually reversed the trend and have higher rates in the most disadvantaged compared to the advantaged, which is so pleasing. Some districts—for instance, I am aware that Sydney recently got in and had intensive efforts across their social housing working in partnership Aboriginal Medical Service [AMS] Redfern in trying to ensure that there is good access for the Aboriginal community in Redfern and Waterloo areas. I know that Margot Mains, the CE of the local health district in Wollongong, is doing a lot of intensive effort around their social housing, and I know that we are doing work in the boarding houses, homelessness—

Ms PEARCE: I can actually add some comments, Ms Faehrmann, because this is information that we are closely looking at. NDIS participants over 16 years of age—this is from data I have in front of me—is around 67 per cent first dose; NDIS participants living in disability accommodation is 75 per cent first dose; and NDIS participants living in residential aged-care facilities are 81.5 per cent. That is back on 10 September, so I would expect those numbers to be increased by now. As Dr Chant said, all of our local health districts—this is a partnership. Again, the Commonwealth Government is participating in this in a very significant way. We have opened our doors in our vaccine centres to disability workers for many, many months, and it did not matter whether they worked for us or worked for any other organisations. And, indeed, for people with disabilities we have vaccinated people in the car parks of our vaccination centres if they could not get inside. If a group came, for example, in a bus or something like that, we would vaccinate those people in the car park.

Blacktown Hospital has, for example, a low sensory clinic for people who cannot not tolerate noise, bright lights and the like, so that they can come there and get vaccinated. But we are really in the space now of going to the people because we recognise that not everybody can come to us. That is a very important part of our strategy. But as I say, the districts are collaborating with primary health networks, in particular for housebound persons, so that we can get to them. The Commonwealth rates of vaccination in disability group homes pleasingly has improved quite substantially over the past couple of months. So I expect to see that continue, particularly given now that the vaccination rates in residential aged-care facilities are now very high. That work is essentially—well, it will never be complete because obviously you always have to move with people coming in and going out, but the focus is very significant with respect to the disability sector.

The CHAIR: Thank you both for that detailed answer. Dr Chant, before there is an agreement to open up parts of regional New South Wales with significant Aboriginal and Torres Strait Islander communities in them, will you commit to sitting down with those local Aboriginal medical services in places like Brewarrina, Bourke and Moree, and ensuring they support the opening up of their communities before public health orders are lifted

to allow for people to travel to those communities? Will you commit to sitting down with those Aboriginal medical services?

The Hon. TREVOR KHAN: Point of order: That is a policy issue that is even beyond the Chief Health Officer to answer. That is a matter to direct to the health Minister.

The CHAIR: I hear your point of order but I am asking—

The Hon. TREVOR KHAN: [Disorder] under the rules of procedural fairness—I think it is rule No. 10 that specifically deals with public servants being asked matters related to policy—I think that is quite unfair.

The CHAIR: To respond, my question is not about the decision about opening up; my question is about whether or not the Chief Health Officer will commit to the process and the procedure of sitting down with Aboriginal medical services. It is quite different to whether or not the ultimate decision is made; that is a matter for Government.

The Hon. TREVOR KHAN: With respect, that is not how you phrased the question, David. That is not how you framed it.

The CHAIR: Well, I will reframe it if that is a concern. Dr Chant, will you commit to sitting down with those Aboriginal medical services in places like Brewarrina, Bourke and Moree, and speaking with them and hearing their concerns and their views before a decision is made by Government—not by you—to open up those regional communities to travel?

Dr CHANT: Can I just say that I will continue to be available to talk to AMSs and the Aboriginal community control and work closely. The Centre for Aboriginal Health is part of whole of government. Aboriginal Affairs are very committed to supporting Aboriginal communities. I have recently had a teleconference, a video Skype link, with some of the Aboriginal community control in northern New South Wales to hear their concerns and discuss issues with them. I would extend that to all Aboriginal communities and AMSs with my colleagues. I just want to acknowledge the work that our districts are doing, and this is very much a partnership with the Commonwealth as well. At that teleconference, Commonwealth representatives were also there to hear about some of those issues. So I would be very happy, as I have been across the pandemic, to hear the concerns so that we are well briefed about them. We have genuine commitment to see Aboriginal immunisation coverage as high as possible.

The CHAIR: Dr Chant, my final question is this: On the last occasion [disorder]—

The Hon. TREVOR KHAN: David, to be fair, your time has expired. We are over the time frame set for this. I am not quite sure how these continue to get extended out and extended out. Your time has expired.

The CHAIR: I think there is a final question, which I will put to Dr Chant—

The Hon. TREVOR KHAN: No. Be fair, David. You have been advised that the time has expired.

The Hon. JOHN GRAHAM: I think we are somewhat over time, Chair.

The CHAIR: Alright. Perhaps I will put it by way of a supplementary question. Dr Chant, Dr Lyons and Ms Pearce, thank you for your attendance today. Again I say on behalf of the Committee that we appreciate your extraordinary level of work throughout the pandemic and we all collectively wish you every success going forward.

Dr CHANT: Thank you.

Ms PEARCE: Thank you.

Dr LYONS: Thank you.

The CHAIR: As I have been reminded by Mr Khan, we have unfortunately run out of time for this session, as a result of which today's hearing will conclude. Thank you.

(The witnesses withdrew.)

The Committee adjourned at 15:55.