REPORT ON PROCEEDINGS BEFORE

PUBLIC ACCOUNTABILITY COMMITTEE

NSW GOVERNMENT'S MANAGEMENT OF THE COVID-19 PANDEMIC

CORRECTED

Virtual hearing via videoconference on Friday, 11 February 2022

The Committee met at 9:45 am

PRESENT

Mr David Shoebridge (Chair)

The Hon. Lou Amato
Ms Abigail Boyd
Ms Cate Faehrmann
The Hon. Scott Farlow
The Hon. John Graham
The Hon. Courtney Houssos
The Hon. Peter Poulos
The Hon. Penny Sharpe

* Please note:
[inaudible] is used when audio words cannot be deciphered
[audio malfunction] is used when words are lost due to a technical malfunction
[disorder] is used when members or witnesses speak over one another

The CHAIR: Welcome to this virtual hearing of the Public Accountability Committee's inquiry into the New South Wales Government's management of the COVID-19 pandemic. Before I commence I would like to acknowledge the Gadigal people, who are the traditional custodians of the land upon which the Parliament sits. I pay our collective respects to Elders past, present and emerging. Today's hearing is being conducted virtually, 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. As we break new ground with the technology, we would appreciate people's patience. If any member or witness loses their internet connection or is disconnected during the hearing, they are asked to rejoin the hearing by using the link that was provided by the secretariat.

Today's hearing will continue the Committee's oversight of the New South Wales Government's handling of the COVID-19 pandemic. We meet today to focus on new challenges presented since the emergence of the Omicron strain and to consider what the public health response should or could be going forward. Since the last sitting of this inquiry, many things have changed, including rates of vaccination, boosters, the impact of Omicron, as well as major public policy shifts. As the Chair, I believe that getting fresh perspectives on this is more essential than ever as we plan for the recovery moving forward.

Today we will hear evidence from the medical community—nurses, doctors and allied health professionals—from independent experts, as well as from those on the frontline in the aged and community care sector. Finally, we will hear from the Minister for Health, the Chief Health Officer and senior health officials. Before we commence, I make some brief comments about the process for today’s hearing. While parliamentary privilege applies to what is said in the hearing, I remind witnesses that it does not apply to any statements made outside. Committee hearings are also not intended to be an opportunity for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, please stick to the issues rather than the personalities.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. It is a matter that this Committee takes seriously. There may be some questions that a witness could only answer if they had more time or with certain documents to hand, in which case witnesses are reminded that they may take a question on notice and provide an answer within 21 days from receipt of the transcript. Today's proceedings are being broadcast live on the Parliament's website, and a recording of the hearing will be uploaded to the Parliament's YouTube channel after the hearing. As always, a comprehensive written transcript will be placed on the Committee's website by Hansard once it becomes available.

Finally, I make a few notes on virtual hearing etiquette to ensure that today's proceedings can be as smooth as possible. I ask committee members to clearly identify who questions are directed to and ask that everyone, if they can, please state their name when they begin speaking. That may seem iterative, but it is of great assistance to Hansard. Members should also utilise the "raise hand" function when raising points of order. Could everyone please mute their microphones when they are not speaking and remember to turn the microphone back on as you prepare to speak. Please speak directly into the microphone. Finally, to assist Hansard, I remind members and witnesses to avoid making comments when your head is turned and to avoid speaking over each other, if at all possible.

Dr DANIELLE McMULLEN, President, Australian Medical Association (NSW), affirmed and examined

Ms SHAYE CANDISH, Assistant General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

Mr GERARD HAYES, State Secretary, Health Services Union (HSU), sworn and examined

The CHAIR: I welcome our first witnesses. Thanks to all three of you. Perhaps if we adopt the same order, I now invite you to give a brief opening statement.

DANIELLE MCMULLEN: Thank you for the opportunity to appear before this Committee on the New South Wales Government's handling of the COVID-19 pandemic. As I commence, I would like to acknowledge the Gadigal and Wangal people of the Eora nation, whose land I join you from today. I pay respects to Elders past and present and all Aboriginal and Torres Strait Islander people. I acknowledge that this inquiry is being conducted at a time when COVID-19 remains an ongoing threat to the health and wellbeing of Australians. We anticipate further analysis of the New South Wales Government's COVID-19 response may be necessary in the future as COVID evolves and presents unique challenges to our health system. Some of these impacts—for example, with regards to delayed care or disrupted training of our doctors in training—may not emerge for years to come.

To date, AMA (NSW) has been broadly supportive of the measures, policies and programs implemented by the State Government and national Cabinet to manage the impact of the pandemic and protect the health of Australians. We commend the State and Commonwealth Governments for their commitment to the COVID vaccine program, which has been a key pillar of the COVID response and immensely important in terms of reducing serious illness and death. The medical leadership in New South Wales has been critical to the success of the State's ability to manage COVID-19. We acknowledge the efforts of our health leaders, including our Chief Health Officer, Dr Kerry Chant, who has provided reliable medical expertise and health advice to the Government and the people of New South Wales throughout the pandemic.

Since the WHO declared COVID-19 a global pandemic on 11 March 2020, the New South Wales health system has faced significant hurdles. In a letter to the former Premier on 19 March 2020, AMA (NSW) indicated that the extent to which New South Wales hospitals can cope with COVID-19 will depend on a rapid and coordinated whole-of-health system response. Then, and throughout the pandemic, we called on State and Federal Governments to keep our doctors safe, keep the public safe, provide clear and transparent data and messaging to the profession and the public and to keep the health of the nation as its top priority. Many of the recommendations made in that March 2020 letter reflect what AMA (NSW) had been seeking for many years: a high-quality, effective, responsive and connected healthcare system that is adequately resourced and staffed. While the State has effectively addressed many of the AMA's early and acute pandemic concerns, that single overriding objective is yet to be achieved.

Looking forward, we need to focus on building well-resourced, coordinated and integrated health systems, we need to be prepared for future waves and we need to get back to providing a full suite of non-COVID care to patients, as well as education and training of our junior doctors and medical students. We need well-resourced, well-staffed hospitals, and we need to support community specialists, particularly general practice, with appropriate funding and workflow pathways under a single health system in New South Wales.

SHAYE CANDISH: I would like to start by thanking the Committee for the opportunity to provide evidence today. For the duration of the pandemic, management of hospital and healthcare services across New South Wales have been far from the gold standard the Government would have the public believe. Our members have often been on the receiving end of a Government announcement that has not been adequately planned for. At the end of 2021 we saw mass fatigue in the health staff workforce, due to two years of ongoing pandemic response. The Ministry of Health and managers across the health system proactively encouraged many health staff to take leave over the summer holiday period.

The Government's decision to lift restrictions in mid-December, when the highly transmissible Omicron variant was circulating, resulted in mass community spread and a significant demand on hospital services at a time when the public health sector was at its least capable to respond. This situation was compounded by the thousands of furloughed staff per day. Mass understaffing and rapid changes to keep policies and processes, such as the healthcare worker risk matrix, rolled out without consultation and at a time when many key staff in the information provision were absent. Mass confusion ensued, with staff and managers being unclear about isolation requirements.

The rapid escalation in hospital cases at this time required rapid expansion in treatment spaces, including temporary marquees to triage and manage large numbers of COVID-positive patients. These work spaces and the

healthcare worker risk matrixes mentioned earlier created a number of work health and safety issues, as staff had little to no access to suitable amenities to take breaks despite working in full PPE outdoors in summer heat. Our members were reporting episodes of heat stroke, dehydration and vomiting, demonstrating the inappropriate makeshift arrangements that were forced to occur within this climate.

As hospital numbers rapidly escalated, the local health districts scrambled to develop surge or escalation plans to manage admissions with the limited numbers of staff available. Nurses were proposed to take on team leader roles overseeing a team of other staff, including non-clinical staff, to manage the care of patients. At no time did the Government explain to the public that they may not have a nurse at their bedside should they be admitted. As the Omicron wave escalated and overwhelmed the public health system, services were reduced where possible. This included the support that had been previously provided to the fragmented and ill-prepared aged-care sector. Providers were required to manage outbreaks in their facilities, despite the knowledge that many providers were simply unable to respond sufficiently if an outbreak occurred within their facility.

Earlier in the pandemic, the Government publicly committed to an ICU bed capacity of 2,000, despite no actual knowledge of workforce numbers available to operate this bed capacity. They announced the Federal private hospital funding guarantee, which was intended to provide a surge workforce, yet nurses in private facilities were being stood down on leave without pay as they were not engaged in the public health system efforts and surgery limitations left them without work. And whilst the system was supposedly coping, we have seen irrational policy implemented in specialties like maternity services, palliative care and mental health that have resulted in support people missing key moments, like births and deaths, and vulnerable patient groups being overlooked.

Fundamental resources such as PPE have been problematic throughout the pandemic, with limited access, supply issues and quality all having been highlighted at different times. The Ministry of Health and local health districts have been dragged by the association to adopt a policy of best practice that includes fit testing of P2/N95 respirators for all healthcare workers working with COVID-positive or potentially positive patients, a decision that has likely saved thousands of healthcare workers from preventable exposure and potential death. Yet alarmingly, this position took more than 12 months to reach and we still have healthcare workers that are yet to be fit tested. I will conclude by expressing our disappointment at the Government's gross undervaluing of highly skilled professional nurses and midwives, who continue to carry the burden of the entire health and hospital services right across our State. The little regard paid by government to the sacrifices each healthcare worker has made and continues to make to keep our community safe in this pandemic is astounding. Thank you.

The CHAIR: Thanks very much, Ms Candish. It was remiss of me in the opening not to acknowledge the extraordinary work of all your members, as well as the members of the HSU, other unions such as the APA and also the work of doctors. Collectively, on behalf of the community, thank you for the work that you and your members have done. Mr Hayes?

GERARD HAYES: Thank you. I would also like to acknowledge the traditional owners of the land that we are meeting on today and pay my respects to Elders past, present and emerging. What we have seen at the moment over the past two years is that the New South Wales health system has been grossly underprepared to be able to deal with a pandemic. We see this every year—and at the heights of the pandemic—that the winter bed strategy occurs and the public health system struggles at that point in time. We have seen over the past six months the pandemic of the workforce. This is a workforce that has become a just-in-time workforce.

The cuts that have been made to health over many years have supplied, not only from our paramedic members to our allied health members to patient transport service, security people, administrative people and a range of others, bare minimum in terms of having any kind of relief, let alone being able to engage in the surge that came. This has absolutely been exemplified recently when we have seen up to 8,000 people stood down or furloughed on a given day and how we respond to that.

The ambulance service responds to that by employing people from the university sector who are trainee paramedics. While that is an opportunity to be able to fill a gap, it does nothing for the professionalism of the service. It does nothing to the professionalism and support of young clinicians who are moving into a career choice that they value very much. We have also seen in recent times that we have allied health professionals—who are physiotherapists, who are social workers—who are now undertaking nursing duties, which is totally inappropriate from our perspective, inconsistent with the discipline that they actually engage in and also identifies the shortage in terms of nursing where they are actually trying to support their colleagues.

Overall I think we can take a lot out of what we have learnt over the past two years, and that is about being prepared. We cannot be prepared going forward to have people, instead of doing eight-hour shifts, doing 16-hour shifts, people wrapped up in polypropylene for 15 hours a day, and then say to people that you must have a third jab or a fourth jab and be mandated. We do not want to get into a mandating argument here, but the reality

is health workers are tired. They are exhausted; they have had two years at the front line. They deserve some respect, and I think consistently dropping health orders on health workers is not something that will bring people together.

This, upon any other time, needs to be a communication issue, and the communication is not there in respect to our members who have been working incredibly hard. It is easier to put a memo out with an edict as opposed to engaging with people, appreciate the support that they have given the community, and their co-workers and their patients, as opposed to just saying, "Do this or else." I think a lot needs to be learnt in relation to how people communicate within health, which is something that has been a chronic issue for many decades. Thanks very much.

The Hon. JOHN GRAHAM: Thanks for those opening statements and your appearance today. I would also like to put on the record for the Opposition our thanks to the health workforce, to all your members over the past couple of years. We will be questioning the Government at the end of today, but I wanted to put the Government position to you and just give you an opportunity to respond to that, because it is quite a different story to what you just outlined—so perhaps the chance to put on the record your views. The Premier tells the New South Wales population that the pandemic has been handled well, New South Wales is stronger as a result and we have almost already bounced back. How do doctors, nurses, paramedics and health workers feel when they hear the Premier put that view, which is so at odds with what you have just told us? It is a question to each of you, and we might just run in that same order.

DANIELLE MCMULLEN: As I said, overall, AMA NSW has been in general supportive of the measures government has taken to try to keep the community safe, but we of course acknowledge and feel strongly that the health system has been under extreme strain and is likely to continue to be so for some months, if not years, to come. We think there needs to be greater acknowledgement of the ongoing impact on the health sector, given the extreme workload that our members have been under for a long period of time now—the reduced access to leave, their long shifts that other people have been talking about, that we now have a tired workforce who needs to get back to providing care to patients who have also had reduced access to care over that past couple of years. Our workload ahead is massive, and we are starting behind the eight ball with a tired workforce who is under-resourced and undervalued. There is a lot of catch-up work to be done, and we cannot lose sight of the fact that, in the want to celebrate any breath of fresh air from COVID, we need to still recognise that there is a lot of work to be done in health, and ongoing commitment to the health sector is going to be needed for some time yet.

The Hon. JOHN GRAHAM: Ms Candish, nurses are striking for the first time since 2013 very shortly. How do nurses feel when they hear the Premier put those views?

SHAYE CANDISH: I think that says a lot, if I am honest. We are in a situation where our health system has been underfunded and under-supported for the past, at least, 10 years. Nurses have been calling for nurse-to-patient ratios and mandated minimum requirements for staffing, which has been refused, and so we entered this pandemic with a level of strain that was not clearly understood. The pandemic has simply exposed all of those cracks and turned them into chasms. Our members are taking this industrial action because they blatantly disagree with what the Government is saying. The system is not coping. We are seeing nurses approaching retirement age deciding to go early. We are seeing new nurses enter the workforce and say, "This is not what I want to do. How can I do this for the rest of my career?"

If we do not do something to invest in the health system long-term, I do not believe we will have even—let alone a robust workforce—an actual workforce to be able to provide the service we require for the New South Wales community, because nurses simply will not tolerate it anymore. The reality of course is that we are in a situation where globally there is resounding evidence around PTSD linked to healthcare workers that have come through a pandemic. We need to see the Government acknowledge that the system is under strain and do vastly different to come in and really invest in the system, because it requires so much further support and resourcing than where it is currently.

The Hon. JOHN GRAHAM: Mr Hayes, you have said your members are tired. They are exhausted. How do they feel when the Premier says that this is going extremely well?

GERARD HAYES: It becomes a little bit like stand-up comedy at the end of the day. We all know what the issue is here. We know how the New South Wales health system, like every other health system, has been tested to the max. We get that. But to be able to say "it is coping" is just not true. I think any chief executive will admit that too. That is not a defeatist attitude; that is just the reality of life. If we do not resource health—and, as I said, it is a competitive area and there is a lot of funding that needs to go into it and does go into it, but that funding is not meeting the expectations of the community that we are seeing at the moment. The community is an expanding community and it is one that has a diverse need right across the clinical aspects and, at this point in

time, getting people to do other people's work because there is not enough nurses or others is a major concern for us. It exposes the stress that is actually there at the moment.

But I totally agree with the previous speakers that this is not over and this is now the tip of the pandemic of the workforce. The frustration and the exhaustion, people working in health generally accept every day because it is a high-pressure job. But they are at the point of not being able to tolerate it anymore. This will not go away in the next six months when we go into an endemic position, possibly. This will go on for the next two to three years because—I particularly agree with Shaye—we have got so many people now saying that, "I was going to retire in the next two to three years; I'm doing it in the next two to three weeks, because I am done with this." So we really need to recognise that it is that pressure on the total health workforce.

The Hon. JOHN GRAHAM: One of the biggest concerns has been in regional communities. I think from the regional health inquiry it is clear that some of those systems are just not there. The services would be more under strain in the face of an Omicron wave and those communities are feeling concerned as they face, for the first time, some of the restrictions, some of the health threats that people in Sydney have faced. What concerns do you have about the capacity of the regional health systems to cope, Dr McMullen?

DANIELLE MCMULLEN: Thanks. Obviously, it has long been on the record from the AMA that we recognise the significant challenges with rural and regional health, even prior to COVID, and of course we have given evidence into the inquiries into rural and regional health in New South Wales. With particular reference to COVID, over the past couple of years, often the feedback we have had from members in rural and regional New South Wales is that restrictions, public health orders, hospital management plans have been metro centric and have not at all times been localised to the situation. There has been tension at times between wanting to protect our regional communities but, sometimes, particularly with regard to elective surgery where there was not COVID in a regional area but there was still demand for things like elective surgery, perhaps a more localised solution could have been given at that stage. With a view to the future, we would prefer that any such edicts around changes to hospital provision of care should be localised.

Obviously, in regional areas there is just less scope for surge workforce. So, in the event of an outbreak, there is a real risk to regional and rural communities if their health workforce is out of action due to COVID or being a close contact. So it is really important we protect our healthcare workforce in those areas in particular, as they are really vulnerable to further lowering of staff. The other feedback over the past couple of years has been around travel restrictions. It has been quite difficult to move healthcare workforce in and out of regional areas from time to time and it has really highlighted how reliant we are in some of our regional areas on interstate or international doctors, and that some of the shortages that were already present before COVID have been exacerbated now. Now, more than ever, we need investment into recruitment and retention of long-term medical workforce in our regional areas to support the fantastic work that does happen out there on a daily basis.

The Hon. JOHN GRAHAM: Thank you. Ms Candish, regional communities are now facing the Omicron wave. If everyone is going to get Omicron, that is going to be big news in some of these regional communities. How are nurses feeling?

SHAYE CANDISH: I would agree with Dr McMullen. I think the challenge that we are facing in some of those regional communities is that the workforce that exists has been under such strain for such a long period of time there is very little meat on the bones in these facilities, so their capacity to be able to deal with the increased strain of a pandemic is already under threat. But access to the community, I think, continues to be the real issue particularly that our members are really advocating around. We need to see, I think, really inventive solutions in this space because there has to be an incentivised program that encourages people to go and work in these regions. I would agree that the metro-specific solutions are not necessarily appropriate. We need broader engagement with stakeholders, including communities and the tertiary sector, to really understand how we can incentivise people to go and work in regional areas which provide us access in areas that we do not currently have. Because having an attitude of providing a surge workforce, where we keep shipping them out from the metro, is just unrealistic when the working conditions are so poor.

We see examples. I received a letter just recently from a member who was engaged for a three-month contract in a regional MPS. Eleven days into that contract, she resigned and said she will not be returning because she is the only emergency response there, she does not have a background in maternity services—she dealt with two women who had to deliver within that facility and then be sent out—she is also managing the onsite residential aged-care patients and doing that with one assistant in nursing, and she is working 16 hours a day. Those circumstances do not attract people to work. So we need to find ways to actually encourage people to come and work in this area, and working conditions will be key.

The Hon. JOHN GRAHAM: Thank you for that. Finally, Mr Hayes. As COVID hits these regional communities, is the health system going to cope?

GERARD HAYES: I do not believe it will and I do not believe it has been coping for some time. Prior to the pandemic we looked at the locum costs for regional hospitals, which were absolutely excessive. Being able to attract and retain clinicians and health workers in regional New South Wales has been something that has been a struggle for a long, long time—so this is a further burden put on. I can say, very clearly, that is was only about four weeks ago at Goulburn hospital that one of our paramedic members was called in to deliver a baby. My response was, "Well, hang on, there's a lot of nurses", and then, "No, there's not." There was not a lot of nurses and that was a real shock to me, to be in that sort of situation. I am happy to supply that evidence as time goes on. But to be in a position where those types of things have happened—I myself, when I was a paramedic, it was not overly uncommon that I would at Kempsey hospital be required to go and tube patients there. Now that goes back some years, but you would have hoped over those years that those clinical services would be available to people in regional New South Wales as they are in the metropolitan areas.

We are seeing paramedics now, and the patient transport service, consistently transferring people from one hospital to another hospital. That takes the service out of a particular town, so that puts an additional pressure on it. Then we have seen the absolute crisis that is aged care now. Many of those residents are being transferred to hospital. That is putting further pressure on the health system. That situation is not abnormal; that has been an issue that has never been dealt with for many years. But now we are also seeing that when the hospitals are trying to return those residents to their aged-care facility it is difficult for them to get back into the aged-care facility because of the potential of infection. So these are all additional pressures on communities that are under-resourced right across the board, whether it is clinical or actually physical resources themselves.

The Hon. JOHN GRAHAM: Thank you.

The Hon. COURTNEY HOUSSOS: I think our time is about to expire, so perhaps it might be best just to move on to the next lot.

The CHAIR: We might move over. We will move over to questioning from Cate Faehrmann. Ms Faehrmann?

Ms CATE FAEHRMANN: Thank you, Chair. Hi, everybody. Thanks for coming along. On behalf of The Greens I want to thank all of your members of the HSU and the Nurses and Midwives' Association and also thank your members, Dr McMullen. You have talked about how exhausted nurses and doctors are—all of the frontline healthcare workers—as a result of the last two years, but previously as well. My first question goes to Ms Candish. What are nurses and midwives calling for to entice—you used the word "incentivise" before—as many of those nurses and midwives who are considering leaving to stay as possible? What can the Government do?

SHAYE CANDISH: Look, we are calling on the Government to improve working conditions, and a fundamental aspect of that is to support nurse-to-patient ratios. It has been an ongoing subject of negotiation for the last eight years. We have not made any progress on it. We have currently got a workforce tool in our enterprise agreement, our award, that is very easily able to be diddled, I suppose. It requires an averaging of patients over a 24-hour period and then over a week, so it means that it is very difficult to have any transparency around the number of patients that are currently in a workplace and the number of staff that have to be provided to them. The challenge that we really see is that there is no control for an individual nurse or midwife to see if they have the right number of staff on. What we have seen is the absolute extreme of staffing through this pandemic, where nurses and midwives were turning up sometimes five or six nurses short and were still expected to provide the same level of care.

That provides a real sense of guilt for those members, because they come to work to provide a really good quality, high level of care to every patient. So our members are really strongly advocating for nurse-to-patient ratios; anything less than that really is just the continued deterioration of working conditions. Secondly, we really want to see genuine investment in pay. We have called for a COVID allowance that recognises the additional challenges that our members have been working within. But, really, we have had a constant undermining of pay since we have had the Government-legislated pay cap of 2.5 per cent, and obviously over the previous years we have had pay freezes. That really does not recognise or value the work that our members do, particularly at a time when I think the community sentiment has really demonstrated how valued our members are in the community. So we would like to see the Government really recognise this and invest in ways to support our members in more appropriate, remunerative ways and meaningful ways.

Ms CATE FAEHRMANN: Thank you. Mr Hayes, do you have a contribution here, too?

GERARD HAYES: Yes, I do. We have been able to look at—I guess over the last two years, but also the last 20 years—where the community is going to and where the funding for public health is. As I said, it takes up one third of the State budget; I understand that. But we cannot have a position where we are not delivering

quality services or those services are dependent upon the personal input of each individual healthcare worker and their psychological input to hold the system together. We look at the Productivity Commission report year after year after year. From an ambulance point of view, we see that we in New South Wales are virtually—we come last at every level.

We must be actually taking a position to invest appropriately. I am mindful in the 2014-15 budget—the Federal budget—there was $50 billion taken out of health over 10 years. Those competing pressures are there, but we cannot be in a position that we have health workers holding the health system together through goodwill as opposed to adequate funding. One way of dealing with that is to actually have a look at many of the awards at the moment, which are so out of date. Many of these awards were created in probably the 1970s or 1980s. I do not think there are any incinerators anymore, but there is an incinerator allowance. We need awards that are fit for practice in 2020 to 2030, not awards that are from 1980 or 1990.

Ms CATE FAEHRMANN: Thank you. I actually just wanted to keep going on that a little bit. I sit on the regional, rural and remote health services inquiry, and that has just completed its final hearings. One of the things that we heard quite a bit of was the challenges around communities that are close to borders with other States, such as the Northern Rivers and such as down near Victoria. The issue is that nurses' and paramedics' wages and conditions are actually better—and the ACT, as well—often in bordering States. I wondered if you could outline some of those examples clearly for the Committee that New South Wales, compared to other neighbouring States, is underpaying their healthcare workers, and that means we are losing healthcare workers to other States at a time we can least afford to do so. Ms Candish?

SHAYE CANDISH: Look, I would say it is sort of a combination of factors. The feedback we get from members is that the key driving factor that sends them to go and work interstate is around secure working conditions. Queensland and Victoria both have nurse-to-patient ratios, so it is a vastly different experience for our members when they work in those hospitals over the border. They have real clarity about how many patients they will be caring for, and the expectation is similar day on day. It is not like that here in New South Wales, which many people do not seem to understand. And so, over the years, we have absolutely seen changes in pay afforded to nurses and midwives across the different States. Queensland has overtaken New South Wales in terms of pay rate and Victoria is encroaching on New South Wales. That is a little varied dependent upon the particular level of nursing that you are because we have incremental increases between one and eight years here in New South Wales, so there are some slightly different variations and relativities.

But if you take a broad brushstroke approach, we basically have Queensland in front and Victoria encroaching in almost all of those categories. Traditionally New South Wales really has set the standard around pay. I think we have been able to compensate because we haven't had ratios, so pay has been one of the factors that people have considered. But the fact now that we are falling behind in both pay and working conditions really does create this competitive environment when people have alternative employment opportunities, and so what we see here in New South Wales is challenges particularly to workforce in those hospitals that sit right on the border. Places particularly like Albury-Wodonga are a really good example because they have two hospitals in one health system that sits across the border, and the way that they have actually managed that is by adopting predominantly Victorian processes and entitlements in an effort to try to even and give people the best scenario of both worlds.

Ms CATE FAEHRMANN: Thank you. Mr Hayes, I have heard the situation with paramedics particularly is that paramedics in New South Wales are the worst paid in the country, the lowest paid in the country. Is that the case?

GERARD HAYES: That is virtually absolutely correct. It has the worst pay, the lowest per capita resource and the highest injury rate from a workers compensation point of view, so they tick all the low benchmarks right the way through—bearing in mind this is a group of people who have, over the last couple of years, become professionally registered, and yet there is no professional scale for them. The other important thing at the end of all of this, as well, is that our response times are getting worse and that they are at the back end of the other States. This all comes out of data from the Productivity Commission report.

Ms CATE FAEHRMANN: Thank you. I wanted to go to the issue of adequate PPE. Dr McMullen, I might ask you this one, to begin with. Do you think that anything could have been done—for example, better PPE equipment? I have had some people lobby me, for example, about powered ventilation masks. Do you think that if we did have better, fit-tested PPE provided early on in this pandemic, it would have prevented the furloughing that we saw of so many hospital staff? Also, potentially would that cost or investment, if you like—in your view, would that have been worth it because it may have prevented the extraordinary cost to the healthcare system of those furloughed health staff?

DANIELLE MCMULLEN: Just quickly, on a previous question—our junior doctors in New South Wales are also amongst the lowest paid in the country and with the least provision for study supplements and other incentives to work in New South Wales. With regards to PPE I will open by saying that I think we need to be cautious of judging yesterday's decisions based on today's knowledge. Having said that, it was fairly clear, from early in the pandemic, that there was some airborne spread of COVID-19 and that protecting our healthcare workforce in particular was highly important to keeping our services open. In the longer term it has been vaccination that has really helped protect our workforce.

But there was, in the early days of the pandemic, a lot of confusion about what PPE was required, how to access that PPE in the context of worldwide shortages and who should be prioritised. I think people did try to make the best decision possible about taking a finite resource of N95 masks in particular and the powered respirators and providing them to the people most at risk. It was our public health measures, like social distancing, reduced movement around the community, that helped quash community transmission and kept our healthcare workers largely safer than many other parts of the world.

We have ongoing challenges. For example, I am a GP in my day job and only just got fit-testing this week, which really shows that, two years into the pandemic, we are still—and, of course, the only two masks that fit are unavailable across Australia at the moment in the private sector, in the private space. So I still remain unable to find masks that are fit-tested, approved. So there are still challenges, particularly for private specialists and GPs, to access appropriate PPE, and I understand that also in the hospitals there have at times been confusing messages around what PPE is appropriate and should be worn. I think that clarity has now come to light. We have now got the appropriate guidelines around the use of PPE, the importance also of ventilation and other measures, such as social distancing and keeping levels of COVID-19 controlled in the community.

So, to answer your question of what could have been done earlier—it is difficult to judge now, given the real shortage of supply that was given back then and the contention about really how airborne or not COVID-19 was. But I think, going forward, we need to be prepared in case of a strain that is more virulent and more severe and transmissible. Now that we know how airborne it is, we need to make sure that the Government has supplies and access to adequate and appropriate PPE, in preparation for the next wave.

Ms CATE FAEHRMANN: Thank you. We do know, of course, in terms of Omicron and how airborne it is, but you have just said to this Committee—which is extraordinary, actually—that you yourself have just been fit-tested and you still are not able to access the fit-tested mask that is right for you. Is that common across other—you said "the private kind of sector" particularly. I would think there would be thousands, therefore, of GPs and other healthcare workers in that situation still.

DANIELLE MCMULLEN: Yes. I would expect that that is likely. That access to the testing, initially and appropriately, was put for people who had to be in the front line, that could not work by telehealth. Obviously, general practice cannot run on telehealth forever. So there are a significant number of GPs and other private medical specialists who have been putting themselves face-to-face on the front line, potentially in inadequate PPE, particularly in the context of high community transmission with the Delta and Omicron outbreaks, where there is a significant risk that patients coming into the practice may be positive and not necessarily know it, with all the screening measures in place.

Ms CATE FAEHRMANN: Thank you. That is very alarming evidence. I think I have got time for one more question, Chair.

The CHAIR: You do, Cate.

Ms CATE FAEHRMANN: Thank you. We go into COVID. We have got a pandemic that hits the country. I wanted to just get a sense from all of you, I suppose, but particularly Nurses and Midwives and the HSU. What did the Government do at that time in terms of discussions with you to ensure that everything possible was being done by them to support frontline healthcare workers and make sure that they stayed in the job, that we retained them? You are talking pandemic pay or COVID allowance now. I know you urged them to do that last year. What has the conversation generally been like with the Government? It just seems that this has dragged on for so long. I cannot believe that we still do not have any higher wages for nurses and midwives, we do not have better conditions, we do not have COVID allowance this far in. What was happening in the early days? I will go to you first again, Ms Candish.

SHAYE CANDISH: I suppose it depends on how you define the discussion. Specifically, we have not met with the Premier. Even as recently as last week, the Premier has declined every request to meet with us. We have met with Minister Hazzard. There have been many discussions, particularly in relation to some of the challenges experienced by the specialty staff. For example, ICU, emergency departments et cetera. There has been ongoing discussions, I suppose, that have not really developed into any genuine solutions. It is really a bit of an

exercise in understanding what the challenges are. I suppose it points out more gaps about the consistencies, with each of those different specialties and services, between all of the LHDs. The Government is in a position where they often do not have all of the information available to them to even be able to make decisions about how to go forward.

In terms of the health bureaucrats I think we have had a really open dialogue, particularly at times when we are moving into a peak or large waves. I think there has been a genuine attempt to do everything possible. But the reality is, by that point, it is incredibly reactive. So they are ultimately trying to implement or retrofit something that is already in train. That is incredibly difficult, given the size of the workforce that we are talking about and the level of service that they are attempting to provide. So I think that is where we have really experienced mass confusion from our members, a lot of Band-Aid solutions, because it is the best that we could do at the time, things like the triage tents and lack of amenities for people.

It is incredible that, in the middle of summer heat, people cannot get a break in an air-conditioned office, when they are wearing head-to-toe PPE for 12 hours a day. But that was the reality of what all of the healthcare workers were dealing with. So were the patients. The other thing I would mention is the patients were in these conditions in some places as well. This was just a health service, I suppose, that was doing everything it possibly could, but everything it possibly could do was still not enough, given the demand that was being placed on everyone, which, clearly, was further evidence that the system was not coping.

The CHAIR: Cate, we might just move to the Opposition now. Ms Houssos?

The Hon. COURTNEY HOUSSOS: Thank you very much, Mr Chair. I too would like to very much thank our healthcare workers for the incredible work that they have done in the last two years with this pandemic but, of course, the work that they do every day when they go and care for our community. On that back of that comment about the fact, all of the witnesses today have talked about that we are two years into the pandemic and that our workforce is exhausted, that the toll is really very heavy. We also know a lot more about COVID than we did two years ago, at the outset of it. We had direct advice, at the start of this new wave, of Omicron, which showed the need for layered prevention strategies, specifically around masking and around social distancing, in preventing the spread. Yet the New South Wales Government made a deliberate decision on 15 December to lift those requirements. We will go through the same order again. Can I ask each of the witnesses to provide a reflection of what that decision made and how that made the effects of this latest wave much worse on our health system.

The CHAIR: We might put that first to Ms Candish.

SHAYE CANDISH: I suppose, I am not an epidemiologist. In terms of the spread, I am certainly no expert. But from the experience of our members, the lifting of restrictions was timed in such a way that we ended up with mass spread across the community. Consequently, the delay that we then have with spread means that we are experiencing hospital admissions roughly two weeks post the initial transmission event, which saw us really experiencing a massive increase in the wave at a time when most of our health system was at its lowest possible capacity to respond.

So there was an active decision made for as many healthcare workers as possible to take leave, but we also see a normal downturn in services over the holiday period of routine surgeries, specialist services and consultant services. All of those things are routinely closed down over that period. We see a lot of the high-level managers take time off. You know, the hospital really goes down into its very barebones methods, where it is providing face-to-face acute care services. So we really did not have access to the infrastructure required to really shift the hospital into this sort of a war zone head set that was needed to be able to respond to this mass outbreak.

You know, as an example, places like Westmead Hospital set up, I think it was, six or seven wards in the Delta period over a period of a few months. They did that exact same piece of work in a matter of days when we went through the Omicron phase. So, you know, trying to do that without the experts, the managers and the support services and doing it at a time when we had mass community spread and healthcare workers were also sick and being furloughed meant that they were trying to achieve the same outcomes with next to no resources to do it.

The Hon. COURTNEY HOUSSOS: I will go to Mr Hayes next. You obviously represent a broad range of healthcare workers, but can you talk specifically about our ambulances and paramedics? What impact did that decision to lift restrictions from 15 December have on the members that you represent, specifically on ambulances and on waiting times?

GERARD HAYES: We all know with the issues of furloughing and with the spread that occurred ambulances not only were required for routine transports but also obviously emergency transports. But then there was a major focus on being able to move ill patients from one health facility to another to be able to allow access to a particular health facility. So there was a very significant logistical approach that occurred to that that was

added to a workforce that was already well and truly overworked. They had been in stage three, which virtually up until probably about six months ago the ambulance service had never been in stage three. That was happening on a reasonably regular basis, which effectively meant they could not necessarily guarantee an ambulance would be able to turn up. So there was significant pressure from those areas.

One of the things I would like to highlight is from the Patient Transport Service with HealthShare through the utilisation of masks with their workforce. They deal with a lot of the overseas travellers and people in hotel quarantine and so forth. They had one person contract COVID, so the significance of the PPE and particularly mask wearing was absolutely beneficial there. I think generally speaking that within the community I agree on that condition in this area. But it would seem to be common sense that—look, by all means, we want to open up to economy but in a safe way. Masks do not seem to be that invasive from my perspective at all.

The Hon. COURTNEY HOUSSOS: Dr McMullen, it sounds as though it was not a surprise. The usual thing for the health system is to go into a slower period over the Christmas break, and yet this was the time that restrictions were being—we let it rip at a time when our health system could not cope. How did that affect the doctors that you represent?

DANIELLE MCMULLEN: We, as the AMA, disagreed with that decision to ease restrictions on 15 December and we had been clear in our public communications in the lead-up to that date that the Government should be cautious of relaxing restrictions too swiftly. As others have said, there is a common reduction in the usual levels of hospital activity over the Christmas break. In fact, we had encouraged our members to use that slowdown to rest, restore and be prepared for a likely surge in the new year and be ready to face the challenges that the health sector faced.

Unfortunately, restrictions were eased and cases did increase dramatically and, as others have said, at a time when we did not have an easily accessible surge capacity and communications were also strained. The usual people who work incredibly hard behind the scenes in the department of health and other sectors to create communications for doctors, the public and other healthcare workers about changes that are taking place and about case numbers and planning—a lot of them were also on leave. So it was quite confusing as to what should be taking place and why, for example, in mid to late December the hospitals were—you were still required to wear a mask and they were under red alert, but in the community you were not. Patients, where there was an increased level of strain in the healthcare environments—in fact, we were seeing more abuse and poor behaviour towards healthcare workers at that time when patients were frustrated about the restrictions in the healthcare sector.

It was obviously difficult for patients to get access to testing, which then makes it difficult to provide care, again, in the hospital but also the community sector, where we were trying to limit the spread in our clinics. Patients not being able to access timely testing really impacts on their ability to get care. There were thousands and thousands of phone calls to general practices in particular over the holidays. We were also short-staffed and had no guidance about how to treat these patients in the community or what was the escalation framework when we knew that the hospitals were also flooded and our doctors on the ground in emergency departments and on the wards in the hospital were also just overwhelmed with the sheer volume.

We have all heard that Omicron is a milder variant. That does not mean that people are not unwell. People still feel quite unwell with the Omicron variant of COVID-19 in a number of cases. They may not all need hospitalisation, but we had an environment where everyone is terrified, scared and under-resourced. A lot of these patients were reaching out for help to know what to do and turning up to our emergency departments. A significant number of them did need admission. There were not so many needing ICU, but our hospitals were reaching capacity as well all in the environment of an understaffed space.

The one helpful part was that elective surgery was not running at that time because it often does not run at full capacity over the Christmas period. It was delayed when the Government had to bring in elective surgery shutdowns. But, again, moving forward we cannot continue to use elective surgery as our surge capacity in the hospitals. We need to be prepared for the next wave and be able to do things in a more orderly fashion than we did the last time and really listen to health advice that simple public health measures do work to curb the spread and slow the spread. Certainly, that decision to lift restrictions on 15 December was not a wise decision.

The Hon. COURTNEY HOUSSOS: Just on that point, Dr McMullen—and thank you very much for those reflections—we do need to prepare for the next wave. Mr Hayes, you raised in your opening statement the question of what we are going to do for winter going forward because it is likely that there will be another wave and there will be another variant. But, particularly, we know that winter is a really difficult time. We have certainly seen that in the northern hemisphere as well. What is the advice that you would give to the Government—and I note that they have not necessarily acted on the advice previously. We have heard that very clearly today. What is the advice that you would say going forward that we need to be doing to actually prepare for this? I will start with you, Mr Hayes, and then I will go to the other witnesses.

GERARD HAYES: Look, I think at the moment it is about building confidence. One thing is actually what we are going to be facing on the ground, but it is also how people are mentally prepared for that. What I have seen now and in the past—particularly in the past six months— within our health workforce, it has gone from chronic fatigue which everyone has got to this level of frustration and anxiety; which is really not going to help matters. We need people all working together at the moment, and it is very hard to do that when we go from a position of A and then we go to B and then we are back to A and then we go to C. That confusion has to stop. We need to have an agreed process that we can all work towards.

We are mindful that there is a level of fluidity to it. My major concern now is that there may well be another variant. But we know any given winter flu strategy prior to the pandemic put significant pressure on hospitals. We have seen bed-block and ramping, and everything that comes with that and the flow on effects of those sorts of things. As I understand it the border is opening and there is different variants of the normal flu starting to come into the country. So we're going to have to be prepared for that. We're going to have to be prepared for Omicron and how that develops going forward. We are also then—we are opening the economy, so we have to be prepared for the normal admissions and presentations to a hospital.

One thing you have not seen for nearly two years is violence at the level it was prior to the pandemic, which was absolutely outrageous. That will start to come back. Thankfully, it is not necessarily thankfully—but given the limited access for people to a hospital from a violent situation, extreme violence has decreased. As we open up, those presentations will occur. So we are going to be dealing with at least a three-phase approach and health workers really need a clear, agreed plan that we can work together with, as opposed to being told one thing which changes the next level and then ultimately the confusion, the frustration builds and then we have a negative impact right the way through the health workforce.

The Hon. COURTNEY HOUSSOS: Thank you, Mr Hayes. My time is running out. I might specifically ask Ms Candish about this future preparation. We have heard the Government talk about stockpiling ventilators. But it is all very well to have ventilators, but it is not much use if you do not have the nurses to operate them. Are we preparing, do we have enough nurses for what is likely to happen during winter?

SHAYE CANDISH: I would say, no. I think we need to see really significant investment into the long-term infrastructure of the workforce. Because the workforce is going to be key to being able to provide any of these services. It is no surprise. This is a highly skilled workforce across all of the membership that we represent here today; each of us. They will not be available tomorrow. We need to invest today so that we can train them so that they are there for when we do need them, and that has to start now. The other thing that I would add, though, is that there has to be acknowledgement of what people have been through in this experience. Because we really run the risk of seeing people come through this pandemic with PTSD, and leave this workforce in vast droves.

There has to be meaningful resilience programs put into place to support people. The number of workforce studies internationally here that demonstrate that all of the normal coping mechanisms that health workers would normally rely upon were also taken away from them whilst they were going through this pandemic. Their capacity to cope has been diminished as well. So we need the Government to acknowledge that. The other thing that I would add is, you know, the obvious thing for nurses is that we need investment in nurse to patient ratios: Anything less is not good enough. But we also need investment in primary health care. Because people have been delaying chronic health conditions for two years now, and when they come into the hospital system that chronic condition is often an acute condition.

So we're going to see sicker patients and if we do not have capacity to be able to respond and deal with those illnesses—that includes admissions and includes staff that are required to be able to support that admission—then people are going to really have poor outcomes. That is not what we are used to here in New South Wales. We have an expectation about the standard of service and we should not drop that. That is fundamental to the rights of an Australian here. I think that is something that is key that we need the Government to understand.

The CHAIR: Courtney, had you finished that line of inquiry?

The Hon. COURTNEY HOUSSOS: I was just going to ask Dr McMullen if she wanted to provide some brief comments about what would be the preparations that we need to be making for winter?

DANIELLE MCMULLEN: I will not rehash what the others have said, because I agree with everything that they have said. Our summary would be that government needs to continue to listen to health advice. They have excellent health advisers and should listen to them. Vaccination remains a priority, along with the influenza vaccine ahead of winter. From a doctor's perspective we need confidence that health will remain the priority into the future and that we recognise that there will be an increase in care requirements, secondary to that delay in care over the past couple of years. We really need that investment into the future. We need support for our workforce. We need extra workforce in a number of places. We need to get back to teaching and training. Doctors actually

really enjoy and value being able to train our next generation, and they have been left short for the past few years. So our doctors in training and our medical students need more time and investment.

We need to reopen services for non-COVID care and give the community back the full suite of healthcare that they deserve. We need to work as an integrated single health system. We need investment in primary care. We need the State to work with the Commonwealth and help us log into Commonwealth to really provide meaningful investment in primary care, because it does benefit our State. We often get this split because primary care is federally funded and the State only cares about hospitals. We know that New South Wales actually does have a strong commitment to a primary care system and leads many other States in that regard, but we can always do better. If we unify as a single health system it is efficient to fund primary care to reduce the load on hospitals and make sure that patients are not getting so sick that they need that acute episode.

The CHAIR: Thank you so much for that. There is so much to do. Ms Faehrmann.

Ms CATE FAEHRMANN: Sorry, if you want to jump to Abigail, David. Sorry, I thought we were heading there. I am confused.

The CHAIR: Okay. Ms Boyd.

Ms ABIGAIL BOYD: Good morning, thank you. I will just ask one question before I hand back over. Thank you and I concur with my colleagues' sentiments to thank you and your members for the work that you have done in this quite extraordinary period of time. I wanted to ask you how much of the additional pressure on the system—which as you have said was already under enormous strain—could have been avoided if the Government had actively consulted with you and pre-planned prior to their decision to lift restrictions?

DANIELLE MCMULLEN: I will jump in first. It is always difficult to crystal ball. But in terms of this Omicron wave, particularly the timing of decisions to reopen and increase movements in the community, could have had an impact on healthcare services over a critical hospital period. We recognise that we were probably never going to stop Omicron. It is so transmissible, even to people who have been vaccinated. But a really meaningful attempt to slow the spread throughout the holiday period may have softened the impact on healthcare services.

The CHAIR: Ms Candish?

SHAYE CANDISH: I would agree with Dr McMullen. It is a little difficult to forecast but I would suspect that given the stresses that and everyone was under, taking a far more collaborative approach would have really leveraged the strengths that every stakeholder could have offered. There were definitely things that were foreseeable and predictable that could have been prevented, had we had the opportunity to be able to consult meaningfully on some of the decisions. How that played out, I suppose we will never know. But I suppose the observation that I would make is that despite everyone throwing everything they had at this pandemic, it was still nowhere near enough. It pains me to see that there was skills and expertise and supports that could have been leveraged more appropriately and yet were not.

The CHAIR: Ms Candish, sometimes you hear about the exhaustion of nurses and how difficult it is. Can you explain to the Committee what it is like for your members to spend 16 hours in full protective equipment, and then do that day after day after day? What is a day like that for a nurse?

SHAYE CANDISH: If you have ever worked outside doing some gardening for a couple of hours and feel that intense amount of heat out in the sun, I would say it is like that day after day. Our members are going to work completely drenched in sweat, having to change multiple sets of clothes per day, because of the amount of sweat that they are producing. It is really challenging to stay hydrated even though you are sweating so much, because of the donning and doffing that is required. We are hearing stories coming through of members having to wear incontinence underwear, because they are unable to get to the bathroom. In a country like Australia it kind of beggars belief that this is what is required. The challenge, I think, is that our members have been up for everything that has been asked of them, and really it is their goodwill that has gotten through so much of this pandemic. We just have not shown the recognition that they deserve. Because what we have asked of them has been that much more than anyone else within this community and we certainly have not paid recognition to what we have asked of them.

Mr DAVID SHOEBRIDGE: As I understand your evidence, there has been this enormous bank of goodwill, which we are extremely grateful for, that your members have brought to this—that sense of service. But that bank of goodwill has been drawn down so heavily over the past two years that we are at risk of an exodus of your members through exhaustion and simply being unable to keep that up. Is that a fair summary of where we are at?

SHAYE CANDISH: I think it is. The reality of course is that these people are highly skilled but they are making decisions to protect their own mental health because that is really what is at risk now. Whilst they have been tired over the past few years—or at least the last decade—it has not presented in the same way that it is presenting now. When you are working 16-hour shifts back to back and on the rare days off that you have you are being peppered with text messages to come in, you know that your colleagues are working understaffed and you know what that experience is like. So it is generating such a sense of guilt that they just cannot keep operating like this because it is starting to really traumatise them. That is what is not fundamentally understood by the Government when they say that we are coping. We are coping because we are putting our healthcare workers in a position where they are being traumatised. That is not what we should be doing.

The CHAIR: I know that I and my colleague Ms Cate Faehrmann have heard about nurses saying that they feel guilty even taking a shift or a day off, even if it is scheduled, because they know if they are not working their friends and their colleagues are going to be run ragged. Is that actually what is happening? Are your members feeling guilty even just taking a day off?

SHAYE CANDISH: Absolutely. It is because you know what it is like when you are understaffed. You are rationing your care. You are deciding: Do I go to patient A or patient B? Who am I late for? Who is going to miss out today? No-one wants to expose their peers to that experience either, so when they are saying, "No, I am not going to come in and do that shift", they understand that the consequence of that is that their peer now feels the way that they feel. So it is just this cycle that we are generating of trauma and re-trauma, having to tell people, "You just have to keep going to work and working under these conditions." We are getting stories from members at the moment about commitments they made to themselves when they were going to start working as a nurse. They would talk about, "I would never let someone not have support when they were passing away," and they cannot keep those commitments to themselves anymore.

The CHAIR: Thank you, Ms Candish. Dr McMullen, is it the same for doctors—that these 16-hour shifts are effectively like gardening in a greatcoat in full summer heat? Is it the same experience for doctors?

DANIELLE MCMULLEN: It is the same, particularly for our junior medical workforce. It is essentially going to work in a raincoat. You are wearing plastic and even indoors in an air-conditioned ward it does not feel air conditioned inside plastic drapes and the mask that you cannot take off. Simple things like toilet breaks and hydrating do require quite a procedure. Our doctors have taken that in their stride in the same way nurses and other healthcare workers have because they want to be there to care for their patients. The distress now is coming from them feeling like they are not able to do that anymore.

We have taken so much from our staff that even in places where we have not had to be wearing the full PPE 24/7, as someone else said earlier, all of the coping mechanisms we normally used to work in a high-stress job—the teamwork we have, the collaboration with colleagues, being able to sit for a couple of minutes and have a cup of tea and debrief after a really difficult case—all of that has been taken away. So we are all practising in silos and it is really tough and it is also in a situation where the patients have more distress. The mental health and stress burden of everyone you see is wearing. We are here to take that burden from you all. When you come to see us as doctors we take that on, we treat your problem and we are supposed to be able to walk beside you, but that is getting harder in an environment where we share the same stresses about the safety of our families and it is tiring. It is hard to articulate why it is hard, but colleagues around the State and around the country have all felt the same whether or not they work in a hospital.

The CHAIR: Well, Dr McMullen, two relentless years of that—it is the same for doctors and nurses, is it not, that absolute exhaustion of those internal reserves and the goodwill? That is the situation we are at now, as I understand it. Is that right?

DANIELLE MCMULLEN: Yes, I think it is that mix of, as you said, physical and emotional exhaustion. COVID—the first few months there was kind of this teamwork fun, the whole community got together; this was a different thing and we were all just going to be in it together. But two years later everyone is tired of that. They want it to be over but it does not get to be over in our job. It does not get to be over in a lot of people's jobs, I recognise that, but it is in your face a lot of the time. That same issue of covering for a colleague if they are doctors in training—one solution we have asked for for that is that doctors in training be able to claim overtime when they are covering for a colleague who is off sick either with COVID or something else and they are covering a short-staffed team. Would that be an approved reason for claiming overtime just to be able to recognise that everyone is pulling in and trying to cover for each other? But we need to find a longer term investment in our workforce to ease that burden a bit.

The CHAIR: Ms Candish, this concept of an investment in the workforce and an investment in the nursing staff—I know your members are going out on industrial action on Monday unless matters have resolved. There were a number of options put forward about what a meaningful investment in the nursing staff would look

like. One is my colleague Cate Faehrmann's proposal for a "nurse keeper" payment. Whether it is nurse keeper or something else, what is needed in terms of that meaningful economic recognition for nurses to keep nurses at work and attract new members?

SHAYE CANDISH: In terms of financial remuneration, it needs to be a pay rise that recognises the value that these members contribute to our society. At the moment when we freeze their pay in the middle of a pandemic and in 2020, the Year of the Nurse and Midwife, we are sending them the complete opposite message. The trust, I suppose, that the Government values their work when they get up every day and say thank you has already been undermined. We have to invest in improving the working conditions. Working conditions—exactly as I pointed out earlier—have deteriorated to a point that it does not even sound like we are talking about a hospital in Australia. So we have to do more. We have to provide enough nurses and midwives to be able to do the job that they come to work and want to do. The only way that we can have that is by mandated minimum staffing, which is ratios. We need the Government to move on this.

I understand that there is some absolute reluctance and of course their wages policy prevents them from agreeing to anything that is seen as an investment in the hospital system, but there is no way that we can continue to provide the same level of service without a significant investment in the workforce. So it has to be about providing enough nurses and midwives to be able to do the job and then providing support services that can help them to re-establish the resilience that we have always had. Giving them access to things like COVID leave when they have COVID would be a really good start. Just basic fundamental principles that really recognise how challenging their working conditions have been, like pay and staffing, would go such a long way to providing some hope to this sector because right now there is no hope. That is why our members are taking action. They do not believe that in one year or two years it will be any different unless they take action. So the Government has to demonstrate that there is hope that it can be different and that they will invest in this system.

Ms CATE FAEHRMANN: Just on that, I have just noticed a tweet by Minister Hazzard that he is excited that there are 2,800 fantastic new nurses who are joining NSW Health. Obviously, that will put more nurses into the system, but I would assume that we are losing a lot of experienced nurses; we are losing nurses with decades of experience. We 100 per cent support ratios and, yes, we need to implement them immediately. But that will take some time, realistically, to ensure that there are enough nurses to ensure that those ratios are met. I think that is true in terms of being realistic there. So the retention of the experienced nurses right now—what can the Government do today over the next few months, Ms Candish? As you are talking I am trying to think what can be put in place before, for example, the winter surge that all the witnesses are saying is going to happen. What can be put in place to ensure that those nurses who are on the verge of resigning do not go?

SHAYE CANDISH: I understand that financial payments seems like the obvious thing. It certainly would go a long way to demonstrating to members how they can be supported, but the reality for our members is that the only thing that is going to change their working life is if there is sufficient staff to be able to deliver care. We do not expect ratios to be delivered tomorrow. We have always had an approach that sees a tranched operational flow-on of nurses to be implemented into the system—a certain number at a certain time. You train some more and then you bring the next lot in. But we need commitment to that now because that is the only way that we are actually going to see a health system that is going to be supported in the long term.

Providing nurses and midwives with a COVID payment, a COVID allowance or a retention bonus—any of those things—is something. But the reality, of course, is that it feels too little, too late, given what they have already dealt with. It actually needs to be a proper pay rise that sustains the challenges that they are working within and really recognises the contributions that they make to society, not some measly couple of hundred dollar payment like we have seen in the Federal system. The reality is it is just not enough, given what these people have gone through. It has to be a long-term, sustained investment that really gives people the capacity to see that, "In six months' time, I know that my hospital will be getting another four nurses on my ward. I can stay. I can wait for that moment because they are coming. In the year after that, I am going to get another 10 nurses"—whatever it is in each person's individual unit. That is the hope that actually will keep people in the sector. It will keep the experienced nurses saying to the junior nurses, "You should come and do this job." Right now, that is not what is being said.

The CHAIR: Cate, we might just go to the Opposition for five minutes and then come back to you again for five minutes, given the time we have.

The Hon. JOHN GRAHAM: We have only got a short time left, but I want to ask each of the witnesses—you have each got members on the frontline of the health system. Have you seen a change in how the pandemic is handled, particularly the role of NSW Health, as we have moved from Premier Gladys Berejiklian to Premier Dom Perrottet? I ask you first, Dr McMullen.

DANIELLE MCMULLEN: We certainly provided some public commentary at the time of the change of Premiers, highlighting how important it was, we felt, for the health advice to continue to be front and centre. We know that our Chief Health Officer, Dr Kerry Chant, has provided that really strong and stable health advice both to Government and also to the general public. There was a sense in the community that her voice and the voice of the health advisers to the Government may have been not as front and centre in the immediate change of Premiers. I must say, in the more recent outbreak and this year, that does seem to have changed and it does appear that the health advice is again being given the priority it deserves. We feel that our qualms were listened to, and we are comfortable with the current situation.

The Hon. JOHN GRAHAM: Ms Candish, we know the 15 December decision of masks off, then mask on—it was written health advice that was ignored. Have you seen a change or have your members seen a change as we have changed Premiers?

SHAYE CANDISH: I would say yes. We have definitely seen health advice given primacy through the beginning of the pandemic and then changing with Premiers. We saw health advice take a backwards step. I agree with the previous speaker that it does appear that health advice is now being prioritised again, which we are very grateful for.

The Hon. JOHN GRAHAM: Mr Hayes?

GERARD HAYES: I think that is right. We have obviously got to move through this pandemic, and there are a lot of people in the community who are suffering dramatically at the moment. We have got to be able to walk and chew gum, effectively. I think it was very wise to put the masks back on. It was not a big cost to do. I think that way we can move forward. There seems to be some stability from a health perspective, as well as the economy moving again.

The Hon. COURTNEY HOUSSOS: Mr Hayes, we talked earlier about the effects of the pandemic in regional areas. Is it true that there has been some regional restructuring done by NSW Health during this period that has actually resulted in cuts to jobs?

GERARD HAYES: That is correct. We are in dispute in, at least, Tweed Heads—the new Tweed Heads hospital. We cannot get any idea of what the staffing levels are going to be there. There are two other hospitals we are involved with there. We have lost 82 positions in the southern local health district. That incorporates Bega and those areas. These positions are—some are managerial, but some from allied health and some from pathology. It beggars belief that you could even countenance that sort of business at the moment—an area of very serious concern that we are taking a knife to. I cannot understand that at all.

The Hon. JOHN GRAHAM: It is surely inexplicable to be cutting staff in Bega in a pandemic.

GERARD HAYES: This has been on the program for a while. We have consistently been in dispute on it. I do not understand that. Yet the development of hospitals, as I have indicated—Tweed Heads, in particular, which is probably going to be two to three times the size. We are in the industrial commission, trying to get some kind of workforce plan as to how that is going to be staffed. If we cannot get to the point prior to a building being established and a facility being established of what makes sense and a good staffing level right throughout that building or that health facility, that becomes incredibly problematic and sets us up for ongoing disputes, lack of service and, particularly on the back of a pandemic, would indicate that we have not learnt a lot.

The Hon. COURTNEY HOUSSOS: Just to be clear, Mr Hayes, we have actually had cuts to pathology in Bega during the COVID pandemic?

GERARD HAYES: We are actually in the industrial commission now. The Ministry of Health have tried to change the pathology award, effectively decreasing pay in pathology. That has now been removed, but they want to do a restructure of pathology, which we would expect, instead of decreasing individual pay, is going to decrease the structure. That will be the workforce. Again, pathology, of all areas—it beggars belief that you could entertain that at this point in time in a pandemic. These people are the ones, like all the other health professionals and health workers, who have got us to the point we are at today. The pandemic is not anywhere near over. We are in the commission justifying why we will cut your wages and decrease the number of people working in pathology.

The CHAIR: As a frequent flyer for PCR tests, I have got to say thank you very much to all of the overworked pathologists across the State. It is disgraceful that anyone would cut their conditions.

Ms CATE FAEHRMANN: Dr McMullen, I wanted to ask you about what the World Health Organization has been reporting on recently, which is the new Omicron sub-variant, BA.2. Just before my next question, have you been following some of the news on that? Just to check—

DANIELLE MCMULLEN: I do not have the detailed knowledge of—I have only seen a couple of news reports. But no, it is not my area of expertise.

Ms CATE FAEHRMANN: I can tell you what they have been saying. Danish scientists have found that this new sub-variant is potentially one-and-a-half times more transmissible than the original Omicron variant, so it is likely that this and other variants, of course, will potentially come our way by winter. What would your message be to the Government right now to help ensure that our health system can cope with this predicted surge in winter?

DANIELLE MCMULLEN: What we do not know about future variants is how transmissible or how severe they will be, but, regardless, we need to be prepared to be able to manage a surge in case numbers but also continue to provide non-COVID care. We are starting to see the effects of that disparity in care provision, and doctors want to be able to provide their usual care to patients. We need to, as we have talked about before, ensure our population is well vaccinated for COVID, well vaccinated for flu, make sure that we have, as much as possible, a coordinated, united, single health system where the patient is getting the right care at the right time with the right person. That means better coordination with primary care, maximising the value of primary care for the mildly unwell, for people who are unwell with other conditions that need higher input while they are isolating at home, and making sure that we have got hospital systems in place for a surge either of the flu or of a COVID variant, which means workforce surging, space surge and emergency department paramedic workflows to make sure that we are clear about how that is going to work in the event of another large outbreak.

The CHAIR: All three of you have spoken about the need for your members and the workforce in NSW Health to have more protections and more support, yet the only clear legislative measure the Government is proposing for the health sector at the moment is to change the Workers Compensation Act to remove the automatic right for your members to be supported if they catch COVID. We have the health Minister coming later today. Briefly, what is your message to the Government on that proposal? I might start with you, Ms Candish.

SHAYE CANDISH: I think it is outrageous. It is a slap in the face for workers that have given everything over the past two years to then have to really justify and prove where their exposure has come from. We know that it can be already a challenging bureaucratic process, just given the mass misinformation and confusion that we were already talking about earlier today when people are going through this process of applying for workers compensation when they have had a COVID-positive test. The prospect of having to put more of that onus back onto a workforce that are already acknowledged to be suffering just makes no sense.

The CHAIR: Mr Hayes?

GERARD HAYES: I would fully endorse what has just been said. I cannot believe that this would be the case. As I understand it, there has probably been about 2½ thousand claims made. That was the last figure I heard, which hardly is excessive. I just think, to health workers who have put us here, that this would be given any kind of credence at all is just quite amazing, particularly when we have seen a lot of the good work that Daniel Mookhey has done in exposing the icare issues.

The CHAIR: Dr McMullen?

DANIELLE MCMULLEN: Thanks. We gave evidence into this inquiry recently and we would agree with the others that now is not the time to even be giving the image of taking away a protection for our frontline healthcare worker staff, and so we are not in support of changing that legislation at this time. We think that at least a 12-month delay should be given to reassess where we are at down the track. It would not go down well with healthcare workers at this time.

The CHAIR: Again, on behalf of the entire Committee, regardless of our politics, I would like to thank you all and your members for the work you have been doing. I look forward to this year having less stressors and more support, and maybe we can start refilling that bank of goodwill amongst our health professionals. Thanks very much.

GERARD HAYES: Thank you, everyone.

SHAYE CANDISH: Thank you.

DANIELLE MCMULLEN: Thank you.

(The witnesses withdrew.)

(Short adjournment)

Professor TONY BLAKELY, Professorial Fellow in Epidemiology and Public Health Medicine Specialist, Melbourne School of Population and Global Health Adjunct, University of Melbourne, affirmed and examined

Professor RAINA MACINTYRE, National Health and Medical Research Council Principal Research Fellow and Professor of Global Biosecurity, University of New South Wales, sworn and examined

Mr MARK BURDACK, Chief Executive Officer, Rural and Remote Medical Services, affirmed and examined

The CHAIR: We are very fortunate to have three eminent experts to speak to us from a public health perspective. I invite you now, if you wish, to give a brief opening statement. Professor MacIntyre?

RAINA MACINTYRE: Going into the pandemic, New South Wales had a well-resourced health system and excellent public health expertise. The pandemic has resulted in a health system crisis in both workforce and sustainability, which will continue to effect New South Wales into the future. In New South Wales, as pretty much everywhere, a vaccine-only strategy has been used followed by surrendering to the pandemic. The vaccines are very effective at protecting against severe disease and death, but two doses barely protects against symptomatic infection with Omicron. To go forward and to have both health and economic success, we do need to address safe indoor air and use additional mitigation measures like efficient test-and-trace systems, masks and ventilation.

COVID is never going to be endemic; it is an epidemic infection. It will continue to come in waves until we have a sterilising vaccine, and it is very unlikely that such a vaccine will not wane after time. New South Wales lifted all mitigations, or most mitigations, on 15 December with extremely low third-dose vaccination rates, knowing that two doses does not protect against symptomatic Omicron, and with children unvaccinated. Really, we should have waited until we had 80 per cent third-dose coverage and full vaccination of children, and until that time at least, retain high test-and-trace capacity, QR codes and mask mandates. Providing high-quality masks like N95s is happening in other countries like the US and has been shown in research to improve control substantially. Providing and retaining those things long-term does not impinge on freedom and will bring the best health and economic outcomes. If we do not stop transmission, we cannot stop illness and death or the emergence of new variants.

I just want to finish by saying that long COVID has decimated the workforce in the UK and the US. The virus has not mutated into a cold. It directly kills heart cells. It invades every body organ, including the brain. Post-mortem studies have shown the virus persisting in every body organ after the acute infection. Studies have shown shrinkage of the brain on CT scan, a drop of seven points in IQ, a loss of myelin around the nerves and pathological changes in the brain similar to Alzheimer's disease. We may well be facing an epidemic of chronic COVID-related cardiac, respiratory and neurological illness, and this matters most for our children. We really should use all available tools to mitigate spread. This can be done without impinging on freedom. It includes good quality masks, test and trace infrastructure, ventilation and safe indoor air. The virus spreads through the air we breathe and we cannot recover economically until we address that. For small businesses, big businesses, for everybody, we must address safe indoor air.

I had other points to make around the Workers Compensation Amendment Bill, urging not to overturn decades of work health and safety gains, and comments about the performance of SafeWork NSW, about the health system and health workers, about the Delta epidemic, about rural New South Wales and Aboriginal communities—particularly the impacts in towns like Wilcannia, about deaths at home—which I think need a formal inquiry into why even young people in their 20s and 30s have been dying at home from COVID, about the collapse of the test and trace system, and about the complete lack of planning for the impacts of massive case numbers on workplace absenteeism, supply chains and critical infrastructure, and then the long-term impacts on workforce. Thank you.

The CHAIR: There is a lot to unpack there, Professor MacIntyre, and we will do what we can to cover it in questions. Mr Burdack?

MARK BURDACK: Thank you to the Committee. I would like to acknowledge that I am talking to you from Orange in Wiradjuri country and pay respects to Wiradjuri Elders past, present and emerging of this country, and to any other Aboriginal people present or listening. RARMS is a charity established in 2001. We work with vulnerable communities like Collarenebri, Warren and Gilgandra to provide primary healthcare services. Prior to 1 March 2001, we also operated community general practices in Bourke, Warren and Walgett. However, we were regretfully forced to close those practices in the towns during COVID.

My focus will be on rural and remote communities, as you would expect, but I think there are lessons that can be learned from the management of COVID for how we deliver health services in New South Wales more generally. In terms of the management of COVID, I would like to make a couple of opening observations.

There is no doubt the scale and severity of COVID took the health system by surprise, given the last global pandemic was in 1918. It was, in some senses, understandable that the early response was a little disorganised, but the ongoing problems with the response is more concerning. We had a national plan for the management of pandemics which was shown to be—like many documents of this sort—an expensive paperweight rather than an actual plan. We had led the world in our response to HIV and to SARS and MERS, yet the same integrated and coordinated health approach seemed to have been replaced by a hospitalist approach in dealing with COVID.

Rural and remote people do not understand why, after the expenditure of so much money to prepare for the inevitability of a pandemic, we appeared so unprepared for actually dealing with it. There is no doubt that everyone was motivated by the best intentions; I do not believe anyone got up in the morning and thought "How can I make things harder for rural and remote people during COVID?" But unlike other national crises, COVID did not bring us together as a nation or a common effort and this was felt heavily on the ground in rural and remote communities. While Ministers were rightly guiding the community about the risks of COVID and the need for urgency, it was a sense of "business as usual" in the early response of the health system. In March 2021, for example, contracts for leading medical officer services in several rural and remote towns were taken away from local rural general practices and awarded to a Sydney-based commercial medical provider, undermining the sustainability of general practice in these towns during COVID and leading to the loss of a number of rural GPs.

Rural and remote people were listening to Ministers correctly saying that we were in the middle of a global health crisis, yet, at the same time, the health system was engaging in activities that they were aware would disrupt the provision of health care in our communities. There is no doubt that rural and remote people suffered disproportionately during COVID due to dysfunction in our rural and remote health system, which has been addressed in the other inquiry into rural health. The failure to anticipate or plan for how this pandemic would impact on rural and remote communities made a bad situation worse, and reflects the problems in the way our health system supports rural and remote communities and our preparedness for dealing with natural disasters and other emergencies.

What the COVID crisis and its management tells us, more than ever, is that New South Wales is increasingly running a hospital system and not a health system. The focus of our response from the beginning was on diseases and cures, not on people and patients. There was a sense that all we needed to do was find a cure and the job was done. Little thought appears to have been given early on to the human interventions of health care, such as how are we going to get these vaccines into people arms and how are we going to deal with the inevitable hesitancy around a rapidly-developed treatment. Primary health care—that is, GPs and nurses on the ground working in rural and remote communities—were not consulted and there was little to no coordination until the system realised that health care is about people, and GPs were the only ones that had the relationships in the communities to address this critical aspect of the response. A disease-focused response resulted in numerous gaps.

The failure to positively engage with people around new vaccines and the sometimes contradictory statements made by government created a void which was readily filled by individuals with conspiratorial ideation. The damage to public health of the emergence of this renewed anti-vax movement will be felt for decades, let aside the damage to the mental health of the individuals for whom our approach to COVID validated misconceptions about the world in which they live. We closed our borders but did not reflect on the impact this would have on the national health workplace market or on recruitment of doctors from overseas, which left rural and remote communities vulnerable.

Following the opening of borders to doctors, we have continued our failure by refusing to give priority to those doctors that have applied to work in rural and remote communities, where they are needed. Rather than engaging with primary health care in rural and remote towns about how to secure reliable health services, our hospital system went to market in competition with primary health to secure a workforce. Locum costs have escalated as hospitals sought to address gaps in their workforce by offering more money, which has made more practices in rural and remote towns unsustainable. RARMS was forced to close one practice and is presently reviewing other practices due in part to the panic to secure workforce in major cities.

I would like to basically just conclude there, but note and acknowledge some of the work that people have done during COVID. RARMS worked with the local community in Goodooga, for example, on a local pandemic plan to address local concerns about the risks to Elders and the unwell if COVID entered this small Aboriginal community. The community was not supported to prepare; it was simply left to its own devices. We worked with that community to develop what was an exceptionally good plan but one which did not receive the support that I think it deserved. We have worked with Khans IGA and Lightning Ridge District Bowling Club to organise online food ordering and deliveries to isolated communities to reduce the need for sick people to come into town, and therefore reduced the risk of exposure.

We prepared a local guide for local government, catered to provide advice on what local governments could do to make sure their community was healthy, particularly those isolated, and ensuring they were being checked on and had adequate supplies. We worked with Manildra Flour, who supplied 2,000 litres of hand sanitiser for free for distribution to GPs, schools, community groups and others in rural and remote areas when we ran out. The outcome of this inquiry I hope is a reorientation of our approach to health, to re-establish an approach which is health based rather than simply disease and hospital based. Thank you.

The CHAIR: Thanks, so much, Mr Burdack, and for the work of you and those communities you work with, particularly in rural and remote Australia. Finally, Professor Blakely?

TONY BLAKELY: Good morning. I would like to keep my comments relatively brief and learning from the past, thinking about the future. Learning from the past, two things we can point to is we actually had very good plans as a country and State at the end of last year for Delta, but we did not really think enough about what other scenarios are there out there. Another lesson we learnt was forgetting to order things like RAT tests. We cannot have that happen going forward. So, in very simple terms, what might a flexible plan look like going forward? Well, I think it is useful to think in terms of three scenarios.

There are more than this, but three scenarios covers the pub test of what most people would say, "Yeah, that makes sense": another virus comes along like Omicron—highly infectious, not too severe or virulent; another virus comes along like Delta—we used to think it was very infectious, but not as infectious as Omicron, and quite severe; and then one that comes along that is the worst of both of those, both highly infectious and quite virulent. The reason I think it is important to have those three in place is that if everybody can understand that type of typography, it means that we can have prime ministers, chief medical officers and all of us—politicians and experts—stopping being forced to make blanket statements like, "There'll never be a lockdown again", because if that one does come along we may need severe measures and fullcore press and lots of things. But we hope we are only going to get these two, and we can manage those relatively well.

The second comment I would make on planning going forward is: What should we do in a plan, particularly thinking about that one at the top, in case that happens? Raina has made extremely good points about ventilation and Mark has made extremely good points about regional healthcare planning. Here are a few other ones. We learned from RATs. We didn't order them. There should have been warehouses full of the stuff ready to roll out. Now, I am assuming that we have that in place; surely we have learned that. But here is another one, and this echoes Raina, but mainly just thinking about that worst-case scenario. We should have warehouses full of KN95 and N95 masks so that if a really bad one does come along—and I hope it doesn't, but if it does—we can roll out to the population these masks and try to keep society ticking along and protect those people who are vulnerable.

That type of thinking, going forward, is a useful framework to carry into the future. The last comment I will make is—and there are people with more expertise than me on this. We are going to get to a point soon where we are going to be making decisions between next-generation vaccines that are targeted at, say, something that looks like Omicron, or something that hopefully is covering more options. There will be an interesting decision point coming up as to whether Australia or New South Wales decides to back a more Omicron-specific vaccine or something that is more multivalent. They will be decisions coming up. That is where I will keep my comments at this point. Hopefully that is a useful framework.

The CHAIR: Thank you all. In fact, the problem we will have is addressing these issues in the time we have available. Professor Macintyre, I know that you have provided a submission. Did you want to table that formally now?

RAINA MACINTYRE: Yes. I just wrote down some points. I also have two testimonials, one from a doctor who works in regional New South Wales and another from a doctor who works in a major public hospital in Sydney, which I think reflects the experience on the ground in the health system both in regional and urban New South Wales.

The CHAIR: We have received the submission, so I will treat that as tabled. If there is anything additional, forward it to the secretariat and I will ensure it gets distributed to the Committee. We will now have three rounds of questions, starting with the Opposition.

The Hon. COURTNEY HOUSSOS: Thank you very much, Mr Chair. I thank all of our witnesses for their time this morning and for their opening statements. Professor Macintyre, I will start with you. You outlined that—I liked your words—"surrendering to the pandemic" is essentially what happened, particularly since 15 December and the lifting of restrictions. What would the alternative pathway have been? What is something that we could have done that wouldn't have put pressure on our health system in the way that we have heard this morning? Could we have learned from around the world about what we should have done?

RAINA MACINTYRE: We have seen different approaches around the world. A lot of countries, particularly in Europe and the UK, have surrendered. They have just said, "I am tired of this now. We're just going to stop. We've given you a vaccine; that's enough. Now we're going to stop." But the vaccines alone are not enough—not at this stage. I do hope that they will be enough in the future because there is a lot of amazing development in vaccines and there is a lot of hope, but for now we do need other measures. As Tony said, masks—particularly providing N95s or P2s or even the Korean KF94s, which are much cheaper than the N95s. In the US they are providing free N95s to everybody. That makes a huge difference. There has just been a piece of research published from California public health showing the difference in protection from a cloth mask to a surgical mask to an N95. On a population level, that is going to make a big difference. It is going to really mitigate the spread and protect people, children, health systems and vulnerable populations that are more at risk.

The other thing we can do—simple things—is addressing safe indoor air. I do not understand why that is such a difficult one. It is actually not expensive to address and is fairly easy to address. Even just educating people—we saw these campaigns on washing your hands. Well, you can wash your hands until the cows come home, but it is not going to help you that much with preventing infection. People do not have that knowledge that it is really the air you breathe and just opening a window—that limo driver who sparked the Delta epidemic in June in Sydney. I bet he didn't know. I bet he had sanitiser in his car and did not know that if he opened his window, he would have reduced his risk of getting infected in that small space—or just switching the ventilation in the car to outdoor air. We can educate people on simple steps that they can take and empower themselves to control their risk, but if they do not know, they cannot empower themselves.

I think education campaigns on safe indoor air—a really concerted effort will make a big difference, because people want to be safe. That is why we saw hospitality bookings collapse for New Year's Eve, the most profitable time of the year. Everyone cancelled because people want to be safe. They want QR codes there. We should maintain them. We have put all that effort into the QR code infrastructure; let's keep it. People want to be safe. They want to be notified if they have been in contact. We have that digital infrastructure and we should keep it and expand on it. If you tell a contact they have been exposed, you are doing a lot to prevent transmission.

Testing and tracing are the pillars of epidemic control, so we need to invest in that testing, in addition to the PCR system. I do not think we should be restricting PCR tests. That was brought in after the system couldn't cope in December. I think it should be expanded and we should expand on the provision of RATs, as Tony said. They should be free or heavily subsidised. You need a lot of RATs. The average family or individual needs a lot of RAT tests to get them through. At $15 a pop, that is not affordable for most people, so I think we really need to look at scaling up that testing. If we have the test and trace piece, that will go a long way, with good-quality N95s, and it will make a big difference.

The Hon. COURTNEY HOUSSOS: How effective is our testing and tracing capacity in New South Wales at the moment, in your opinion?

RAINA MACINTYRE: Not very. We do not even have a good handle. The testing system essentially collapsed in December, so we had a two-pronged failure. One was that the PCR testing could not keep up and, in response, several of those public testing sites were actually closed down—the drive-through sites. It was a great thing that the New South Wales Government put in those drive-through sites, because they really reduce the risk of getting infected. You do not want to go for a test and walk into a building and get infected as a result. The drive-through was a fantastic thing. They were everywhere.

Suddenly all these centres were closed down right when people needed it to stay safe for Christmas and New Year, and there were no RATs to be had—none. You couldn't get them. That wasn't the fault of the New South Wales Government; that was a failure in planning at the Federal level. But if you have a plan to surrender to the pandemic, then you have to account for all those other things. You have to make sure there is adequate testing capacity. If we do not address testing and tracing, we are going to see the same problems occurring intermittently in waves into the future. But we can do a lot to have a sort of equilibrium and prevent that boom and bust cycle.

The Hon. COURTNEY HOUSSOS: Thanks very much, Professor Macintyre. My time is limited, so I am going to move on to Professor Blakely. You talked about three different scenarios and they are very logical scenarios. How well do you think our health system in New South Wales can actually cope with those, or perhaps in Australia?

TONY BLAKELY: Let me back up and brainstorm it. The two lower ones down here—I think we are all pretty good for that now. On the surrender to the pandemic or not, I agree with Raina up here for something that comes along that is really what we don't want, but we still have to plan for it. The full planning should be done for that. In that eventuality, which I hope doesn't happen—I assume it is well less than 50 per cent the next year, but there is a possibility—we do need to be able to mobilise the masks and mobilise the testing. Another

point I want to make today is that we have talked in the last 24 hours about having updated [inaudible] status on vaccine certificates and things. They do not need to be on all the time, but we need to pull them on when we need it. For example—this is where I might deviate a little bit from Raina—we do not, perhaps, need to have vaccine passports in place in the whole time.

When there is no virus around, we can still go out to the pub even if we haven't been vaccinated. But when a new variant comes in that is of concern, particularly that top one, we pull these levers on. That also includes having density limits and that sort of thing—people like me working at home, and all the rest of it. Your question was specifically about how well prepared we are to manage going forward. On that top one, we have not yet got it in place. On these ones down here, particularly if it was another Omicron-type one, I think we will manage that reasonably successfully—I was going to say "bumbling through"; that is not quite fair—by muddling our way through it. I think we will do that quite well. This is the one that worries me. I cannot guarantee it is going to happen, but we need to plan for that eventuality.

The Hon. COURTNEY HOUSSOS: But, two years into the pandemic, we do not really want to be fumbling our way through. Surely we have had enough time now to prepare and to ensure that we actually can approach this in a more planned way.

TONY BLAKELY: As far as planning for this one, which is where I have focused my efforts, yes, we could have done better. I will include myself in that failure. I applauded the plans last year because I thought they were really good, but I was not thinking enough about the scenarios and a worst-case scenario or something really infectious, like Omicron. That is the type of learning we need to do to improve our plan. I think the things announced by National Cabinet yesterday, of having updated, up-to-date-ness—that is great. We get that architecture in place. The architecture we need in place to plan is having that ready to pull on if we need it, having the KN95, the N95 stockpiles there, ready to roll out if necessary, being nimble and adroit to bring into the country the new vaccines at the right moment in the future, all that type of thing. We should be much better at that now, having learnt from the past.

The Hon. JOHN GRAHAM: Can I just come back to your point about testing. I agree with some things that we adjust rapidly to, but it was clear from the start just how crucial testing was going to be. It was one of the first things we discussed when this COVID oversight committee questioned the Minister and the Health team. How is it that we have ended up in this situation where there are no RATs, where we certainly did not have warehouses stocked full of RATs in New South Wales? I will certainly be asking whether we do now, to go to the point you made in your opening statement. How did we get to this position?

TONY BLAKELY: I assume that question is directed at me. Just reflecting on that, I cannot remember when I first started talking about—"We need lots of RATs." I am sure it was a couple of months after Raina. But let us say it was August last year. It was not just me. Everybody knew it. The Premiers knew it. The Prime Minister knew it. They just did not get ordered. Yes, there was world supply limitations, but not severe enough that we could not have ordered those supplies in. Whatever happened, let the history books sort it out. Going forward—this is why I keep coming back to masks. I assume that we will now have good stockpiles of RA tests to use when we need them. We do not need them all the time. But, when there is a bad variant around and we want to keep schools open, RA testing the kids twice a week—go for it.

The one other example I can think of, like that, is—Raina is exactly right. That paper released just four days ago is quite phenomenal. It shows an 83 per cent reduction in your chance of transmission by wearing a KN- or N-95 mask, whereas it is still good but only 40 per cent for cloth. If a variant comes along, that has big vaccine escape, we will not have time to wait around for a new vaccine. But we can get masks out to people in one week and have at least the fit and healthy—if they get infected, it is not going to be too bad—moving around society, as well as protecting people in workplaces and all the rest of it. Please, let us get some warehouses completely full of these masks that we can roll out, if we need to, to the population.

The Hon. JOHN GRAHAM: These are population-wide, strong interventions that we need to be planning for, certainly, for a future wave, which has been talked about. How important might they be, though, for managing Omicron while it is still around in what is still such large numbers?

TONY BLAKELY: Again assuming that question is directed at me. I bifurcated that point. For the people who are vulnerable, with comorbidities, and there is still a bit of Omicron around, my neighbours, for example—if they are going out and about, I really want to see them wearing a high-quality mask to protect them because they are the ones at most risk. For people like me—I have already had my infection. I have still got a small chance of getting it, but it is much less. I am still reasonably young, in my mid 50s. Younger people than that—I think the need for high-quality masks when you are moving around the community now is diminished because actually, probably, half of us have been infected by now, on the east coast. There will be remaining infection. I know that, whilst we do not individually want to be infected, having a lot of us having been infected

with Omicron will diversify our immunity, going forward. So, to answer your question there, John, I think personally that those high-quality masks—right for the moment, they are for the people who are vulnerable in the community. Of course, in aged-care, healthcare settings, everybody should be wearing them in those high-risk settings.

The Hon. COURTNEY HOUSSOS: Mr Burdack, can I just ask you. We have heard previously—[disorder]

The CHAIR: We have not had that before. I am not quite sure what that was. But there seem multiple scenarios someone wants to talk about. We will go back to the Opposition.

The Hon. COURTNEY HOUSSOS: Mr Burdack, I will just try and ask you a question and see how we go. We have heard pretty compelling evidence this morning about the workforce pressures that have been placed across the State as a result of the lifting of restrictions on 15 December by the Premier. What is your reflection on the way that that has played out in remote and regional areas? You talked about, in your opening statement, the difficulty in getting health workers in regional areas, particularly with the city drawing [disorder]

The CHAIR: Mr Burdack, I do not know if it possible to have a look at if you have some headphones or some earbuds that you can attach. If you can try one of those localised solutions, we will come back to you. Sorry, Courtney. Have you got another line of inquiry?

The Hon. COURTNEY HOUSSOS: Yes. Not a problem. I might just then come back to Professor MacIntyre. Apologies. You were talking about the impact of long COVID. How well do you think the New South Wales health system has prepared for the support that is going to be required for health care going forward in treating long COVID?

RAINA MACINTYRE: I do not think any country in the world is prepared for it. Long COVID is a heterogeneous entity. It describes a kind of fatigue and symptom persistence beyond the acute illness. But the causes are manyfold. One cause could be cardiac. Right? We know the virus affects the heart. You could have subclinical heart failure that is actually making you tired. Another cause could be respiratory impairment. We again know that you can get long-term respiratory impairment, after the virus, and episodes of shortness of breath and fatigue because of the oxygen not getting in the blood properly through your lungs. The third cause could be neurological. There is quite a lot of studies now showing the impact of COVID on the brain. It is possible we will have an epidemic of dementia, young-onset dementia, or even young-onset heart failure. We really do not know. It is still early days. But it is very clear that there are substantial chronic disease implications. My guess is there is going to be a major burden of disease on the health system in the decades to come, including in children—into adulthood will carry the chronic impacts of this infection, some percentage of them.

The CHAIR: We will now move to the crossbench. But, before we do that and before we open up questioning, Mr Burdack, let us give it a try. How are things up there on Wiradjuri land?

MARK BURDACK: I am hoping that you are hearing this.

The CHAIR: Indeed. We can hear you. That is coming through nicely. I might just invite Ms Houssos to put that question again. If she is not in a position to do so, we will come back to that. But I will go to Ms Faehrmann now.

Ms CATE FAEHRMANN: Thank you, Chair, and thank you, Mr Burdack. I am glad you got your audio sorted because I did want to ask you a question. We were very much enjoying that as well, in a strange way. That was a pretty scathing assessment that you made at the beginning about the Government's responsibilities in the rural and remote health sector that they have failed them, really, over the past couple of years. I, as you know, have communicated before as part of the regional, rural and remote health inquiry. What can the Government do now, in your view, immediately and in the next couple of months to help stem the exodus of healthcare workers to help ensure that the health system in rural and remote New South Wales is better able to cope for what could be an even worsening situation, of course, as we come into winter? What are your recommendations?

MARK BURDACK: There are a couple of things. One is we are now seeing doctors come through, as you know, rural communites rely on overseas doctors to staff general practice and hospitals. We are seeing them come through, we get applications, we have interviewed at least sixty doctors. We cannot get them evaluated at the moment because no priority is given to examining and assessing those doctors. It is a first-come first-serve basis. I think we are up to about July or August before any of those doctors who want to work in rural areas are able to get an examination. That would be the first thing - for the State to work with the Commonwealth to have a look at the prioritisation, so we can get doctors there. It is not a shortage issue, it is an issue of process and lack of prioritisation. That would be the first.

The second is that I think the New South Wales health system needs to work with general practice. We need to coordinate planning around recruitment at a local level. Rather than each system trying to get a doctor, there should be coordination on a town by town basis to bring medical workforce into those communities. Thirdly, there do need to be some resources. For example, we need to look at HEPA filters and air flow in general practices in these communities. They are often very old buildings being not particularly well designed in a lot of cases.

Access to resources to incorporate air flow systems would be an extremely helpful thing right now. It worries me. We are still putting most of our patients out under awnings out the front. That is great until it gets to 50 degrees in Lightning Ridge, and then it gets really uncomfortable to be sitting outside. So it would be great to be able to bring people into air conditioned comfort, particularly those who are ill. But we need to address the air flow issues without just simply opening the back door, which opens up another set of issues that we would need to address.

So they would be three top priority issues. Access to PPE in the community remains an issue. We need to recognise community groups are subject to significant—some of the worst poverty in New South Wales. The subdividing communities into those who can go down and get a RAT for free and those who can't get out for a RAT. It is not a useful division. We need to acknowledge that. People in rural and remote areas are more likely to have two or more chronic diseases. They are more likely to be at risk and know all these factors. They should simply get access to these services and this equipment now and get access freely to reduce the impact because we know that impact is going to be much more.

Ms CATE FAEHRMANN: Thank you very much, Mr Burdack. Professor Blakely, I just wanted a quick clarification of something you said earlier. Did you say that half of the east coast population has had COVID? Did I hear that correctly? If not, what is your view in terms of how much of the population—I think the official figures are something like 14 per cent, if you go by the cases that are recorded officially. What is your view on that?

TONY BLAKELY: The honest answer is that we do not know. But the reality is that there are a heap of sources. I will not take up your time, but you can triangulate from all sorts of things like leaked Doherty modelling before Christmas, work by the institute of health metrics and evaluations and all sorts of places. Roughly, we think in high-income countries about half the population is going to be infected through this wave of Omicron.

Ms CATE FAEHRMANN: Great. Thank you. Just around the issue of N95 masks, it was something that I remember asking the health Minister early on in the pandemic. We just heard from the head of the Australian Medical Association [AMA] that she has just been fit tested for her masks and, in fact, she still cannot access the mask that fits her correctly. She is a GP and she is the head of the AMA. You are talking about warehouses full of masks. I might go to you for this, Professor MacIntyre, and the need to have these masks. The US is handing out free N95 masks. Why have we got it so wrong? Is it because the New South Wales Government and the Australian Government just has not prioritised it, or can they genuinely not buy any? What is your view on this and how do they fix it?

RAINA MACINTYRE: There have been shortages of the really good quality N95s, but there are alternatives, like the Korean KFN94s or the Chinese KN95s. The Korean ones are regulated and undergo regulatory testing in Korea, so we know they meet a certain standard for the filtration of the material. I think those have been plentiful. I think one of the problems is more that for probably 18 months of the pandemic there was denial of airborne transmission of SARS-CoV-2, and Australia was probably the stronghold of that denial. It was everywhere, including WHO, but Australia was one of the last countries to agree that SARS-CoV-2 was transmitted through the air. If you do not accept that then you do not talk about N95s because N95s are for airborne transmission to prevent you breathing in contaminated air, rather than being splashed with droplets. So I think it is related to that. Both that the culture of denial, which is complicated and relates to—it is not a specific New South Wales issue. I think if someone had been motivated enough, there were solutions. You could have got better products than surgical masks.

The CHAIR: Ms Boyd?

Ms ABIGAIL BOYD: Thank you, Chair, and thank you to our witnesses for coming along today. I wanted to ask a couple of questions about people who either have or care for people who are immunocompromised or at risk. Currently, I am getting a lot of calls and emails to my office from people in this situation who are imposing a voluntary lockdown on themselves. Perhaps I will start with you, Professor MacIntyre. In relation to schools—and you did touch on this in your opening remarks—what I am hearing is that a lot of parents are making the choice to keep their children at home and they do not see the current approach of the New South Wales Government in relation to schools and testing as being appropriate. Do you have any comments on what they could be doing differently in order to provide a safer school environment?

RAINA MACINTYRE: I think here again we see that having the means makes a difference. A lot of private schools are offering parents the choice of face-to-face or online learning, and parents can tailor their child's learning depending on their particular circumstances. But that is not the case in public schools. I think offering some flexibility and understanding that families have different needs and different circumstances is good for everybody. It means that those who want to send their kids to school can and those who want to have them learn online can do that. That also reduces the number of people mixing in schools, which will be good for outbreak control in the long run. The fact is that kids are still not fully vaccinated. Many of them have had a first dose, but we really—I do not understand why the vaccination of children was not possible. That is not a New South Wales matter, obviously, but I think the timing was just really unfortunate that we had this Omicron wave start and schools open with children essentially unvaccinated.

Ms ABIGAIL BOYD: The other thing that we are hearing a lot of is people's frustration that the QR code system is not being used with the same seriousness that it was before. Obviously for people who are trying to make sure that they do not infect someone who is immunocompromised or at risk, it is very important to know they have been exposed. What we are hearing is that with the Government's attitude towards living with COVID, the public is perhaps not as serious about using the QR code system. Does that accord with what you are seeing as well, and what do you think the Government could do to reinforce or bolster that system?

RAINA MACINTYRE: I think we have to, the New South Wales Government has put a lot of resources into the whole digital tracing infrastructure, and it is a real shame just to let it go. I think we could strengthen it and, you know, use it into the future bearing in mind there may be more severe variants are coming into the future that will take-off very, very quickly, just like Omicron did. I think having that infrastructure in place is a good thing. Contact tracing makes a difference to the number of cases that you have eventually. I think it might be worthwhile doing some public polling asking people: Do you want to know if you have been exposed to someone with COVID? My guess is some people will not want to know but I think probably at least half the population will want to know, because half the population lives with a chronic disease of some sort.

Ms ABIGAIL BOYD: Thank you.

RAINA MACINTYRE: If people want it and we have got the infrastructure, why not use it. We could invest more into digital technologies that make it a lot more automated. It is all there. Maybe we could invest in some sort of technology where you do not actually have to scan the QR code. [Disorder].

The CHAIR: If nothing else, that needs to be made as simple as possible, does it not? I do not know how many people have contacted me with the deep frustration of having to repeatedly enter in their pass code to ensure that they register in New South Wales. It does not happen in other States and Territories. Making that seamless and easy initially is part of it, is it not?

RAINA MACINTYRE: Yes, it is. But I think the privacy issue is the big hurdle. If you make it automatic that the privacy barrier is the biggest barrier in western countries. In some Asian countries there is not the same degree of restriction.

The CHAIR: They seem to have overcome that barrier in the ACT and Victoria, from my recent experience. You scan the code and you press check-in. You do not then have to put in your login code. It was a relief, I might say, when I travelled in those jurisdictions.

RAINA MACINTYRE: I do not think you need to in New South Wales. When I have used it you just scan the QR code and click check-in and it is done.

The CHAIR: Professor Blakely, could I get your opinion on the use of check-in codes now when there does not appear to be anything being done with that data and that information by NSW Health. Is that one of the reasons why people are feeling that there is less enthusiasm, as Ms Boyd would put it, for using QR codes?

TONY BLAKELY: Okay, so let us pull back. QR coding is sort of an entryway into the contact tracing. If your systems are overwhelmed—I am not saying us—but if the State is not too worried about Omicron, they are not going to contact trace. You have to ask yourself what is the utility of having QR coding at that point in time. From my perspective going forward—this is thinking about the planning again—which is what I keep returning to. We certainly want to keep all facilities and people able to QR code. Whether they need to keep QR coding at all times or it is another lever that we just pull on if a bad variant comes around, is the issue here. From my perspective I think we should pause the QR coding and just turn it back on when there is a variant around of concern, which will probably happen a couple of times this year. There are the people, whose view I respect, who say we should leave it on for two reasons. One is Raina's point, is that there are still some people moving around the community who would like to be notified. But I am not sure that they are being notified. The other reason being, like Pavlovian dogs we should all keep using our QR code so that we are well-trained when we need it in two months time. I think that we have all done it enough that we can turn it back on within 24 hours.

The CHAIR: Professor Blakely, is it your view that we are likely to get at least two more waves this year? Or is that just one of the likely scenarios that we should be pre-planning for?

TONY BLAKELY: It is impossible to predict. I do not have the crystal ball, I do not think anybody does. We can talk about likely scenarios. I think the minimum is that we see Omicron bounce along as people wane and enough people get susceptible that it kicks off again. A more likely scenario next year is that Omicron is doing that and then something else comes along and causes another wave of some sort. Hopefully far less serious, because we are getting more and more immunity. The worst case scenario is that something comes along that is highly infectious and because it is innately more infectious it has a higher R-naught and/or has vaccine escape and is virulent, i.e., tends to put you in hospital. If that happens I do not care how many of them happens—I hope only one of them happens—but it will be a serious event. So, sorry, I cannot give you an exact answer to that. I can only talk about scenarios.

The CHAIR: One of the best ways of dealing with that future uncertainty is not to make blanket statements like, "We will never go into lockdown. We will never do X. We will never do Y." But in fact to be honest with the community and say, "Well, if we get a particularly virulent strain we will rapidly put in this kind of response. Hopefully we won't." That kind of honest openness is necessary, do you think?

TONY BLAKELY: Yes. I think that has been my major goal in the last three weeks each time we talk about these three scenarios. I am trying to give people something that is easy to remember at the pub or at the dinner table and it is [inaudible] like this. So that the Prime Minister, or whoever, does not get forced into a corner to say yes- or no we will never have lockdowns. The answer is, if a really bad thing happens we may need a full court press that has lockdowns. But hopefully, and I think more likely, it is not guaranteed, is that we will just see these lower case ones which means that we will probably not need a lockdown. So, yes, in answer to your question.

The CHAIR: Finally, Mr Burdack, if you think about protecting the communities you work in, remote and regional communities, probably even more flexibility is required because you need to engage with those communities on the ground with their unique circumstances, is that right?

MARK BURDACK: Yes. Look, the situation in our communities is that people have higher rates of chronic disease so there is a much higher risk of exposure. The service access on the ground is also very thin. I have just been advised this morning that we have had to close one of our practices because a staff, who has been going to work every day, has contracted COVID. So, we have shut down that practice. That means no health services in that town. We will get the doctors onto telehealth and we will provide the services by that mechanism. What we have found over the last year and a half is as soon as the community hears of one case, everyone goes to ground. They isolate because the level of fear in those communities is so high. That is why we need to take some special measures to reflect the nature of the disease profile of those communities, the lack of health resources, so that we are providing greater comfort and security and that their unique circumstances are being recognised and addressed.

The CHAIR: Thank you, Mr Burdack. I will hand over to Government members now. Mr Farlow.

The Hon. SCOTT FARLOW: Thank you very much, Mr Chair. To both Professor Blakely and Professor McIntyre, I take it you're both familiar with the NSW Health modelling in terms of both hospitalisation for the Omicron wave and the ICU usage as well. You're both familiar with that, which had the scenario of New York, the scenario of London and what has happened in New South Wales. On that scenario: In New York it was peak hospitalisations of 6,000, ICU of 600, based on that modelling; London, 3,100 and 272 for ICU; the peak in New South Wales was, in terms of hospitalisation, a little over 2,800 and 217 for ICU. From your reckoning can you see why New South Wales did not at all reach those same peaks of both London and New York?

RAINA MACINTYRE: I might add my thoughts there. So, we have a much higher two-dose vaccination coverage than both the UK and the US. Australia has always had really high vaccination rates, so an excellent vaccine culture. We have the prospect of getting 90 per cent plus vaccination rates for any targeted age group that we choose to have a vaccination program. That is great advantage for us. But I think the other thing was the use of hospital in the home and the guidance that went out saying that if you are under 65 do not come to hospital, look after your COVID at home. I think there needs to be more follow-up to look at what happened with people who are managed at home. It goes back to my point about deaths at home and actually looking into doing a review of the outcomes of people who did not go to hospital. Only some of those were formally in hospital in the home, a lot of people were just self-caring. We also know that a lot of people did not do COVID testing. So their outcome, how are they counted, because they either could not get a test or, you know, were pretty sure it was COVID and did not bother. I do not know. But we do not have a handle on any of that. I think in terms of epidemiology and counting of outcomes, there is a lot of uncertainty.

TONY BLAKELY: Thanks for the question, Scott. I will add to what Raina said. I think a fundamental issue goes back to the question that Cate rose: How many people are infected? The modelling before Christmas was thinking in terms of fatality and hospitalisation rates from the data that we had and people were kidding themselves a bit. They were thinking in terms of the notified cases and the hospitalisation rates and then they were applying that to all infections. But actually what was happening in the UK at the time was that there were not just notified cases; there were all the asymptomatic people infected and the people so mild that they did not get reported. What that means is that amongst the full population of the infected—it is not just the notified cases—the hospitalisation and the death rates are much less. So when you model that in a country like New South Wales and use those estimates you can overshoot and many countries overshot in their estimates of what the hospitalisation and mortality burden would be. That is not the only explanation but I think it is an important part of it.

I have two more comments. The next one is that we are good at doing lockdowns here, so we did our own self-imposed lockdown—a shadow lockdown. We retreated quite well even though it was Christmas and New Year when things were going bad in New South Wales. And then the other thing—and this is just to point out that we do not yet know everything. I have actually got a masters student look at all the [inaudible]. If you go to the ABC COVID track app website, it is fascinating. For example, Victoria—we only have about half the peak in hospitalisations per capita that we saw in New South Wales. New South Wales actually has a tabletop mountain at the moment and has only just started to really come down recently. There are lots of odd things in there that tell us that we do not understand completely what has happened in all the States with all the things that matter like mobility, mask wearing and all the rest of it. So just adding to Raina my two extra comments about that initial data that we kind of misused in the modelling, and then also our ability to do shadow lockdown is perhaps why those numbers are less.

The Hon. SCOTT FARLOW: Thank you very much. Just picking up on that point in terms of the global experience as well, what other jurisdictions would you point to in terms of the management of Omicron, particularly in terms of infection rates, that have prevented Omicron from appearing in other countries?

TONY BLAKELY: I assume that it is a question for me.

The Hon. SCOTT FARLOW: For both yourself and Professor MacIntyre.

TONY BLAKELY: I will go first and then hand over to Raina. Australia is in its own camp, really, with New Zealand and Taiwan and China, with not having had much infection before, so it is not easy to make those cross comparisons. That is point one. Point two: Any country that has had Omicron has had pretty much a full-blown wave, so it is so infectious that it is going to do that anyway. Point three: We will learn from Western Australia and New Zealand in due course as to how much better you can manage this with having more time to plan and think about it. The New Zealand experience has been very slow so far on the uptake, but I am assuming that Omicron will take off there. I am hoping that they will see only about 600 to 700 people in their hospitalisation rates because they will have learnt more about flattening the curve. Western Australia is the same. So I cannot give you an exact answer on that. I will hand over to Raina.

RAINA MACINTYRE: I agree with Tony that our situation is a bit unusual. In terms of countries that have had a fair degree of transmission, I suppose Singapore is one to look at. They have used—I think every family was sent out a pack with N95s and rapid antigen tests. So they have kind of made the effort to use those other strategies—test and trace and the N95s—to keep it under control. Having said that, I have not looked at comparative data for Singapore compared to other countries recently, but it is probably worth doing that.

The Hon. SCOTT FARLOW: Just looking at some of the interventions in other countries, we saw that the Netherlands and Austria both implemented hard lockdowns when it came to COVID interventions. Now, from my reckoning, both of those countries seemingly only delayed the inevitable when it came to this surge. I think the Netherlands currently has 118,000 daily COVID cases in a population of 17.4 million, while Austria has 32,000 with a population of 8.9 million. With Omicron is it possible to actually flatten the curve, so to speak, or is it just delaying the inevitable? Even looking at the New South Wales or Victorian case curves, it seems like Victoria was delayed from New South Wales but still followed a similar sort of case trajectory to New South Wales with accounting for population.

TONY BLAKELY: I can speak to that. Actually, we need to learn about this. But if you look really closely at those numbers, the rate of increase in Victoria—the percentage per day increase in hospitalisations, which is the only number I trust now—was much less in New South Wales. So we were doing something better here at slowing the rise and flattening the curve a bit better. So you can flatten the curve with Omicron. By flattening the curve I mean flattening its rise and getting it to a lower peak rather than up here and then keeping it there and bringing it down. It is not easy though. You make a good point that to some extent Omicron will do what Omicron does. But we can still manage it somewhat within that landscape, if you like. As far as those hard

lockdowns, let us think about New Zealand. They are not in lockdown mode but they have been pretty stringent. They are keeping standing up.

You can get fatigue amongst your population and then they all relax and it takes off at the very point you want to be stopping an increase, which is on the way up from about 10 per cent to 90 per cent of your peak. That is when you put the real pressure on to slow the incline to get the flattening of the curve. So there is lots we are going to learn about here and I imagine there will be textbooks written about when is appropriate to really put the pressure on by making the public health social measures really tight, maybe not doing it too early but letting the numbers go up a bit if it is a mild variant and then really squeezing while the population can hang in there for four weeks or so to help flatten the curve. So there is a lot to be learnt there. But in general terms, Scott, yes, we can moderate it a bit but Omicron will kind of do what it wants, at least in the number of people it eventually infects. But we can draw that out, we can make it last longer, so that peak on the health services is not as bad.

RAINA MACINTYRE: I agree with all of that. There are lots of things you can do to flatten the curve even with Omicron. Most of the immunological data that has come out suggests that it actually has a similar reproductive number to Delta so it is innately not more contagious, it is just the immune escape that makes it spread really fast. Therefore, measures like masks and testing and tracing will make a difference and can mitigate the curve. I just did look up Singapore and they have a much higher rate of testing compared to Australia as a whole. They have had a lower rate per million people of cases as well. I think Singapore is a good model to look at in terms of how we could do better.

The Hon. JOHN GRAHAM: Can I just ask how high their rate of testing is, Professor MacIntyre?

RAINA MACINTYRE: Their testing rate is about more than 40 per thousand and ours is less than 10 per thousand.

The Hon. SCOTT FARLOW: To both you and Professor Blakely, on that mask point and the impact of masks, I saw recently—I think it was from *The New York Times*—an analysis between US states with a mask mandate and without a mask mandate when it came to the caseload, which showed effectively a fairly similar result between those states. Is that something you have seen and what would explain that from your perspective?

RAINA MACINTYRE: I am not sure which study you are referring to but the data I have seen on mask mandates does show lower cases and hospitalisations in states that have had mandates over the whole course of the pandemic at different times compared to those that have not.

The Hon. SCOTT FARLOW: This one is just in relation to Omicron, so I think it goes from—and the US numbers are throwing me a little bit—1 November 2021 until 31 January 2022. It effectively shows the trajectory in states with mandates and no mandates are the same in terms of case numbers.

RAINA MACINTYRE: Without looking at the data and without looking at all the other compounding factors like vaccination rates and other mitigation measures, it is really hard to comment. I think the California data that came out did include part of the Omicron wave—it was both Delta and Omicron, I think. Maybe you can remind me, Tony because I do not remember exactly. It was only just published. I will just have a look.

TONY BLAKELY: Just while Raina is having a look, Scott, I have three comments. One, I have not seen this paper. Email it to me if you want us to have a closer look and I will get back to you offline. Two, previous studies pre-Omicron certainly showed that higher mask wearing in states did make a difference. Actually, I have four points. Three, you may end up with the same number of people infected even if you have higher mask wearing but if you flatten the curve out you are going to protect your health services better. Four, I do not know this paper because I have not seen it but I have seen some earlier studies like this where they were poorly reported because they were looking at things like percentage increase and a couple of percent on this particular metric actually makes a lot of difference. One study I can recall was misreported. I do not know about this study but I would be very wary about how some of these studies are getting reported given that they are time series ecological analyses. I will stop there.

RAINA MACINTYRE: I think we would both be happy to have a look at it.

The Hon. SCOTT FARLOW: I am happy to send that across. I will start with you, Professor MacIntyre, in terms of your reasons why you do not believe that COVID will become endemic, and then, Professor Blakely, as a right of reply, in a sense, whether you share that view or whether you have a different view. I think that will be it for time for me.

RAINA MACINTYRE: Endemic and epidemic are technical terms. They have a technical scientific meaning, but those words have been widely misused during the pandemic, including by experts. An epidemic infection is defined mathematically by the R0. An endemic infection is one where the rates stay relatively constant over time. They may change, generally over years or months but not days or weeks. Epidemic infections tend to

come in waves. They go up very quickly, in days or weeks, and then they come down. That is the pattern that we are seeing with SARS-CoV-2. It certainly meets the definition of an epidemic infection by its R0—the mathematical definition. It is the pattern we see with things like measles and influenza. Those are also epidemic infections. They come in these waves.

Unless we use mitigation measures to maintain a sort of equilibrium and a steady state—which means masks, safe indoor air et cetera.—we could possibly achieve something that looks like an endemic pattern, where it is there all the time but at a relatively constant rate. But otherwise, it is going to cause those surges and the waxing and waning pattern that then is like a boom or bust cycle that goes on and on and is exhausting. In the long run, I think it is possible to avoid that, but it means addressing all those other things we can do to reduce the transmission.

TONY BLAKELY: Right of reply. There have been some [audio malfunction] moments in this pandemic. One of the ones that I have liked most is when Raina explained to me that I was wrong using the word "endemic". What she is saying is technically correct. Another way to think about this is that throughout the pandemic, certainly in the beginning, we used the words "quarantine" and "isolation" as though they were synonymous. They mean slightly different things. It is isolation if you have got the infection and quarantine if you are trying to not get it—that sort of thing. Raina is also right that a lot of experts and very eminent people are using the word "endemic" at the moment in a way that Raina would not agree with.

We have got this thing that is coming through society like this. Raina is right, that if you get the exact public health and social measures—it is impossible to achieve if you keep it at that level going along. The reality is that by more of us getting vaccinated and, yes, many of us getting infected, over time the ability for the virus to do these massive peaks will get less and the waves will come through, we hope, at a lower amplitude like this so that it becomes more manageable, even if it is technically still an epidemic phenomena. That said, right back to where I started, there are three scenarios. There is still the possibility this virus really does something bad to us and comes out more infectious, through vaccine escape or natural innate infectiousness, and is highly virulent and we end up with something like this again. We cannot guarantee that we are going through lower amplitude oscillations, but I hope that is where we are heading. That is what a lot of people are calling endemic, which, as Raina said, is technically not quite correct. But the idea that it is something lesser that we can manage is a correct judgement, if you like.

The CHAIR: We have unfortunately run out of time. We cannot work out whether or not an endemic pandemic is going to be a term that we use. We will try not to. Professor MacIntyre, thank you so much for your evidence today. We have got your updated document. We will table that and, if the Committee is willing, publish that. Professor Blakely, thank you for your assistance again today. Mr Burdack, thank you again for your assistance. I am glad we overcame those technical difficulties.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr PAUL SADLER, Chief Executive Officer, Aged & Community Services Australia, sworn and examined

Mr MARK SEWELL, Chief Executive Officer, Warrigal, sworn and examined

Ms MARY CARPENTER, Director, Governance, Risk and Quality, Uniting NSW/ACT, affirmed and examined

The CHAIR: Welcome to the first of two afternoon sessions of the inquiry into the New South Wales Government's management of the COVID-19 pandemic. The next three witnesses will focus on concerns and issues in the aged-care sector. Thanks to the three of you for coming. We know how extraordinarily busy things are at the many and how many stressors there are in front of you. There is an opportunity now, if you would like, to give a brief opening statement. We may go in the same order, if that is okay, in which you were sworn in.

PAUL SADLER: Thank you very much. It is a privilege to appear before the Committee to give you evidence of the impact of COVID on the aged-care sector, in particular our relationship with the New South Wales Government and the various departments. I would like to start by talking about the engagement between NSW Health and the aged-care sector. The aged-care sector has appreciated the level of engagement offered during the pandemic. Senior people from the Ministry of Health have met regularly with peak bodies Aged and Community Services Australia and Leading Age Services Australia, and all of the local health districts have engaged with aged-care providers in their region. It is true to say though that the quality of this engagement has varied through the pandemic. At first, health staff at departmental and local health district level approached aged care with a bit of an air of superiority. Infection protection control visits by public health units' staff were too frequently conducted with little appreciation of the context of residential aged care as older people's home. Gradually, with the pandemic, that tone did change, and both Ministry of Health and PHU engagements have improved. Some LHDs have developed very strong engagement mechanisms with their local aged-care providers, and the Illawarra Shoalhaven where Mark Sewell's organisation operates is a good example.

The second thing I want to comment on in my opening remarks is decision-making, and I will comment on this at two levels. First, older people in aged care are probably the most vulnerable population to the COVID-19 coronavirus disease. New South Wales government decisions on pandemic protections to apply to the general community have in our view sometimes lacked a focus on their impact for the aged-care sector. Most egregious was the decision to relax community distancing and mask-wearing requirements in mid-December 2021, when Omicron had already started circulating. Within days of the Premier's decision, outbreaks in residential aged care skyrocketed, resulting in death and despair in the majority of aged-care homes in the State. Second, while communication with the sector was generally strong, as I outlined earlier, there have been a number of decisions delayed or never taken despite our representations to health authorities. Examples include the refusal to take COVID-positive residents to hospital in Newmarch House in 2020; delays in mandating vaccinations for staff and visitors in 2021; unwillingness to listen to sector pleas for a switch from reliance on PCR tests to use rapid antigen tests in mid-2021; and no decision until, we believe, today through the AHPPC regarding mandating booster shots for staff.

The final thing I would like to talk to is consistency. Aged and Community Services Australia would like to point out the importance of greater consistency across New South Wales local health districts. Providers are too frequently frustrated by different advice or instructions issued by PHUs, both across local health districts but sometimes within them as well. A particular concern here is differing requirements for lockdowns when an outbreak occurs. Some PHUs, or individual staff within them, are very understanding of the context of aged-care homes. But others apply strict lockdowns, including confining residents to their rooms and stopping any visitation at all, with no appreciation of the impact this has on older people and their families. Applying hospital-like approaches to people's own homes is frankly ridiculous. ACSA is looking forward to NSW Health applying new national guidelines that were agreed by National Cabinet last night, and we are looking forward to greater consistency in this regard across all local health districts. Thank you.

The CHAIR: Thanks very much, Mr Sadler. Mr Sewell?

MARK SEWELL: Thank you, Chair. Thank you, Committee. What I might do is give a context for my role and the things that I have been doing and then also unpack a bit of the ground level examples, so that might form some valuable context or issues for the Committee to discuss. I am the CEO of a not-for-profit organisation called Warrigal. We are based in the Illawarra regional area but operate 26 different aged-care homes, retirement villages and home-care services across 14 suburbs and towns across various regions—the Illawarra, the Southern Highlands, up through the Southern Tablelands of New South Wales and across the ACT. Because our services span four local health districts, I have participated in the COVID planning and response meetings across four local health districts and am aware of the differences between them that Paul just eluded to.

I have to declare, I am also an ACSA director in the same organisation that Paul is the CEO of and I am an ACSA regional chair, so I often get to host regular meetings of other providers besides Warrigal's and in fact often all the not-for-profit aged-care operators in the Illawarra and South Coast regions. I can, I think, talk about the regional perspective in a broader sense. Because of that role, I was invited onto the Illawarra Shoalhaven Local Health District aged care and health care COVID response committee, and we did meet weekly to prepare for the pending emergency and then spent a lot of time managing the rapid outbreaks through last year and of course this year. I am also a regional advisory counsel on the NSW Business Chamber for the Business Illawarra region, and so I also hear and discuss the general business policy environment and strategies to assist general businesses reopen or stay closed or stay COVID-safe, so I understand a bit of the tension between business reopening and health, disability and aged-care services staying safe and the impact that these two conflicting policy and contexts were managed by the New South Wales Government.

My organisation's recent COVID experience included two years, since the pandemic began, without one case in any of our services. But since 29 December, just before New Year's Eve, we have experienced an explosion of COVID cases across our network, with more than 500 staff and residents becoming infected. This very intense response relationship between the Commonwealth Department of Health, the New South Wales Department of Health and the local health districts were all activated in a very extreme crisis environment over the past six week or so. We are now gladly through the worst of the experience, with just 20 people remaining COVID-positive, but it was an experience in January 2022 that we never want to go through again and none of our communities across these regional areas want to go through again. But there are many learnings and reflections that we had that I hope will be useful today. Thank you.

The CHAIR: Thanks very much, Mr Sewell. I am quite certain there will be questions about those learnings from Committee members. Finally, for the opening, Ms Carpenter?

MARY CARPENTER: Thank you, Committee. I would like to thank you for inviting Uniting and making sure that we are able to be heard in this inquiry. I am very grateful to be here in front of all of you. As a director for governance, risk and quality within Uniting, we have been near the front line of all of the COVID pandemic, particularly in the aged-care section. As you are aware, in Uniting we also provide services across early learning and community services. We are the largest residential aged-care provider in New South Wales and the ACT; we have 73 facilities. As of today, we look after almost 7½ thousand residents in those services, with about 9½ thousand clients receiving home and community care and about 3,000 clients in independent living units. With a massive context that we have, we have been able to gather insights and able to learn along the way from our work colleagues living interstate and in other service providers. There is certainly no doubt that the Omicron variant was unexpected, which is why we are very pleased to be here and to really call upon the New South Wales Government to start planning for the potential impact of the next variant of COVID, knowing that we are also going to enter a worse influenza season over the next few months.

Over the first 18 months of the outbreak, we did not have any exposures of cases in our homes. We are very grateful for that and especially for our staff and managers that worked diligently to protect themselves as well as our clients. We only had about a handful—about eight cases—under the Delta surge. But under Omicron, we alone, within Uniting, over a span of four weeks between mid-December to mid-January, had 63 out of our 73 homes have an outbreak. Currently, we still have about 15 of those services still managing an active outbreak. As you can imagine, the work remains as diligent as possible. It does not stop and we remain on high alert because a number of those services do finish their outbreak but it will come back on again over the next few days. So the impact to our services and to the residents really has been relentless over the last few weeks.

In our experience, we really would like to call upon the Government to start planning for, firstly, the transfer to hospital. We know—and we have experienced the success of this, especially for the index case and for the exposure size and the outbreak size—how integral it is to ensure that we are able to prepare and care for the rest of the residents and limit the risk and exposure to the others. In our Uniting [inaudible] when this occurred in 2021, we were able to close that outbreak within 15 days because we were able to transfer, with the cooperation of the local public health unit, the index case into hospital. We are grateful for that, because it certainly has not been the case for other providers. We are also quite concerned that when elective surgeries were cancelled for private hospitals we have not been afforded the resources of those private hospital beds—so, hopefully, being able to transfer some of the residential index cases into those facilities.

We know the pressure the public health system has experienced through these surges and we are certainly ongoing in working with them in how we can support them, so that they can support us as well. This also brings me to the second issue that I would like to flag. Part of the royal commission into aged care recommendations 56, 69 and 70 is improving the relationship, the engagement, between healthcare systems, as well as aged care, and ensuring that the right of our older people to gain access to the services that the rest of the community have been able to enjoy is available to them. In Uniting, we have a war memorial hospital that we manage and we have a

flying squad. That really is supporting the local community in ensuring that those residents in that residential care home do not need to go to hospital and are able to experience and be comfortable in the home that they are currently in.

The other issue that I want to flag is the total wellbeing of our residents. As I illustrated earlier, we have residents who have been in isolation for weeks on end. If you have experienced isolation yourself, it is not something that I would want any of our residents to experience weeks on end. It is not healthy for them; it is not healthy for their physical health and certainly not for their mental health. We have been risk assessing visitation and ensuring that loved ones are able to visit our residents when possible. We do know that the Government is about to release, or currently reviewing, the total wellbeing protocol or differing landscape on how that will go about. It is really important that we ensure that the people that we look after are able to experience joy in the final years of their life.

Lastly, I would like to ask the Government to start planning for the workforce issues within aged care. This has certainly been highlighted and we know that it has been a systemic issue within the aged-care workforce. I would like to thank all of the aged-care staff members who tirelessly come into work every single day, feeling brave, working in PPE even in the heat. I know myself how difficult it can be for anyone to work in residential aged care or any other healthcare session. But we need to ensure it. We would like to call upon the Federal and New South Wales Governments to support the providers in attracting and retaining as many people as possible into the aged-care industry, because that really is the only way that we can remain sustainable and be able to look after the most vulnerable people in our community. Again, thank you for the opportunity. I look forward to your questions.

The CHAIR: Thanks to all three of you, your members and particularly the workforce that is on the ground doing this critical care. I will hand over to the Opposition now to commence questioning. Ms Houssos?

The Hon. COURTNEY HOUSSOS: Thank you, so much, Chair. I too, on behalf of the Labor Opposition, would like to thank all of our aged-care workforce. We know it has been an incredibly difficult time over the last two years and we know how important caring for our aged and vulnerable people is. We just want to thank them for what they have done, particularly over the last couple of months but also for what they do each and every day—so thank you very much. I just want to touch on something that came up in a couple of the opening statements. I might start in reverse order with Ms Carpenter and then go to Mr Sewell and Mr Sadler. This question is about advice from the public health units and the variability in it. So there was not a standard arrangement for transfers to hospital, but also around other advice around lockdowns. What effect did that have on your facilities and on your residents and on their families?

MARY CARPENTER: Thank you for the question. The differing advice across public health units definitely created uncertainty. It created some anxiety level for our family members, because they do know how transmissible COVID can be. It certainly created fear. So that created a lot for us—to ensure that we bolstered communication, and ensuring that they are safe. That requires daily emails, daily family meetings, especially during an outbreak, as well as ensuring that everyone is comfortable. It also created a lot of advocacy from our end and ensuring the public health units are well aware of where we are coming from. Having an index case in a facility can also create anxiety for our staff members. We do have staff members who have refused to turn up for work because there is a positive case there. Now, as you can imagine, we have some staff members who [inaudible] because they may be a close contact already, as part of the protocol, and this can only exacerbate if there is an index case within the facility—so, a lot of management on the local ground, a lot of collaboration and conversation with the public health units. I would also like to thank some of the public health units that we do deal with and I share their challenges as well at the other end. But that certainly has been our experience.

The Hon. COURTNEY HOUSSOS: Thanks, very much, Ms Carpenter. Mr Sewell, you said you were operating across four different local health districts. How much did this differing advice actually then contribute to the spread of COVID in your facilities?

MARK SEWELL: Thank you for the question. It is hard to attribute it directly, but the important advice we get from the Aged Care Quality and Safety Commission about managing an outbreak is to be decisive—take control, take command, assess risk and be decisive. It was quite complicated to read the different tone and profile of the different public health units in the different local health districts about whether transfers would be accepted quickly. There is a very big difference between some of the local health districts' stated views about residents in Commonwealth-funded aged care; whether they are the full citizens of that local health district and have access to their hospital network for medical treatment, or whether they are in a nursing-supported health facility funded by the Commonwealth and should only be granted access and transferred to a public hospital if nurses collaborate and a hospital doctor permits the access. That is differently managed by different local health districts.

I can think of a couple of occasions where—on one day I was meeting with one local health district and the CEO was making it very clear that as soon as someone needed transfer on our assessment by a registered nurse, they would make the way for a prompt assessment to be undertaken and a transfer to hospital beds. They even set aside wards, empty hospital beds set aside specifically for COVID outbreaks in aged care. The next day I was on the same meeting with a different local health district where each aged-care home was asked to report to the meeting what they were doing to prevent hospital transfers. If homes had not made requests for hospital transfers, they would be celebrated, with good data trend graphs showing a decline and a very significant reduction of calls to ambulances asking for transfers to hospitals.

That is an example of the very different states that different local health districts can have. When you have a COVID case or two and the home gets declared "in outbreak", where those COVID cases will be managed and how they will be managed and whether they will receive medical assistance—because aged-care services do not have medical resources, only nursing resources. They rely upon community medical assistance via GPs. Whether they will be managed in situ or managed as an outreach service of the local health district's medical support or transferred to a medicalised environment, like a hospital, is critical to understand how quickly and fast the infection spreads, and that was not clear. It is quite different.

The Hon. COURTNEY HOUSSOS: Thanks very much, Mr Sewell. Mr Sadler, you raised the case of Newmarch House in your opening statement. That was clearly an example where residents and particularly their families were not communicated with very well, but where residents and their families who wanted to go to hospital were not actually able to get there. What was your experience in terms of the variable advice from public health units about transferring to hospital especially and how that impacted your response?

PAUL SADLER: Just to go back to Newmarch House, I will make two comments on that. The first is that it is really important to acknowledge the communication issues in that very early case of an outbreak. It was basically the second big outbreak in Australia in an aged-care setting. Clearly not only Anglicare, who were the owners of Newmarch House, but all of us learned a lot about the importance of communication with families. Nowadays when there are outbreaks, we work very closely with the Seniors Rights Service in New South Wales in terms of holding sessions that family members can participate in so that each of the homes' management can communicate with family members, who, as we have been saying, are often locked out at that point.

The second thing to say about Newmarch House is, following the tragedy that occurred there where the disease spread rapidly through the aged-care home and many people perished, Aged & Community Services Australia publicly advocated and put in a submission to the then-active aged-care royal commission saying that index cases, as Mary and Mark were talking about, really should be transferred to hospital because that will give us the greatest protection against an uncontrolled spread in aged care. To some extent, between Newmarch House and the beginning of the Omicron wave, that was occurring not entirely consistently across all LHDs, but certainly more often, for example, through the Delta outbreaks that happened in 2021.

Unfortunately what happened from mid-December onwards was that the Omicron wave overwhelmed the aged-care system. It overwhelmed hospitals. It overwhelmed the general community and, therefore, the sorts of examples Mark gave began to be a common experience. Some LHDs would still be trying their best to provide help to aged-care services. Others were really saying to older people who lived in aged care, "You're not part of New South Wales. You don't deserve to get in. We've got other people who are our priorities."

The Hon. COURTNEY HOUSSOS: You touched on the impact of the Omicron wave on workforce in particular. How effective has the surge workforce been? Have you had any feedback from the surge workforce at either a State or at a Federal level?

PAUL SADLER: Yes. The Commonwealth Government is obviously responsible for the funding and regulation of aged-care services. One of the issues for you as a Committee looking at the impact for aged care will be working out what were the components that State authorities, including the health services, were responsible for and what were actually Federal responsibilities. Clearly the Federal Government has a significant responsibility here, and they were working with the sector to put in place a surge workforce capacity to assist where aged-care homes were losing staff due to COVID. Again, that was proving reasonably helpful when the Delta wave was going on, but what happened once Omicron started was that we lost anywhere from 25 to 50 per cent of our staff within a two- or three-week period.

To give you a bit of a sense of what that meant, the labour statistics we have, which are now about 10 days old, were that there were around 140,000 shifts going unfilled on a weekly basis in residential care homes across the country. The surge workforce is providing 1,250 shifts of care in a week. It was providing 1 per cent, basically, of the lost shifts once Omicron started. That is why the aged-care industry and the unions have been calling, for example, for the Australian Defence Force to help out. Can we stand up some volunteer programs? Can we work

with families more efficiently to get help through partners and care programs? Can we assign other staff who have a responsibility in aged care, for example, doing assessments? Can they be diverted to the front line?

All of those steps we have been trying to work on, but the reality has been that the Omicron wave, as I said, has really overwhelmed our capacity in aged care and the consequences for older people have been dire. I might just comment, as an aside, to the residential care experience. This same problem of staff availability has hit home care services across New South Wales. In particular, regions like the Hunter and the Central Coast were particularly severely affected with loss of staff for home care services. We have had reports from our members of, again, up to 30 per cent of their staff being unavailable and, therefore, cancellations of essential services to older people in their homes.

The Hon. COURTNEY HOUSSOS: Thank you so much, Mr Sadler. Just to be clear, you haven't had any assistance, or you are not aware of any assistance, from the New South Wales Government in terms of the [disorder]?

PAUL SADLER: The New South Wales Government, along with the Federal Government, has provided some assistance in some instances. There absolutely has been a stand up of public health personnel from New South Wales. There was a recent announcement by Greg Hunt, the Federal Minister for Health and Aged Care, about the capacity to access private hospital staff; that, again, is done in conjunction with the State Government. There absolutely has been assistance provided, where it was possible to do so, from the State. But, of course, the State health system was experiencing the same loss of staff at the same time we were through the Omicron wave, and so the capacity for the State system to provide a backup workforce into aged care was negligible.

The Hon. COURTNEY HOUSSOS: Absolutely. Thank you very much, Mr Sadler. Mr Sewell, did you want to provide some brief remarks about the surge workforce? I note Mr Sadler's comments about the scale of the problem—140,000 shifts per week—and that the Federal surge workforce is providing such a small part of that. Did you want to provide any additional comments to that?

MARK SEWELL: Only a couple of examples, if I may. We certainly had a very good relationship with one of our LHDs, who committed to a joint surge workforce arrangement all the way through 2021. All aged-care providers were developing surge capacity in an emergency. We shared those numbers, and the hospital network did the same. I think I then applied, at one point, about 25 nurses and clinical nurse specialists, who would be able to respond in an emergency. They put the word out to all the region's 4,000 staff and got a small number of people who were able to put the hand up and be available for a surge. Obviously, that number—in fact, not only for all the operators, but the health department—disappeared, as the vaccination hubs were established. They also found themselves hard pressed. We lost quite a few staff. I lost at least 50 important enrolled and registered nurses to the vaccination centres being established in the hospital and the community.

We did recently need emergency surge workforce assistance to prevent an aged-care home being closed and 60 people being automatically transferred to the local hospitals and the other 80 people being supervised by carers who were not nurses or doctors. I rang the CEO. She rang every private hospital and public hospital in the area to ask for assistance for our one home. After three days, there was one registered nurse located, from one of the hospitals, to volunteer to work overtime at one of my homes for four days, four 12-hour shifts, over a Friday, Saturday, Sunday and Monday. At the same time, we lodged to the New South Wales ministry a surge workforce assistance application form. It was quite an onerous, complicated process, but it went to SHEOC, the State Health Emergency Operations committee. Those forms took me a couple of days to fill in, but they were lodged. They then were approved to go across the Healthcare Australia agency, that, I think, NSW Health had engaged for just this kind of situation. They got back to me after 48 hours and told me they were not able to assist. There was five days of hoping and applying, without assistance.

We then did get off to the Commonwealth. The Commonwealth did respond. They took another few days but did end up sending six registered nurses to assist that home and keep it open and to prevent transfers to the local hospitals. That ended just yesterday, Thursday night, last night. I lodged an application to the ADF for assistance for that home on Tuesday. We got a call last night, saying they would provide five ADF personnel from next Monday. They could not start earlier, because they needed to be inducted into aged care over the weekend. I was happy to do that induction if they could come before the weekend. That home does have a reducing number of outbreaks. Staff are returning. But that ADF assistance next week will be gladly received. We will put those people to good use. But the home has really been held together by that late Commonwealth surge assistance, that one person from a local hospital and lots of volunteers from my head office and relatives who got trained, as Paul said, using a partner-in-care online training module and then turning up to assist. That is our experience through a very difficult situation, using or trying all the surge opportunities, at four different levels.

The Hon. JOHN GRAHAM: That is a really useful rundown, Mr Sewell. I will just ask on that point about the Defence deployment, as this is happening right now, just from either of the other witnesses, any views about how that is now rolling out, given it is happening immediately.

PAUL SADLER: Have you had any ADF assistance yet, Mary?

MARY CARPENTER: No, not yet. We are currently assessing and putting an application for ADF. But from our perspective it would have been a lot helpful if they were brought into our assistance four weeks ago, when we first raised that issue in terms of workforce.

PAUL SADLER: The feedback I have had from members is it is only just starting to arrive. The Prime Minister finally authorised it, as Mary said, four weeks after we had asked, only on Tuesday this week. So the first ADF support was going into homes on Wednesday. Initially it was only going to be 50 personnel in each State, ramping up to 200 in each State, and a maximum of 1,700 at the moment committed.

The Hon. JOHN GRAHAM: I might turn to another issue, Mr Sadler, just on the question about testing. We have had evidence earlier on from some of the public health experts about the collapse of the testing system before December. Obviously, their view is that has been a very important part of the response and that was a real setback. What has that meant in aged care, though? What is the access to testing like? How has that more generalised failure of the testing system been reflected in the aged-care world?

PAUL SADLER: I think two things to say there. Firstly, we, like everybody else, experienced that collapse of the testing system as Omicron began to take over. The immediate impact for us was the difficulty in getting results back for residents or home care clients who might have been potentially exposed. So we did not know what the risk profile was necessarily, as a result of PCR testing not coming back quickly. Secondly, of course, was the impact on the workforce. Where people were having to isolate but they potentially were going to test negative, we were not getting results back for those weeks in the lead-up to and immediately after Christmas.

I need to go back one further step then and talk about rapid antigen tests, because we—there had been a trial of rapid antigen tests in aged care, which the Federal Government had initiated in Sydney, actually, during the Delta outbreak. That was happening around October. The feedback we were getting from the aged-care members who were participating—Uniting was one of those—was that this was a good process and it was actually helpful in getting the within-15-minute response as to whether somebody was likely to be positive or not. We do know that rapid antigen tests are less accurate than PCR tests. So it does introduce an extra level of risk in terms of your decision-making. But clearly the feedback that we were receiving was it was helpful. So we basically said to the Federal Government, at the beginning of November, "We need rapid antigen tests rolled out across all aged-care homes and funded", because it is very expensive to pay for rapid antigen tests for staff or for family members coming in and out if it is not made available for free. The Federal Government was very slow to act on that. They really did not get rapid antigen tests out in any substantial way through November.

Once Omicron hit, in December, we were then stuck with no access to PCRs—or effective access—and very little supply of rapid antigen tests from the Federal Government. Again we did go to NSW Health and the local health districts. In some cases, they were able to help with access, either priority access for PCR tests or rapid antigen test availability. But this was an area where it was clearly the Federal Government's responsibility to make sure rapid antigen tests were available. They really were not, which impeded our ability to get staff back to work through January. Only in the last week has the supply of rapid antigen tests from the Federal Government to aged care begun to work properly. We actually do now have all of our members who are reporting to me that they have received supplies in the last week from the Federal Government. We are hopeful that that supply will continue in coming weeks.

The Hon. JOHN GRAHAM: Great. Thank you. I might hand to my colleagues.

The CHAIR: We will hand over to Ms Abigail Boyd.

Ms ABIGAIL BOYD: Thank you, Chair, and thank you very much to all of you for coming this afternoon and for everything that you have been doing throughout this crisis. I can imagine it has been very far from easy and I hope you are all looking after yourselves as best as you can as well. I want to take us back to I think it was 15 December when those restrictions were lifted. Did you have any consultation with the New South Wales Government before that happened? Were you given the opportunity to suggest measures that should be in place before those restrictions were lifted? Perhaps I will start with you, Mr Sadler.

PAUL SADLER: The first thing to say is by this time in the pandemic, like in early days in 2020, our communication was very good with the ministry of health. Mark and Mary will both be aware that for example ACSA members are meeting on a weekly basis with people from NSW Health Federal department quality and safety commission in an open online forum. My State manager, Anna-Maria Wade, has a really good relationship

with Health. We knew because it had been announced both nationally and by the incoming new Premier, Dominic Perrottet, that the intention was to relax in early to mid December once we hit those vaccination goals. We had been raising with NSW Health and with the Federal Government that there would be potential risks attached if we opened up the general community and there was a wave of the disease which was coming.

By the beginning of December the first Omicron cases were being detected and it was already evident from South Africa that it was more transmissible—much more transmissible than the previous strains. So we were already flagging with the New South Wales Government "For goodness sake, be very careful here. We don't think we are prepared sufficiently because there is not a supply of rapid antigens tests coming from the Federal Government yet and because there would be other potential consequences on workforce if there was widespread community transmission." Of course, what happened was the Premier made the decision to continue down the pathway of opening up. As I mentioned in my opening remarks, within days the number of outbreaks in residential aged care skyrocketed. There are now hundreds of deaths in New South Wales in aged care since that decision was taken.

Ms ABIGAIL BOYD: To clarify, you told the Premier or the Government that the aged-care sector was not prepared for an outbreak. You could see it coming, but the Premier went ahead and relaxed those restrictions.

PAUL SADLER: I believe that to be accurate.

Ms ABIGAIL BOYD: And the result is hundreds of deaths in aged-care facilities.

PAUL SADLER: Correct.

The CHAIR: Do we know the situation from Ms Carpenter's perspective and then Mr Sewell's perspective? Ms Carpenter?

MARY CARPENTER: Yes, thank you. We were certainly aware of the date and the opening into the community. We had made provisions and preparations to test the scenarios in terms of how we would deal with the surge. Unfortunately, we actually had the first Omicron case in residential aged-care facilities in one of our services. That is how we felt the transmissibility of Omicron was quite fast. We have also been preparing for the furloughing of staff members because that was one of the key issues which we were quite concerned about and we have raised that numerous times to the New South Wales ministry as well. So, as you can imagine, there are different contexts around the decision that certainly impacted our ability to manage the COVID outbreak as effectively as what we would have liked.

We spent over a $100,000 a month on preventative measures across our network. That is not funded by the Government. We purchased N95 face shields and our own masks and PPE to support our workforce as well as some of our residents and their loved ones as well. That also includes the rapid antigen tests where we could not get them from the Government. That is what we really relied on when we were getting PCR tests with up to five to six days delay from when it was done. At that time the management of COVID has really fast tracked into something a little bit further than what can be managed as when you get your test result on the day or even 48 hours later. So I suppose that is kind of how we managed. We are not surprised that we were experiencing over 60 of our services within the three to four week window of December-January.

The CHAIR: Mr Sewell? While that is happening, Ms Carpenter, maybe you could just have a little look at your virtual background because we are losing you into it. Mr Sewell?

MARK SEWELL: Yes, thank you. I support what Mr Sadler has claimed and what Ms Carpenter has given an account of. I might just describe some of the moods and some of the discussions that were had through that period. There was certainly a lot of confusion and concern. I remember speaking to many people who could see the media floating or surmising about the restrictions being released and the announcements that might have been had up until that date on 15 December.

I do walk-throughs of retirement villages and because of COVID they were mostly door-to-door type walk-throughs, and our direct care staff also represent older people in their direct care relationships. Many people had the catchcry about it "This is going to save livelihoods and I can understand why this approach is being taken, but what about our lives? This is a business approach to save the economy, but what about older people? Are we prepared enough?" In fact, that tone was also on the State collaboration committee that Paul just talked about of all aged-care providers for the State. The senior health public policy officer always attends and gives an account, and he fielded an enormous number of questions in that meeting and the week before about what will happen if these restrictions are lifted and what do we do if cases take off in widespread numbers.

I think it is fair to say—because I am on the business council as well, I could see the delight about the restrictions being applied and the livelihoods being rescued. I arranged at one of those meetings for the CEO of a local health district to come and give a briefing on the health impact on hospitals of a rapid outbreak. There were

projections and statistical modelling being done on the impact on hospitals, on the workforce and on aged-care and disability services, and there were clearly two worlds that clash here.

I think most people understood what was happening, but were aware that we did not have the resources to respond and the resources that Paul has mentioned. Clearly we needed everyone with booster three or third-dose vaccination level first and we clearly needed a large number of rapid tests in stock and PPE in stock to cope with this modelling. All of us hoped that the numbers would not escalate but within a few days we started to trickle and then saw a massive explosion, as I said earlier, within 14 days.

Ms ABIGAIL BOYD: I think you have touched there, Mr Sewell, on the point that we have got decisions that governments make that are always balancing up competing interests. We had a lot in the community who wanted the restrictions to be lifted and wanted to get back to some form of normal. You can understand that from an economic and mental health perspective. But knowing that that decision would have such a devastating impact on particularly people within aged-care facilities, older people more generally, people with disabilities and people in other at-risk categories, would it have been better to have at least got some extra protections in place before lifting those restrictions?

MARK SEWELL: I think it would be fair to say that it is universally accepted now that it happened too quickly and that inevitably it would need to happen for Australia to get back to work. But it should have been deferred until the middle of January not only to improve the vaccination rates and the resources stockpiling, but also because State- and Federal Government resources were on holidays and closed for Christmas and only becoming available again in the second week in January. Some big important programs like communication, information or actual resources, were stalled and paused in that period. That was the triple whammy, if you like, that led to what we believe to be a crisis that could have been foreseen.

Ms ABIGAIL BOYD: Thank you. We needed some rapid antigen tests on board, we needed to make sure that supplies of PPE were there, that people had had their boosters, but also that timing of the Christmas/New Year break where we had government departments taking breaks. But also staff were exhausted and wanting to take leave as well. Your evidence really is that a lot of the hype could have been avoided if we had waited until mid-January?

MARK SEWELL: Yes. If I can just add one more comment. We also can trace most of our exposures to the super spreader events of Christmas and New Year's Eve. Many of our staff were exhausted after two years of battling the pandemic and were with family and friends on one of those days or both, and were exposed and contracted virus that way.

Ms ABIGAIL BOYD: If we could maybe look forward then, because this is by no means over. What could the Government be doing now to reduce the number of deaths and to try and I guess help the sector to play catch up, particularly in relation to the considerations that are going on at Federal level now about whether the fourth shot or the second booster might be required?

PAUL SADLER: I might kick off on that one. In terms of what next, I think three really important things. Firstly, we need to complete the booster rollout into residential aged care services on the residents. We are sitting at somewhere around 70- to 80 per cent perhaps for the residents. That needs to be completed, because they are the most vulnerable group. Secondly, we need to make sure that the boosters are rolled out to the staff. There was an agreement with national Cabinet yesterday that the third shot, the booster shot, will be made mandatory for aged care staff. That can only be activated by the State Government passing a new Public Health Order that authorises that. It is really important that the State Government get straight on to this and actually does it quickly. I mentioned in my opening statement that at times there seem to be delays in the sorts of processes. We cannot delay in the middle of a pandemic.

The third thing is that we wrote to Ministers Hunt and Colbeck federally, and put it out in an open letter to the Prime Minister yesterday that we are now recommending that there be a national aged care COVID coordinating centre established. And it would have a node in New South Wales that would be a standard capacity between the Federal and State governments to manage this better for the next wave. We already have the national Chief Health Officer, Paul Kelly, warning us that there is likely to be either an Omicron wave or another variant wave in winter and quite possibly in conjunction with a flu wave, which we have not really had to any huge extent in the last two years. We are forewarned. This is still months ahead of winter. Let's get on and get a proper emergency management structure for all of this coordinated between Federal and State governments and that will absolutely help us be prepared for the next wave.

Ms ABIGAIL BOYD: Ms Carpenter, did you want to chime in on that?

MARY CARPENTER: Thank you. I do agree with what Mr Sadler has alluded to. The one thing that I would like to stress as well is, supporting us in terms of workforce. We know whatever variant will come what

preparation we could do from testing, from PPE, from coordination, but without actually starting on the ground we will not be able to care for the residents. I think it is certainly one of the priorities that we should do and have a coordination between the Federal and State and how that would work.

The CHAIR: Ms Boyd, do you mind if I just ask one question on the workforce at this point? Ms Carpenter, we have heard that the surge workforce that was provided was not quite 1 per cent of the staff time that was lost. Is that a model that can succeed going forward if those resources were doubled or tripled, or do we need to rethink how that assistance is provided if we find ourselves in a similar situation with so much of the workforce down?

MARY CARPENTER: In the work that we are doing we are currently redefining and doing our own modelling in terms of our workforce strategy. During the Delta and Omicron we did develop our own flying squad that we can send to sites with outbreak, and when that failed we also had to get our head office staff members to provide care on the frontline as well. I think there is going to be different layers, in terms of what workforce strategy will be required to support the aged care sector. I do not think it is just going to be a one support from ADF or just one particular stream of injection. I think there is going to be different levels, which is why I am suggesting start planning in terms of what that will look like because as things currently stand it is not sustainable.

The CHAIR: There has been a lot of attention and heat and light about the ADF deployment. But if you are talking 1,700 staff across the entire country when the kind of need has been so much greater than that, has that been more of a distraction than a solution do you think? I might ask Mr Sadler that first.

PAUL SADLER: I am happy to take that one. We were calling for it too. So I do not think it was a distraction in the sense that things were so desperate that any help we could get was going to be valuable. The ADF has two very important capacities, which they are now bringing to the party. The first is that they do have a medical and nursing corp. So they have got some skills to be able to do that. The second thing is they have got, through their general duties personnel, a lot of expertise in logistics and things like cooking, those sorts of areas, which are absolutely some of the areas that aged care homes have been hit with. I think the ADF contribution is valuable. And to be honest its most important message from the Prime Minister accepting the need to do it was to acknowledge what Mary and Mark and all of the other aged care teams around the country have been experiencing, that this is a crisis.

We bring the army in to help when there are national emergencies. This was a national emergency, it still is a national emergency. I think it was helpful in its own right. Is it sufficient, as you said, Chair, given the scale of the challenge? No it is not sufficient, so we do need to do more. That is why we believe this idea of a national coordinating centre with a node in New South Wales could really help from that point of view. Because they could be the coordinating area that brings together ADF resources and other surge workforces that the Commonwealth has engaged, and what help we can get from the State health system at times of crisis.

The CHAIR: Mr Sewell or Ms Carpenter, do you want to add anything on that?

MARK SEWELL: Yes, I will. Thank you, Chair, and Committee members. I think it is absolutely essential that the message of assistance is there. Aged care homes are in every town in Australia. Every community needs aged care services for people who are in their last couple of years of life and need 24/7 support. Many organisations can survive and will survive, and have extraordinary community support. If they have a much closer relationship with the local health service and they together understand the needs ahead of time, they will get through. The ADF assistance needs to be perpetual. The idea that it is going to be ramped up, people are going to get induction training over the weekend and it is going to start from next week and they will get sent if people apply for them, is slow and clunky and does not acknowledge the rapid response that a crisis needs when people need 24/7 assistance.

If people do not have someone to care for them for 24 hours, they will pass away. They are in aged care because they need that assistance. But there is lots of practical things, not just medical and nursing assistance, needed. I would highly recommend that they be ready to respond, just like they would be ready to respond to any small community with a disaster. The ADF knows how to respond and get there quickly and assist. This is a lesson, I guess, for vulnerable people living in 24/7 care without the kind of State Government health infrastructure that hospitals are used to. The ADF, or similar national response bodies, are needed on a perpetual basis.

The CHAIR: This was very like a wildfire and that same kind of urgent readiness should be in place. Is that right?

MARK SEWELL: Exactly right. If I can just add to the comments earlier about what recommendations are to be made, the Commonwealth coordination centre with the New South Wales hub is an excellent initiative and I hope that it becomes accepted. The last thing we would want is for the State to think that the Commonwealth will make all the decisions and aged-care homes will not need local intervention. Ideally, that should be

harmonised with the State and Territory health departments' views and local health departments' relationships with their aged-care services because they are their oldest citizens in their community. The best thing that could be done from this is to establish formalised relationships at the State and regional levels between health, hospital and aged-care services. That has happened in some places. There are exemplars where the relationship will be strong forever.

We have public health units that have staff who have visited every aged-care home. They have never been there before—ever—and they now have seen every single one. They understand the environment, they have met some of the residents, they talk to the staff and understand the Aged Care Act and its requirements. That close cooperation will be an enormous asset for any future outbreaks. I believe it must be institutionalised or formalised, and every LHD needs an aged-care response liaison person who chairs regular meetings to discuss how aged care and health care are going together, not just for COVID but for all significant health issues any time there is an infection, anytime there are a number of vacancies in aged-care homes and an oversupply of older people in hospitals and the transition arrangements—all those things only work well if there is an ongoing relationship, and I believe it needs to be formalised and established.

The CHAIR: It is an opportunity to build resilient infrastructure for not just COVID but for other unforeseen circumstances going forward.

MARK SEWELL: Exactly. I think a blind spot has been exposed here and some public servants, bureaucrats and local health district professionals have learnt something new that will put them in good stead for future responses.

The Hon. JOHN GRAHAM: Mr Sadler, returning to those points that you were making about the testing system in aged care, which you really took us through that journey. There was a significant period after the testing system fell over where, in the aged-care system, as in the general community, it was impossible to get a RAT test no matter how hard you looked. You were just at the point about saying that was improving just recently, so is some of that starting to come through?

PAUL SADLER: Yes, it has really been in the last week or so that we have heard both from the Department of Health federally and from our members that the deliveries of rapid antigen tests from the National Medical Stockpile are now flowing. There were two big issues. First, as I mentioned, the Federal department did not do the pre-planning to get rapid antigen test stocks and then out to aged-care homes ahead of the Omicron wave, even though we had been advising them from early November to do so. Secondly, of course, as we all know from going to Coles and Woolies, the supply chain broke down over Christmas because all of the truckies were catching the disease as much as everyone else was and that impacted both the deliveries for the National Medical Stockpile of rapid antigen tests to aged-care homes and also interrupted the supplies of personal protective equipment, which were essential for aged-care staff to be using during high rates of transmission of the disease. So on both those fronts we really struggled through around Christmas right through January and it is only in the last few days that we are beginning to see those logistical issues improved to a point where we can be more confident that aged care has the resources it needs.

The Hon. JOHN GRAHAM: I agree it would have been ideal had the Commonwealth been able to manage this but I do not necessarily accept that there is no State role. This was one of the very first issues this Committee raised with the health system and testing was always going to be crucial. Those questions about the alternatives to PCR testing came up very early on. Would it not have been better if the State had been able to step up or, perhaps more importantly, would it not be good if New South Wales was able to step up now given the challenges and given how central testing is to those?

PAUL SADLER: Yes to both. Responding to something like a pandemic has always been a joint responsibility. It is not just a Commonwealth responsibility or just a State responsibility; it has to be dealt with jointly. I agree with you that clearly the collapse of the largely State-based, though with some private providers having the same struggle—when the PCR system basically collapsed it absolutely made things worse for aged care.

The Hon. JOHN GRAHAM: Ms Carpenter, I might ask you and then Mr Sewell, are you seeing those RAT tests out of the national stockpile in your facilities at the moment?

MARY CARPENTER: Yes, we are. We are slowly receiving them and we are hoping that they will continue to be sent to us over the next few weeks as well. I do know that there is certainly extra effort coming from the Commonwealth to ensure that stock is being delivered to the services and we have seen a lot of that in last week.

The Hon. JOHN GRAHAM: Mr Sewell, is that similar for you?

MARK SEWELL: Yes, it is. We are delighted when a pallet arrives and we work out what it is and open it and discover whether it is in fact shields or gowns or masks—what type they are, whether they fit and whether there are tests, lots of them and what type they are. Ideally, we want individual serve tests that staff can take home. We go through 1,000 a day because every single staff member does one before they go to work anywhere near an older person, of course, and sometimes they are not like that. They are batching models that have to be broken up and dispensed into tubes and then handed out, so we spend hundreds of hours sorting it out. Regardless of that, it is the first time we have had free rapid tests. Initially they were affordable at a wholesale cost. Then they became very expensive, even at wholesale, and we were beg, borrowing and stealing them anywhere we could.

It is actually a delight to finally have some free ones. It is interesting to also note that the public health units at each of the local health districts do have different views about rapid tests versus PCRs, and sometimes suggest that everyone in an aged-care home—who lives there, works there or visits there—should be PCR tested via an external pathology visiting company at a certain threshold of days to check that the virus is not there. Other PHUs are very comfortable with rapid testing of just the neighbourhoods or the houses or the communities where people are exhibiting symptoms and every other piece of advice in between. I guess that is not unusual [disorder] advice.

The Hon. JOHN GRAHAM: I just want to come back to the question about the future challenges. We have had some strong evidence this morning about heading into winter. You have also talked today about the possibility of a different wave of Omicron strengthening and rolling through again. We know, and you have made the point really strongly, about that 15 December decision, which was made then reversed—too late for aged care—that ignored the written health advice at the time. In your view, what is the most important factor, the most important piece of health advice, that needs to be adhered to as we face those challenges that cannot be ignored and have an impact on aged care? What do we really need to watch out for over this period as we face those challenges?

PAUL SADLER: I think the first thing we learnt from the Omicron wave—and Mary alluded to this earlier—is that it was so transmissible in the broader community that as soon as it began to spread rapidly its entry into aged care was inevitable. It has been interesting just in the last 24 hours we have seen Western Australia have its first real incursion of Omicron into an aged-care home, in spite of all the border barriers, and it has taken off once it got it. It went from one resident and one staff member to 10 residents in 24 hours. So this is a very transmissible disease.

Therefore, protection needs to happen at two levels. We need to get proper funding from the Commonwealth and resources and help to be able to protect against it getting in in the first place. The Commonwealth stopped the funding of preventative measures on 30 June last year. The consequence of that is now obvious. The second thing is that any decision by State authorities around mask wearing, requirements for boosters and so on, they need to take into account vulnerable populations like aged care, disability care and the like. If you do not take those into account, you can end up with the most vulnerable populations having tragic outcomes.

The Hon. JOHN GRAHAM: Ms Carpenter or Mr Sewell, from a State point of view, what is the most important thing you want to see that we are keeping a very close eye on over this period?

MARK SEWELL: I fully support what Mr Sadler ended with there, which was every time a policy decision is made that changes behaviour, that the likely clinical impact on older people or vulnerable populations is fully informed and shared. Getting access to the clinical advice and clinical research, either overseas or locally, is very critical. I think NSW Health has some excellent research that should be shared regularly with vulnerable populations. Those facts, that modelling and that preparation of impact should be clearly articulated before policy decisions are made. Different, pressured perspectives, like [disorder].

The Hon. JOHN GRAHAM: Thank you.

MARY CARPENTER: Further to that, I agree with Mr Sewell and Mr Sadler. The other one that would be ideal is ensuring the consistency in application of those policies. It would be greatly appreciated across LHDs and public health units. Further to that is ensuring that the support and the services are supported and available to aged care where they are required. To date, we hear from most of the public health units when we have an outbreak. Unfortunately, in some public health units, we do not. There has got to be consistency in that support. It is greatly appreciated by our frontline staff.

The Hon. JOHN GRAHAM: I have, perhaps, one final question for Mr Sadler. When we have put issues to the Minister about the aged-care sector, he has often washed his hands of State involvement in that. You have said that you really put it to the Government, ahead of that 15 December opening, that this would have a real

impact on the aged-care sector. That decision was clearly squarely in the court of the New South Wales Government. How strongly was this put to the Government? To whom was it put? When we raise that with the Government, what information can you give to us about how you put this view in front of the Government so it was unable to ignore it? Was the Government aware of it at the time?

PAUL SADLER: As Mr Sewell said in his earlier evidence, through the regular communication mechanisms that Aged & Community Services Australia and Leading Age Services Australia—the other major peak body in the sector—have with the department of health, we were giving them that message in those two weeks from the beginning of December, when Omicron was starting. In the regular forums where member organisations were meeting with NSW Health and Federal officials, members were raising the significant concern that this would potentially spiral out of control quite quickly. That message was given to Ministry of Health employees. We understand, from the feedback they gave us at the time, that was absolutely being put through the appropriate channels within the ministry to raise the concerns of the aged-care sector.

The Hon. JOHN GRAHAM: So, in your mind, there is no way that the Government could not have known how concerned the aged-care sector was?

PAUL SADLER: They absolutely knew.

The CHAIR: We will pass to Ms Abigail Boyd again for questioning.

Ms ABIGAIL BOYD: If I could turn, in the time we have got left remaining, to people who are outside of a residential home and the unique, particular challenges that they are facing. My office has heard tales of people who have tested positive, they require a carer to come into their homes to shower them and they have not been able to, for example, work out what to do in that circumstance, when it comes to the wearing of PPE or how they should proceed. The point is that there seems to be a lack of guidelines given from the Government. Are you able to comment on that or inform us as to any other things we may not have heard of so far that apply, particularly to those people in their homes? We will start with Mr Sadler.

PAUL SADLER: In terms of services to older people in their homes—and, obviously, both Mr Sewell and Ms Carpenter can comment further on this because their organisations provide substantial home care services. Through the whole of the pandemic, we had a significant impact in most of the group activities that are provided. For example, Commonwealth home support program providers were on pause in one form or another. So the social isolation challenge for people in their own homes has been a significant one through the whole of the pandemic. That has obviously gone up and down dependent on what the requirements were for social connectivity from the State Government, predominantly. The Federal Government was largely following what the State required in terms of how group activities could be conducted. When Omicron hit, as I mentioned earlier, we had the same staff loss in home care as we did in residential care. We were getting up to that 25 to 30 per cent of shifts—sometimes higher than that in some regions. I called out the Hunter and Central Coast earlier, in particular. There was absolutely a substantial impact on the ability of us to then provide services to people in their own homes.

The feedback I had from major home care providers was that the people were trying to prioritise personal care over other forms of assistance in the home, so we made sure that the people who had the most personal, intimate needs were prioritised. Where we could swap to doing things online, particularly some of that social isolation and following people up, if we could do that—if the older person was capable of managing an iPad or things like that—we were doing that. We were phoning people up to check on them on a regular basis. Obviously, once our staff numbers plummeted for those six-plus weeks from just before Christmas through January, we were cancelling 30 per cent of the home visits that we would have been doing during that period.

Ms ABIGAIL BOYD: Does that mean that people were going without essential things, such as showers and meals?

PAUL SADLER: In some cases, showers might have been not done as regularly as they would routinely have been done. Meals on wheels services were doing this for their delivery. They were prioritising delivery of basic things like meals wherever they could, and so were the other home care staff.

Ms ABIGAIL BOYD: Ms Carpenter, did you want to comment on this issue?

MARY CARPENTER: Yes. That has certainly been the case. We have had to prioritise essential services only to the higher needs of our home care clients. In different contexts, we have also asked some family members of theirs as well if they have the ability to provide care and if they are within the same house, just because of the furloughed staff and the extensiveness of it. It has certainly been a lot more challenging in regional areas, especially western New South Wales has had a big surge over the last three months. The remote areas have certainly been impacted.

Ms ABIGAIL BOYD: Mr Sewell?

MARK SEWELL: Yes. I am so glad you have raised this issue because it is a very important issue which is not covered well by the media or understood by government or the public. Many people who need and rely upon regular drop-in support have cancelled it. They have either had it cancelled by us because of lack of staff or cancelled themselves through fear and concern of having someone come in the home who might be visiting other people. That whole idea about visitors and household safety and the numbers and all that is very frightening for someone living at home on their own. There are many more people living at home on their own than in residential aged care in Australia, so the numbers are quite large. I do personally fear that we will discover many awful stories when this is all over and we start to reconnect with those people and understand clearly when their families are back across borders visiting and when we get back visiting every single person and assessing their situation. There may be many people who can no longer stay home because of the ill effects of not having good support during this time.

We did maintain a lot of contact via phone call, but that is often very difficult to assess a person's wellbeing. You cannot assess their living situation. They might say they have had good meals that day, but unless you can actually have a look at the dirty dishes and have a peak inside the fridge and double check and assist the person, you cannot make that assessment. We did roll out hundreds of iPads and deliver those to people and offer to show them how to use them, but unless they were able to maintain that, that was very difficult for them to maintain connection. GPs were also unable to take people to visits and often required phone call consultations, and, again, a phone call consultation with a GP is nowhere near a thorough medical or health assessment as a visit. For all those reasons, I fear people at home who are vulnerable are suffering very significantly during the pandemic era.

Ms ABIGAIL BOYD: I understand that in Victoria they have had a government-run service across the State that goes in to people with mobility issues or who cannot leave the house and do testing and boosters and things like that. I am aware of maybe a limited service that the NSW Health department has run in the inner city. Are you aware of that service anywhere else?

MARK SEWELL: I am aware that some of our LHDs—we had that service offered in the Illawarra Shoalhaven Local Health District. But, interestingly enough, it was actually delivered by the primary health networks, so the federal support for primary health GPs. They would coordinate contact and ask GPs who was available to do home visits for COVID testing and vaccination. There were more than maybe a dozen GPs who were willing to do that and we made those referrals to the primary health network coordination team, and they arranged those visits. But unless we knew of a person's need, unless someone was willing to have a different GP arrive and do that—and I do not think that service was offered across the Southern Tablelands or the Southern Highlands.

The CHAIR: We are about to run out of time, but our next session will have the health Minister and senior NSW Health bureaucrats. Between you, you have raised a number of critical alternate responses the New South Wales Government could have done: the initial public health response when we get a wave, taking into account the vulnerability of the aged-care sector when making those decisions; greater ease of transfer of index cases into the hospitals; as well as full cooperation to ensure seamless cooperation at local, State and Federal levels. I know it is an impossible question, but if you wanted us to put one thing squarely in front of the Minister in the next session from an aged care perspective, what would you prioritise? We might just quickly go to Mr Sadler, Ms Carpenter and then Mr Sewell.

PAUL SADLER: I would put, Chair, to the health Minister the idea of this national coordination centre and State nodes. Is that something that the State Government is prepared to negotiate with the Federal Government, other State colleagues and with the sector?

The CHAIR: Thanks, Mr Sadler. Ms Carpenter? Again, I know it is impossible.

MARY CARPENTER: Yes, thank you. For us, it would be to have a revisit on how we manage COVID from an outbreak management perspective and the coordination of resources that are available to the residential aged-care community.

The CHAIR: And ensuring your sector is in the front of decision-making and also—

MARY CARPENTER: Absolutely.

The CHAIR: —adequately resourced from the first day?

MARY CARPENTER: Absolutely. Yes.

The CHAIR: Thanks, Ms Carpenter. Mr Sewell?

MARK SEWELL: Thank you. I would like to see a policy and structural imperative in every LHD, with the CEO of each LHD responsible for KPIs to prove they had engaged with aged-care services in their district and established good communication, committees and preparation arrangements for the health citizens in their LHD, and make sure that lasts beyond this current pandemic environment.

The CHAIR: Between you, you sort of built the readiness, dealt with the coordination, and then, Mr Sewell, you link the two together. Can I say, on behalf of the whole Committee, thank you for your assistance today. I found this session extremely enlightening.

(The witnesses withdrew.)

(Short adjournment)

The Hon. BRAD HAZZARD, Minister for Health, before the Committee

Mr PHIL MINNS, Deputy Secretary, People, Culture and Governance, NSW Health, sworn and examined

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

Ms ELIZABETH KOFF, Secretary, NSW Health, on former oath

Ms SUSAN PEARCE, Deputy Secretary, Patient Experience and System Performance, NSW Health, and Controller, State Health Emergency Operations Centre [SHEOC], sworn and examined

The CHAIR: Thank you for joining us in this afternoon session of the Public Accountability Committee's review of the New South Wales' Government's response to the COVID pandemic. This afternoon we have the Minister for Health, together with senior officers from NSW Health, including the Chief Health Officer and Deputy Secretary Dr Kerry Chant. Minister, thank you for joining us. I remind you that you are on your oath as a minister and you are not required to be sworn. Dr Chant, I remind you that you are on your former oath that you have given for the Committee. Ms Koff, I think you also have previously been sworn in for the Committee, and I just remind you that you are on that former oath. Thank you to all of you for the ongoing work you have been doing. It has been an extremely stressful end of 2021 and commencement of 2022, and it was not as though the previous year and a half had been easy either. So we do appreciate the enormous amount of work and we appreciate your time today. Minister, did you or another of the staff with you wish to make a brief opening statement?

Mr BRAD HAZZARD: No, Mr Shoebridge. We are happy to take questions. Thank you and the Committee for your ongoing interest in the work that the NSW Health officials are doing. I think they have done an extraordinary job and so have the Health staff, the other emergency staff and, of course, the community who have been with us on the journey. Thank you to everybody who has been involved.

The CHAIR: Alright, well then, I will just straightaway hand over to the Opposition to commence questioning.

The Hon. JOHN GRAHAM: Thank you, Chair, and thank you, Minister, for those comments, which I would agree with and join with you in commending those people. We have had some quite disturbing evidence though over the course of the day, in no small part from the aged-care sector. I might put that to you, just straight up-front, and give you the chance to respond with your view. The view of the sector was very strong, particularly in relation to that decision on 15 December, which was then reversed shortly afterwards, to open up to remove masks. The sector has put the view that, within days of the Premier's decision, cases spiked and, in their words, "that resulted in deaths and despair". How do you respond to that view from the sector, Minister?

Mr BRAD HAZZARD: I am sorry, can I ask who is "the sector"? I did not see this morning's hearing, so who are the sector?

The Hon. JOHN GRAHAM: I think the Chair can tell you the three witnesses we have just had, Minister, if that was not made available to you.

Mr BRAD HAZZARD: That would be helpful, if I knew [disorder].

The CHAIR: Minister, just to assist, it was the session we had just after lunch. I think Mr Graham has expressed the evidence we got from the three witnesses: Mr Paul Sadler, who is the Chief Executive Officer of the peak body Aged Care and Community Services Australia; Mr Mark Sewell, who is the Chief Executive Officer of Warrigal Care, a large provider; and Ms Mary Carpenter, the Director of Governance, Risk and Quality at Uniting NSW—I think probably the largest provider of aged-care facilities in the State. That was the panel we just had and that is the evidence Mr Graham is speaking to.

Mr BRAD HAZZARD: Okay. Look, All I would say is, I did not hear that evidence but obviously there have been some challenges throughout the pandemic and some very unfortunate outcomes in the aged-care sector. But, obviously, the primary responsibility for the aged-care sector is not the New South Wales Government. It is not a State government responsibility. Having said that, a lot of work has been done by NSW Health, from time to time, to assist the aged-care sector. Right from the word "go", really, if the Federal Government needed assistance or if there was something that we could do to help then, obviously, that has been done. [Disorder].

The Hon. JOHN GRAHAM: But you agree it was, of course, the New South Wales Government's responsibility to make that decision to open up on 15 December, and that is what they are commenting on. Were you aware, when that decision was made, of the strong view of the sector that it would cause at that time, with the preparations that were in place at the time, significant problems for their sector?

Mr BRAD HAZZARD: What we were aware of was that we had been through two years of the pandemic and through a number of iterations of the COVID virus, and through that, of course, that we had received, obviously, advice from a number of different sources, including the public health unit of NSW Health but also broader advice from the broader health team in NSW Health. We had also received advice through what was then called the Crisis Cabinet. It later became the Recovery Cabinet or subcommittee of Cabinet with other departments, including police, Treasury, Service NSW. So what we were constantly weighing up right through the whole aspect, and it continues today, is, how do we take the community with us and how [disorder].

The Hon. JOHN GRAHAM: But Minister that is understood and agreed, I think, that there are some difficult balancing acts to here. My question is this: Were you aware of the aged-care sector's view? They say this resulted in deaths and despair. They say they advised the health agencies through the forums they had, very strongly. They thought the message got to the Government. They say they absolutely knew this was the risk. Did you know—were you aware, as you balanced all those very difficult issues?

Mr BRAD HAZZARD: Are you asking me personally or are you asking of the Government's position?

The Hon. JOHN GRAHAM: I am asking you on behalf of the Government.

Mr BRAD HAZZARD: I do not recollect, at this point, that there was a specific focus on the aged-care sector; it was on the broader community. Certainly, I remember that we had made announcements—I think that Omicron, from memory, came to New South Wales in the last week of November and there was very limited, knowledgeable information about Omicron at that stage. Our focus, the majority of cases, was still Delta—because there was a very minimal number in that period in November and very minimal in the first week of December. But I do recollect that, as a government, we had weighed up the public health advice, the broader health advice, the sentiment of the community—how it had hit people coming with us on the journey after two long years, a very tiring two years. But I remember that—without referring to any notes now, this is the best of my recollection—we had indicated to the community that we would hopefully get to a certain point with vaccinations where we could, if you like, give people back more of their normal life, and that was 1 December that we were aiming for. And so, that was right at the intersection of Omicron arriving in New South Wales.

The Hon. JOHN GRAHAM: Minister, what I might do is—you are going exactly to the dates that the sector has put. I might just put this to you and allow you to respond. I will put to you the evidence we just had put to us that between 1 December and 15 December the aged-care sector put to your Government in strong terms the warning that the sector was not ready to open up. Do you agree or disagree with the evidence that was put to us?

Mr BRAD HAZZARD: I cannot say that is the case. I previously did not have that information put to me, and we were certainly looking at all aspects of the community, as we always have. That information certainly was not something that I recollect being at the forefront of the discussion. What I was trying to finish, if I could just finish, is that we had given the community a very strong statement that we would open more broadly on 1 December. And then, I recollect that we were concerned particularly about some of the regional areas that didn't have their vaccination rates up, so the Premier made a very cautious decision to—well, the committee that works on the issues made a cautious decision to push that back to 15 December. And then, on 15 December, I remember there was a meeting that day again looking at all the issues, the meeting of the equivalent of the old crisis Cabinet—

The Hon. JOHN GRAHAM: Minister, as you turn to the more general issues, I might hand to my colleague.

The CHAIR: Just before we do that, John, could we get an answer—

Mr BRAD HAZZARD: [Disorder]. I have not been able to finish my answer at all, but I am just making a point. If we don't want the answer, okay.

The CHAIR: Minister, can I be clear: If you feel like you haven't finished your answer, please do feel free to finish it. But then we might find whether or not the aged-care sector communicated that to either the Chief Health Officer or the department and go to Dr Chant and Ms Koff. Minister, if you could finish what you wanted to say.

Mr BRAD HAZZARD: Thank you, Mr Chairman. What I was trying to get to is that by 15 December we obviously were still weighing up all those difficult issues, and we had seen people overseas and in the streets here in New South Wales and in Victoria who were exercising their right to democratic statements that they were not happy with the current state of restrictions even at that point, so we were constantly weighing up those issues. We were looking to try to get the economy and the employment going. At the end of the day, we made a decision that on 15 December we would take some more freeing-up steps.

Having said that, I also recollect that we still gave strong advice. In fact, Dr Chant stood out on the grass on level nine of Parliament, I think it was, from memory, and said that the recommendation was still to wear

masks and take some of the precautions that we keep talking about every day that we've got the media. So I do not recollect any specifics of what has been talked about apparently that was evidence this morning, but I am happy to ask whether any of the health officials here had any discussion with that particular sector that they are aware of. It certainly wasn't on my agenda. It wasn't something which [inaudible]. We might have to take it on notice if no-one can remember that today. They might have to go back and check their notes. Does anybody have any recollection?

The Hon. COURTNEY HOUSSOS: Minister, before you pass to—I think we will have some questions for Dr Chant later on. Can I put to you what we heard from the nurses this morning? This is a direct quote, which is, "The Government's decision to lift restrictions in mid-December, when the highly transmissible Omicron variant circulated, resulted in mass community spread and a significant demand on hospital services at a time when the public health sector was at its least capable to respond." Our nurses are about to go on strike for the first time in a decade. With the benefit of hindsight, should you have not lifted the restrictions on 15 December?

Mr BRAD HAZZARD: I think what we had done at the time was the right decision at the time. I think Omicron, as has been evidenced across the world, obviously was getting going, but it spread very rapidly. I think a hypothetical question about "Can you, with hindsight, look at these issues?" is extremely just that: It is hypothetical. We have managed this issue to the very best of our ability. Compared to other nations, our death rate is infinitesimally smaller. It is still very sad that we have more than 1,600 people who have died, and quite a few of them in more recent times, but the reality is—compare us to Europe. Compare us to the United States. Compare us to the United Kingdom. Compare us to South America. Compare us to Asia. New South Wales and Victoria have done an extraordinary job of striking a balance. I think both governments have done their best with the proper advice that we have been given.

The Hon. COURTNEY HOUSSOS: Minister, it is not about a comparison with elsewhere in the world. What we are actually asking about is off the back of the evidence we received today, which is that after two years of a global pandemic our health workers are exhausted. At a time when our health system was least able to cope the New South Wales Government decided, against health advice, to let it rip. You are saying that you still think that was the right decision to take?

Mr BRAD HAZZARD: I object to the rather colourful terms that have been used by the Labor Party in this period. Each of these decisions—every one of them that we have taken over more than 700 days of constant meetings on all of these issues, which are very, very complex and have been, to say the least, weighing heavily on everybody's shoulders and minds—have been done to the very best of our ability. Of course we recognise the pressure on our frontline staff, and I have talked about that many times. I have talked with frontline staff about it. I have talked with the heath sector broadly about it. But I think your question to me is a hypothetical, which I do not think is really a fair question. It is not a question that I can answer. What I would say is: Whoever has given their evidence today is entitled to their opinions, but they weren't sitting inside this very difficult decision-making body trying to strike the balance between having people get what they wanted, which was to get back to some degree of normalcy, and also keep safe. We have done that to the very best of our ability all the way through.

The Hon. COURTNEY HOUSSOS: This was a dramatic change in the course of the pandemic, though. When you lifted the restrictions of 15 December you acted, as has been publicly canvassed, against the health advice. There was health advice. The sector says that you knew on 15 December that this would lead to increased pressure on our hospital system, in the words of the nurses, when it was at its least capable to respond. You cannot actually say, though, that you think that was the right decision to take. Surely with the benefit of hindsight you think that you could have taken a better course of action. That was what put such an impact on our health system at the time when it was least capable to respond.

Mr BRAD HAZZARD: Every decision that we have taken in the last two years, I have turned on the TV, turned on the radio, and occasionally listened also to Labor Party members giving exactly the contrary view or warning of doom and gloom. I have to say that whilst we listen to those views, we also have to weigh up all of the collective information that we have on making sure—for example, you referred to health advice. You would have heard me, I think, I hope, refer many times, both under the former Premier and this Premier, to—there is a broad array of health advice that we get. It is not just the epidemiological advice. It is also advice on mental health, for example, and getting the economy going so people feel like they are back on a degree of normality.

We know the impact on mental health has been very, very substantial. These issues are complex issues and to oversimplify them now, with the benefit of being obviously just critical, doesn't help anybody. I think the community knows that we have tried our best. You can take your view now, with the benefit of the latest advice that you have from a group or a couple of groups who weren't involved in those discussions, but I assure you that nothing has been done lightly. It has been done with great gravity and literally thousands upon thousands of hours

of work with the entire team, not just one or two or three—the entire team, and the Treasury, and Customer Service.

The Hon. COURTNEY HOUSSOS: Minister, the Centers for Disease Control and Prevention on 2 December—

Mr BRAD HAZZARD: I'm sorry, could you say that again? I missed the first part.

The Hon. COURTNEY HOUSSOS: The Centers for Disease Control and Prevention on 2 December talked about the importance of layering prevention strategies to reduce the transmission of Delta, Omicron and all variants of COVID-19, why then did you decide to lift off this layering on 15 December? How can you say then that your decision was in accordance with the health advice?

Mr BRAD HAZZARD: Which particular layering are you referring to?

The Hon. COURTNEY HOUSSOS: This talks about layering of masking, improving ventilation, distancing, handwashing. Your decisions of 15 December removed the mandate for masks and increased the density we were in, particularly in indoor venues.

Mr BRAD HAZZARD: They were very, very modest changes and those changes did not mean that the sort of provisions that you are talking about, social distancing, handwashing, there was no removal of that, that is still in place to this day and we recommend that. We also recommend masks, and recommended at that point, in situations where even if you are outside you cannot distance you might choose to wear those masks. There is a whole range of things.

The Hon. COURTNEY HOUSSOS: Minister, my time is expiring, but you cannot say that the minimum mask mandate did not result in less people wearing masks.

Mr BRAD HAZZARD: What you are seeking to do is trying to rewrite history, rewrite the complexities. It is not that easy.

The CHAIR: We will now move to the next round of questioning from Ms Cate Faehrmann.

Ms CATE FAEHRMANN: It has been mentioned and I am sure that you are aware that nurses and midwives will go on strike next Tuesday, which is the first time in almost a decade. The Premier has hinted that the Government is considering pandemic pay of some sort for nurses. I know you have received more than 15,000 emails in support of NurseKeeper specifically. When will the Government provide pandemic pay to nurses, paramedics and other frontline healthcare workers?

Mr BRAD HAZZARD: Let me say again that what our frontline staff, our entire system, not just the ones at the front line but the entire system have done in the last two years has been extraordinary, not just them of course but also police. The police have had to do jobs that they would never have imagined they would have to do, particularly in hotel quarantine. Teachers have obviously had challenges, there have been loads of challenges right across the system. Certainly, we have done what we could in the earlier stages to try to assist nurses in a range of ways, medical staff, allied health staff and I thank the councils, for example, that we worked with to ensure there was free parking in side streets and so on during the period when obviously public transport was eased off.

We also made sure that in terms of car parks within our hospitals, we tried to take the pressure off the nurses so they know that they can park there and not pay for them. There have been a host of things that have been done. You are asking me though, Ms Faehrmann, what we might do going forward and obviously those are decisions that the Cabinet has to make. I am not going to indicate, I cannot indicate to you, and I think you are aware of that, I do not mean to be disrespectful or rude, but I just cannot indicate what Cabinet might be considering doing. But we are very conscious of the fact that our nurses, our midwives and our allied health staff and our doctors have all been amazing during the course of this pandemic.

Ms CATE FAEHRMANN: This pandemic, the current wave, we heard from the unions this morning and we have heard from many nurses and midwives themselves, it has come up in the regional health inquiry, about the severe lack of nurses, particularly experienced nurses, registered nurses, nurses with decades of experience leaving years before they are actually due to retire. What can the Government do, immediately if you like, before what could be another wave hitting our hospitals in winter? What is the Government considering now to incentivise particularly those experienced nurses from resigning?

Mr BRAD HAZZARD: The first thing I would say to you is that I spend a lot of my time in hospitals and with medical staff and nursing staff. What you are saying is a fair representation of some of those staff's attitudes, but I think there are a lot of staff in the New South Wales health system, and many expressed this to me, who feel a little—do not get me wrong, many of them are tired and they have worked really hard and they continue

to work really hard, but they also do it because of much more altruistic reasons than simply some sort of financial benefit. Obviously, I would like them to have as much money as we can give them, but the reality is that is not necessarily what they talk to me about all the time. I certainly hear that from the Nurses and Midwives' Association, the union that represents them, and I have discussions with them, I have discussions about the staffing levels generally, and there are some things that I have talked to the association about.

In recent times—I think in his job he is called the general secretary, Brett Holmes—Brett has brought nurses in from various parts of the health system to talk about the sorts of stresses and pressures they work under, not just during the pandemic but more broadly, and we are certainly working with them to look at what other steps we might take. Some of them obviously reflect staffing arrangements, some reflect management and how it impacts on staffing and those issues are issues which I have given an absolute commitment to the association to work with them on. But I do not think that necessarily just the money aspect is the sole issue, it is a lot more broad than that.

In terms of staffing, I can tell you that only yesterday we announced 2,800 new nurses and midwives, 2,800 just coming on board right now, and 40 per cent of those are going into the regions. That is a lot of staff to bring on, and yes we lost some, a relatively small amount, because we insisted at that point that they had to be vaccinated to keep patients safe and that was on public health advice and the broader health community's advice. That was a relatively small number that we lost. I could ask Mr Minns, if you like, to expand on what number actually had to leave, but we are certainly making sure there are a lot more coming in. Mr Minns, could you advise us, or you need to take it on notice, what the number of people was that we lost as a result of the mandating?

PHIL MINNS: I can do that, Minister. This staff note is from a week ago, but we can advise that we had 296 resignations across the entire workforce, so that is medical, nursing, allied health, corporate, mental health, et cetera. So far we have 886 terminations that are either commenced or still in the process of being discussed before the IRC and there is a potential further 346 that may yet lead to a termination process.

Mr BRAD HAZZARD: What I would also ask Mr Minns is what is the current position with regard to nursing staff, because Ms Faehrmann was asking specifically on nursing staff, what number of nurses do we have operational in the system?

PHIL MINNS: I can find that, if you just give me a few minutes.

Ms CATE FAEHRMANN: That is okay. If you can please provide that on notice. Thank you for the detail, which is really important. It is also important to know the breakdown of how many registered nurses are being lost and replaced by nurses with—it is fabulous that new nurses are coming into the system, but of course it is important to know whether they are AINs or less experienced nurses and what that means in terms of the balance of experience versus new recruits. Is that also able to be provided, Mr Minns?

Mr BRAD HAZZARD: We can look at that because I would be interested to know that too. Can I ask, actually, I thought all university graduates were registered nurses or midwives. Is that not the case?

PHIL MINNS: Yes, they will be registered nurses coming on board. That number has increased over the decade from about 2,000 annually to this current number of 2,800. Last year we had 2,900 and we expect we will be over 2,900 when we do the second half of the year intake.

Mr BRAD HAZZARD: But what we are seeing is really interesting actually, Ms Faehrmann. Because of the pandemic we are actually getting more people wanting to be nurses and so we are getting more people going into university programs. Yesterday at the nurses opening—just out of yesterday were Charles Sturt University, Sydney University and Western University. Basically, they are training all over the place and they are all registered and graduate nurses.

Ms CATE FAEHRMANN: Minister, are you aware that paramedics in New South Wales are paid the lowest, as I understand, in the whole country?

Mr BRAD HAZZARD: I am working with the Health Services Union on those issues. Obviously Gerard Hayes is doing an excellent job on behalf of his union members. But there are some differences in the base pay and then the additional amounts that they earn. By far the majority of paramedics actually earn more than the base pay because they are on allowances that take them beyond that, and overtime amounts. It is not as easy to make eggs and eggs that are eggs and oranges in terms of the systems that operate.

Certainly, we had many people attend the graduation of paramedics three weeks ago and we had people coming from Queensland and Victoria because they felt the system here was the better system with better arrangements in terms of additions. So you cannot really compare eggs and eggs with oranges. I do understand and value all of our paramedics, and I particularly value the advice and work that Gerard Hayes and his team at

the agency were doing on behalf of paramedics. I think that certainly we are able to continue those discussions with the Health Services Union.

Ms CATE FAEHRMANN: Thank you. I just wanted to go to something that Professor Raina MacIntyre raised with the Committee this morning. It is also something that many public health professionals around the globe have been talking about, which is long COVID. Professor McIntyre said that it will lead to a major burden of disease on the health system. She talked about potential early dementia and impacting our hearts. It is quite frightening, in fact. I have read a fair bit about it myself. I have asked this before actually, but what is NSW Health doing to look at the potential impacts of long COVID and educate the community, particularly those people who have already had COVID, about looking out for the potential symptoms of long COVID and what they can do about it?

Mr BRAD HAZZARD: First of all I will just say that long COVID has been with us from very early on. We realised that was a real issue. A relatively small percentage of people end up with long COVID, as far as we have seen. It is so early so there is going to be a lot more research done. I have heard regularly Dr MacIntyre's views on matters and I will not pass any comment on it other than the fact that she is not part of the New South Wales public health team. So what I will do is ask Dr Chant, who leads the public health team, for her advice and information for you, Ms Faehrmann. Dr Chant?

KERRY CHANT: Thank you, Ms Faehrmann. Look, clearly I will answer some components of this, but I also acknowledge the work that another deputy secretary who is not represented here today, Dr Nigel Lyons, is also undertaking through the clinical practice groups who are obviously discussing long COVID and have a strong interest in making sure that models of care for long COVID are in place. Clearly there is a lot to be learned about long COVID and researchers in New South Wales have actually been contributing to the international understanding about long COVID, particularly some academics associated with the University of New South Wales and others.

We are keen to, through our datasets, gather more information about long COVID to understand its impact and also, most importantly, look at therapies or other interventions we can put in place. We have issued guidance to make sure that people are resting if they should experience those symptoms, and also the role of vaccination. It does appear that there is some—there are always exceptions to the rule, but there does seem to be a greater likelihood of perhaps long COVID linked to more severe symptoms and we know that the vaccines work in two ways. They moderate the disease severity if you happen to get breakthrough infection and they also prevent you from getting the infection in the first place, although that prevention effect is strongest in proximity to your initial vaccines, including booster doses.

For those reasons I think we need to be very watchful, but I am also aware that there are a group of clinical clinicians that are involved in looking at this issue specifically. They are looking at models of care to support the rehabilitation should people experience these symptoms. I know that there is also a pattern of these symptoms and there may actually be subsets within the whole umbrella of long COVID. I think it is an area that we certainly need to continue to work on.

Ms CATE FAEHRMANN: Thank you. I just wanted to turn to a question about what paramedics are experiencing, specifically around Westmead and Blacktown hospitals. I understand that paramedics have been asking for an air-conditioned workspace while they are waiting with patients, and that has been rejected by the LHD. We have got paramedics obviously in PPE having to wait outside in very hot environments. The LHD has rejected their request for an air-conditioned space. Are you aware of that, Minister?

Mr BRAD HAZZARD: No, I am not, Ms Faehrmann. Paramedics are doing incredible work and it is a challenging job at the best of times. They deal with all kinds—

Ms CATE FAEHRMANN: I am going to interrupt you there, Minister. I am aware that paramedics do a very good job. This is a specific example of the fact that paramedics are waiting with patients for a very long time and they have requested from the Western Sydney LHD in Westmead and Blacktown for air-conditioned units, if you like, to be able to wait in. Apparently the LHD does not want to do it because of the [inaudible] potentially be high that patient offloading is taking too long. Has the LHD spoken with you about this? Are you aware of this request? Why would paramedics not be able to wait in air-conditioned facilities?

Mr BRAD HAZZARD: As I was trying to say, I think they are doing an incredible job. But you have got to understand, Ms Faehrmann, there are 170,000 people in the health system and roughly 4,000 are paramedics. There are 15 local health districts and I as the Minister am not across all aspects of every operational issue. Having said that, now that you have raised it—I have not heard about it before answering your question. Paramedics have not raised it with me, to my knowledge. They might have raised it with my office, but they certainly did not raise

it with me. So I will raise it with the chief executive. As the secretary is sitting here, I will ask her to raise it with the Chief Executive of the Western Local Health District to see what can be done.

Ms CATE FAEHRMANN: Thank you. I will keep going until I am interrupted. Hopefully I have still got more time. I also understand that—

The CHAIR: Sorry, Cate, I should have interrupted. We are going to cycle through to the Opposition. It was a very worthy attempt.

The Hon. PENNY SHARPE: Thank you both. Hello, Minister. Hello, Dr Chant, Ms Pearce, Ms Koff and Mr Minns. My first question is just to go back to the aged-care issue. Minister, you said that you were not aware of the concerns of the aged-care sector before Cabinet took the decision to open up on 15 December. Was anyone else sitting at the table aware of that?

Mr BRAD HAZZARD: I am happy to ask whether there has been any specific—just keep in mind, Ms Sharpe, that we have discussions with every part of the community. The specific question to me was if I was aware about the context of the decision-making around what we were going to take into the community about opening up and my answer was, "No, I was not aware of that." We were obviously very aware that it has been a major challenge all through the aged-care sector—ask any of [disorder].

The Hon. PENNY SHARPE: Minister, there has been a significant [audio malfunction] as a result of that decision. I am very concerned that there has been a breakdown in communication. If you were not aware of their concerns, I would like to know who was.

Mr BRAD HAZZARD: We will ask. But what I am saying is that there has always been liaison on a whole range of issues. When we had the breakdown in Summer Hill, one of your Labor colleagues and I were discussing that. There were 62 residents—

The Hon. PENNY SHARPE: We do not have a lot of time, and we have got a lot of questions for you. I am really not asking the question to you; I am asking the question to the officials at the table.

ELIZABETH KOFF: If I may, Ms Sharpe, there was no specific knowledge of representations about that issue of reopening, as you describe it. I must emphasise that we continued to meet regularly with all aged-care facilities, the peaks and the Commonwealth consistently through the period.

The Hon. PENNY SHARPE: I will make a comment. How is it possible [audio malfunction] and say how concerned they were and that they believed the Government understood. You are essentially saying that you did not specifically know.

ELIZABETH KOFF: You are asking a specific question about an issue of restrictions easing, which we would not have been aware of or they would not have had the prescience to know what was occurring either to flag that issue specifically. It is, I think, an unreasonable expectation.

The Hon. PENNY SHARPE: That is okay. I will move on, but I am very concerned that there seems to have been a massive breakdown in communication. I accept that everyone is very busy, but aged-care residents, as we all know, are the most vulnerable, have been the hardest hit and have experienced the most deaths. There seems, to me, to have been a massive breakdown in communication. I think that is of some concern. I want to move on.

Mr BRAD HAZZARD: That is not right. There were constant discussions with the aged-care sector. You asked, and your colleagues asked, a specific question in regards to a decision that was being made. What we are saying is there was nothing on that specific decision. That is all we are saying. Of course there are discussions with—heavens, I personally rang heads of various organisations to jump up and down about things that we thought were not being done properly in the aged-care sector. That has gone on for the entire two years. But you asked a specific question and we answered it specifically. The Secretary has given you the answer. I think that you should probably move on to another question.

The Hon. PENNY SHARPE: I am happy to move on. Minister, why hasn't the land been secured for the Eurobodalla hospital?

Mr BRAD HAZZARD: It has. This is absolute rubbish. You and [disorder].

The Hon. PENNY SHARPE: Minister, how has it been secured? It is my understanding that it has not been secured. It has not been sold.

Mr BRAD HAZZARD: You do not understand, obviously. I fear that if the Labor Party gets elected, if you do not know after all the years you have served in Parliament about the land acquisition processes, we have a problem. There is legislation that sets down what you have to do with land acquisition. It is called the just terms

legislation. What that requires is that there be genuine negotiation. If you wish to have a look at the Supreme Court decision of August last year on what is involved in genuine negotiation and discussion to try to arrive [disorder].

The Hon. PENNY SHARPE: Minister, I am very familiar with both that case and the just terms compensation. You have been promising this hospital for a long time—

Mr BRAD HAZZARD: Are you going to let me finish?

The Hon. PENNY SHARPE: —but the land is not secured. You keep saying that it is. It is not secured.

Mr BRAD HAZZARD: Are you going to put silly assertions or are you going to let me answer the question? Thank you. I will answer the question. When we made the announcement that we were going to build a brand new Eurobodalla hospital, Health Infrastructure, which is one of the major parts of NSW Health, at arm's length from the Government went about the process of them doing what they need to do, which is to go and find appropriate land. They usually look at anything up to 30 sites. They did. They then found a site, which is a fantastic site on the side of a hill—low, beautiful land with beautiful views. The farmer who actually owns that land was not in agreement with the price that was put to him. Negotiations took place over a period of 13 months. They tried very hard, I am told by Health Infrastructure, to agree on a price.

On 20 December a Proposed Acquisition Notice, called a PAN, was served. That notice gives them 120 days to finalise any negotiation on a price, so the farmer can still agree on a price. In the second week of April, which is now only about seven or eight weeks away, the land will automatically be acquired, I will sign the resumption and it will be gazetted. The land will be in taxpayers' hands by the second or third week of April. Then the Valuer General, under the legislation, will determine the price the farmer will get. I am hopeful that in this current period from when the PAN was served on 20 December by Health Infrastructure—I might add not by the interference from a political arm. I know that there was a lot of political interference down there from the Labor Party, who do not seem to understand the decency and the processes that are required in the legislation.

The legislation has been followed, the land will become ours and then, of course, there will be early works done during the course of this year. Within three years, there will be a brand spanking new hospital, which, I might add, the Labor Party never promised to deliver and would not deliver. When the South East Regional Hospital was promised by the Labor Party, they walked away from it. That is the history. Labor promises things down there and does nothing down on the South Coast. We have done a lot, and we will do more.

The Hon. PENNY SHARPE: Thank you. We will take that as a comment. To go to the point, what has changed since December? You have been promising that it is now going to be level 4, after the letters in response to the petitions relating to this hospital suggested it would only be a level 3 hospital in December. What has changed now? Is it just the election? You have just indicated that the land is not secured, but you are still working on it. You are now saying that it is going to be level 4 when, just a few weeks ago, you were saying that it was going to be level 3.

Mr BRAD HAZZARD: What you are doing is absolutely irresponsible. As late as last night, I was talking to the senior public servants who have been working on this for two years. One of them said to me, "Minister, every time we have the Opposition making these comments, which are simply not true, it undermines the confidence in the community to work with us on achieving the type of hospital that we need the community to be involved in." You are now perpetuating that, Penny. I am really disappointed. I remind you this is supposed to be about COVID, not about that. You are just taking political pot shots. Let us get back to the main game.

The Hon. PENNY SHARPE: The point I make is that someone who has worked there for 20 years is so concerned that he is actually running in elections because of the issues in relation to that. I might hand over to my colleagues at this point.

Mr BRAD HAZZARD: That someone was a doctor there who walked away when he was offered the opportunity to update his practice by the Clinical Excellence Commission and to make sure that there was resilience and safety built into his practice. He walked away from the patients and made sure that politics was his priority. You guys facilitated that. This is a Labor Party deal that has been done by you people. You are not [disorder].

The CHAIR: I am going to intervene here.

The Hon. PENNY SHARPE: That is an extraordinary accusation about someone who has worked for 20 years in that—

The CHAIR: I am going to intervene here as Chair. When we opened this Committee, we said it is not an opportunity to make adverse reflections against individuals. That applies as much to you, Minister, as to any other witness that we have. I would ask that we stick to the issues, and we will get through this a great deal quicker.

Mr BRAD HAZZARD: Can I ask a question? We came to you with all—

The Hon. PENNY SHARPE: No.

Mr BRAD HAZZARD: I will put this to you because otherwise there is no point having very senior public health officials here talking about COVID. If we are going to get dragged into—

The CHAIR: Minister, I do not—

Mr BRAD HAZZARD: [Disorder] which is what the Labor Party is doing.

The CHAIR: With all due respect, Minister, the answer you gave was designed to inflame, not to assist the situation. I will go back to the Opposition now to ask questions in relation to the terms of reference of the inquiry. If we all stick to that, it will be a productive afternoon.

The Hon. COURTNEY HOUSSOS: Thank you, Chair. Minister, we have heard evidence this morning that, during the pandemic, NSW Health has actually sought to cut jobs in pathology and to downgrade conditions at the South East Regional Hospital. How would you respond to that?

Mr BRAD HAZZARD: That is complete rubbish. The Secretary can comment on it.

ELIZABETH KOFF: I have no knowledge of that.

Mr BRAD HAZZARD: Mr Minns?

PHIL MINNS: I have made inquiries about those matters that were referred to me. There is a process going on of reform in New South Wales pathology, and I am assured that no part of that process involves the removal of what you might call the frontline pathology workforce who are engaged in their scientific tasks. Whilst there might be some restructuring across the network, and that could have the effect of some managerial jobs being seen as at a lower seniority level, that has the potential to affect six to eight people and all of those have been assured that their current payment conditions et cetera will be grandfathered. It is a process of restructuring the network and trying to work on the award, and I think comments were made this morning about how some health awards are in pretty desperate need of updating. No part of that process affects the pathology workforce conducting their work, and the people who may have a potential consequence will not experience it personally because of the grandfathering commitment that has been made.

Mr BRAD HAZZARD: Can I add that absolutely nothing on that front has been directed by the NSW Government, but we do appreciate the work that has been done by pathology because the partnership between both public pathology and private pathology has been incredible, which is what we should be talking about. In the COVID period as late as two weeks ago, I was at Campbelltown Hospital in south-western Sydney where the Premier and I visited a new [disorder]—

The Hon. COURTNEY HOUSSOS: Minister, I am going to stop you there. I am asking very specific questions about pathology at the South East Regional Hospital. This is a COVID inquiry, as you have said. Are you concerned, given that we have seen what happened over Christmas with the issues around testing, with the issues with delays, particularly with getting results, that at this point this would be a time to restructure pathology and that instead we actually need to be putting in more resources, particularly into regional areas?

Mr BRAD HAZZARD: I entirely endorse—and we have put millions of dollars more into pathology. But I think what is happening, from what Mr Minns has just described—and I rely on the senior public servants in this regard—is that they are actually making sure that pathology services are able to be delivered in the most efficient way right across the State. I think the only reason you are asking about south-eastern is because you want to make, again, another political point because there is a by-election going on down there. Let's talk about COVID.

The Hon. COURTNEY HOUSSOS: Minister, we are talking about COVID. We have serious questions that we want to ask about the pathology services in a part of the State that saw the same kind of delays that happened across the State, particularly over Christmas, and we have now been told this morning that there are a number of job cuts that are actually occurring. This is a hospital that has been chronically understaffed over a number of years, and now it appears that there will be issues with the pathology department going forward.

Mr BRAD HAZZARD: I think what Mr Minns has just said is that in that hospital, which was the hospital that Labor promised and never built but we built when we came into government—that is the South East Regional Hospital [disorder]—

The Hon. COURTNEY HOUSSOS: Minister, there was plenty of Federal money that went in there as well. Plenty of Federal Labor money went in there as well.

Mr BRAD HAZZARD: You are admitting the Labor Party never built it, even though they promised to build it. Thank you for at least admitting that Labor never built it—

The Hon. COURTNEY HOUSSOS: There was plenty of Federal Labor—

Mr BRAD HAZZARD: —[disorder] and as a result, we have come in and there is pathology there and those pathology services are going to continue in the appropriate way that Mr Minns has just described.

The CHAIR: I think we will be assisted if we keep to events that have happened in the past decade. I will go back to the Opposition.

Mr BRAD HAZZARD: Actually, South East Regional was built by the Liberal-National Government because Labor did not do it in the previous 16 years, Mr Chairman.

The CHAIR: The last decade.

The Hon. JOHN GRAHAM: Minister, just following on from that discussion about the collapse of the testing system in December, one of the bits of evidence today from the public health experts was that to be prepared for next time, one of the things they had hoped was that the Government had warehouses full of RATs and full of N95 masks, or some of those equivalents, given what we now know about COVID and about Omicron. Can you give us any reassurance that their hopes will not be disappointed?

Mr BRAD HAZZARD: Can I say, I do not accept your hypothesis that the testing system collapsed. The testing system was under enormous pressure, because early on in this pandemic back in 2020 we thought we were doing extraordinarily well when we got up to 40,000 PCR tests a day; that is huge. But late last year, it got up to nearly 200,000, so five times that level. The [disorder]—

The Hon. JOHN GRAHAM: Minister, like a lot of people, I spent Christmas Day in isolation because of the collapse of your system, so you will not persuade me. Do you want to move to that question? Do we have warehouses full of RATs and N95 masks as the hope was of these public health experts today?

Mr BRAD HAZZARD: I find it remarkable that you are trying to undermine the work that has been done by the health system and pathology system, and the puerile point scoring—it is pretty pathetic actually. I will ask the Secretary [disorder]—

The Hon. JOHN GRAHAM: Minister, [audio malfunction]. This was one of the first issues we discussed with you in June of 2020 when you first appeared. You were rude and dismissive then about the importance of testing. We asked you then about the capacity. At the time, it was 21,000; that was our surge capacity. We asked about alternate testing to PCR testing. Now, a year and a half later—longer—we are asking about the testing in New South Wales. Why don't we have warehouses full of RATs?

Mr BRAD HAZZARD: We do, and, in fact, we have made those public comments about the fact that we are buying massive amounts of rapid antigen tests, and I will ask the Secretary to comment on that aspect specifically.

ELIZABETH KOFF: Thank you, Minister. To date the New South Wales Government—and it procures via HealthShare, which is the agency within health that does the procurement. We have procured more than 50 million rapid antigen tests, with 100 million further to come. From our projections that has supported both the return to school, which has been highly successful with the rapid antigen testing, and we are supporting disabled groups. We are even providing to aged-care facilities, and we will continue to procure as necessary. But we are confident, with 150 million in our warehouses, that we will manage immediate demand.

The CHAIR: I am sure we will come back—

The Hon. JOHN GRAHAM: When will those 150 million—

The CHAIR: No, John, I am sorry, time has expired. Ms Boyd.

Ms ABIGAIL BOYD: Thank you very much, and good afternoon, Minister, and to everyone in your department. I echo the thanks from the rest of the Committee members in relation to the work you have been doing over this period. I wanted to come back to the aged care panel and the testimony that we received this afternoon. Could you tell me, in the two weeks prior to deciding to lift restrictions—we are talking about 15 September I believe it was—did the Government consult with the aged-care sector?

Mr BRAD HAZZARD: Ms Boyd, can I just say that the public health officials at senior levels were dealing all the time with the aged-care sector, but I am going to ask if anyone would like to answer the question on what level—

Ms ABIGAIL BOYD: Just before you do, I will make it very clear the information I am after. I want to know whether the aged-care sector was asked if they felt adequately prepared for those restrictions to be lifted.

Mr BRAD HAZZARD: Just to emphasise to you, before I pass to whichever senior officials wish to talk about it, the aged-care sector primarily is working under—is regulated and managed by obviously—various organisations that are under the domain of the Federal Government, not the State Government. The State Government's responsibility is public health.

Ms ABIGAIL BOYD: Of course. This decision—

Mr BRAD HAZZARD: Without [disorder]—

Ms ABIGAIL BOYD: Sorry. The decision, though, was a decision of the State Government to lift restrictions in the context of the aged-care sector at the time.

Mr BRAD HAZZARD: It was not just in the context of the aged-care sector; it was in the context of the entire community. Of course, you would recollect too—I am quite sure you would recollect because I had to sign off on various exemptions to allow people to have demonstrations in the street saying they wanted their freedom. There were a whole lot of factors happening at the time. But does anybody here have anything they can add? Secretary.

ELIZABETH KOFF: Specifically, as Dr Chant mentioned, Dr Nigel Lyons is the deputy secretary responsible and met regularly with the residential aged-care facilities, the Commonwealth Department of Health and the peak bodies for aged-care facilities. They have had over 30 meetings since June 2020 to discuss how outbreak management occurred within their facilities. In terms of dates of meetings, I will have to take that on notice and determine whether any of those [inaudible] issues were raised about the concerns that had been expressed by the aged-care providers.

Ms ABIGAIL BOYD: If you could take that on notice, that would be very helpful. I understand that as of a couple of days ago there were 525 aged-care homes across New South Wales that were currently experiencing an outbreak of Omicron. Do you know the current number today?

Mr BRAD HAZZARD: I do not think we have had any advice from the aged-care sector on that today, but I would say, Cate, that Omicron was obviously more broadly throughout the community, so it is also in the aged-care facilities. We will take that on notice and I will let you know as soon as I can.

Ms ABIGAIL BOYD: Thank you. It is flattering to be confused with Cate Faehrmann.

Mr BRAD HAZZARD: Sorry, Abigail. [Disorder].

Ms ABIGAIL BOYD: It is okay.

Mr BRAD HAZZARD: Apologies.

Ms ABIGAIL BOYD: That is okay. If you could also tell me, and you may need to take this on notice, how many of the New South Wales deaths during Omicron have been aged-care residents?

Mr BRAD HAZZARD: Dr Chant has just given me the most up-to-date figures and, correct me if I am wrong here, Dr Chant, but it would appear that, sadly, 419 people in aged-care facilities have passed away.

KERRY CHANT: Could I just clarify—

Mr BRAD HAZZARD: Sorry, maybe not. Ms Boyd, if I ask Dr Chant she can clarify it from the detail [disorder].

KERRY CHANT: Just for accuracy, if we looked at the Omicron period as between 1 December—remembering that in some areas there would have still been Delta and Omicron, just for clarity. But if we look at the period from 1 December 2021 as the start of the Omicron period, there were 419 aged-care facility deaths during that period until 4.00 p.m. on 10 February 2022. Obviously, the deaths are reported to us. There is sometimes a lag. So, just with those caveats, that is the data that I can provide for the Committee today.

Ms ABIGAIL BOYD: Thank you, that is very useful.

Mr BRAD HAZZARD: If I could answer that—actually, I won't answer it, I will ask Dr Chant to just explain something. I know what she meant, but it is not that clear if you don't know. Could you explain why we did not know the difference between the influence of Omicron at that point and Delta, please?

KERRY CHANT: Well, just that we know in some areas that the majority of cases were Omicron and at the moment it is very clear that Omicron would be the predominant source in both BA.1 and BA.2. The BA.2 is a sort of a sub-lineage of the original Omicron. We believe that Delta has been totally suppressed. At this point in time, we are continuing to watch that. But, obviously, we do not genomically sequence all of the test results. And, obviously, with the rapid antigen testing—and that is now used as a confirmed case, particularly in the context of an outbreak in an aged-care facility—then, with those caveats, we will not ever know for certain. So, therefore, we have to apply those sort of epidemiological principles. So, with those caveats, that is the data.

Ms ABIGAIL BOYD: Thank you, that is very useful. A group of people who are not given perhaps as much coverage in the media is of course people with a disability, and particularly people in disability homes. Do you have any data for how many deaths there have been in disability homes?

Mr BRAD HAZZARD: If you do not mind, Ms Boyd, I am going to ask Dr Chant to answer that because it is a really important issue. Dr Chant?

KERRY CHANT: We would collect that information but I just have not got it with me and, yes, you rightly point out, it is a very important component. We have been reporting on our death data every Friday and obviously there are some sensitivities in identifying individuals through that data, but we will certainly move to make sure we are very clear on reporting disability group home deaths as well in that data. We do report on a number in aged-care facilities as well.

Ms ABIGAIL BOYD: Thank you. If I could ask just a couple more questions on disability before I hand back to my colleagues. First, I understand from advocacy organisations that there has been no guidance from NSW Health about the protocols that disability support service workers are supposed to follow when providing support services to people who are COVID positive. In particular, they have mentioned the difficulties with not knowing when they are going into a person's home who has COVID and they are trying to shower them—are they supposed to wear PPE? What is the protocol? We are hearing that there is a real dearth of information. Can you confirm that or take it on notice?

Mr BRAD HAZZARD: I will ask Dr Chant whether she can answer it. If she cannot answer it now, let's take it on notice but [disorder].

KERRY CHANT: I would have to investigate the specific concerns. But, clearly, there are quite clear—a person that has got COVID, that is infectious with COVID, you would need to take a very high level of protection to protect yourself against that. The CEC, the Clinical Excellence Commission, has got guidance on what that would look like. But if I could just take that on notice and work with my colleague Dr Lyons just to see what information has gone out, and if there are issues that it needs to be made clearer or simpler then we would be happy to do so. But I would have thought that there was some guidance. I think one of the challenges here is making sure that the communication gets outs effectively to everyone who needs it, so I will follow that up as a matter of priority.

Ms ABIGAIL BOYD: I understand. I might try and ask my other question later, because I am out of time. Back to you, Chair.

The CHAIR: Thanks, Ms Boyd. Minister, I want to go back to the issue about aged care at the time that restrictions were lifted on 15 December. We had evidence from Mr Sadler, the Chief Executive Officer of the peak body, Aged Care and Community Services Australia, that they had raised with the New South Wales Government their concerns about the lifting of the restrictions before Christmas, before the break, and they were concerned that if that was done without adequate RAT tests and without adequate masks and without adequate warning it would have a severe negative health outcome in the aged-care sector. But, nevertheless, the restrictions were lifted. Is there nobody on your team who can recall those representations coming from the aged-care sector?

Mr BRAD HAZZARD: David, I think I have answered that. Look, I am happy to ask—I will let anybody at the table answer the question. Does anybody here know anything that you can help the Chair with on that particular issue, or shall we take it on notice?

ELIZABETH KOFF: Nothing more than we have already said, Minister. I will take it on notice.

The CHAIR: Well, Minister, I look forward to getting those answers. When we asked the sector what their key wishes were going forward, one of those wishes put forward was for the New South Wales Government to commit to being part of a national aged-care coordinating centre which then has State-based nodes and ensuring that NSW Health is part of a national aged-care coordinating centre. Is that something that the New South Wales Government has considered?

Mr BRAD HAZZARD: Mr Shoebridge, that has not been put to us. But, can I say, anything that would help that—well, we would love to be involved in anything that would help, but I think you have got to also

understand that, in the first instance, any propositions like that probably should have been—maybe you would know, I don't know because I didn't see it this morning because I was a bit busy, but have they put that to the Federal Government to actually do it through the National Cabinet? Or what have they done? I don't know.

The CHAIR: It is my understanding, it is the national peak body and it has been progressed at both a national and at different State and Territory levels. But could I understand from this, you have no opposition in principle—in principle it seems sensible, but maybe you will take on notice a more detailed response?

Mr BRAD HAZZARD: I would do anything at all to assist in trying to do anything we can to assist in the aged-care sector. I think NSW Health and the team within NSW Health in every local health district has done that right from the word go. We would be delighted to help in any way we can, but it has got to be done through a coordinated way. I think, from the sound of what you are proposing, through some sort of proposal.

The CHAIR: Indeed. Minister, the aged-care sector were very clear in their evidence to us about the impact that the decision of 15 December had on them. They said that because the restrictions were lifted before they had adequate masks, N95 masks, before they had adequate stockpiles of rapid antigen tests and before they were prepared to deal with it, that that led to the loss of lives and the unnecessary loss of lives in the aged-care sector. Will you commit to doing some forward engagement with the aged-care sector so that if we get another surge or we get another variant they are at the table, or you know their needs, before these decisions are made?

Mr BRAD HAZZARD: Of course, anything that can be done we would do. But I can honestly say, again, there was no discussion with me, there was no discussion with any of the senior health officials here, and in the normal course it would be done through the Federal Government because it is a Federal Government responsibility. [Disorder].

The CHAIR: But, Minister—

Mr BRAD HAZZARD: Hang on.

The CHAIR: —it was a State Government decision to change the public health orders and that seems to be where we have got this gap. Aged care is federally regulated, but decisions that the State Government would make had such a big impact on them, but there was no actual connection between the two. That seems to have been what has gone wrong.

Mr BRAD HAZZARD: I am hearing you, but I—anyway, I will ask the Secretary if she has some comments.

ELIZABETH KOFF: The point I make, Mr Shoebridge, is that quite clearly the adequacy of PPE and rapid antigen tests for aged-care facilities is a Commonwealth responsibility. They secure their supplies through the national medical stockpile and, similar to the vaccination rollout at the aged-care facilities, it was a Commonwealth responsibility. We have been quite happy to support, where necessary, where aged-care facilities did not have adequate supplies of PPE or rapid antigen tests. We have assisted them, wherever we can, across the State.

The CHAIR: It seems to me that this evidence is coming back to how essential it is to join the dots up and to closely review that proposal for more coordination. But, Minister, one of the other requests that came from the aged-care sector, and it was a very practical one, was to ensure that the chief executive officer for each local health district has engaged with each aged-care provider in their area and have connections in place to draw upon when we have the next surge, when we have the next requirement, so that we do that.

Mr BRAD HAZZARD: David, you're speaking—all three out of four. You're all saying, "They have."

The CHAIR: With each aged-care provider in their local health district.

Mr BRAD HAZZARD: Absolutely. Let me tell you, I don't know who you got evidence from, but I sat in this very room in NSW Health headquarters. Going back to when the Victorians came up here in mid-2020 seeking advice on how we were approaching it, at that time I spoke to all of the executives, in this very room, of all the local health districts. What I actually said to them was, "We need you to get your teams to know the absolute workings of every single aged-care facility in your area. I want to know that you know. Are they capable of isolating people?" Let me finish, David, please. You asked the question. "Are you aware of the precise detail of whether or not they have areas within their aged-care facility that can allow isolation? Do they have staff that are qualified? Are the staff trained?" Now, that wasn't our responsibility at that stage—that was the Federal Government's—but we had already worked out that we needed to do more to fill the gap. I will ask the senior executives here, because they all got pretty stirred up when you put that proposition. Would you like to say something, Dr Chant?

KERRY CHANT: Look, I think Ms Pearce would be able to talk about the incident management arrangements and the collaborative approach with [disorder].

Mr BRAD HAZZARD: Deputy Secretary Pearce?

SUSAN PEARCE: Thank you, Mr Shoebridge. One of the areas of focus definitely has been via health districts with residential aged-care facility providers within their geographic areas. We have certainly learned over the years—and I am going back even to the 2017 winter flu season, where we had in-reach models into residential aged-care facilities. What we have done over the period since that time is strengthened those. It is my understanding from our district chief executives that the relationships now between the local health districts right across New South Wales and residential aged-care facility providers—and, for that matter, disability providers—are as strong as they have ever been. We have actively assisted residential aged-care facilities right across this State all the way through this process, whether that is the provision of assisting them to find staff when the Commonwealth was unable to do that, whether that is the provision of RATs or PPE, whether it is going and testing residents and assisting with booster shots. Whatever we have needed to do to help protect those elderly residents, we have done it.

The CHAIR: Minister, I am not doubting you had the meeting and I am not doubting you have asked for the connections. But the real concern I have is that when your Government made the decision in mid-December to lift the restrictions, you do not seem to have known how woefully unprepared the aged-care sector was and how they knew they did not have enough RATs. They knew they did not have enough PPE. They knew that it was a real risk to the people in their care, but that message never got through to you. I hear what you say, but how do you explain what went wrong in mid-December?

Mr BRAD HAZZARD: First of all, you are picturing it as "gone wrong". [Disorder].

The CHAIR: I am reflecting the evidence we got. I am reflecting the evidence we got from the sector, Minister.

Mr BRAD HAZZARD: Well, okay, but I could bring in another 50 people who would give different views to those three. I don't know who they are. I don't know what level they are, but I am telling you that we decisions we took—

The CHAIR: They are the chief executive officer of the national peak; the director of governance, risk and quality of the biggest single aged-care provider in New South Wales; and the chief executive officer of another major aged-care provider. These are people you should listen to, Minister.

Mr BRAD HAZZARD: Let me tell you, some of the aged-care sector providers that I have had to deal with—I have had to express my absolute horror at the failure by some of those aged-care sector people to be prepared.

The CHAIR: That cannot be your answer.

Mr BRAD HAZZARD: I have personally done that and made phone calls to them to let them know that they have failed in a whole lot of areas. So, I am sorry, but for you to be asserting that we failed—what we did back in December was exactly what we said earlier. We weighed up all the advice from all the people that came. We looked at the issues that were happening. We looked at the fact that the population wanted to get back to some degree of normalcy. There was next to no Omicron here at that point. There was next to no knowledge about Omicron. We made a balanced decision, and that is all I can say here at this point.

The CHAIR: My time has expired. I will hand back to the Opposition for another short session.

The Hon. COURTNEY HOUSSOS: Thanks very much, Chair. I wanted to ask Ms Koff: You said that you have 50 million rapid tests now in the warehouses and 100 million more on order. When will they arrive in the warehouses?

ELIZABETH KOFF: They are scheduled over the period of February. We have the time line for February week by week: 9.1 million on 7 February; 16.2 million on 14 February; 11.8 million on 21 February and 9.5 million on 28 February. It is a well-orchestrated logistics campaign. The biggest challenge that we have had is the fragility of the international supply chains because air freight has been problematic, as everybody is aware, over the duration of the last month or two.

The Hon. COURTNEY HOUSSOS: And were those RAT tests centrally purchased by Health, or is that all of the RAT tests that are available across Government?

ELIZABETH KOFF: The RAT tests are centrally purchased by Health, but I do understand that Education purchased some additional RATs themselves. But, as I mentioned earlier, we have been the primary

supplier to Education for the distribution, plus we are giving to vulnerable population groups such as the disability sector, social housing tenants and the homeless, and Aboriginal community-controlled health services. The Stronger Communities cluster is helping us progress the distribution to some of their client groups.

The Hon. COURTNEY HOUSSOS: Just to be clear, within the New South Wales Government your testimony is that only Health and Education have been purchasing the RAT tests?

Mr BRAD HAZZARD: No, that's not correct. She said that she is aware of that. She didn't say they were the only ones.

KERRY CHANT: Transport.

Mr BRAD HAZZARD: Dr Chant is just saying that Transport has its own. There will be various agencies, but you cannot ask us what other agencies are doing. If you want us to do that or you want to know that—

The CHAIR: No, no. Minister, we accept that you are here to speak on behalf of Health. If questions could be put about Health, Courtney.

The Hon. COURTNEY HOUSSOS: Yes. I am just wanting to get clarification on whether you are the central point of purchasing for all of the Government or whether individual departments are making their own arrangements, and I think we have made it clear—individual departments.

Mr BRAD HAZZARD: NSW Health has taken a major responsibility but other agencies are also doing it, and you will need to talk to those other agencies.

The Hon. COURTNEY HOUSSOS: I understand that. Thank you, Minister. Minister, can I move on? In June 2020 you announced an additional $380 million for elective surgery. How much of that has been spent?

Mr BRAD HAZZARD: Actually, at some stage it was more like $458 million, I think it was, and then there was another $80 million, so there is a lot more money being allocated. I will ask Deputy Secretary Pearce, who has done some amazing work on that to clear the earlier list, supported by, of course, the people who do it—our frontline clinical staff. Ms Pearce, would you like to comment on that?

SUSAN PEARCE: Ms Houssos, the money that was allocated for elective surgery has been expended. The Minister is right—$458 million, and then a further $80 million. That assisted us, after the initial surgery suspension in 2020, to reduce the number of overdue patients right back down to a fraction of what it was at the end of that period.

The Hon. COURTNEY HOUSSOS: I am sorry, Ms Pearce, my time is about to expire, I just wanted to get an answer. So, it has all been expended, is that correct?

SUSAN PEARCE: That is what I have been advised.

The Hon. COURTNEY HOUSSOS: If you can on notice provide me with a breakdown by LHD of how that money was spent, if that is possible please?

SUSAN PEARCE: I will have to ask the team about that, obviously it is a large part of the budget that we expend on surgery generally, so it is not a straight forward process.

The Hon. COURTNEY HOUSSOS: But if you know that money has been spent, then surely you can give us a breakdown of where it has been spent?

Mr BRAD HAZZARD: If it has been expended then what Ms Pearce is saying, she is not sure she can give you precision of the question you are asking, because obviously it melds into the money that has been spent on surgery more broadly across 15 local health districts. It may not be something we can do easily. If it is something that can be done easily, then it will be done and provided to you as soon as possible. If it cannot be done easily, I have to say right now the health staff should be concentrating on looking after patients, but we will try.

The Hon. COURTNEY HOUSSOS: Thanks Minister. I have one final question, given that you have said that it was the right decision on 15 December to lift restrictions, what then are you doing to prepare for the oncoming task given what we have learnt with what has happened over summer with our health system and the incredible pressure that it has been put under?

Mr BRAD HAZZARD: There is a lot of work. The public health team here in New South Wales is by far and away the best health system in the country, by a long shot. Dealing with the oncoming winter season is obviously a concern, we have seen what has happened overseas. I think it is timely to remind the community that

Omicron may be in some ways, in some ways, less severe but it is still severe in terms of population, and we know of a number of people who are both getting it and dying from it, albeit it less currently in the ICUs.

What we do face at the moment is the flu season. For the first time in three years we are expecting a flu season this year, which will sadly coordinate in time with what we expect of a possible increase in the COVID situation and of course we do not have any clarity at this point, there is BA.1, BA.2 and BA.3 floating around at the moment. We know that BA.2 is obviously doing certain things. I will ask Dr Chant whether she has anything she wants to say at this point. Having said that, I think there is a lot of work going on and preparation is just the same as we do every year for major dramas on these sorts of things.

The Hon. COURTNEY HOUSSOS: Well, Minister, let me ask you this, before you go to Dr Chant—

The CHAIR: No, no, no, Courtney, your time has expired. We either get the response from Dr Chant or we move to Ms Faehrmann. Dr Chant, did you want to briefly—

The Hon. SCOTT FARLOW: It is Government time, Mr Chair.

The CHAIR: Yes. I will go to Dr Chant, then one question from Ms Faehrmann, then we will go to the Government. Dr Chant?

KERRY CHANT: So, Ms Houssos, we are planning obviously for subsequent waves. We obviously have to also prepare for new variants or a resurgence of Omicron after both natural infection, immunity waves, as well as that attributed to the vaccines. We are also planning for concurrently flu, and some of the issues that we know we need to do is lift our vaccination coverage for our six-month to five years, because unlike with COVID we have to have a strong focus on that age group, the under-fives gets hit very hard every year from flu. We are also looking at integration of our response and how clearly we seamlessly integrate into out testing strategies as well as the protections for aged care. The same settings that are vulnerable for COVID will be vulnerable for flu. For instance, our aged-care facilities and whether we need to pre-deploy things like Tamiflu, noting the Commonwealth has pre-deployed oral and virals and we helped, assisted the Commonwealth with some regulatory issues in that way.

We are also working with our partners in general practice and also making sure that we have got good testing and an understanding of how the interaction between COVID and flu may occur in terms of diagnostic pathways, care pathways and escalation. That will be the year ahead. Clearly, COVID variants are still expected and we need to be vigilant and watch for those and clearly we know the range of strategies that are useful in dampening down community transmission. We also may need to roll out another booster dose. It is likely that booster doses, additional doses and we need to change our nomenclature now to be up-to-date and think about vaccination as an ongoing experience. But that is likely to be increasingly targeted at our most vulnerable who are likely to bear the best benefit from the repeat vaccinations. That is probably some of the contingencies we need to put in place for the flu season but be ever vigilant.

The CHAIR: Ms Faehrmann, one question.

Ms CATE FAEHRMANN: We have heard a lot today about the exhaustion, we have heard a lot over many months actually about our exhausted nurses, midwives and paramedics, stories of paramedics working, lots of people working double shifts, 12, 14, 16 hours, forced overtime, forced meal breaks, paramedics for example having to skip two out of three meals. You have just talked about new sub-variants, winter flu, what guarantee can you give to these workers today that their lives are going to get any better, that their workload is going to decrease any time in the next couple of months?

Mr BRAD HAZZARD: Ms Faehrmann, obviously, as we progress and there is less pressure because of the hopefully less pandemic that we will all be under less pressure. I think in terms of the specific matters you raised I will ask Mr Minns to comment.

PHIL MINNS: Yes, Ms Faehrmann. Look, we accept that for many staff it has been an incredibly challenging period and some staff might have been asked to come back from leave during that Christmas period and there are certainly some extra shifts being worked. It is a pattern that is not consistent though across the State. We did some analysis to try to talk about how much overtime is normally worked in our system and our nursing workforce: September 2019, 1.7 per cent of the hours were overtime; September 2021, so Delta, 2.5 per cent; December 2021, 2.2; and January 2022, 3.2. So, yes, that is a demonstrable increase in the amount of overtime being worked but it is not their entire workforce working double shifts and excessive overtime.

It is very much a pattern that will affect the workforce unevenly and it will affect critical care areas in our major metropolitan areas and more likely affect the workforce in smaller remote, rural settings and sometimes in our regional critical care areas. So, the other thing that I mentioned in the rural and regional committee is that we are right in the middle of a piece of work that is designed to recast all of our workforce strategies to understand

what we might need to do to seek to recover and recuperate our workforce and that work is underway now, particularly minded ahead of the winter season.

The CHAIR: Thank you, Mr Minns, and if you are in a position to table that data today with the Committee we would really appreciate that. I will now hand over to the Government.

The Hon. SCOTT FARLOW: I will make it one question because I know that members and most likely our witnesses as well have pressing time constraints for 4.30. I start by thanking all the health officials for their great work during this period and also to turn to the modelling that was done by NSW Health, which of course took inputs from both New York and as well London and South Africa. We never reached any of those peaks in that modelling. I wonder if NSW Health and the Minister have any reflections on why that has been the case in New South Wales and why the load on both hospitals and ICUs has not been as significant as we had modelled?

Mr BRAD HAZZARD: Thank you, Mr Farlow. What I will say is there has been very significant pressure on particularly our paramedics, emergency departments, ICUs and wards. But, fortuitously, the pressures were not as great and the results were not as high as even the best case in the modelling that was made public now a couple of weeks ago. It is always challenging though in terms of modelling. I think sometimes the community thinks that the modelling is precise, but I recollect earlier on in the pandemic sitting in this very building—sorry, sitting in the health building, which is slightly a few metres away from here—and being told 25,000 people would die in our first year in New South Wales. Of course, we had a very low number of people die in that first year. I think that reflects the fact that modelling outcomes are very much dependent upon the available inputs. When the available inputs in a local context are not high, it makes it very difficult.

What we have of course in New South Wales—thanks to the community and thanks to our NSW Health staff, who work so hard—is one of the highest double vaccination rates in the world. Those double vaccination rates, and indeed we are now up to about 45 per cent of boosted people as well, has made, with the benefit of hindsight, a difference. But I am sure Dr Chant would say also the community have listened to a whole lot of other messages, including the ones that she gave on 15 December, which were that whilst it may not be mandated it was certainly advisable for people to wear masks in certain situations, maintain social distancing and to maintain hand washing and do all those things that we have learnt which have made us incredibly capable of being more resilient than we were to even the flu, hence no flu the previous couple of years. So I think there have been a whole lot of factors that have come into it and I think that as long as we continue to do that then we are going to continue hopefully to have good outcomes.

Having said that, we also need to be alert to the fact that, as Dr Chant was just saying, we could face further variants. This virus is not giving up easily. It is here to do whatever it can. Fortuitously, this particular variant that is now circulating, Omicron, has been more upper respiratory and has had, as I said, less immediate impacts on a whole host of people. But it is still having a lot of impacts and a lot of hurt and deaths particularly for people who are older and over 65 and particularly people who are immunocompromised and have previous health conditions. So we still have to be on high alert.

What we are seeing though is that there was a period of plateauing. It did not reach even the highest or best or most optimal position, but it did play on. It played on for a bit longer than perhaps we anticipated or our planners anticipated. It is still sitting higher than we would like, but as we progress I think as long as we all do move into getting boosted—hopefully we will—then we should see that plateauing moving much quicker and declining much quicker. But my final message, if I could, to those members of the public who might hear this, is please go and get boosted. If you are part of the 50 per cent—95 per cent double dosed and 45 per cent who have had their booster, that roughly 50 per cent—please go and get boosted. Do it for your own sake, your family's sake and the community's sake.

The CHAIR: All right. I think the current term is "Let's all get up to date with our vaccinations." Minister, on that note, something we are all on the same page on, thank you for your attendance this afternoon. Thank you to the officials who have come with you. Again, it has been an extraordinarily tough two years. Mistakes will be made and lessons will be learnt, but we are all grateful for the collective work of the NSW Health team. With that, we will conclude today's hearing. Thank you to the committee members for their cooperation as well today.

(The witnesses withdrew.)

The Committee adjourned at 16:33.