LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON THE COVID-19 2021 PANDEMIC RESPONSE

(Reference: Inquiry into the COVID-19 2021 pandemic response)

Members:

MS E LEE (Chair)
MS S ORR (Deputy Chair)
MS J CLAY

TRANSCRIPT OF EVIDENCE

CANBERRA

MONDAY, 1 NOVEMBER 2021

Secretary to the committee:
Dr D Monk (Ph: 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

WITNESSES

COLEMAN, DR KERRYN, Chief Health Officer, Public Health, Protection and Regulation Division, ACT Health Directorate **82**

CROSS, MS REBECCA, Director-General, ACT Health Directorate **82**

PEFFER, MR DAVE, Interim Chief Executive Officer, Canberra Health Services **82**

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Amended 20 May 2013

The committee met at 4.31 pm.

STEPHEN-SMITH, MS RACHEL, Minister for Health
CROSS, MS REBECCA, Director-General, ACT Health Directorate
COLEMAN, DR KERRYN, Chief Health Officer, Public Health, Protection and Regulation Division, ACT Health Directorate
PEFFER, MR DAVE, Interim Chief Executive Officer, Canberra Health Services

THE CHAIR: Good afternoon, and welcome to the fourth public hearing of the Select Committee on the COVID-19 2021 pandemic response. The committee acknowledges the traditional custodians of the land we are meeting on, the Ngunnawal people, and wishes to acknowledge and respect their continuing culture and the contribution they make to the life of this city and the region. We also acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be attending today's event.

Please be aware that today's proceedings are being recorded and will be transcribed and published by Hansard. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if you could please state, "I will take that as a question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

Today we will be joined by the Minister for Health, Ms Rachel Stephen-Smith; Ms Rebecca Cross, Director-General, ACT Health Directorate; Mr Dave Peffer, interim CEO, Canberra Health Services; and Dr Kerryn Coleman, Chief Health Officer, Public Health, Protection and Regulation Division, ACT Health Directorate. Welcome. Please be aware that today's proceedings are protected by parliamentary privilege, which provides protection to witnesses but also, of course, obliges them to tell the truth. The provision of false or misleading evidence is a serious matter and all participants today are reminded of this. When you speak, can you confirm that you have read and understood the pink privilege statement? Minister, would you like to make an opening statement?

Ms Stephen-Smith: No, I do not have an opening statement. I have read and understood the privilege statement.

THE CHAIR: I will start with a question perhaps for you, Minister, or it might be for the Chief Health Officer, but I will let you two work that out. I wanted to go to the management of COVID from here on. We have obviously reached a certain point now with vaccinations and, whilst we still have restrictions, things are slowly getting back to normal. What is the plan for managing any outbreaks and, in particular, in some vulnerable settings?

Ms Stephen-Smith: That is definitely a question for the Chief Health Officer, Chair. I will hand over to Kerryn.

Dr Coleman: I have read and understood the privilege statement. Thank you for the question. I think it is a really useful question. I get asked this all the time in many different guises. I might just start by saying that the thing that we need to keep

uppermost in our mind is keeping the epidemic growth or the likelihood of getting increasing cases in the community under control. We only have three levers. The first lever is our vaccination coverage. We have actually got to a level which I think has astounded us all, here and in New South Wales. The second one is the public health social measures. These are the ones that people do not really like. They are the lockdown scenarios and restrictions on what we can and cannot do out in the community. The third one is what we call our TTIQ, so our test, trace, isolation and quarantine measures. All of these will need to be adjusted and adapted as we move forward, to try and keep that growth at a relatively R=1 level, and that is the effective reproductive ratio.

I think your question explicitly goes to: how do we manage TTIQ or our response to outbreaks, and particularly our vulnerable and high-risk settings, moving forward? We need to accept that there will be cases in the community, and our focus will very much pivot towards those that have high consequences or high impacts. I think we will do very much the same thing in terms of focusing our response. Our key aim will be identifying cases in those high-risk settings, or where there is a high risk of impact, as early as we possibly can. We need to isolate that case as quickly as we can, to prevent onward transmission, and then we need to contact trace that case as quickly as we can to prevent onward transmission in those settings.

How and what that looks like depends very much on the setting which we are talking about. It might look a little bit different for a residential aged-care facility. We have a couple of examples where we have had the option of being able to do that in the ACT. I think one of the settings is in the community where there are a group of people who find it much more difficult to quarantine and isolate due to life circumstances or other factors.

We have worked really hard with our partners, both in government and outside of government, to be able to deliver a wraparound service for these cohorts or groups of people who need that little bit of extra support for quarantining and isolation, moving forward. I do not think people will see much difference in what we are trying to achieve; it is just about how we are going to be doing that. We will be trying to adapt what we do very much to fit a bit more into a business decision model.

THE CHAIR: Going back to some of the particular settings, we have already seen positive cases at schools, for example. What is the advice for schools? Obviously, parents will be quite concerned, especially for primary school children, because there are no vaccinations. What will happen if there is a known case? What happens now?

Dr Coleman: We have worked very hard with Education around trying to agree on a risk assessment framework that tries to keep schools as open as possible but gives us a safety reassurance as well. The response at the moment is similar to what I just discussed, but we are trying very hard to limit who our close contacts are and, therefore, the impact of quarantining.

In the two schools where we have just had cases in, in primary school, we have focused the close contact tracing on just that year group. Unfortunately, that has resulted in quite a high number of children and teachers still needing to stay at home for the full 14-day quarantine period because the majority of them are unvaccinated at

this point in time. That is about 60 or 70 at each school. I think that is too high at this stage. We will work very hard on what we can do to adapt our risk assessment, moving forward, as we learn a little more about how the virus is going to spread in schools.

We have not had as much experience in schools as some of the other jurisdictions, but we are on a committee where we are sharing experiences across New South Wales, Victoria and the ACT. We are trying to very much understand and are being really reassured that, while there are lots of cases appearing in primary schools, children of that age do not really transmit as much as we have seen in other settings. That is really reassuring. There is the potential for some other mechanisms that we might be able to use, such as rapid antigen tests, into the future around how we might assist in keeping people at school longer.

THE CHAIR: You mentioned in your answer to my first question that you are working hard to assist people who are finding it hard to quarantine because of their life circumstances. Can you just walk us through that, and what measures you have taken to ensure that you can assist those people as much as possible?

Dr Coleman: There are a couple of things we have done. The biggest thing that is probably fairly visible is that we have what we call Ragusa, an alternate accommodation facility, available at the moment. For some people it is quite difficult to find a place to safely quarantine or isolate. Some people have lots of family members at home. What that means when you are a case is that, if you have 10 or 12 people in your home, you are constantly, every day, putting those other people in your home at risk. Having a good place for either the case or the contacts to go to is really supported. We have NGOs available onsite, as well as our colleagues from the hospital, to provide supports where needed. That is a really strong example. We also have that wraparound service available to people in the community who choose to quarantine or "isolate in place", as we call it, which is either at their own home or at another chosen accommodation location.

We have a wonderful wellbeing team who make daily contact with people who are cases, as well as the COVID care-at-home team. For us, compliance is not about enforcement. Compliance, for me, is about cooperation. I think one of the things that we have demonstrated in the ACT is being able to provide daily wellbeing checks. Opportunities for the things that people can do in their own home will assist them in remaining in isolation and quarantine. I think there are quite a few levels we have worked towards there.

MS ORR: Dr Coleman, you mentioned that the focus would be on vulnerable groups, going forward. Can you elaborate and clarify what you consider to be the characteristics of vulnerability in the context of COVID?

Dr Coleman: There are two things, or maybe three, that come to mind. I guess the first one is anyone who is unvaccinated, for whatever reason. That will be, clearly, our under 12-year-olds. That age group does not have access to a registered vaccine yet. Then there are people who, for whatever reason, are either unable to access or cannot make the decision to have a vaccination and remain unvaccinated.

We have done a lot of work around some of those groups who traditionally find it difficult to access healthcare services or do not want to come into contact with healthcare services. I know that Rebecca Cross is quite keen to discuss some of the measures that we have used to access as many of those people as possible and offer them vaccination, and that is the best way in which we can reduce their vulnerability.

I think there is also a group of people who are more likely to have a serious outcome from infection because of their underlying comorbidities. They are people we have focused on first in getting high levels of vaccination. If they do become a case then we need to filter and prioritise them in the program that Dave Peffer can talk to, once they become a case, and make them a high priority so that the outcomes are not actually too bad.

Then there is the third aspect of your social and economic circumstances. We all talk about the socio-economic risk factors of health. They are the other things that I think we have been talking about already around certain cohorts or groups of people who are vulnerable due to their life circumstances. They are the things that we need to embrace and either reduce risk of infection or, if there is infection, reduce the risk of poor outcomes, as well as transmission.

MS CLAY: Just going back to the schools, there was a lot of anxiety about returning to school. I have a seven-year-old. We were all nervous, but I am delighted that she is back now. I heard there was a lot of confusion among parents about how the decisions had been taken. In Victoria, for instance, they are mandating masks in primary school; whereas here there are no masks for the younger kids. It may be up to the discretion of parents—we are not quite sure—for the middle age group, and then for year 7 and above it is definitely masks. How did you come up with the system that we have? Do you think parents are still confused about that grade 3 to grade 6 cohort?

Dr Coleman: There are a couple of ways in which we consider public health strategies which can reduce the risk of infection and transmission, and I think masks are one of those. There are a whole range of things that we have provided advice on—and I know that the Education Directorate has put them in place very well—like cohorting people, having social distancing where we can and smaller groups outside where we can: those kinds of things. First of all, it is important to remember that mask wearing is just added to that layer.

There is a difference with mask wearing. That is because, for under-12s, the evidence is much less clear about not only the impact of that but also the feasibility and the pragmatic reality of children under 12 wearing masks in a consistent fashion and in a way that does not create more risk. I have trouble wearing my mask every day and I am constantly tugging on this one. I think one of the risks is if you are exposed to someone infected or you yourself are breathing into a mask with infected viruses, if kids have them skew-whiff or are constantly touching other people's masks or pulling it off themselves. We have discussed the fact that that in itself is a risk factor. That is why we made the recommendation that it was at the parents' discretion. That allows parents to take into account how they think their child is, from a maturity perspective, able to wear it safely.

MS CLAY: Do you have any information—and it might be too early for you to tell—

as to what kids and parents are actually doing and whether most of the parents have felt confident to send their kids back to school?

Dr Coleman: No, not at this stage. It will be useful to get some of that information from the Education Directorate. One of the things that we have acknowledged through the whole pandemic—and we do this a lot in public health—is that it is really important to have a quality assurance cycle. So you actually look at your recommendation, you look at how that has played out and what were the negatives in rolling it out, but you also look at what were the positives and how do we strengthen what we do. I think it is the first week back for all kids this week, isn't it?

Ms Stephen-Smith: Yes.

Dr Coleman: There are so many different dates. "Mixed feelings", many parents have said to me. I think it will be really important that, at the end of this week and next week—and we have regular meetings with the Education Directorate to actually touch in and see how things are going—we look at whether we need to adapt our recommendations, based on how it is going.

MS CLAY: Thank you.

MS ORR: In our very first hearing we had the Human Rights Commission in. They raised a number of points around human rights, including the considerations that go to human rights for health directions. Can you run us through what considerations you take into account when you are making the individual public health directions, when they are put together?

Dr Coleman: I am getting all the questions.

Ms Stephen-Smith: That is because you are the Chief Health Officer.

Dr Coleman: As I think I have said a couple of times on this, both at media conferences and also to other people, I take the obligation around not only human rights but also public health directions really seriously. It has caused me some angst some evenings around these considerations, because they are broad and there are both positive and negative obligations when we are considering the human rights stuff.

First of all, I have to keep coming back to the intent and what we are trying to achieve here. The Delta virus has proven to be highly infectious, particularly in an unvaccinated community. It has quite high levels of morbidity and mortality in certain groups, and in overseas countries we have seen it really get out of control. I think the intent has always been to protect lives and the health of the Canberra community. That is what I always come back to. I always need to consider the risks—spread, hospitalisations, poor outcomes—with this new variant, as opposed to the Alpha one we saw last year. This year was a very different picture to what we saw last year, and it did escalate the risk and actually lowered the threshold for me in terms of making some of those directions.

Then I think we need to consider all of the rights that are protected under the act. The really important ones, for me, are recognition and equality, for everyone to be treated

equally. That is where the positive obligation comes in as well. Everyone has a right to freedoms and choices as long as they do not impact on other people's rights to the positive aspects of that. That is really important.

Life and privacy are where the other aspects of some of those come in. When you weigh up the need to put in place some public health social measures or some of our quarantining and isolation aspects, those people who are not impacted have a right to life, a right to live free of disease, if they possibly can, and that is where the balance comes into it. I guess that is my short summary, but I am happy to talk a little bit about any of those.

MS ORR: Could you walk us through those? Is there an example you can think of where there have been human rights considerations in your decision-making process, just to illustrate the process you undertake?

Dr Coleman: I think everyone would like to hear the mandatory vaccination example, because that is a really challenging one.

MS ORR: Yes.

Dr Coleman: Certainly, from a vaccination perspective, we have a vaccine that is proven to be safe and effective. It is safe in terms of the number of vaccines that have been taken up worldwide, and it is extremely effective at reducing hospitalisations and severe outcomes, as well as transmission. We have a safe and effective vaccine. We know that it is effective at reducing transmission. So that is a really important one. Then we look at what setting would we need to have the threshold at, which would be important to make vaccination mandatory.

Some jurisdictions have gone for a wider set of workers to be mandatorily vaccinated. In the ACT we have had an excellent take-up of our vaccines, but there are settings in which there are significant consequences of one or two people not being vaccinated and hence introducing disease. One of those, in particular, is a residential aged-care facility. We know that in Victoria at this point in time unvaccinated aged-care visitors are actually introducing disease into aged-care facilities. Victoria has got transmission in aged-care facilities, which is up to eight to 10 cases, and we are all seeing not nearly as many but, unfortunately, earlier deaths, for residents living in there. When we consider all of those options, such as right to life and right to equality, and are balancing that up, there is a recognition from my perspective that, for certain workers, making that mandatory for the greater good provides the balance of reducing the risk of introduction and spread in that facility.

MS ORR: Noting that it would probably end in quite catastrophic consequences; is that it?

Dr Coleman: Yes. The settings that we have chosen or that we have selected from a policy perspective that are being implemented are residential aged-care facilities, healthcare settings and disability residential settings—we are looking at disability—so all high-risk populations or high-risk settings where we know that a poorer health outcome is much more likely if infection does occur, or rapid spread. That is how it happens in a residential aged-care facility.

I am sure Dave can talk to the impact of having a case in a hospital setting. It is not just the impact, I guess, of the actual disease itself; it is the impact of the workforce being what we call "furloughed" if they are unvaccinated, and then we run the risk of having significant workforce shortages. In the education example, there is an unvaccinated cohort all on the same side and a restriction in trying to keep it to those settings where the majority of children do not have the choice to get vaccinated.

MS ORR: Are there any other occupations or industries that you are looking at in terms of mandatory vaccinations?

Dr Coleman: At this point, none that I am looking at from a mandatory perspective.

MRS JONES: I have been presented with a couple of cases where someone can definitely fit the definition of being covered by the mandate but could equally be interpreted as not fitting it. How do you expect the mandate to be interpreted? I will give you a couple of examples. One is a social worker who works for ACT Health out of a health community clinic.

Ms Stephen-Smith: Canberra Health Services?

MRS JONES: Yes.

Ms Stephen-Smith: It is not ACT Health.

MRS JONES: Thank you. They work for the ACT government; that is what I was trying to get at. They have been working during the lockdown from home, doing online work with people. The mandate says a worker at a healthcare facility must not work at the premises if they are not vaccinated. They have been told that when the date arrives they will have to take leave. The other one is someone who is driving for one of the pathology companies.

Is it intended that those people are also covered, given that, of course, they do work in health settings? If they are able to do their work outside the health settings, are they meant to be captured? I understand it is very simple for government, but it is more complicated when you are dealing with people's livelihoods. Is that the right interpretation?

Ms Stephen-Smith: I might ask Mr Peffer to go to how Canberra Health Services is managing this, because the mandate covers, effectively, the whole of Canberra Health Services.

Mr Peffer: I acknowledge that I have read and understood the privilege statement. In terms of our rollout of the public health direction, you are right: there are some grey aspects to it. It is not all black and white. We are working through those on a case-by-case basis.

The good news is that those individual cases are quite small, in terms of the overall context of the rollout. Last Friday, I think we were still waiting on about 327 individuals to either provide evidence or go through a process of advising us that

they do not intend to have a vaccination. Today, that is down to about 60, and we are working through that. Forty-seven have confirmed that they will not be getting vaccinated and 23 of them—about an hour ago, so the numbers move—have been redeployed or we have looked at alternatives for them to not work in the workplace. For some of the services, through the lockdown, we made changes to how they are delivered, whether that is virtually, remotely or with people working from home.

MRS JONES: If a person has been working remotely during COVID, are they allowed to continue to work remotely, if they are a social worker?

Mr Peffer: That would depend on the individual service. I cannot give a blanket guarantee that that is how that service will continue to be delivered in the months and years ahead. We have had to change quite a lot of service delivery. We have many people who traditionally would work at the Canberra Hospital, on the campus, who we have had to ask to work remotely through the lockdown, because we have had to scale up new teams. COVID Care@Home, for example, are now taking up a large area of accommodation in the tower block. We have had to make changes to the way that we deliver services. That might not endure. Some of it, particularly some of the virtual care that we are working on, we do hope will be an enduring feature.

MRS JONES: Going briefly to the case, if they consider that perhaps their conditions or their situation could be reconsidered, who do they speak to?

Mr Peffer: They can speak to People and Culture or their supervisor. For individual service lines of decision—

MRS JONES: What if their supervisor has clearly said they have to take leave?

Mr Peffer: That is probably a pretty good indication that that particular service is intended to come back onto campus and be on—

MRS JONES: What I am saying is that there is no review mechanism, if someone is concerned that the interpretation is not what it could be.

Mr Peffer: I think there are review mechanisms within CHS.

MRS JONES: What is your review mechanism?

Mr Peffer: If someone wants something like that reviewed, they have an opportunity to go to our People and Culture team and talk through their particular circumstances.

MRS JONES: The People and Culture team?

Mr Peffer: That is correct.

MRS JONES: Minister, as far as the private sector is concerned—a pathology provider—is that the only interpretation for a pathology driver? I know they have to go in and out of facilities. Is that the determining factor in that particular case?

Ms Stephen-Smith: I think it has been.

Mr Peffer: I can speak for some couriers, not all of them. Certainly, for ours, the expectation is that they are moving through specimen collection. They are in and out of our facilities, collection centres, clinics and walk-in centres, for example. The expectation is that—

MRS JONES: Okay, so that is not against expectations?

Mr Peffer: I do have to give a shout-out. We have quite a number of volunteers who have been helping with our COVID specimen deliveries, which is a terrific initiative—on motorbikes.

Ms Stephen-Smith: We are missing the Chief Health Officer's shout-outs.

MS ORR: Dr Coleman, would you mind walking us through some of your thinking behind the Canberra Health Services mandatory vaccination direction, or whatever we call it, and why it was necessary to put in place this extra line of response?

Dr Coleman: It goes back to what we discussed before. I spoke with the chief executive officers of facilities, including Dave, and Barb Reid at Calvary. We have had a relatively good uptake, but still not what I had really hoped for, with a very high—over 90 per cent—uptake by our healthcare workers, without the mandatory vaccination.

The impact of the introduction of a case in a healthcare facility is significant. That is why the entire healthcare facility has been captured, because of the movement of staff across hospitals, as well as other aspects of the facility. Perhaps Dave Peffer could talk a little bit more about that, if you are interested. It is very much about that.

We are also very aware that there are some very unwell people, very sick people, and they deserve and expect to be safe when they come into hospital, particularly in places like the oncology ward and other places like that. Having maximum vaccination of all of the staff who come into contact with them, to prevent any additional risk of infection, was really important in those places.

MS ORR: Mr Peffer, Dr Coleman indicated that you might be able to give us the perspective of Health Services.

Mr Peffer: Yes. We were strongly supportive of this. Kerryn and I had a number of conversations. Also, through our Clinical Health Emergency Coordination Centre, we talked to many of the general managers and chief executives of the larger private facilities. All of them strongly supported this measure being introduced in terms of protection. What you have in a hospital is a real concentration of very unwell, very vulnerable individuals. Whatever you can do to protect them, I think you should. We have an obligation to do that.

The flip side, of course, is the workforce impacts, and doing whatever we can do to minimise the downtime of our workforce. Every time we have an exposure event, that impacts people. For some of our teams, if you take out half of the team, some of them are not big teams, and you have half of the team left, trying to carry the load and keep

the service going. That has big impacts on people's mental health and physical wellbeing. For a range of reasons, it really did make sense to introduce the measure.

MS CLAY: You have got modelling looking into the future, and that is obviously going to change. You do not have control over that. What are your numbers looking like for February, March and April next year in terms of case numbers and hospitalisations.

Ms Stephen-Smith: In talking about this at a press conference recently, Mr Peffer explained the February-March-April issue very well in terms of when you are reading a book: you can see the words really, really clearly but as you move the book further and further away the words become less and less clear. You can think of modelling in that way.

If you have seen the Doherty pictures, if you have seen the modelling, you see that the confidence interval gets wider and wider and wider the further you go out. So from here, if we are looking to February, March and April, we have this very, very wide confidence interval. I am not using exact numbers, but we may have somewhere between 1,000 cases and 10 cases a day. It is not super helpful when we are looking out that far.

What we have found is that we are getting a relatively accurate picture when we are only looking three or four weeks ahead, based on what our current cases are at the moment and how those are trending up or down. So that is what we are finding is the most useful thing to think about our hospital capacity, while at the same time planning for what a surge would really look like if we did have to be in that scenario.

MS CLAY: Obviously, everybody wants to know what is going to happen next, but nobody can really say. We understand that. But I am not sure that the Canberra community is quite across the fact that we are still in a really big period of uncertainty. We are also making a lot of choices at the moment. Summernats is going ahead. I am wondering if the Multicultural Festival is going ahead. They are in January and February, and that is quite soon. How are you working through communications with the public so that we have managed expectations and some of those decisions about big events that we really need to be making now?

Ms Stephen-Smith: I think we have said a number of times in our public conversation that we are in this environment of uncertainty. We are stepping out of lockdown in a way that no other jurisdiction our size, with our vaccination rates and our case numbers, has done. So we really do not know. I think we all would have expected that we would have continued to see cases bubbling along at that 30 to 40 a day rate and maybe even going up. But instead we have seen right down to under 10 a day for the last week. We are really in a very unknown situation. We have tried to be really upfront with people about that. I will ask Dr Coleman to talk about how, in that environment of uncertainty, we are making decisions on the settings we put in place.

Dr Coleman: Thank you, Minister. You are exactly right—I remember standing up at a presser and actually saying, "No, no, those days of teens are over. We'll never see the teens again." My crystal ball said, "No, no, no, you're always going to be above 30." But I have been really pleasantly surprised, and also pleasantly surprised with the

trajectory of New South Wales, which has continued to come down as well. I think both of those go to those very high vaccination levels.

MRS JONES: And the effectiveness of the vaccine?

Dr Coleman: Absolutely, yes.

MRS JONES: And for transmission, too.

Dr Coleman: Absolutely, yes. The Canberra community has been unbelievable in terms of being able to embrace the COVID-safe behaviours. Looking forward, we have introduced this concept—and I have tried to have this conversation at some of the media pressers—around the vaccination, the social measures and the TTIQ and how, when one of these comes down as we come to the next stage of easing, we will have another period where we will get more movement of people, but we therefore need to ensure that our TTIQ is rock solid and we need to work out what that equilibrium of cases is going to look like.

I also think, pragmatically, that we have all realised that we have to live again and we have to work out what we are willing to forgo and what level of risk we are willing to take, moving forward. That is why, when we talk about this, moving forward, very much our focus is not on drilling down on every case but on talking about how many people in hospital do we have, how many people in ICU do we have, what is the impact on our ability to deliver care that is non-COVID related so that our hospitals are not sucking all that up.

MRS JONES: Presumably a lot of the cases will not be that symptomatic for some people? So you are looking at a number, but what does it actually represent?

Dr Coleman: One of the other real challenges we have is that, certainly, you can still get infected and become a case and transmit when you are vaccinated. You are also less likely to have symptoms, but we still want someone with symptoms to get tested who is vaccinated. We know there is going to be a proportion that we do not know about in the community and it is about us being agile and flexible and not going too quickly so that we can adapt if we need to.

With events, we have learned a lot from other jurisdictions, as well as our own experience, about how we can put protections around how we run an event to limit the impact if there is significant COVID there. We have had some fantastic conversations with Summernats around how we might put in some of those protection mechanisms. That is about keeping daily numbers down, so maybe not the 50,000 per day or whatever, but we might look at 10,000 per day and keeping it to morning and afternoon sessions. We are looking at how we can do events safely, moving forward, because we might be in this position for another three years.

MS CLAY: Are you having the same conversations with the Multicultural Festival?

Dr Coleman: Across government we are absolutely having those conversations. We have an events committee which has representatives from those government directorates involved in that. We are discussing with the various ministers, as well as

the external stakeholders, what we would need to do to deliver safe events into the future.

MS CLAY: Are you able to give guidance on event sizes and numbers and things, and then festivals can decide if they can meet that?

Dr Coleman: Yes. Because we are so small, we offer a really good support service to individual large events as well. Often some members of our team will develop personal relationships with larger events to provide quite bespoke advice around how it can be run. We have spent a lot of time with the Handmade Markets to try and assist with how we can have that safely, because that is a relatively high-risk activity. Summernats is one example, but there are some other really important festivals coming up next year that we have not seen for such a long time.

MS CLAY: Fortunately, a lot of them are outdoors.

Dr Coleman: Which is fabulous. We are very keen to support that. If it is not available yet, the event protocol is certainly in its final stages of being updated, and that includes advice in terms of immediate as well as longer term things to be looking for.

Ms Stephen-Smith: Knowing your interest in this, Ms Clay, I will speak about live performance events as well. That is also an area where our exemptions team have very good relationships with a number of the live music and live performance venues across the ACT. We are obviously conscious of the issue around live music versus live performance last time, so we are working through that.

MS CLAY: Every time I have sent an individual one to you, Minister, we have gotten a very quick response. It is not always the response that people wanted, but it is usually the same day, so thank you very much for that.

MRS JONES: I want to go to the emergency declaration itself and the system that we have. I know it fairly well, but I get asked a lot of questions about it. The current declaration we are in was made on 13 August, and I believe it concludes on 14 November. A couple of people in the community are saying, "Is it all over then?" I explained to them that we are likely to get another one. Would you like to take us through your expectations of what will happen with at least the next three-month period, once we get to 14 November?

Ms Stephen-Smith: Yes. Then maybe I will ask Ms Cross to talk about what our future thinking is. I think we talked very early in the pandemic about the fact that the Public Health Act, while it could be used and has been used very effectively to respond to the pandemic, was not really written for the purposes of the pandemic.

We have been doing some work around amendments to the Public Health Act and new legislation to effectively replace an emergency declaration that will enable us to continue to respond to the impact of COVID-19. As Dr Coleman indicated, it will be quite a long time. We expect that that will continue for a long time into the future, that there will need to be some kind of public health restrictions and responses in place.

We have been working on legislative amendments around that, but obviously they are not going to be introduced and passed before 14 November. My expectation is that we would do a further three-month extension from 14 November.

MRS JONES: And come back next year and do some more legislation?

Ms Stephen-Smith: I am hoping that we will introduce legislation before the end of this calendar year, and that will give the opportunity for the Assembly and the relevant committee to consider that and then come back next year to make those changes, which will then provide a new mechanism for the kinds of restrictions and decisions, including vaccination, as well as public health restrictions. Kerryn, did you want to talk about the considerations over that three-month period, the decisions that go into the extension of the declaration and then what that is going to be like?

Dr Coleman: You are right. We know, even now, that we need to continue to have many of those protections in place beyond 14 November. Importantly, one of those is that we still do not have a registered vaccine for the under 12-year-olds. We know that there is a submission with the TGA and ATAGI is considering it, but we also know that there is only one other country, the FDA in America, which has recently approved that. There are some significant considerations; so it is not going to be a quick turnaround. We will need to be able to continue those projections.

I think we have only just today opened the border to overseas arrivals. We have at least another couple of months to understand the impact of—

MRS JONES: New strains?

Dr Coleman: Absolutely. I had not even got there, but, yes. We need to equilibrate—there is that word again. As the illness, as the disease, the virus, rolls out across Australia as domestic borders come down, there will be a passage of equilibrating across Australia. But also, how do we account for this constant flow of people coming in and out from countries where some countries have a low, some countries have a high? Singapore actually has quite a high level of community transmission at the moment but we will be opening our borders on the—

MRS JONES: But they also have a high vaccination rate, do they not?

Dr Coleman: They do. It is my understanding that we will not be ready by 14 November to know that.

The Biosecurity Act, which is the one that the commonwealth owns, will have to have some things in place still for quite a while. They will not be continuing as strongly as they are. We have had a routine of three-month extensions, and three-month extensions give us that opportunity to get that legislation adequately through that process.

MRS JONES: Can I just ask: are the considerations you are making amendments to the Emergencies Act or a new and different provision for endemic disease management?

Dr Coleman: Primarily amendments to the Public Health Act, because it is still really the appropriate act to respond to infectious diseases. Ms Cross, did you want to talk about that?

Ms Cross: I have read and understood the privilege statement. We are looking at amendments to the Public Health Act, and in that we are approaching it differently to Victoria. You would have seen Victoria was recently—

MRS JONES: Yes, there was quite a lot of coverage.

Ms Cross: Yes. I guess we will look at the debate in Victoria, look at the issues that you raise there, and take that into account, looking at an amendment to our Public Health Act rather than a separate piece of legislation.

MRS JONES: I think when we started down this track of COVID, certainly in briefings that I was in with Mrs Dunne and yourselves, we discussed the fact that we would need to review the act. That might be good to do at the same time. Potentially it is something the committee could consider as a recommendation, because we have been through perhaps the toughest time of restrictions. Fingers crossed, toes crossed—everything. It might be a good time to reflect. That act was only ever designed for physical emergencies, not really health emergencies. We did not quite see this coming in that form.

Ms Stephen-Smith: Yes. In theory, the Public Health Act was, but it turned out that, with the pandemic, it did not quite work as well as we would have liked it to. We have clearly managed, as has every other jurisdiction. I think the way I was considering it was that the amendments that we are talking about will enable us to continue to respond to COVID in this next 12-month period.

We also need to really look back and have a good look at the appropriateness of the Public Health Act and responding to a new pandemic, because essentially what we are going to be responding to through these amendments is a disease that we know about and that is becoming endemic in the community, if I am using my public health terminology correctly.

But we do really need to then also take that look back and say, "Actually, what is the appropriate legislative basis for responding to a new pandemic?" whether that is a flu pandemic or whether that is a new, novel disease that we really need to think about and that you will need to respond to quite differently and quite strongly. I would hesitate to hold up the imminent amendments that are really about responding to COVID in order to take the whole review.

MRS JONES: The Assembly would probably be able to get right into that as a whole concept.

THE CHAIR: I want to go to hospital capacity. Obviously, we want to think that we are, as Mrs Jones said, over the worst of things, without being complacent. How comfortable or confident are you, Minister, about the ACT's ability if there was an outbreak, and have we got the hospitals ready?

Ms Stephen-Smith: I am really confident in the planning that has been done, the fact that there has been really significant planning done and that people are thinking through that. One of the things that have become really apparent during this outbreak is that those plans are never static. There is a constant sort of rethinking of what the other pressures are on the system or, "We thought this was going to be the best way to do it, but actually, as we start to implement that and we talk to staff, maybe there's a better way to do things."

Of course, we are in an environment, as all states and territories are—and we have therefore written to Minister Hunt about this—where our hospitals are already under pressure. As we open up, we continue to see those normal pressures on the hospital, in addition to COVID. The COVID pressure comes in two ways. First, it is obviously patients, either definitely COVID-positive or suspected COVID patients. But then that extra level of infection prevention and control, PPE, and all of that stuff also adds—and particularly in the emergency department—a layer of time in supporting patients through the emergency department. I might throw to Mr Peffer to talk about how that modelling that we were talking about earlier and the hospital capacity planning all fits together, but also how it continues to evolve.

Mr Peffer: In terms of the planning work that we have done, we have used the modelling. Recognising the comments that have been made about the confidence interval stuff, it can get very broad very quickly. You have to anchor it back to: what has been the experience overseas for jurisdictions who have opened up ahead of us, who perhaps have a similar vaccination rate? What has been the impact on their hospital systems, so how realistic do the scenarios that we can put together actually seem for the months ahead?

We are planning on the worst case scenario but really hoping for the best, and I think that is what most jurisdictions have been doing. We look at the scenarios, we look at what is likely to be the occupied ward capacity if we perform very poorly, we look at what would be our ICU-occupied capacity if we perform very poorly, and then we start planning on that basis and hope that we do not actually get to that.

The challenge in activating COVID wards, and we have a number of COVID wards activated at the moment within our intensive care units and—I am talking territory-wide, both in the Calvary Public Hospital out at Bruce as well as Canberra Hospital at Garran—is that, when you start to take offline hospital capacity and designate it as a red zone, as a COVID zone, it is really inefficient. The reason for that is that you cannot have treatment spaces side by side in a ward where you have a COVID-positive patient and then a non-COVID patient. That is where you start to introduce risk.

We have seen this in an exposure that we experienced in 10A, our surgical ward, where we had a patient unknowingly come in positive and transmit it to two other patients in the ward-based environment. So you simply cannot scale a bed at a time. You actually have to designate a ward, and that becomes your established red zone. Then you have got everyone donning and doffing as they enter or leave the area and you put in place all your infection prevention and control. You can imagine that across the hospital system, where we look at ward bed capacity and then intensive care capacity, each time you make a decision to say, "We think we'll need this much

capacity," it is actually a step. It is not sort of gradual, one-bed—you actually take out whole wards.

Ms Stephen-Smith: A whole chunk.

Mr Peffer: That is right. That impacts your footprint where you traditionally provide these services. You are taking offline, then, quite a number of beds that would otherwise be used to flow patients through.

MRS JONES: Like the paediatric stuff you have had to do.

Mr Peffer: That is exactly right; having a paediatric medical ward out, for example, or having some of our pods out in intensive care. They are treatment spaces that would otherwise be used for patients recovering from surgery or having a variety of deteriorating circumstances. That does start to place pressure on the system.

What we saw last year was a big dip in activity. Elective surgery slowed right down, so we were able to accommodate possible activity. We did see a drop in activity this year, but it has bounced back much quicker. The trade-off for all health services not only here in the territory but also around the country, and the consideration for chief health officers, is really: to what extent can you allow COVID to crowd out non-COVID activity? It is not really fair to say that, if someone has got COVID, they take priority over anyone else who requires hospital services. All these things factor into our thinking about being able to scale.

The other aspect to it, which I think is more important than the infrastructure itself and the beds, is the workforce. We have a workforce who have been under a lot of pressure. It is a tough grind and they have been in this now for going on two years. That elevated level of risk to them, the anxiety that they bring to the workplace every day, because they know that risk is ever-present, is draining and there is no magic workforce. There is no magic healthcare workforce around the country. We are asking a lot of people to sustain the business as usual effort but also to be able to surge and handle COVID.

THE CHAIR: What is the future of the Garran surge centre? I think you have spoken previously, Minister, about the capability of that centre to be stood up if we needed it. What is the current thinking in terms of the future of that surge centre?

Ms Stephen-Smith: Obviously, it was designed as a supplementary emergency department, so it is not really a space for long-term treatment. It has been fantastic for testing and vaccination. One of the things that we have just done—I think it is starting this week—is establish, next to the surge centre at Garran, in partnership with the University of Canberra, the use of the mobile clinic for the Sotrovimab infusion treatment. At the moment that is sitting outside of the Garran surge centre in that clinically built facility, which was designed to be a clinical facility. If we were to see lots of cases that required short-term treatment, that might possibly be an alternative use for the Garran surge centre.

We were just saying this morning that, with the number of cases we are seeing and the high levels of vaccination in the community, the indications for something like

Sotrovimab are actually for unvaccinated older people. And there are not very many of them in the ACT. We have moved it out there in order not to have those people come into the hospital, because the fewer COVID-positive patients coming into the hospital unnecessarily, the better.

One consideration is the extent to which we can use the surge centre or part of it for a treatment facility. It is obviously doing a great job at the moment as a testing facility. I think we are all hoping that it never needs to be used as an emergency department, because that would really indicate a very high level of pressure across the system. The next question will be: when do we dismantle it and restore the oval? We do not know the answer to that question yet. That is definitely something that is going to have to be considered over the next six months.

I think we also need to take into account that we do not know what the impact of winter is going to be. In the Northern Hemisphere, as they go into winter, they are starting to see increased cases and increased hospitalisations. But we could get to next winter with an approved oral treatment. We just do not know. We just do not know what the situation is going to be like in six months. That is why there is no certain answer to that question. But we are constantly considering the best use of the facility.

MS ORR: Just picking up a little on what we were talking about with the groups of people who have not got vaccinated and the various reasons why they might not choose to, what work have you been doing to broach that group that is not vaccinated, beyond those who philosophically just do not agree with vaccination?

Dr Coleman: It is not really a short answer, but we can probably hit the highlights for you. I might just touch on a couple of things and then hand over to Ms Cross. I think it is about knowing your community and your population really well. We have done a lot of sub-analysis looking at postcode-related data and other indicators, such as culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander indicators. We have looked at opportunities to provide vaccination within normal routine services to which they might engage with and leverage that, as well as provide additional services such as inreach and pop-up sites.

Ms Cross: We have had a lot of inreach to public housing sites. We have used providers that people in those sites are familiar with, directions from those sorts of providers. In addition to that, although Kerryn has not mentioned it, one of the groups where we have had huge success in getting the vaccination rates up is actually people with disability, through our access and sensory clinic, which is probably, I would say, nation leading, if not world leading. We have seen a great uptake of that and a very positive response.

We have tried to have a bespoke approach. If you look at the first doses that we had last week, there were an additional 442 Aboriginal and Torres Strait Islander people. So, again, it is by having pop-up clinics in places where there is a high population, organised through groups which they are familiar and comfortable with. We have been out to Oaks Estate. We have had some outreach there. We are trialling, this week, outreach with a coffee van. We are basically doing everything we can in the communities where we know the uptake is not as high as we would like to get the vaccinations, first dose, second dose, through. Where it is appropriate, we combine

that with testing as well; so sites like Jerilderie Court, Oaks Estate and all those sorts of places.

THE CHAIR: On behalf of the committee, thank you, Minister Rachel Stephen-Smith, the Chief Health Officer, Mr Peffer and Ms Cross, for your evidence today. The secretary will provide you with a copy of the proof transcript of today's hearing, when it is available, to check for accuracy. No questions were taken on notice. I thank the witnesses. I know that it is a very busy time for assisting the committee.

The committee adjourned at 5.31 pm.