Q22/111

Transcript page: 5

COVID-19 management in evacuation centres

SUSAN PEARCE: Can I just make a comment there, Ms Houssos? We have a document that clearly guides anybody with suspected COVID or with COVID in evacuation centres that was reissued to our entire health system the night that we evacuated Ballina hospital. Dr Gale and her team have been involved in that. It sets out all of the things you would expect: social distancing, hand hygiene, mask wearing, the use of RATs, et cetera. In addition to that as the Minister said, Mr Jones has made arrangements for a separate facility. Wayne, did you want to comment on that?
Mr BRAD HAZZARD: I will ask him to say that, but I also want to point out that we have just been advised that no gastro has been reported in the evacuation centres as late as yesterday afternoon. There is some gastro outside of evacuation centres because it is more broadly through the community. Mr Jones, can you just clarify, because I know you have that separate premise for COVID patients? Could you just let the Committee know that quickly, please? It is time to move on to another group, I think.
WAYNE JONES: We have identified 18 beds at Casino hospital, where we are isolating COVID-positive patients. We do have a couple more than that who can manage isolation in their own facilities, but we will also be looking at a large facility in making one of the evacuation centres near the [inaudible] as a drop-in and making one of the evacuation centres a COVID isolation area, to make sure there is enough capacity if we get any more cases going up through the evacuation centres.
The CHAIR: Thank you. Ms Pearce, I would be grateful if you could provide a copy on notice of that document you referred to.
SUSAN PEARCE: Certainly.

ANSWER:

Please see attached:

TAB A – Guideline – Evacuation Management COVID supplement (October 21).

TAB B – Managing COVID-19 risks in evacuations centres (March 2022).

Q22/112

Transcript page: 7

Subsidies for nurses

Ms CATE FAEHRMANN: On the point of accommodation, I was going to ask as well I know of quite a few families including nurses who have lost everything. I have been informed of some who are staying in motels now in town to continue working in hospitals because they cannot get home. Does NSW Health subsidise that or is that something that the nurses are paying for themselves? Do you know, Minister or Mr Jones?
Mr BRAD HAZZARD: Wayne?
WAYNE JONES: Sorry, I do not know that answer, but I am happy to take that on notice and get an answer to that.

ANSWER:

NSW Health is committed to assisting staff who have been impacted by the severe weather events in NSW. A range of additional supports have been introduced by NSW Health for staff who have lost their primary residence and/or are unable to attend work due to the impacts of the severe weather and flooding. These supports include a special allowance payable to employees for temporary billeting arrangements, and access to discretionary special leave ensuing from the declared emergency.

Q22/113

Transcript page: 10

Average length of stay for COVID-19

The Hon. WALT SECORD: On that note, Dr Gale, on 1 January the average stay in hospital for COVID was 4.5 days. Yesterday the average stay was 9.3. What is happening? Explain why it has gone from 4.5 days to 9.3 yesterday.
MARIANNE GALE: I will take that on notice and come back to you in terms of that specific data. We do know that, as I said, BA.2 does not appear to have evidence of being more severe clinically. I will come back to you about that particular point. But to your earlier point about the reasons why we might be seeing increased case numbers, our theory is that that increase in proportion of BA.2 is probably playing a role. But, additionally, we know that in recent weeks we have had more social mixing, particularly in younger people with schools and universities going back, tertiary education going back, more social mixing and a relaxation of restrictions. All of those things play a role and probably are working in combination to see those case numbers rise.

ANSWER:

The data referenced relates to length of stay for patients discharged in the previous week. As hospitalisation numbers decrease, this result will be more volatile as a smaller number of people are contributing to the average, and a small number of long stay patients will have a large impact on the average. The median length of stay has been relatively stable.

Q22/114

Transcript page: 13-15

Funding for sexual violence services

Ms ABIGAIL BOYD: Yes, and that has been the case for decades. What is your total yearly spend on New South Wales sexual violence services?
NIGEL LYONS: I will have to take that on notice, I am sorry.

Break in transcript

Ms ABIGAIL BOYD: Sorry, if I could interrupt you because my time has run out. Will you please provide on notice—
NIGEL LYONS: I have only got a couple more points and it will only take two seconds, if you like.
Ms ABIGAIL BOYD: Sorry, can I just finish my sentence? After you finish doing that, if you could also take on notice the total spend on sexual violence services from the Department of Health in the last year and then if you could also provide that for the last five years so we can see a trend that would be great.
NIGEL LYONS: Certainly, I am happy to take that on notice. I want to mention the New Street Services, which have also been expanded for harmful sexual behaviours for 10- to 17-year-olds, and a range of other statewide programs that have been put in place.

ANSWER:

NSW Health Sexual Assault Services (SAS) receive approximately $22 million per annum in funding, with annual adjustment for inflation. The full list of NSW Health SAS locations is available online at: https://www.health.nsw.gov.au/parvan/sexualassault/Pages/health-sas-services.aspx.

In addition to this base funding, NSW Health allocated recurrent annual funding of $10 million from FY2017-18 for the NSW Health Violence, Abuse and Neglect Redesign Program. The VAN Redesign Program aims to integrate and enhance the NSW Health response to violence, abuse and neglect, including providing 24-hour specialist integrated psychosocial, medical and forensic responses to sexual assault and child physical abuse and neglect, and broadening the scope of these services to respond to domestic and family violence.

NSW Health has also invested $67.1 million over 5 years from 2018-19 to implement key elements of the NSW Government's response to the Royal Commission into Institutional Responses to Child Sexual Abuse. This funding allocation includes $19 million recurrent from 2022-23 for the enhancement of the Aboriginal Sexual Assault Service workforce, services for adult survivors of sexual abuse with complex needs and the implementation of the Safe Wayz program, which supports children under the age of criminal responsibility with problematic and harmful sexual behaviours. It also includes additional investment of approximately $4.5 million for New Street services in addition to the existing investment of $5.9 million. New Street services provide therapeutic treatment for children and young people aged 10 - 17 with problematic and harmful sexual behaviours.

NSW Health provided funding of $766,000 over 2019-2021, and a further $300,000 in 2021-22 to Survivors & Mates Support Network, a non-government organisation providing trauma-informed counselling and groupwork programs to adult male survivors of childhood sexual abuse and their families and supporters.

NSW Health has a long-standing funding arrangement with the non-government organisation Full Stop Australia (formerly Rape & Domestic Violence Services Australia) and since 2017-18 has provided funding of approximately $1.8M per annum to Full Stop Australia, to provide 24-hour telephone and online counselling for victim/survivors of sexual assault and face to face counselling one day per week in 6 Women's Health Centres for female adult survivors of child sexual abuse.

Any pre-budget submission from an organisation is considered as part of the annual budget process.

Q22/115

Transcript page: 16

Increase in average length of stay for COVID-19

The Hon. COURTNEY HOUSSOS: Ms Pearce, I want to come back to you. My colleague asked earlier and talked about the difference, to Dr Gale, in the average length of stay, that we have seen it quite significantly longer, in fact more than twice as long. On 12 January it was 4.5 days; as of yesterday 9.3 days was the average length of the stay. I understand that we are seeing lower numbers, but if we are likely to see a new increase and we are seeing a lengthening of the period that people are going to hospital, how confident are you that, given what you said about the health workforce being fatigued, you will be able to still provide the best possible care to the New South Wales community?

SUSAN PEARCE: The team are looking at the length of stay right now because my understanding is the average length of stay is not at nine days but, rather, since 1 January it is at 4.1 days. So happy to take that on notice and provide more information to you.

The Hon. COURTNEY HOUSSOS: Let me just clarify, Ms Pearce. The average length of stay, according to publicly available data on the Health NSW website, was 4.5 days as of 12 January; yesterday it was 9.3 days. I accept that there are lower numbers of people going into hospital, but my concern is that nurses are constantly telling us that they are overworked and understaffed, that this is something that is happening right across our health workforce. If we are seeing COVID cases in hospital for longer but we are also seeing increasing numbers, then how is our health system going to cope?

Mr BRAD HAZZARD: The health system is coping, and we have had far more numbers. Let me make it very clear that our staff have all been under massive pressure for two years and they continue to be under pressure—less pressure, but still pressure—because like all of us who have been through this we are still suffering from the past two years of absolute exhaustion. The health system is a big system. Our system is networked; it is a $30 billion system.

SUSAN PEARCE: Can I finish and maybe I might pass to my colleague Dr Lyons? What we look at is the conversion rate of COVID into hospitalisation. That is one of the critical factors in terms of how we assess what we are likely to see going forward—so the number of people with COVID, how that converts to both hospitalisations and ICU admissions. Those numbers have stayed quite stable; there are small movements in those. With length of stay, when you discharge patients who have been in hospital for a long time, that will skew the length of stay because the minute you discharge them that adjusts the number. So, as I said, I am happy to take on notice that question so we can provide you with accurate information with respect to what is happening.

ANSWER:

I refer the Member to the response to the question taken on notice on page 10 of the transcript for Portfolio Committee No. 2 – Health – Budget Estimates Hearing – 10 March 2022.

Q22/116

Transcript page: 17

Climate change

Ms CATE FAEHRMANN: That is very good to hear, Minister. What work is NSW Health doing at the moment to assess and manage the risks of climate change on public health?
Mr BRAD HAZZARD: Climate change obviously has ramifications, particularly in regard to people with a range of conditions. But I will ask Dr Lyons—who might, I am not sure, but just to keep him on his toes—whether he has anything, otherwise I will take it on notice. Dr Lyons, can you contribute anything to the question by Ms Faehrmann?

ANSWER:

Dr Nigel Lyons answered the question on notice on pages 17 – 18 of the uncorrected transcript.

Q22/117

Transcript page: 19

Sexual assault services for child victims

The Hon. EMMA HURST: I have got another question, moving back to the sexual assault issue. What services are available in New South Wales for child victims of sexual assault, particularly for victims under 16?
Mr BRAD HAZZARD: I will ask Dr Lyons to address that, but I was just handed a note from one of my staff noting that apparently New South Wales will receive $80 million in total from the Commonwealth. This is what Ms Boyd was asking before. New South Wales will receive $80 million in total from the Commonwealth under the family, domestic and sexual violence responses national partnership agreement 2021-23. The first of four $20 million Commonwealth payments under the NPA was received in November and has been allocated. More than half of the first Commonwealth payment, so $10.5 million, was used to bolster existing frontline domestic and family violence services, which experienced significantly increased demand due to the COVID pandemic. There is a lot of work going on in that area. Specifically in relation to children, I will ask Dr Lyons if he can assist us. If he cannot, we will take it on notice.
NIGEL LYONS: We might have to take the detail of what—could you just repeat the question?
The Hon. EMMA HURST: The question was what services are available in New South Wales to child victims of sexual assault, particularly victims under 16 years of age?
NIGEL LYONS: There are services available as part of the comprehensive services that we offer for sexual assault victims. We have some specific services available as well, as I started to outline in relation to problematic harmful behaviours. What I would like to do is indicate that those services are available. To give you the specifics, we might take that on notice and provide those specifics to you on notice.

ANSWER:

NSW Health provides Sexual Assault Services (SAS) to respond to child and adult sexual assault in NSW, with at least one SAS in each local health district offering the full range of services 24 hours a day, seven days a week.

The three specialist children's hospitals (Westmead, Randwick and John Hunter) also have Child Protection Units/Teams who respond to all forms of child abuse and neglect, including child sexual assault, and provide clinical advice to doctors and nurses across the State via the 24-hour Child Abuse and Sexual Assault Clinical Advice Line.

In line with the recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse, NSW Health also provides a range of targeted programs for children and young people which contribute to the broader child protection response.

Q22/118

Transcript page: 23

Staff deployment to regional NSW

The Hon. COURTNEY HOUSSOS: Ms Pearce, you said that similar occurrences had happened around the State at the same time during the peak of the Omicron wave. How many Health staff were despatched from Sydney to regional hospitals to fill voids at that time?
SUSAN PEARCE: Can I just clarify: By that I meant that COVID, obviously at the time in terms of the impact on staff furloughing, was not just impacting regional hospitals. It also impacted metropolitan hospitals. I would need to take on notice the number of staff deployed at the time, but we certainly had other examples within major hospitals in Sydney where particular discrete groups of specialist staff may be impacted at times. That resulted in us having to come up with solutions to address those issues, which is what we did right the way through Christmas and the new year. Can I also add, I would like to thank the individual who went to Yass and disrupted their own Christmas plans to assist. I think that gets lost in these conversations. We have had staff move right across the State to assist each other, to help their colleagues throughout this entire pandemic, and that will continue.

ANSWER:

In the period between 1 January and 28 February 2022, the State Health Emergency Operations Centre (SHEOC) coordinated the deployment of 175 full time equivalent (FTE) staff across NSW Health's Local Health Districts and Specialty Health Networks. 108 FTE staff were deployed to six Local Health Districts (LHDs) in rural and regional NSW, including Far West, Hunter New England, Murrumbidgee, Mid North Coast, Southern NSW and Western NSW LHDs.

The deployed staff included clinical and non-clinical staff, and were sourced from within NSW Health and from external agencies including private hospital operators, the Rural Fire Service, State Emergency Services and St John Ambulance.

Q22/119

Transcript page: 23

Specialist unit closures

The Hon. COURTNEY HOUSSOS: We do appreciate that. Ms Pearce, you said that there were specialist units that were completely knocked out by COVID and by close contacts. I understand—
SUSAN PEARCE: No, I did not say they were completely knocked out; I said they were impacted. I would have to take on notice the number.
The Hon. COURTNEY HOUSSOS: Yes, that is what I was going to ask. Could you provide, on notice, the number of specialist units across the State that were required to be closed.

ANSWER:

Please see response to the previous question on ‘staff deployment to regional NSW’ (Transcript page 23).

Additionally, no specialist units were closed during this period and access to emergency and urgent care was not restricted. Where hospitals were impacted by staff furloughing, safe and appropriate strategies were put in place to maintain service continuity for patients. Strategies included redeployment of staff from private hospitals or other public hospitals or the use of home-based care, where it was safe to do so.

Q22/120

Transcript page: 23

Regional hospitals without a doctor

Mr BRAD HAZZARD: Can I just say that the secretary is being very nice, saying she might be able to do that, but I know I have asked that question in the past and I was told it was a massive amount of work to go back and try to work that out. Right at the present we are in the middle of a COVID pandemic and floods, so I just ask that—
The Hon. COURTNEY HOUSSOS: Minister, I appreciate that. Ms Pearce has just taken it on notice. I am interested to know how many regional hospitals were left without a doctor over the Christmas period as a result of the COVID cases.
Mr BRAD HAZZARD: Many local regional hospitals work on the basis of the local GPs being on call into the hospital, so it is not that simple to categorise that.
The Hon. COURTNEY HOUSSOS: Yes, I understand that, but I am interested to know. This is a specific—
Mr BRAD HAZZARD: We will do as best as we can, but I am just highlighting that that is the system that operates.
The Hon. COURTNEY HOUSSOS: Yes, that is fine.

ANSWER:

I refer the Member to the response provided at LC 8298.

Q22/121

Transcript page: 25

Increase in funding for sexual violence services

The Hon. EMMA HURST: I only want to know about sexual violence services. I am splitting those up. I think where a lot of this confusion is coming from is that, yes, there is a lot going into domestic and family violence, which is desperately needed, of course, but that there seems to be this neglect on these sexual violence services. You mentioned, Dr Lyons, that there are other sexual violence-specific services in New South Wales. Have you received requests from any of those services for increased funding as well?
NIGEL LYONS: Not to my knowledge.
The Hon. EMMA HURST: Are you able to take that on notice to confirm?
NIGEL LYONS: Yes. Happy to do that.

ANSWER:

NSW Health provides a network of Sexual Assault Services (SAS) to respond to sexual assault (both adult and child) in NSW. The full list of NSW Health SAS locations is available online at: https://www.health.nsw.gov.au/parvan/sexualassault/Pages/health-sas-services.aspx.

NSW Health also funds two non-government organisations responding to sexual violence: the Survivors & Mates Support Network (SAMSN) and Full Stop Australia (FSA) (formerly Rape & Domestic Violence Services Australia). Both SAMSN and FSA also receive funding from other sources, including other NSW Government funding for SAMSN and Commonwealth funding for FSA.

NSW Health has funded FSA for nearly 50 years, providing over $1.5 million for the NSWSexual Violence Helpline in 2020-21. FSA has made recent funding submissions to the Ministry of Health and other NSW Government agencies, including the Department of Communities and Justice (DCJ).

Any pre-budget submission from an organisation is considered as part of the annual budget process.

Q22/122

Transcript page: 26

Increase in sexual violence services during COVID-19

The Hon. EMMA HURST: Thank you. Has the presentation at sexual violence services increased during the pandemic in the same way as we have seen an increase in the presentation in domestic and family violence services?
Mr BRAD HAZZARD: Do you know that, Dr Lyons?
NIGEL LYONS: I have not got the details. We will take that on notice, thanks.
Mr BRAD HAZZARD: We will have to take that on notice, I think, Emma.

ANSWER:

In the period 2018-19 to 2019-20 there was an increase in the number of service events in NSW Health Sexual Assault Services and the number of individual clients. Unfortunately, data for 2020-21 is not yet available.

The *NSW Recorded Crime Statistics Quarterly Update June 2021* produced by the Department of Communities and Justice's Bureau of Crime Statistics and Research (BOCSAR) indicates that sexual assault showed a significant upward trend in the 24 months to June 2021. More detail can be found online at: https://www.bocsar.nsw.gov.au/Pages/bocsar_media_releases/2021/mr-NSW-Recorded-Crime-Statistics-Quarterly-Update-Jun-2021.aspx#:~:text=In%20the%2024%20months%20to,Motor%20vehicle%20theft%20%E2%80%93%20Down%208.6%25

Q22/123

Transcript page: 27-28

Death at Junee Correctional Centre and findings

Mr DAVID SHOEBRIDGE: No. I will come to you, Ms Pearce, in one sec. We found out from Corrections budget estimates earlier this week that the man who died alone in his cell after being diagnosed with COVID, who apparently had comorbidities that made him more vulnerable to COVID, was put on the transport list to be taken—
Mr BRAD HAZZARD: From Junee?
Mr DAVID SHOEBRIDGE: —from Junee to Sydney but was then removed from the transport list and left by himself in the cell overnight, during which he died. Were you aware of that?
Mr BRAD HAZZARD: No.
Mr DAVID SHOEBRIDGE: Ms Pearce?
SUSAN PEARCE: Look, Mr Shoebridge, I can make some high-level comments in respect to what we did after that, not in regard to that particular example that you just gave about the transport. On 3 February there was a multidisciplinary review from NSW Health on site at Junee to look at infection control practices. The review team found improvements were required to personal protective equipment and cleaning practices in the management of COVID-positive patients, the administration of boosters and other governance arrangements. Those findings have been communicated to Corrective Services NSW for action and follow-up and, as the contract signatory, Corrective Services are responsible for that follow-up and rectification plan. We will certainly have an interest in ensuring that those things have been attended to, and we would need to take other aspects of this on notice.
Mr DAVID SHOEBRIDGE: Are you in a position to table that review with the Committee?
SUSAN PEARCE: I would have to take that on notice, Mr Shoebridge.
Mr DAVID SHOEBRIDGE: I understand. I am more than happy if it gets taken on notice. Was Justice Health or Health advised of the fact that the man who died alone in his cell without medical treatment had been taken off the transport list?
SUSAN PEARCE: I would have to take that on notice. I am not aware of that.
Mr BRAD HAZZARD: There is no-one here from Justice Health and we were not notified that we were going to be asked questions specifically on Justice Health, so we will have to take it on notice.

ANSWER:

I refer the Member to the response provided at LC 8465.

Further, on 3 February 2022, a multi-disciplinary review from NSW Health led by the Network conducted an onsite review of infection control practices at Junee.

Attached is a copy of the review.

Q22/124

Transcript page: 28

Death of Jonathon Hogan

Mr DAVID SHOEBRIDGE: Minister, I accept you have a genuine concern. I accept you respond when matters are raised with you. This is, given the heat of matters that we have had to deal with, the earliest possible opportunity I have had to raise it. I am not doing this as a gotcha moment in any way. Minister, could I ask you, when you review that concerning evidence that we had from Corrections about the man being taken off the list, to also review the fact that this same facility, Junee, has had two coronial reports in the last two years about other deaths—both of those are First Nations men—where there are a series of caustic, very negative findings against Junee for inadequate health care? Ms Pearce, were you aware of those two relatively recent coronial findings, one as recent as November last year, pointing out the inadequate health care provided at Junee?
SUSAN PEARCE: Not in detail, Mr Shoebridge.
Mr DAVID SHOEBRIDGE: To assist, the first in terms of the coronial report was into the death of Jonathon Hogan, a young Wiradjuri and Murrawarri man who died on 3 February 2018. That coronial report was delivered in, I think, May 2020. It made a series of recommendations about trying to address the grossly inadequate mental health services at Junee. Do you know if those recommendations have been implemented?
SUSAN PEARCE: I would need to take that on notice, Mr Shoebridge.

ANSWER:

I refer the Member to the response provided at LC 8465.

Q22/125

Transcript page: 28-29

Death of Danny Keith

Mr DAVID SHOEBRIDGE: Which is exactly why I am here, Minister. The second death was the death of Danny Keith Whitton who died in November 2015 after an overdose of paracetamol. Again, a whole series of deeply critical findings about the lack of training, the lack of adequate attention, failing to escalate his deteriorating condition and have him taken to hospital—those findings and recommendations were delivered on 19 November 2021. Can you indicate if you can, as soon as you can on notice, the extent to which those recommendations have been implemented that you are aware of?
Mr BRAD HAZZARD: Absolutely, if we can find out, and we will do what we can to find out what they have done. I am happy to talk to you offline about it because I share the same concerns if that is what is going on.

ANSWER:

I refer the Member to the response provided at LC 8465.

Q22/126

Transcript page: 29

Clinical Services Plan for Forster-Tuncurry Hospital

The Hon. COURTNEY HOUSSOS: I understand that. Minister, this says that the Forster-Tuncurry hospital will actually be set up as a satellite urgent care centre. Ms Pearce, you might be best placed to explain this. How many nurses are likely to be employed at an urgent care centre?
SUSAN PEARCE: I think we would have to take that on notice, noting that an urgent care centre is a different proposition to an emergency department. Dr Lyons, did you have any comments to make on that?
NIGEL LYONS: We will have to take that on notice because it will depend on the volume of patients that are likely to be seen through the centre. The minimum staffing you would have on would be two on each shift, so there would be at least two every shift of the day, three shifts a day, seven days a week. It may be that there is more staff than that because of the volume of patients likely to be seen. We will take it on notice.
Mr BRAD HAZZARD: Sometimes what they are doing is they are looking at the particular demographic. I think Forster-Tuncurry has an older population more likely to come in and it depends on whether there are other GPs in town and what is the likelihood of the numbers coming through. There are a whole lot of other factors that would need to be sorted out on that front.
The Hon. COURTNEY HOUSSOS: The clinical services plan goes through the fact that there is a low number of GPs in the area and, therefore, it would be a nurse-practitioner-led model. It also goes on to talk about the need to consider an aged-care model obviously given the demographics. Ms Wark, can I turn to you because I asked you about the hospital in March last year? You said at the time that we would need to wait for the clinical services plan before we would start the planning for the hospital. Have you purchased the land for the hospital now that the clinical services plan has been completed?
REBECCA WARK: No, we have not, but we have done a site investigation report and investigated approximately 10 sites as possibilities.
The Hon. COURTNEY HOUSSOS: Do you have a time frame for purchasing the land?
REBECCA WARK: The clinical services plan will need to be approved by the Ministry of Health and then we can do some planning concurrently with that.
The Hon. COURTNEY HOUSSOS: Do you know when the clinical services plan will be signed off by Health? Do you have a time frame for that?
REBECCA WARK: No, I will have to take that on notice.

ANSWER:

Comprehensive clinical services planning was undertaken by the District to determine the future range of health services required for communities in the region.

The Ministry of Health has approved the Lower Mid North Coast Clinical Service Plan (CSP). As the CSP is sector-wide, it informs the future service needs and priorities for the entire Lower Mid North Coast Sector, including Forster Tuncurry.

Q22/127

Transcript page: 30

Funding for Forster-Tuncurry Hospital

The Hon. COURTNEY HOUSSOS: I understand. If you are happy, Minister, perhaps you could take that one on notice and give me a breakdown of how much of that $7.9 million went towards the Forster-Tuncurry hospital project.
Mr BRAD HAZZARD: I am happy to take it on notice. I would be surprised if they could actually do that, but maybe.

ANSWER:

The NSW State Budget 2020-2021 included $7.9 million for Planning Future New Works, including hospital and health facilities in Forster-Tuncurry, Grafton, Gunnedah, Moree and Ryde, a new helipad at Port Macquarie Hospital and the John Hunter Hospital car park.

For planning future new works at Forster-Tuncurry, activities will include clinical planning, site review and selection process, and due diligence.

Q22/128

Transcript page: 30

Campbelltown Hospital Emergency Department

The Hon. WALT SECORD: Minister, I want to take you to south-western Sydney hospitals and the new emergency department at Campbelltown Hospital. I understand that the capacity for the emergency department is a 67-bed facility. When will the emergency department operate at that capacity?
Mr BRAD HAZZARD: I cannot answer that straight off. I would have to take it on notice. I know I was down there a couple of weeks ago. Have you been down to look at it?
The Hon. WALT SECORD: Not in the last couple of weeks but in the last few months.
Mr BRAD HAZZARD: You should go and have a look. It is incredible. That new acute services building I think is about eight or nine storeys and it has been built for future capacity because Campbelltown and that south-western region is growing. Some of the areas may or may not be opened immediately, which was also adopted under the former Labor Government. If you have cranes on site and building on site, it is cheaper to build for today and tomorrow. The question you have in terms of a—
The Hon. WALT SECORD: The question I had was specific. When will the emergency department operate at capacity? If you do not know, Minister, you can take it on notice.
Mr BRAD HAZZARD: I am just saying it may not be known at this point because it depends on future growth in that local area, but it is quite amazing and I know everybody is very keen to get in there as soon as possible.

ANSWER:

In mid-2022 the Emergency Department will move to its new larger space and initially operate at the capacity required to meet current demand for emergency care. Additional beds will open as part of the Emergency Short Stay Unit. Overall there is capacity for 82 beds in the Emergency Department and a staged approach will be taken to open the additional beds over time and in response to future demand for emergency care.

Q22/129

Transcript page: 31-32

Children travelling from Macarthur to Randwick and Westmead

The Hon. WALT SECORD: Based on what you have said about Westmead and Randwick, how many people or how many families—how many children—actually make the trip per week from the Macarthur region to Randwick and to Westmead? If you are unable to provide that answer today, please take it on notice.
Mr BRAD HAZZARD: That would not necessarily be easily done.
The Hon. WALT SECORD: Yes, it would be.

Break in transcript

The Hon. WALT SECORD: Minister Hazzard, in our earlier exchange I asked you to take on notice and you did not really take it on notice—I wanted to know the number of children and families that seek services at Randwick or Westmead Hospital, and you did not take that on notice.
Mr BRAD HAZZARD: Over what period do you want it?
The Hon. WALT SECORD: I would like to know in the last financial year.
Mr BRAD HAZZARD: I will take it on notice. I am not going to guarantee that we will give you the answers because, if it takes an enormous amount of work from Health, it is not warranted. But if we can get it out of Health, I am happy to do it because I would be interested to know too. Can I ask, Mr Chair, who is speaking next?

ANSWER:

For the 2020-2021 financial year, Sydney Children's Hospital Network cared for over 170,000 children. This is reported in the 2021 Sydney Children's Hospitals Network Annual Review 2021 which is available at: https://www.schn.health.nsw.gov.au/about/network-management/corporate-strategic-information.

Whilst children are treated locally at Campbelltown and Camden Hospitals, the average number of patients per week who attended The Children's Hospital at Westmead or the Sydney Children's Hospital, Randwick from the Macarthur region was 60 and 28, respectively.

Q22/130

Transcript page: 32

New Clinical Services Plan for Hunter New England Local Health District

The Hon. COURTNEY HOUSSOS: Ms Pearce, I wanted to ask one final question on the Forster Tuncurry hospital. The existing clinical services plan for Hunter New England expired in 2017. Do you have an estimated date of when that clinical services plan will be signed off by the ministry?
SUSAN PEARCE: I would have to take that on notice. Could I just make one further comment with respect to the south-west, however, regarding population growth. The Health funding model very significantly accounts for population growth and I think we did raise these issues in the inquiry regarding the South Western Sydney Local Health District. I can advise the Committee that over the past 10 years, that area has had a 73 per cent increase in budget, the highest increase of any local health district in New South Wales.

ANSWER:

The Ministry of Health has approved the Lower Mid North Coast Clinical Service Plan (CSP). As the CSP is sector-wide, it informs the future service needs and priorities for the entire Lower Mid North Coast Sector, including Forster Tuncurry.

Q22/131

Transcript page: 37-38

Leptospirosis cases

The Hon. EMMA HURST: I want to return to zoonotic disease outbreaks, which we seem to be talking a lot about recently. Earlier this week SafeWork NSW put out a press release urging people to be wary of floodwaters and muddy soil that could be contaminated with leptospirosis. Have we seen any cases in New South Wales of leptospirosis? What is the current situation?
Mr BRAD HAZZARD: On that one, I will absolutely defer to Dr Gale because leptospirosis is not my area of expertise.
MARIANNE GALE: In the context of floodwaters, leptospirosis is always something that we watch out for carefully. We know that in certain parts of the State and up north in the past we have had some localised outbreaks of leptospirosis. It is certainly something that we are vigilant about. As to the current case numbers, I do not believe there are any but I will come back to you. I am happy to take that on notice as to an update on any cases and also the measures that have been taken. In the context of floods—and it has occurred in the past in parts of the State, outbreaks of the disease leptospirosis—I am happy to take it on notice and come back to you with some details.

ANSWER:

Leptospirosis is currently at usual levels in NSW, with 3 confirmed cases so far in 2022. Any impact from the floods remains to be seen.

Up-to-date counts of leptospirosis notifications are available online at: https://www1.health.nsw.gov.au/IDD/#/LEPTO/.

Q22/132

Transcript page: 40

Paramedic/nurse at Yass Hospital

Mr BRAD HAZZARD: Sorry, can I interrupt for two seconds? I have just been advised by the secretary that she wants to clarify. The Hon. Walt Secord, you asked about Yass before?
The Hon. WALT SECORD: Yes.
Mr BRAD HAZZARD: Ambulance have given us information which, nuanced a little bit, needs to be clarified in relation to the person who was brought in that was a paramedic and a nurse. We now think it is possible—we have got to do some more checking but we want to put it on notice—that the person was a paramedic and a medic, as I understand it. We will take that on notice to clarify once we pin it down, having in mind the diverse advice that we have got at this point, which just happens in such a big system.

ANSWER:

On 31 December 2021, 1 and 2 January 2022, a NSW Ambulance paramedic was deployed to the Yass Hospital Emergency Department, working within a multidisciplinary team, including a doctor who was available onsite 24/7.

The paramedic is registered with the Australian Health Practitioner Regulation Agency (AHPRA), and is a qualified Intensive Care Paramedic, and a Critical Care Paramedic.

A normal part of a Critical Care Paramedic's role is to attend small or regional hospitals and work alongside the existing staff to triage, assess, treat and stabilise patients.

At all times the paramedic operated within the approved scope of practice for their role.

Q22/133

Transcript page: 41

Body-worn cameras for paramedics

The Hon. WALT SECORD: In 2019—actually, I remember it from the estimates. It came from an afternoon session and we asked one of your departmental officials about a pilot involving body-worn cameras.
Mr BRAD HAZZARD: Yes. For security or for paramedics?
The Hon. WALT SECORD: For paramedics. It was announced that in November 2019 there would be three locations for a 12-month trial. What were the findings and recommendations of that?
Mr BRAD HAZZARD: It went well. The discussions that I have had with the chief executive of Ambulance are that it went well, and I have spoken to a lot of paramedics on the front line. It went well. What actually happened, though, is that it went on hold during COVID because suddenly the paramedics could not actually wear the camera on their clothes because they were covered with PPE. So it all came to a bit of a stalling halt. But the early indications in the trial while it lasted, pre-COVID and pre-PPE, were that it worked well. I am not sure whether they have now got to a point where—because not all paramedics are wearing PPE all the time now. I am just not sure where they got to. I am happy to take that on notice because it was something which was in my mind as well to ask the commissioner, but I have not asked him in the last few weeks.

ANSWER:

A pilot involving the use of body worn cameras by paramedics is occurring at three locations: the Sydney Ambulance Centre, the Liverpool Superstation, and the Hamilton Ambulance Station.

A reduction in the use of the devices coincided with the peak in COVID-19 response activity and the requirement to use PPE. The Surveillance Devices Regulation 2014 provides for the use of the cameras until 30 November 2023, which will allow the trial to generate sufficient data.

Q22/134

Transcript page: 43

Staff impact from transport strikes

Mr BRAD HAZZARD: Why not? Madam Secretary, could you answer the question please—the relevant issue in terms of the staff impacts by the railway line closure?
SUSAN PEARCE: Ms Houssos, we would have to take on notice the actual quantum of staff. If we can get that information for you, I would be happy to do that. What I can tell you is that every Monday we have a meeting with all of our chief executives across the State just to check how the weekend has gone and understand what Monday is looking like in terms of patient flow. As I recall, the train strike was on a Monday, if I am not mistaken.
The Hon. COURTNEY HOUSSOS: It was.
SUSAN PEARCE: We asked our chief executives during the course of that morning as to any staffing impacts that were associated with the transport strike. Certainly I am not saying that there were none. What I can say, though, is that the impacts were relatively limited, from what I can recall from those discussions, but we can take on notice the specifics for you.

ANSWER:

Data relating to the impact of the transport strike is not centrally available.

Q22/135

Transcript page: 45

Continuity of Care

The Hon. COURTNEY HOUSSOS: How many hospitals currently offer the continuity of care model?
NIGEL LYONS: I would have to take that on notice and get the detail of that, but there are many hospitals that offer community midwifery programs and continuity of care through midwife practice.
The Hon. COURTNEY HOUSSOS: Can you also provide if any of them do outreach specifically with CALD communities?
NIGEL LYONS: Certainly.
Mr BRAD HAZZARD: Sorry, what was that question?
SUSAN PEARCE: CALD communities. I do not know whether the Chief Nursing and Midwifery Officer would like to comment, but certainly the last time I looked at this, all of our local health districts had midwifery continuity of care models and they are quite extensive across the State.

ANSWER:

NSW Health supports a variety of models of care to increase continuity of midwifery care.

An updated NSW Health *Maternity Care Policy* will be released during 2022. Whilst NSW maternity services already have strongly embedded continuity of care models, the policy will guide local health districts in their development of sustainable programs that address specific local needs, including Aboriginal and culturally and linguistically diverse women and families.

Q22/136

Transcript page: 46

Alternatives to animal research

The Hon. EMMA HURST: Sorry, to clarify, it is a little bit different. The use of animals in research, yes, they are supposed to meet certain criteria to use those animals and they do look at alternatives and they are required to, but what I am actually talking about is research into the alternatives to actually switch it. The UK and the US have specific funding available for researchers to find alternatives. One alternative that people are looking at at the moment is the forced swim model where they drown animals in water. So people are actually trying to say, "Can we look at depression under a different model that does not use animals in that way?" There are a lot of different governments around the world that have specific funding to look into research. Can we do this on tissues?
Mr BRAD HAZZARD: I would be very sympathetic to that position, but I would like to take some advice from those who are more expert than I am in it. But if at all possible, yes, I would support it. But I guess it depends on if there are research funds available and it is limited and it is going to save, for example, lots of little kids or something with research. I would want to know what the balancing act is, but, first principles, I agree with you. If we can avoid having as much as possible any research involving animals, that would be fantastic. I totally agree. The rest of it I will take on notice, if you do not mind.

ANSWER:

I refer the Member to the response provided at Portfolio Committee No. 2 – Health and Medical Research – Budget Estimates Hearing – 4 November 2021 – question on notice – transcript page 44-45.

Q22/137

Transcript page: 47

Current policy directive on animal research

The Hon. EMMA HURST: On the New South Wales medical research website there is a policy directive entitled "Human and Animal research and the National Health and Medical Research Council Act 1992". This policy is listed as being obsolete since September 2018 and does not seem to have been updated since then. Are you able to explain why there does not appear to be any kind of current policy regarding animal research?
Mr BRAD HAZZARD: I will ask Dr Penna whether he can answer that and if he cannot, we will take it on notice.
ANTONIO PENNA: I think we will need to take it on notice. I need to find out why.
The Hon. EMMA HURST: Thank you, if you do not mind. I have a couple of other questions you probably would want to take on notice because they are follow-on questions from that. Are there plans to update that policy? I note that there are current policies on the same page surrounding human research, so it is actually quite unclear why animal research has been left out there. Where would people working within NSW Health look for guidance regarding the rules and ethics surrounding animal research in the absence of a current policy?
ANTONIO PENNA: At the moment a lot of that is on the Department of Primary Industries regarding the ethics and scientific review of animal research. But we will look into all of that to ensure it is all covered.

ANSWER:

The Policy Directive on Human and Animal Research and the National Health and Medical Research Council Act (NHMRC) 1992 (PD2010_057) was made obsolete in September 2018.

Relevant and specific legislative and policy requirements affecting human research are set out in individual NSW Health policy directives. As such, on review of PD2010_057, it was deemed unnecessary to have an additional policy that merely provided a generic reference point for overarching Acts and non-Health policies.

Legislation and non-Health policies related to animal research are primarily the responsibility of the NSW Department of Primary Industries (DPI) and the National Health and Medical Research Council (NHMRC). All relevant requirements are listed in detail on both the DPI and NHMRC webpages as the governance bodies for those legislation, policies, committees and panels. The obligation to follow the law does not depend on the Act being listed in a separate NSW Health policy mandating that obligation.

I am advised the Office for Health and Medical Research will update its website to include references to both the DPI and NHMRC information so people working within NSW Health can find where to look for guidance on animal research. This approach avoids unnecessarily replicating information from those sources.

Q22/138

Transcript page: 47

Paramedics in Wollondilly

The Hon. COURTNEY HOUSSOS: Minister, I would like to ask you about if you are aware of the concerns raised by residents living in the Wollondilly region about significant delays in their access to paramedic treatment?
Mr BRAD HAZZARD: I am not specifically aware of that, no.
The Hon. COURTNEY HOUSSOS: My understanding is that your Government made a commitment to recruit an additional 12 paramedics for that area over the course of this term of Parliament. Is that correct?
Mr BRAD HAZZARD: I have not made that undertaking, but what we did do is we announced—it was before COVID so would have been about three years ago, down at then Ambulance headquarters with Gerard Hayes from the HSU—that we were employing another 750 paramedics over this next few-year period, and maybe out of that Ambulance decided that there were going to be allocations for particular areas. I can ask Ambulance for you and give you an answer on notice. That level of allocation I am not familiar with.
The Hon. COURTNEY HOUSSOS: Could you provide us with an answer specifically on the 12 that were slated for Wollondilly?

ANSWER

I refer the Member to my response to LA 7233.

Q22/139

Transcript page: 50

Survey dates for nursing hour's wards

The Hon. COURTNEY HOUSSOS: Mr Minns, are you able to provide on notice the dates and in which wards the surveys were conducted? Is that possible?
PHIL MINNS: Yes, it would be with respect to the nursing hours' wards, the 380 or thereabouts.

ANSWER:

Local Health Districts provide weekly reports to the NSW Ministry of Health on Nursing Hours per Patient Day (NHPPD) compliance in the 382 NHPPD wards. The Ministry collates and produces reports each quarter for the previous six months based on returns received from Local Health Districts.

Q22/140

Transcript page: 51

Coal Ash Inquiry

Ms ABIGAIL BOYD: The Public Works Committee held an inquiry into coal ash repositories, about which I think we once had a small chat. One of the recommendations in that inquiry was that NSW Health undertake an assessment of the health of residents near a coal ash dam to establish the health impacts. In that inquiry, although it was acknowledged there were health impacts, a lot of research is yet to be done to work out what that looks like. In the Government response, the response was, "NSW Health is committed to understanding the impacts of coal ash on the health of communities." It then goes on to say, "NSW Health will propose alternative study types"—alternative to the epidemiological assessment that was suggested—"which are better able to address the community's health concerns." I just wanted to see where that was up to, just off the top of your head.
Mr BRAD HAZZARD: What an excellent question, Abigail. Thank you for that. Coal ash, as in like next to power stations, is that what we are talking about?
Ms ABIGAIL BOYD: Yes, it is kind of leaching into the water.
Mr BRAD HAZZARD: I vaguely recollect you raising that once before, and I do recollect many years ago there were some concerns about selenium, I think; there were some arguments about it possibly causing fish with two heads and various things.
Ms ABIGAIL BOYD: It does, yes.
Mr BRAD HAZZARD: But, interestingly, selenium is in hair shampoo and other things but in a different form. Is anyone here at this table of learned health experts able to contribute to this?
MARIANNE GALE: No, but I am happy to take it on notice.
Mr BRAD HAZZARD: Sorry, Abigail.
Ms ABIGAIL BOYD: That is okay. Yes, if someone could take on notice what is being done in relation to that response.

ANSWER:

The Environmental Health Branch and the Hunter New England and Central Coast Public Health Units are currently in discussion with the Environmental Protection Authority (EPA) about a joint approach to community engagement to inform alternative study types that are better able to address the community health concerns. I am advised that NSW Health are planning to engage the community in the coming weeks in partnership with EPA.

Q22/141

Transcript page: 52

Funding for women health centres

Ms ABIGAIL BOYD: Can we turn back to the funding for women's health services, in particular in relation to trauma and other issues connected with sexual assault? In fact, sorry, slightly differently, the women's health centres in New South Wales. I understand that they have had no increase in core funding since 1986. Except for restricted indexation and award variations, they have had no increase in their funding. Why is that? Will the New South Wales Government look to increase the funding to women's health centres?
Mr BRAD HAZZARD: I hope that is not exactly correct. Maybe it has gone up at a certain ratio, but I hope it has. Can I ask, Dr Lyons, do you know anything about that?
NIGEL LYONS: I do not know the specifics of the women's health centres, but with our non-government organisations we provide support to ensure that there are increases that reflect our increases of salaries and wages and goods and services costs each year. So that might be the indexation you are referring to that has gone up and not an increase in terms of service enhancement. That is what I think you were alluding to.
Ms ABIGAIL BOYD: Or even the CPI increases.
NIGEL LYONS: For all of our non-government organisations, the relationship includes any increases that would include wages and CPI costs.
Mr BRAD HAZZARD: In my 5½, almost six years as Minister, I have never come across an organisation who has not got growth money each year. Maybe what they are saying is they have not had a big expansion of funds beyond the normal growth stuff. Do you have any details of the particular ones you are talking about?
Ms ABIGAIL BOYD: Perhaps if you could take that on notice.

ANSWER:

I am advised that historical data sets indicate NSW Health has provided funding increases of more than 75 per cent to NGO Grant Program recipients over the last 30 years, reflecting an annual increase of approximately 2.5 per cent. It is understood that this exceeds National CPI rates for the same period (based on ABS data “All Groups” at June each year).

This funding is in addition to Social and Community Services Equal Remuneration Order funding increases provided to eligible NGOs, noting that this arrangement has provided funding increases exceeding 15 per cent over the last decade to assist eligible NGOs to meet the costs of salary increases associated with the Order.

In 2021-22, NSW Health is providing $12.2 million in grant funding to 20 Women’s Health Centres across NSW. Funding to centres is administered by the relevant local health district who also oversee the agreements with centres and continually work with them to monitor service demand and their capacity to respond to women’s health and wellbeing needs.

Q22/142

Transcript page: 52

Increase in funding for sexual, domestic and family violence healthcare pathways

Ms ABIGAIL BOYD: Sorry, I am going to start again. The question is in relation to the sexual, domestic and family violence healthcare pathways, which I understand is a program that is currently being funded. Is there going to be any increase in that funding to take into account the impacts of COVID-19 on the rate of sexual, domestic and family violence in New South Wales, which has been increasing under COVID-19?
Mr BRAD HAZZARD: We were talking before—I think it may have been Emma who raised it initially; it may have been you, but Emma raised some of it as well. I think there have been increases. Dr Lyons, do you have any specifics on that?
NIGEL LYONS: I have not got any specifics. I did talk in response to a question previously this morning about that pathway that we have invested in to provide that support, recognising that there have been issues in relation to COVID. But I do not have an answer on whether there is likely to be more funding provided, so I will take it on notice.

ANSWER:

In 2021-22, NSW Health is providing $12.2 million in grant funding to 20 Women's Health Centres across NSW. Funding to centres is administered by the relevant local health district who also oversee the agreements with centres and continually work with them to monitor service demand and their capacity to respond to women's health and wellbeing needs.

The Sexual Domestic Family Violence Healthcare Pathways (SDFV Healthcare Pathways) is an initiative proposed in the Women's Health Centre's Pre-Budget Submission 2022-23.

I am advised that relevant initiatives have been proposed as part of the pre-budget submission process for 2022-23.

Q22/143

Transcript page: 53

Housing and Mental Health Agreement

Ms ABIGAIL BOYD: The Housing and Mental Health Agreement, which I understand was going through review and had quite a lot of consultation, where is that up to in terms of implementation process for the new HMHA?
Mr BRAD HAZZARD: I think it has largely been managed through the Minister for Mental Health's office. Does anybody at this table have any capacity to answer any of that or should we take it on notice?
NIGEL LYONS: I think we will need to take it on notice. I am just looking to see whether I have got anything.

ANSWER:

Following extensive consultation, the new 2022 Housing and Mental Health Agreement (HMHA) has been approved and will be published on the NSW Health website shortly.

I am advised that a Service Delivery Framework and Governance Framework are being developed to support implementation at state, district and local levels, and any funding required to facilitate implementation will be considered through these processes.

Q22/144

Transcript page: 54

Co-location of domestic and family violence services

Ms ABIGAIL BOYD: I understand there was a domestic and family violence service hospital co-location pilot project in six New South Wales hospitals. When will the evaluation results be available for those?
Mr BRAD HAZZARD: We might as well harass Dr Lyons again.
NIGEL LYONS: What was that about? Sorry, I was looking for the other one.
Mr BRAD HAZZARD: Can you repeat that please, Abigail?
Ms ABIGAIL BOYD: There are many varied questions here. It was looking at the co-location of domestic and family violence services within six New South Wales hospitals. There was a pilot project done.
NIGEL LYONS: I am not sure about the co-location. I know we have done a lot of work with domestic and family violence in relation to screening programs and new models of care, but I am not aware of that one. So we will need to take that on notice, I am sorry.

ANSWER:

NSW Health undertook a pilot of Domestic Violence Routine Screening in Emergency Departments (DVRS in EDs), which aimed to improve screening, identification and response to victims of domestic violence in busy regional and metropolitan emergency departments. The pilot was funded by the Commonwealth Government under the Health Innovation Fund.

I am advised the twelve-month pilot ran from November 2020 to October 2021 in six emergency departments across three local health districts and that the evaluation is currently underway and scheduled for completion in 2022.

Q22/145

Transcript page: 54-55

Termination services in regional NSW

Ms ABIGAIL BOYD: Yes, the abortion law reform. We were hearing a lot about, especially in rural and remote areas, there being nowhere to go to get a termination. Have you got any oversight as to how that is tracking and what is needed to ensure that every woman can access a termination under that legislation?
Mr BRAD HAZZARD: I have not seen anything in the last little while. But I know it was a real issue because there was a service, for example, down near Wagga, I think it was, from memory, that was taking women from hundreds of kilometres away. It was a real challenge. First of all, I will ask the team. It is a selective intellect here.
NIGEL LYONS: I can offer some comments on that. That has been a big issue and we have been working very closely to do what we can to provide choices and advice for women who are in that position. The first thing to mention is that we introduced the NSW Pregnancy Choices Helpline, which was in October 2019. This gives people who call for advice about where they might be able to access providers in their location and support for how their specific needs might be able to be met, recognising that there are some challenges in some parts of the State in accessing those services.
We have also been having discussions with a range of non-government organisations about how we can have additional supports provided for access to terminations through the services they provide. Those are ongoing discussions, recognising that the vast bulk of the terminations that are actually provided in New South Wales are not provided in NSW Health services. They are actually provided in early pregnancy and usually by providers outside of what we do. The sorts of terminations we do in Health are always at the complex end of the spectrum and are usually those that are later in pregnancy. The vast majority of the other terminations are provided outside of our services. But we are very keen to ensure that women can access the care they need, and we are looking at how we can get some further non-government providers active in that space.
Mr BRAD HAZZARD: I stress that from the Government's point of view, obviously, the legislation is now in place. From the health Minister's point of view, I will be supportive of services that provide a holistic approach and obviously not just, "Here is the abortion" but all of the counselling that should go before it so people know and are given advice on what is a really challenging and awful decision they have to make.
Ms ABIGAIL BOYD: Perhaps on notice, if you could provide by local health district the number of, I guess, registered—
Mr BRAD HAZZARD: Available services.
Ms ABIGAIL BOYD: Yes, available services or registered providers.
Mr BRAD HAZZARD: I would be interested to know that too now because it has been, I think, a year and a half—no, because that was before COVID, was it not? It has been two years.
Ms ABIGAIL BOYD: Yes. If you could also put for the 12 months prior so we can just see how that is tracking and whether it is improving.

ANSWER:

Affordable and timely access to pregnancy termination is a whole of sector response shared by the public health system, private providers, primary care and accredited non−government organisations. The availability of pregnancy termination services offered by public hospitals

is determined by local health districts based on locally identified population needs and service capacity. NSW Health does not regulate or register private providers of termination of pregnancy services.

In October 2019, following the introduction of the *Abortion Law Reform Act 2019* (NSW), NSW Health implemented the Pregnancy Options Helpline to provide information on accessing services.

In May 2021, the Ministry of Health engaged Family Planning NSW to replace this service with an enhanced multiplatform service. The new NSW Pregnancy Choices Helpline and website assists NSW residents to find termination of pregnancy service providers that meet their specific needs, as well as pregnancy options support and counselling.

The dedicated website is written in plain English and includes translation into 10 community languages. Women can also call the Translating and Interpreting Service on 131 450 and ask to be connected to the Pregnancy Choices Helpline.

In 2021, Family Planning NSW was engaged to lead a new pilot service, called the SEARCH Project (Service Equitable Access to Reproductive Health services in regional NSW). Family Planning NSW is partnering with local services to support the delivery of community-based termination of pregnancy services and long-acting reversible contraception for women who experience barriers to services in regional NSW. The service model utilises Medicare arrangements, with NSW Health funds contributing to administration, workforce training and education, and auxiliary service costs.

The first pilot site, based in Newcastle and Hunter region, started service delivery in July 2021. Clinical service delivery includes pregnancy options counselling, surgical and medical termination of pregnancy, and contraception (including short term, long term, permanent, and fertility awareness-based contraceptive methods).

The SEARCH Project will be implemented across several other local health districts, including partnerships with Aboriginal Community Controlled Health Services, Rural and Remote Medical Services, general practice and Women's Health Centres.

Q22/146

Transcript page: 55

Cardiac surgery at Sydney Children's Hospitals

The Hon. WALT SECORD: Minister, I would like to return to cardiac surgery at Sydney Children's Hospital. You said that you were going to get one of your advisers to provide—
Mr BRAD HAZZARD: I was going throw it to Dr Lyons, if he has got that there.
NIGEL LYONS: Thanks for the question, Mr Secord. You are aware of all of the complexities around this particular issue, and the Minister has alluded to them as well. It is a very vexed clinical issue. The issue is that the tertiary services of paediatric cardiac surgery—the numbers of children requiring those surgeries have reduced down, because of technology and some of the other less interventional procedures that are now available, to around 350 children a year. Having that provided across the two sites was becoming increasingly challenging and so there has been a series of reviews around that, getting independent experts and everybody else involved.
Where the Sydney Children's Hospitals Network is at at the moment is that there is a service that is provided across both sites, but there is an emphasis on ensuring that the care is provided in the appropriate setting, depending on the complexity of care that is required in relation to the cardiac surgery. The more complex procedures are undertaken at the Westmead end, and there is the ability to provide appropriate cardiac surgery at the Randwick site. The advice I have is that there have been around nine or 10 procedures undertaken at Randwick of the non-complex nature. There is a joint service for both paediatric cardiology and paediatric cardiac surgery, and the teams are working jointly to ensure that there is appropriate access for children at the site that most appropriately meets their needs and provides the care that is safe and high quality.
The Hon. WALT SECORD: Do you have a breakdown of what occurs at Randwick and what occurs at Westmead?
NIGEL LYONS: I have not got that in front of me. We could provide that on notice, but the emphasis here is that, with 350 procedures or less, the ability to keep highly skilled paediatric cardiac surgeons undertaking the number of procedures that they need to do to maintain the skills required to maintain those services in a sustainable way is at a point where it would be impossible to have two rosters independent of each other.

ANSWER:

Cardiac services are currently being provided at both the Sydney Children's Hospital, Randwick and The Children's Hospital at Westmead, including Patent Ductus arteriosus ligation, pacemaker insertion and removal (not neonates), repair of vascular rings, pericardial effusion management, trauma and ECMO.

More complex and atypical cardiac surgery provided at The Children's Hospital at Westmead includes Complex Congenital Heart Disease and Hypoplastic Left Heart Syndrome.

Q22/147

Transcript page: 56

Wait times for cardiac surgery

The Hon. WALT SECORD: Dr Lyons, what is the current wait for cardiac surgery if your child is a patient at Randwick? And what is the wait if your child is at Westmead?
NIGEL LYONS: I do not have the waiting times for each site in front of me, Mr Secord, but I would say that the waiting times will be managed very carefully to ensure that children were categorised to ensure that those that had the highest needs were able to have their surgery as quickly as possible. I am aware that some of these surgeries have been undertaken at very short notice because the clinical situation with the baby or the child was such they needed that surgery in a very short time frame and that is accommodated.
The Hon. WALT SECORD: Could you take that on notice?
NIGEL LYONS: I will.

ANSWER:

Cardiac services are provided by the Sydney Children's Hospitals Network (SCHN) at both the Sydney Children's Hospital, Randwick and The Children's Hospital at Westmead. All patients are reviewed and considered by the SCHN Joint Cardiac Committee. There is not a separate waitlist for each site.

Q22/148

Transcript page: 56-57

Salary sacrifice

The Hon. COURTNEY HOUSSOS: Minister, I have asked you over many estimates about the issues around salary sacrificing for Health staff. This is something, obviously, that is being campaigned on by the HSU. My time is about to run out, so I am just interested in how much money—what did the New South Wales Government receive as a result of the salary-sacrificing arrangements for healthcare workers in the year 2021.
Mr BRAD HAZZARD: Is this the doctor arrangements?
The Hon. COURTNEY HOUSSOS: Salary sacrifice. You get 50 per cent—
Mr BRAD HAZZARD: Yes, I know. But it is actually a Federal issue. But I will ask Mr Minns if he can answer any part of that question.
PHIL MINNS: To give you the precise number for that year, we will take on notice.

ANSWER:

In 2020-21, Health employees saved more than $209 million through salary packaging arrangements. Likewise, the total tax savings for NSW Health was $209 million in 2019-20. The share of tax savings from salary packaging is retained by the Health entities, principally local health districts.

Q22/149

Transcript page: 57

Plant-based meals in hospitals

The Hon. EMMA HURST: Minister, at budget estimates back in 2019 I asked about the availability of plant-based options in New South Wales hospitals. I was told on notice that meat-free options are available at every meal, which is not quite the same as plant-based meals, which include no animal products whatsoever. Are you able to provide an update as to whether plant-based meals are available at every New South Wales hospital?
Mr BRAD HAZZARD: I can't right now. Does anybody know that, or do we take that on notice?
NIGEL LYONS: Take it on notice.

ANSWER:

I am advised the response provided to the question on notice taken on page 30 of the transcript at Portfolio Committee No. 2 – Health – Budget Estimates Hearing – 12 March 2020 remains accurate.

Q22/150

Transcript page: 58

Support for women with endometriosis

The Hon. EMMA HURST: Thank you. One of the conditions identified in the framework is endometriosis, which affects at least one in 10 women in Australia. Are you able to advise me of any work being done to particularly support women with endometriosis in New South Wales?
Mr BRAD HAZZARD: Can I just say that in terms of the endometriosis issue, you are well aware we have discussed that before. Of course, there is a national framework, too, that is relevant to guidance for the States and Territories off the back of the national framework. Again, Dr Lyons, would you like to respond?
NIGEL LYONS: I have not got anything specific about it, Ms Hurst. Of course, all of our services would be providing care to women who have endometriosis and there are a range of different treatments and options that are available which will be part of the services we offer. But in terms of the specifics, I will take that on notice.

ANSWER:

The NSW Government is one of many partners to the National Action Plan for Endometriosis. The Plan outlines a five-year strategy to improve awareness and understanding of endometriosis, speeding up diagnosis, and developing better treatment options.

Primarily, women with endometriosis will receive ongoing care and monitoring of their condition via their general practitioner, with support from community-based support services such as clinical nurse specialists, dietitians, exercise physiologists, lifestyle consultants or counsellors.

Further supports to women with endometriosis are provided in NSW:

- The NSW Women's Health Framework acknowledges the impact of endometriosis on women's wellbeing. The Framework guides NSW Health organisations' planning and delivery of high-quality services and programs for all women and girls, including those with chronic conditions such as endometriosis.
- In 2021-22, NSW Health is providing $12.2 million in grant funding to 20 Women's Health Centres across NSW. In addition, Ministerially Approved Grant funding of $251,000 will be provided to the peak body, Women's Health NSW. Many of these centres have in-house general practitioners who refer women presenting with symptoms indicating endometriosis for appropriate medical care.
- Further to primary health care and community-based support services, women may also be referred to pain specialists in pain clinics at local health districts, where multidisciplinary teams use a range of tools to tailor pain management plans to each individual. This may include pain management through mental health supports or exercise programs.
- A number of local health districts also have locally agreed clinical pathways between primary and secondary care for NSW clinicians focused on endometriosis or chronic pelvic pain.

Q22/151

Transcript page: 59

Hospitalisation of children for vaping

The Hon. WALT SECORD: I remember a number of years ago I followed this closely and I am coming back into it. Dr Gale, you mentioned there have been hospitalisations and things like that. Do you have data on the number of children or number of appearances at emergency departments and hospitals due to minors vaping and causing themselves injury?
MARIANNE GALE: I certainly know of some specific instances of people who had severe experiences, but I would be happy to look into that and take that on notice.

ANSWER:

Discrete data about children's hospital attendances related to use of e-cigarettes or vapes is not available.

Emergency Department data captures presenting problems, rather than underlying causes, so presentations are not always readily linked to vaping. Children and young people may present to hospital with a range of respiratory symptoms or fever of unknown origin. For example, E-cigarette or Vaping Associated Lung Injury (EVALI) is established retrospectively once a range of other differential diagnoses have been ruled out.

Q22/152

Transcript page: 60-61

Palliative care unit at Westmead

The Hon. WALT SECORD: Minister, this is to you or to the appropriate official. Given the Government's commitment to and announcement about the reopening of the palliative care unit at Westmead, can you update the Committee on where the commitment is up to?

Mr BRAD HAZZARD: You would know, Mr Secord, that palliative care has been one of the big areas of concern for the Liberal-Nationals Government. It does not matter whether it is at Westmead or in any of our hospitals right across the State, palliative care is a vital service for people who may not be immediately at end of life but certainly there are periods where towards the end of our lives palliative care is of vital assistance. There have been very substantial funds put into palliative care under the Coalition Government. You would remember that a commitment was displayed when we had more than 20 roundtable conferences around the State with local staff and local community members to talk about what was necessary.

In fact, one of my proudest moments, not in the city area but in the furthermost part of the State, was to attend Broken Hill hospital to see the incredible outreach of palliative care services that were being done there and the pride of the palliative care staff, who were reaching out to the individuals in their homes—Aboriginal and non-Aboriginal—and travelling for hours in some cases to get to their homes to be able to give them the appropriate services and support that were necessary.

Westmead is one part of a massive effort and approach in relation to palliative care. I have obviously visited many of these facilities in my time as health Minister. Westmead has a particular facility where palliative care is offered, but it is for patients who are currently in with others who require a range of other very serious clinical attention. That service, in my view, would be best delivered, as advised to us by a number of the palliative care specialists out of those roundtable forums, if it could be done in a specialised palliative care structure. By that I mean a ward that would allow for the individual patients to be cared for by appropriately qualified nurses, doctors and allied health staff, but also to allow, most importantly, for family to be very much part of that palliative process. A lot of the older facilities generally do not have, for example, spaces for families to sit quietly with their loved ones during the journey, which can be many months or indeed years on occasions.

Westmead has a good facility, but it is not as good as I think it can be. I have asked the western local health district, as part of the rebuild of Westmead—and you would know there is vast amounts of money being spent at Westmead—to try to ensure that there is a dedicated ward that is in that facility. The last advice I have is that it is proceeding with the planning of that proposal. I cannot give you an absolute deadline on the timing at this point, but I am happy to take it on notice and get that from the local health district as soon as I can and, of course, provide the answer to this Committee.

The Hon. WALT SECORD: As part of the taking on notice, if you could tell us where the commitment is up to as of this week and the time line for when it will be operational, and maybe the funding allocation for this year's budget for that project.

Mr BRAD HAZZARD: Sure.

ANSWER:

Western Sydney Local Health District (LHD) received the final report for the independent Clinical Palliative Care Review late last year.

The report and its recommendations have been accepted by the Western Sydney LHD, including a recommendation that there should be a dedicated acute palliative care ward developed at Westmead Hospital.

Western Sydney LHD has set up a Palliative Care Governance Working Group to oversee and prioritise the report's recommendations.

Q22/153

Transcript page: 62-63

Resignation of nurses

The Hon. COURTNEY HOUSSOS: I appreciate that, Minister. I want to move on to the question of resignation of nurses. Do you have a figure on how many nurses have resigned since 15 December?
Mr BRAD HAZZARD: Since 15 December?
The Hon. COURTNEY HOUSSOS: Yes.
Mr BRAD HAZZARD: Was that when the compulsory—
The Hon. COURTNEY HOUSSOS: When the restrictions were lifted.
Mr BRAD HAZZARD: Are you talking about the mandatory restrictions?
The Hon. COURTNEY HOUSSOS: Yes.
Mr BRAD HAZZARD: All up, I think Health had—out of 170,000 staff I think there were approximately 1,000. I will ask Mr Minns.
The Hon. COURTNEY HOUSSOS: Just to clarify, this is not about the vaccination status; this is about how many nurses have left since 15 December.
Mr BRAD HAZZARD: Okay.
PHIL MINNS: I will not be able to give you the rates since the 15th.
Mr BRAD HAZZARD: Why the 15th?
PHIL MINNS: I will take it on notice.
The Hon. COURTNEY HOUSSOS: That is when restrictions were lifted.
PHIL MINNS: But we have done some analysis of what is happening to our separation rates. Over the long term, our retention improved through the first period of COVID, reflecting, I think, a commitment of staff to support the system through what it was experiencing. We have seen a slight increase in separations in the period after Delta—so from about September. There is an increase in separations in the month of January, for the whole month, but that is pretty standard as a seasonal time when people choose to end their employment in the system. I will give you the correct answer on notice, but if we have seen a change at all in the last quarter, it is in the order of less than 1 per cent. But I will confirm that precisely.
The Hon. COURTNEY HOUSSOS: If you could give me the figure for that particular period and then for the same period the previous year that would be helpful.

ANSWER:

There is continuous movement in the nursing workforce across the year that aligns with seasonal activity variation. As such, NSW Health reports workforce information at fixed points of time so that accurate comparisons can be made.

As at 30 June 2021, an additional 3,040 full time equivalent nurses and midwives had been added to the NSW Health workforce since March 2019.

Q22/154

Transcript page: 63

Iluka Ambulance Station recruitment

The Hon. COURTNEY HOUSSOS: I would like to move to a separate issue, the Iluka Ambulance Station. Minister, I understand that the station was originally to be a 24-hour rostered station with a full complement of staff, which would have meant 12 staff. I am advised that currently four staff work there. Do you have any plans to recruit more or what are the efforts going in to recruit additional officers for that particular station?
Mr BRAD HAZZARD: As I said to you before, those sorts of staffing issues are entirely operational matters within the purview of the Ambulance service. What the Government is committed to—and you heard from Mr Minns before that we have been delivering on that commitment—is the additional paramedics that are being employed within the service, and allocations are then made by the service as it considers appropriate. But I am happy to take the question on notice and direct it to the Ambulance chief executive, who is not here, and ask him for his advice and I will table it.
The Hon. COURTNEY HOUSSOS: If you can provide us with the current officers, the current staffing level, at that particular station; are there any efforts to recruit additional staff; and how many additional staff are attempting to be recruited? That would be helpful.

ANSWER:

Iluka Ambulance Station commenced operations on 12 March 2022 with a roster model that provides 24 hour paramedic coverage to the community.

I am advised the staffing profile of five full time equivalent positions is commensurate with similar stations of a similar workload.

Q22/155

Transcript page: 63

Foster-Tuncurry Hospital site selection and consultation

The Hon. COURTNEY HOUSSOS: I have some final questions coming back to the Forster-Tuncurry Hospital site. You mentioned there were 10, and one preferred site. Are you planning on doing any community consultation around the selection of that particular site or is it just what Health chooses?
REBECCA WARK: I am sure there will be consultation ongoing through the whole planning process both around site selection and then generally what the function of that will be and how it will be planned and delivered.
The Hon. COURTNEY HOUSSOS: Perhaps you can provide on notice what that community consultation plan is and who is going to coordinate it?
REBECCA WARK: I am happy to take that on notice.

ANSWER:

Health Infrastructure and Hunter New England Local Health District will undertake the site selection and planning process for the new facility in collaboration with staff, the community and key stakeholders. There will be a range of opportunities for the community to engage with the project and further details will be made available as the project progresses.

ANSWER TO QON 22/111 TAB A

Evacuation Management Guidelines

COVID-19 Supplement

V2.0 (October 2021)

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1 Context

Emergencies mean that people and their pets may have to temporarily relocate or evacuate to a safer place. The period of evacuation may be for hours, days or weeks. The NSW *Evacuation Management Guidelines* outline the principles, processes and responsibilities for managing evacuation. The NSW *Major Evacuation Centre Guideline* outlines the management of a major evacuation centre.

There are also provisions relevant to evacuation management in the *State Emergency and Rescue Management Act 1989* and the EMPLAN.

Evacuation is a risk-managed decision that balances the risks of staying put against the risks created by moving. The COVID-19 pandemic introduces new risks to evacuation management. These include:

- the risk of transmitting the virus as people relocate,
- the risk that staff and volunteers will not be prepared/allowed to work in traditional evacuation centres, and
- risks associated with collecting, distributing and maintaining supplies to evacuees.

This supplement outlines controls that may reduce the risk to as low as reasonably practicable.

Local Emergency Management Committees and combat agency decision-makers should consider four evacuation scenarios in the context of the pandemic:

1. **short-term evacuation** is a temporary relocation where no accommodation is needed, such as to avoid a hazmat release, nearby fire or similar incident.
2. **pre-warned/managed evacuation** requires people to be away from their homes for at least one night, such as to avoid flooding.
3. **self-managed evacuation/relocation** where individuals, families or community groups move away from a danger area, generally for more than one night.
4. **temporary housing**, such as where a home has been destroyed.

The recommended approach to evacuation is to rely on people moving to stay with family and friends.

Looking after companion, assistance and support animals will remain an important requirement during any evacuation.

1.1 Definitions

An ***assembly area*** is a place that provides a temporary safer area for a short-term evacuation, a temporary stopping point before moving evacuees to evacuation centres for alternative accommodation, and a source of information about the evacuation process, the hazard, sheltering, return options, evacuation centre location/s and how to get to them (AGD EMA Handbook 4, *Evacuation Planning*).

Evacuation is a risk management strategy that may be used to mitigate the effects of an emergency on a community. It involves the movement of people to a safer location and their return. For an evacuation to be effective, it must be appropriately planned and implemented (AGD EMA Handbook 4, *Evacuation Planning*).

Evacuation centre is a centre which provides affected people with basic human needs including accommodation, food and water (*Australian Emergency Management Glossary*). In

NSW it provides information, advice and connection to government services. It need not be a physical location but can be a call-centre.

Higher-risk individuals includes:

- Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic medical conditions
- people 65 years and older with chronic medical conditions
- people 70 years and older
- people with compromised immune systems (see Australian Government Department of Health)

Physical distancing means keeping a 1.5m distance when interacting with other people and avoiding having multiple people in a confined space.

Registration is the process that enables people to be identified, supports their safety and welfare, reconnects them with family and friends, and facilitates access to community workers, welfare and support services (AGD EMA Handbook 4, *Evacuation Planning*). The preferred system for registration is Register.Find.Reunite (RFR), complemented with referral to appropriate services.

Shelter refers to a location that provides for the temporary respite of evacuees (AGD EMA Handbook 4, *Evacuation Planning*). Shelter can be *congregate* (e.g. an RSL Club or evacuation centre) or *non-congregate* (e.g. a motel room).

2 Scope

This supplement provides guidelines and considerations to complement the NSW Evacuation Management Guidelines during the coronavirus pandemic. It is relevant for any incident or emergency where people must leave their home.

It is not intended for use in planning site-specific evacuations such as commercial facilities covered by AS3745:2010 *Planning for emergencies in facilities,* or for vulnerable facilities that are required to develop their own evacuation plans under AS4083:2010 *Planning for emergencies—Health care facilities.*

Due to the changing nature of the situation and associated risks, this supplement will be reviewed on a two monthly basis or as required to incorporate relevant changes as the situation evolves.

3 Planning principles

Preferred approach:

1. Evacuation is an option of last resort; however evacuation to a safer place may be necessary
2. The preferred safer place is with family or friends where the host family and the evacuees are not COVID-19 cases or in self-isolation and not in a higher-risk category
3. Evacuees should make their own arrangements for safe alternative accommodation wherever possible.
4. Commercial accommodation, if available, may be more suitable than staying with family or friends to promote physical distancing and minimise travel; or for higher-risk individuals
5. Any evacuation should be recommended or ordered with as much notice as possible

Evacuation risk assessment:

1. Evacuation management approaches will be locally led and depend on the COVID-19 risk profile in the community at the time. Considerations include the level of COVID-19 transmission, the public health orders, the public health advice and available resources within the impacted area.
2. Local emergency management committees (LEMC's) must engage with Local Health Districts (LHDs) to maintain situational awareness of the COVID-19 context and to ensure a proactive approach to managing people who are self- isolating. Evacuation approaches may include:
    a) Commercial or non-congregate accomodation if available.
    b) The use of existing evacuation shelters with measures to separate or cohort appropriate groups. In a highly vaccinated population, family groups known to have COVID may be directed to a specific area of the facility (eg a designated floor area). Mixing of family/household groups should be generally discouraged in the centre.
    c) If available, persons with known COVID-19 and their households should be accommodated separately, if unavailable then a designated area should be made available in the facility.

3. Rapid Antigen Tests (RATs) should be performed prior to people entering any congregant facility, if individual (or household group) accommodation is not available. LHDs should develop local procedures regarding procurement of RAT kits and provide advice at the time of the incident on:
    a) who performs testing
    b) who requires testing
    c) how often testing is performed

4. Risks at evacuation centres can be minimised through early planning with communities to seek alternatives.

Evacuation management:

1. NSW Health must be involved early in any evacuation decision where there may be a need for temporary shelter of people or their animals.
2. Travel should be minimised wherever possible.
3. COVID-19 cases, individuals instructed by NSW Health to self- isolate and symptomatic individuals may present to an evacuation centre. LEMC's must ensure appropriate mechanisms are available (e.g. assembly, screening and isolation areas) to effectively separate or cohort COVID-19 cases and those in self isolation from the general population.

4. COVID-19 safe practices including physical distancing and good personal hygiene should be maintained regardless of where an evacuation takes place.

5. Evacuation centres must have a COVID-19 safety plan and Service NSW COVID-19 safe check in QR code.

6. Pre-symptomatic and asymptomatic individuals can transmit SARS-COV-2.

7. Individuals who have been told by NSW Health that they must self-isolate at home should not attend an evacuation centre or animal holding area. If attendance is unavoidable, they should wear a mask. Where possible, specific evacuation arrangements should be considered to transport these individuals separately to the general population.

8. Mandatory mask wearing is likely within evacuation centres during localised community transmission.

9. Everyone entering an evacuation centre or animal holding area should be screened. If an individual refuses to be screened, that individual will be treated as ill and will be placed in isolation. The requirement for screening should be discussed with the local Public Health Unit.

10. Evacuees who show signs of illness, should be provided with a mask, and must be effectively separated from any shelter population. Screening may include administration of RATs in areas with high prevalence of COVID-19.

11. Evacuees requiring emergency accommodation will have limited support, fewer resources and may present with significant health issues.

12. Evacuees need access to information promoting hand hygiene, respiratory etiquette, masks, physical distancing and regular cleaning.

1. Relevance to other plans

This supplement may be relevant to managing community outreach centres following an emergency.

2. Hierarchy of controls

The hierarchy of risk controls, from most to least reliable, is:

1. **eliminate** (not currently applicable)
2. **substitute** (such as sending washing to commercial laundry rather than doing it in an evacuation centre)
3. **isolate** (dedicate specific areas with appropriate controls, such as evacuate to commercial accommodation, separating activity zones in an evacuation centre, eat in-room)
4. **engineering controls** (such as partitioning, or barriers plus enhanced cleaning)
5. **administrative controls** (such as rostering meal times, maintaining physical distance)
6. **PPE** (masks)

4 Operational expenditure

The coronavirus pandemic has not changed existing funding arrangements.

5 Decision-making checklist

Decisions to evacuate and subsequent actions for most evacuees are largely unchanged by the pandemic; however, public information must reflect the need to maintain physical distancing and good hygiene practices.

5.1 Initial actions

1. Discuss the population COVID-19 risk profile with the local Public Health Unit where possible.
2. Confirm the need to evacuate, for how many people and for how long.
3. Align combat agency strategy with public health strategy:
    a. identify confirmed COVID-19 cases and close contacts in the evacuation area
    b. confirm if staying with family and friends is an appropriate strategy
    c. develop clear risk communication messages
4. Confirm if accommodation is available in a non-congregate setting and the number of rooms available.
5. Consider activating an evacuation assistance hotline.
6. Confirm site(s) if an evacuation centre and/or animal holding area is needed.
7. Set up area drive-through evacuation centre:
    a. Set up a site with enough parking to allow evacuees to remain in their car
    b. Provide an information site or distribution point
    c. Ensure staff are available to oversee physical distancing for essential activities, such as bathroom facilities. Arrange to provide water and catering if necessary
8. Develop a coherent and comprehensive warning and messaging strategy (see example message at Attachment 1)

5.2 Transport

Consistent with normal practice, encourage evacuees to use their own transport to move to alternative accommodation or attend an evacuation centre. The combat agency or EOCON will arrange transport for those unable to do so for themselves. Physical distancing requirements will constrain transport capacity.

Ensure people stay in their cars or other transport wherever possible e.g. at an assembly area.

The Transport Services Functional Area (TSFA) will apply COVID-19 loading and cleaning protocols consistent with the airport repatriation operation where possible. This will reduce vehicle capacity to 30%, which will, in turn, affect the rate of people movement.

When TSFA has organised transport for passengers, the driver’s primary focus is the driving of the vehicle, not providing support services to the passengers. The driver’s role will not include enforcement of physical distancing. Physical distancing will be supported where operationally possible.

5.2.1 Additional transport-related processes

If time permits and does not cause a threat to life, the following actions may be undertaken:

1. diversion of known positive cases to NSW Health transport process (e.g. ambulance, patient transport)
2. manifest creation (name, mobile, bus ID/number, destination, expected duration of trip).

5.3 Opening evacuation centre(s)

Consistent with existing processes, encourage evacuees to be self-reliant and stay with family or friends or organise their own commercial accommodation.

Evacuation management approaches will be locally led and depend on the COVID-19 risk profile in the community and the available resources within the impacted area at the time. LEMC’s should engage with LHD’s to determine the most appropriate evacuation management approach.

An evacuation centre will help individuals or families to access support where needed. It is important to minimise the number of people attending any physical evacuation centre by one or more of the following strategies:

1. encourage self-reliance in public messaging
2. consider diverting attendance at a physical centre by activating and publicising a “evacuation assistance hotline” and encouraging people to use RFR
3. stage evacuations over time
4. establish drive-through evacuation centres to hold evacuees in their car

5.3.1 Evacuation assistance hotline

A telephone-based registration and assistance capability (evacuation assistance hotline) can be established to divert people from attending a physical evacuation centre. It will:

- register evacuees
- provide initial triage and referral to other government services, such as:
    - Public Health Unit for persons with COVID-19

- Ag and Animal Services for persons unable to arrange somewhere for their companion animals
- Housing Contact Centre for persons unable to make their own accommodation arrangements
- Provide options for other immediate welfare requirements

Agencies will be encouraged to publicise the evacuation assistance hotline contact number widely. In addition, people may be encouraged to self-register on the RFR system.

5.3.2 Physical evacuation centre

A physical evacuation centre may or may not include an animal holding area (either attached to the physical evacuation centre or in close proximity). Where a physical evacuation centre and/or animal holding area is needed:

1. Contact the facility(ies) to confirm availability, capacity and lead time to re-open if required
2. Confirm purchasing and payment arrangements following existing procedures
3. Arrange centre staffing to ensure any higher-risk individuals avoid face-to-face contact with evacuees
4. Open and operate the centre following existing arrangements *plus* the additional requirements to meet physical distancing and good hygiene practices below.

Set up

1. Obtain guidance from the local Public Health Unit, including risk-based advice about local case numbers and those in self isolation, the use of RATs in areas with significant outbreaks and the immediate or staged requirement for screening.
2. Establish agreement on COVID-19 cleaning and sanitation requirements with facility or contract arrangement, in consultation with the local Public Health Unit.
3. Establish an Assembly area, Screening Area and an Isolation Area (see Attachment 2).
4. Confirm the protocol for managing COVID-19 cases, individuals currently self isolating and symptomatic evacuees (suspect cases) if they present to an evacuation centre.
5. Space out furniture to encourage flow and maintain physical distancing in queues.
6. Apply tape to floors to define areas of significance and encourage physical distancing.
7. Where absolutely required, set up any sleeping area in consultation with the local Public Health Unit.
    a. Ensure the Screening Area and Isolation Area are physically separate from any sleeping area.
    b. Ensure proper sleeping area space allocation per evacuee; ideally 10sqm per person (but no less than 4sqm) with 2m separation between edges of each cot and arrange cots “head-to-toe”.
    c. Allow families to move their cots closer together.
8. Begin screening for all evacuees, workers, and visitors before entering the facility, where required in accordance with advice provided by the Public Health Unit.
9. Begin daily screening logs for evacuees, staff, partners, and visitors. Consider issuing a different coloured sticker each day to indicate a person has been screened.

Registration

1. Develop and distribute an information pack describing physical distancing and hygiene requirements.
2. Distribute sanitiser (if available).

Operation

1. Screen everyone (evacuees and staff) daily and whenever they arrive at orre-enter inside the shelter, in accordance with advice provided by the Public Health Unit.
2. Distribute masks for everyone entering the evacuation centre.
3. Encourage anyone who develops symptoms or becomes unwell to advise staff immediately. Seek advice from NSW Health about the implementation of testing protocols (e.g. PCR, rapid antigen testing) and if this should be conducted onsite or offsite.
4. Continually promote and enforce physical distancing and hygiene requirements.
5. Maintain enhanced sanitation protocols and other related instructions from NSW Health.

5.4 Animals

The Agriculture and Animal Services Functional Area (AASFA) will coordinate animal services resources at any physical evacuation centre or animal holding area. The requirements for the opening of a physical evacuation centre (5.4) will equally apply to an animal holding area.

Consistent with existing processes, evacuees with animals/pets are encouraged to be self-reliant and stay with family or friends or organise their own commercial accommodation. Alternate accommodation could include animal holding establishments such as pet care and pet stay hotels, RSPCA, vet clinics, and council pounds.

An evacuation centre will assist owners to access support where needed. It is important to minimise the number of people attending any physical evacuation centre with animals by one or more of the following:

1. Encourage self-reliance in public messaging
2. Stage evacuations over time taking into consideration animal type/animal welfare (stress/feeding etc)
3. Establish intermediate assembly areas to hold evacuees in their vehicle/trailers where able (factoring animal welfare i.e. temperature/stress).

5.4.1 Physical evacuation centre

Animal holding areas should be attached to, or located nearby physical evacuation centres. Where an animal holding area is separate from an evacuation centre, the animal holding area should ideally be situated close enough to a physical evacuation centre to allow owners to have reasonable, easy access to provide care for their animals.

6 Responsibilities for decision-making

6.1 Responsible agencies

In relation to Section 5, the following agencies are responsible for decision-making in relation to the establishment of an evacuation centre in a pandemic scenario.

- **Welfare Service Functional Area Coordinators** (WelFACs) - must participate in the decision making and planning discussions to establish evacuation centres that require sheltering evacuees as an absolute last resort (refer to *Section 6.2* for detailed responsibilities). Welfare will be responsible for deciding the best strategy for sheltering of evacuees.

- **NSW Health** – decide the arrangements to check for COVID-19 from door knocking through to shelter. Provide support to the WelFACS in the early stages of establishing an evacuation centre to establish and communicate physical distancing and infection control protocols, and providing risk-based advice on the requirements for screening at evacuation centres and animal holding areas.

- **NSW Police Force** – decide on the evacuation of Locked-Down areas, how public order issues arising from COVID-19 will occur during evacuations, and how registration will be conducted. Private security may be engaged in lieu of or to augment NSWPF resources where required.

- **NSW Public Works –** in consultation with the Facility Owner, decide to implement additional cleaning and disinfection routines where required.

- **Agriculture and Animal Services Functional Area** – decide the best strategy for sheltering and handling of animals and the human interaction and interface in the process.

- **Transport Services Functional Area** – decide on the best method, mode and utilisation of transport. Decision on traffic management in conjunction with NSWPF and road owners.

- **Facility/Land Owner –** confirm availability and provide authority to use the facility to SEOC and/or MEC Manager; and decide in conjunction with NSW Public Works to implement additional cleaning and sanitation routines.

- **Community Partners (e.g. Red Cross) –** in conjunction with the WelFACs, provide additional resources in managing the evacuation centre and associated works such as food runs, counselling, and registration services.

6.2 WelFACs detailed responsibilities

If evacuation centres are required, WelFACs will need to:

- Participate in the decision making and planning to establish Evacuation Centre via Welfare Services Functional Area Liaison Officer placed in the EOC.
- Plan and implement in partnership with NSW Health the establishment and function of the evacuation centre considering physical isolation and infection control measures.
- Support the development of clear and concise messaging to community partners and DCJ staff about physical distancing and infection control protocols that must be in place to manage the evacuation centre.

- Support the development of clear and concise messaging to members of the public accessing an evacuation centre on the physical distancing and infection control practices of the evacuation centre during the COVID-19 pandemic.
- Ensure PPE (if available) and COVID-19 resources are available in Evacuation Centre Kits.
- Provide support to staff and community partners to manage the function of an evacuation centre ensuring physical distancing and infection control protocols are in place.

Annex 1—risk controls

The following risk controls are specific to COVID-19 and are in addition to the considerations already included in the SEMC *Evacuation Management Guidelines* (Annexures A and F) and NSW Health GL2018_002 *Major Evacuation Centres: Public Health Considerations* (Part 5 and Appendices 2 and 5).

Risks are considered in each evacuation phase; decision, warning, withdrawal, shelter and return (which includes the transport risks of withdrawal).

Agencies, Functional Areas, REMOs and LEMCs should review their current plans and guidance against the controls described below and consider how they can be met.

Decision

Risk	Control(s)	Agency
Person to person transmission (PPT) during evacuation and in alternate accommodation	Consult with local Public Health Unit as part of the decision-making process Validate requirement to evacuate as a risk management strategy Consult with EOCON and supporting agencies prior to decision Consult with community as early as possible Confirm numbers of individuals who are confirmed cases or close contacts and any other available information about those have been told by NSW Health that they must self-isolate at home or are awaiting results	Combat Agency or EOCON HSFA

Warning

Risk	Control(s)	Agency
Misunderstanding evacuation strategy and COVID-19 specific requirements	Develop clear, consistent, actionable messages, including options to register and seek help via the 'evacuation assistance hotline', if established Encourage self-reliance in all messaging Provide specific advice for individuals with respiratory symptoms and higher risk individuals	Combat Agency or EOCON HSFA
Person to person transmission (PPT) during face-to-face warning (doorknocking)	Do not use higher risk individuals for doorknocking Use vaccinated individuals in preference to unvaccinated individuals Minimise face-to-face doorknocking Use alternative warning methods, including vehicle loudspeakers, SMS messaging, Emergency Alert, SEWS, radio, TV and social media Ensure doorknock teams stay >1.5m from a door Leave documents in the mailbox or at the door Local Public Health Unit to contact individuals who have been told by NSW Health that they must self-isolate at home and give doorknock teams the address(es) Confidentiality on the residents' COVID-19 status must be Upheld when known.	Combat Agency or EOCON HSFA

Withdrawal

Risk	Control(s)	Agency
PPT during travel (withdrawal or return)	Encourage travel in personal transport wherever possible Load communal transport to no more than 30% capacity (one person per row, every second row). Ensure masks are on and worn correctly.	Combat Agency or EOCON TSFA
PPT during assembly	Establish assembly areas in large carparks or similar venue Encourage evacuees to remain in their vehicle wearing masks Complete immediate assessment while evacuees remain in the car (consider "drive-through" registration and assessment process) Monitor physical distancing (e.g. movement to and from toilets or to attend the evacuation centre)	Combat Agency or EOCON WELFA
Transport vehicle contamination with coronavirus	Decontaminate communal transport vehicles after passengers disembark	TSFA
Breach Public Health Orders	Confirm any gathering is "for the purposes of emergency services" Confirm travel is "essential" Confirm people in self-isolation can leave their home	NSWPF

Shelter

Risk	Control(s)	Agency
PPT during registration and processing through the evacuation centre (including animal holding area)	Consider Evacuation Assistance Hotline and promote registration by phone or using RFR Do not allow higher risk individuals (ie those unvaccinated or immunosuppressed) to work in a physical evacuation centre or animal holding area Use staged evacuations to reduce numbers moving through facilities Consider "drive-through" registration process or similar where evacuees remain in their vehicle, if appropriate Establish NSW Health screening process Ensure access to hand-washing facilities and/or sanitiser Minimise the number of people in the facility (reduce capacity to ensure ≥4sqm/person if possible) Set up desks and queues to maintain physical distancing (>1.5m between chairs or across desks) Require one person to register on behalf of family groups Refer to Disaster Welfare Assistance Line for support rather than returning to evacuation centre for assistance for those with alternative accommodation Encourage physical distancing and personal hygiene practices Provide additional supervision/control to manage distancing Avoid sharing writing implements and minimise document handling	WELFA HSFA NSWPF AASFA

Risk	Control(s)	Agency
PPT in evacuation centre – sleeping	Use physical barriers between family groups where possible Separate sleeping areas >4m apart (e.g. wide corridors) Ensure capacity allows ≥4sqm/person Monitor physical distancing and hygiene Discourage mingling between family/household groups	WELFA
PPT in evacuation centre – general	Establish separate recreation and exercise area(s) Establish usage/access rosters for meals, recreation, laundry or similar communal facilities to reduce crowding Ensure seating allows for physical distancing Ensure access to handwashing facilities and/or sanitiser Encourage good hygiene practices Consider commercial laundry options if required	WELFA
PPT while at friends/family accommodation	Promote good hygiene practices Do not isolate with family/households who are isolating if any alternatives available Provide information about symptoms to look out for	Combat Agency or EOCON HSFA
Added evacuee stress and anxiety due to COVID	Proactive communication and support Provide access to emotional support staff and/or mental health support (face-to-face or by phone outreach) Provide education and/or outreach resources, including contact numbers for support services	WELFA HSFA
Facility contamination with COVID-19 cases	Implement additional cleaning and disinfection routines	FACILITY/LAND OWNER NSW PUBLIC WORKS
Breach procurement requirements	Use existing contracts or panels Use existing procurement processes and staff	All agencies

Return

Risk	Control(s)	Agency
PPT after returning home	Reinforce physical distancing rules (e.g. for tradespeople fixing damage or during clean-up activities) Outreach information about symptoms to look out for	HSFA WELFA

Attachment 1—public information message

Extracted from SES Evacuation Order as an example only. This will be refined in consultation with PIFAC.

Where to go: Stay with family or friends outside of [location].

If you are unable to stay with family or friends contact TBC on NUMBER for advice; alternatively, an evacuation centre has been set up at [enter location details].

If you are in self-isolation, ensure that you identify yourselves to persons providing assistance and ensure you wear a mask.

Attachment 2—screening

Screening area

Responsibility: NSW Health is responsible for the function of health screening for COVID-19 symptoms in an evacuation centre

Location: Dedicate specific locations for screening (e.g. assembly area and in centre screening).

Staffing: The screening area is ideally staffed with two persons — but can be reduced to one if necessary. Screening should not be carried out by staff who are higher-risk individuals.

Equipment:

Hand sanitiser

Gloves

Goggles

PPE [surgical mask][1]

Rapid Antigen Tests and instructions for use

Work instruction:

1. Ask each person attending the evacuation centre the following screening questions:

    a. Do you have *any* of the following symptoms (even mild): fever, cough, shortness of breath, chills, body aches, sore/scratchy throat, headache, runny nose, muscle pain, vomiting, nausea, diarrhoea or loss of taste or smell?

    b. Are you COVID-19 positive or currently in mandatory isolation?

    c. Have you had any household contact with a COVID-19 positive case in the last 14 days or been told to isolate by a health official?

    If the answer to any of these questions is "yes", provide a face mask, and:

    a. move the individual to the isolation area

NSW Health recommends that **anyone with respiratory symptoms or unexplained fever or loss of sense of smell of taste should be tested** for COVID-19.

2. Wearing of masks

In the event that physical distancing cannot be guaranteed, NSW Health will recommend the wearing of face masks in an evacuation centre at all times except when eating or drinking. The Welfare Services Functional Area will provide masks for members of the public in an evacuation centre.

[1] PPE requirements may change. Always check with the local Public Health Unit when setting up a screening area.

Isolation Area

An isolation area is an area where persons who are symptomatic are distanced from others. Isolation areas may also be used for any known COVID-19 positive evacuees or individuals in self isolation who present to an evacuation centre. Isolation areas must be physically separate from the rest of the evacuationcentre. Anyone waiting in the isolation area should wear a surgical mask.

The Isolation Area is higher risk and should be monitored by the screening staff.

Local PHU's should be consulted in setting up isolation areas for different cohorts of people (COVID-19 cases, individuals in self isolation, unvaccinated / under vaccinated individuals and asymptomatic vaccinated individuals).

Persons with symptoms of eg gastroenteritis should be cohorted separately to people with respiratory symptoms.

References

American Red Cross 2020, *COVID-19 Operational Decision-Making / Shelter Facility Opening Checklist*, accessed 15 April 2020

American Red Cross 2020, *Sheltering in COVID-19 Affected Areas*, accessed 21 April 2020

Australian Disaster Resilience Handbook 4: *Evacuation Planning*, 2013, Australian Institute for Disaster Resilience

NSW Health 2020, *CIVID-19 Rapid Evidence Brief – Fever screening for COVID-19*, NSW Government

Smith C. and Parsons C., 2015, *Preferred Sheltering Practices for Emergency Sheltering in Australia,* Australian Red Cross, paper presented at Australian and New Zealand Disaster and Emergency Services Management Conference, May 2015

NSW Health

Fact sheet

Managing the risk of COVID-19 in an evacuation centre

Principles

- Safe shelter is a basic human need. People with COVID-19, COVID-19 symptoms or who are known contacts should not be turned away from evacuation centres if they have no safe alternative accommodation.
- At a minimum, the following two groups of people should be separated as much as possible in the available physical space:
  1. *People potentially posing a COVID-19 risk*
     - known COVID-19 positive
     - symptoms of COVID-19
     - known COVID-19 contact
  2. *People at increased risk of severe illness*
     - >65 years
     - immunosuppressed
     - other chronic illness
     - pregnant
- Family or household groups should be kept together as much as possible. Each group should be physically separated from any other family or household groups.

Key COVID-19 actions for evacuation centres

1. Wherever possible, **organise the physical space** so there is maximum separation between people *potentially posing a COVID-19 risk* and *people at increased risk of severe disease* (as listed above). This could involve:
   - Using single or separate rooms if available
   - Marking separate zones in a shared area with as much space as possible in between. This may include using wall signage or floor markings such as tape.
   - Keep family or household groups together while managing the separation of these two groups wherever possible.

2. At registration, obtain basic information to **assess COVID-19 risk** for all evacuees. Recommended questions are:
   - Have you tested positive for COVID-19 in the last 7 days?
   - Has anyone in your household tested positive for COVID-19 in the last 7 days?
   - Do you have any COVID-19 symptoms (common symptoms include: cough, fever, sore throat, runny nose)?
     - Anyone with serious symptoms such as chest pain or difficulty breathing must be directed to urgent medical attention.
   - Do any of the following apply to you?
     - >65 years
     - Pregnant
     - Chronic medical condition such as liver, heart, lung or kidney conditions, diabetes, cancer or other conditions that suppress the immune system

If someone answers yes to any of these questions, please direct them to the relevant area of the facility (with their family or household group where possible) and contact the Public Health Unit or clinical support if on-site.

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3. Encourage **family/household groups to remain physically together.** Keep as much space as possible between different family/household groups.

4. Ask evacuees to **use masks** while indoors. When distributing masks, prioritise anyone *potentially posing a COVID-19 risk*. Please note that masks should not be worn by babies and toddlers as they are a choking risk.

5. Encourage **hand and respiratory hygiene.** Offer facilities for handwashing with soap and water and/or hand sanitiser where available. Promote behaviour to cover coughs and sneezes and wash/sanitise hand immediately afterwards. Use available wall signage to remind evacuees of hygiene behaviour.

6. Encourage evacuees to promptly report any symptoms. Where a symptomatic person is identified liaise with health staff to arrange testing.

7. Liaise with health staff to make **urgent clinical assessment** available for any person who appears unwell.

Please note

Where possible, rapid antigen tests (RATs) should be made available and can be used as an additional measure to help manage COVID-19 risk in evacuation centres under advice from the local Public Health Unit.

Public Health Units are available to support evacuation centre workers in managing COVID-19 risk by phone or virtual means.

You can contact your local Public Health Unit on **1300 066 055**, or via the following local contact information:

Local contact information:

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Answer to QON 22/123 TAB C

Junee Correctional Centre Infection Control Review

February 2022

Health
Justice Health and Forensic Mental Health Network

Context of the review

In January 2022, Junee Correctional Centre (the Facility) had COVID-positive transmission within its patient cohort. COVID-19 outbreaks also occurred at other correctional centres due to Omicron variant spread throughout the community and as restrictions and controls were relaxed in late 2021. Higher community prevalence contributed to higher case presentations to the facility.

Corrections Services NSW (CSNSW) directed GEO Group Australia (GEO) to place the centre on a hard lockdown for 10 days (until 6 February 2022) to help control the outbreak.

On 3 February 2022, a multidisciplinary group of people from Ministry of Health, Murrumbidgee Local Health District, Justice Health and Forensic Mental Health Network (the Network) and Clinical Excellence Commission (CEC) visited the Facility to conduct a COVID-related inspection.

The group’s focus was to determine the effectiveness of the Operator’s approach to infection control in the prevention and mitigation of the spread of COVID-19.

Disclaimer

- The review team’s recommendations are based on the operational environment at the time of the review. While every effort has been made to ensure the accuracy of this report, it is acknowledged that it is a dynamic environment and errors may occur.
- At the time of review, Junee Correctional Centre was in full lock-down so not all areas were accessed and usual routine could not be observed.
- The review team’s focus was on measures that may prevent and mitigate COVID-19 transmission during usual operations not just under lockdown conditions.
- This review does not constitute monitoring as usually conducted by the Commissioning Unit under the Performance Management Assurance Framework.
- GEO Group may choose to accept or reject review recommendations and support at its risk.
- The review team and its employers do not accept liability for any costs or damage incurred in relying on this review.

Review team and acknowledgements

- Thank-you to the NSW Health members that conducted the review.

Onsite	Offsite
Trevor Puckering, Director Commissioning, JHFMHN Leo De Jesus, Monitor Nurse Manager, JHFMHN Natasha Hyde, Clinical Director Primary Care, JHFMHN Fiona Montroy, CNC Sexual Health Nurse, JHFMHN Lillian Kingham, ICP, CEC Glenda Fischer, Environmental Health Officer Mary-Clare Smith, CNC ICP	Michael Douglas, Senior Medical Adviser, Deputy Controller, Public Health Response Branch, MoH Alison Nikitas, HARP Manager, Murrumbidgee LHD Tracey Oakman, Director Public Health, Murrumbidgee LHD April Roberts-Witteveen, Manager Surveillance, Southern NSW LHD Kathy Dempsey, NSW Chief ICP & HAI Advisor, CEC

- The review team thanks GEO Group representatives for their time and assistance in facilitating the review at short notice
- It acknowledges the effort and measures GEO has put in place to prevent and mitigate COVID-19 transmission within the centre
- It also acknowledges the dedication and perseverance of GEO’s staff against the backdrop of the broader community Omicron spread that has tested staff and services.

Scope

The effectiveness of the following risk controls were assessed.

COVID-19 transmission

Preventative

- Does GEO have training and governance arrangements in place to train staff in PPE use and check for ongoing compliance particularly in high-risk areas such as kitchen?
- Does GEO understand areas of infection risk in its facility such as clustering points, poor ventilated areas and air flow, dynamic flow of staff and inmates in the facility, quarantine areas, cross section interaction?
- Does GEO's vaccination roll-out comply with ATAGI guidelines and reporting requirements?

Mitigating

- Does GEO utilise cohorting of patients and staff strategies to limit broader infection?
- Does GEO follow JHFHMN procedures as at 1 February 2022 with regard to COVID-positive patients:
  i. Process for the transfer of COVID-positive patients including courts
  ii. Identification, management and release from isolation of high risk exposures
  iii. COVID-19 guidelines for the clinical care of COVID-positive patients
- Does GEO conduct surveillance testing and utilise infection information (positive RATs/PCRs for staff and patients) to inform risk areas and future action?

PREVENTATIVE MEASURES

Governance and training in the use of PPE

Findings

- GEO reports that they have PPE training available for staff – structure, competence, governance and compliance is less clear.
- GEO only supplies one size KN95 respirators to staff, which are unlikely to be suitable fit for all persons required to wear them. Implementation of a respiratory protection program would provide additional benefit to ensure staff have appropriate education and training and the ability to achieve a fit check seal for respiratory protection with a variety of respirators.
- Many staff observed compliant during review with some observed breaches and non compliance during doffing.

Supporting information

- PPE training videos sent to staff via APP (the loop) but no report available to management of staff completing the training
- Limited evidence that all staff have received PPE training and records
- Face to face PPE/ICP training at preemployment orientation but no ongoing additional face to face noted
- Limited evaluation of learning or competency in ICP/PPE skills
- Report of regular surveillance checks by management on walk arounds but no records maintained
- KN95 is the only respirator supplied and is required of all staff to wear them

Recommendations

- Implement a structured PPE/ICP training program with appropriate governance to include options of face to face/interactive virtual/and self-directed learning.
- Opportunity for system improvement, competency assessment, strengthening of records and understanding who has completed. This is usually recommended to staff in an outbreak.
- Consider development of train the trainer program targeting staff and inmate workers.
- Increase options of masks/respirators available to staff and inmate workers.
- Develop a respiratory protection program.
- Commence training of fit check as a priority – consider just in time approach.
- Develop and implement an audit program to demonstrate compliance and safety improvements
- Improve gown doffing.
- GEO to not roster staff with facial hair to work in high-risk/red zones throughout the Centre'

Standards

- Standards Australia
- Work safe Australia
- CDNA National guidelines
- Clinical Excellence Commission(CEC)
- NSW Health
- JHFMH policies and guidelines
- Therapeutic goods Australia (TGA)

Others

- Guidance available from ICP consultant based in Melbourne when required
- National training coordinator will commence February 20222 to provide support 1x week
- Consider a program which includes assessment and monitoring of competency

PREVENTATIVE MEASURES

Environmental considerations

Findings

- Information was not available on ventilation assessments and opportunities for improvement through proportion of outdoor air concentrations or grades of filters.
- All used PPE is being disposed of in clinical waste bins. This is causing problems with build up of waste and cost to the centre.

Supporting information

- Discussions with CSNSW Monitor for Junee
- Observations whilst on tour of the facility
- Cohorting – markings on the floor, person limits exist

Recommendations

- Consult the HVAC maintenance company to review system for opportunities to improve proportion of outdoor air and upgrade filters.
- Education and information needs to be given to staff re PPE and disposal.
- Health Services Manager to review current PPE disposal arrangements in mitigate risks of cross contamination

Standards

- ASHRAE 52.2
- PPE red zone staff factsheet
- Protection of the Environment Operations Act 1997
- GEO infection control procedure on environmental cleaning

Others

- Contact to be made with Weston and Weston (HVAC maintenance provider for assessment and opportunities for improvement

PREVENTATIVE MEASURES

Infection Prevention and Control

Findings

- Cleaning process with the high frequency touch points and requirements for infection prevention and control needs to adhere to GEO infection control procedure.
- Opportunity to improve understanding of modes of spread and risks associated with increase spread.

Supporting information

- Observed lack of hand hygiene facilities; limited to bathrooms/toilets
- No evidence of guidance on appropriate procedures or products for cleaning surfaces appropriately; high use of Glen 20
- No record of cleaning schedule implemented or frequency it is completed

Recommendations

- Additional PPE stations positioned around the facility as required by zoning
- Provide a supply of TGA approved cleaning products that meet requirements to clean and disinfect surfaces. High touch point and communal areas require more frequent cleaning during an outbreak. Glen 20 spray is listed as a disinfectant aerosol and not for cleaning surfaces. Requirements for cleaning and cleaning procedures should comply with the National Document.
- Introduce a schedule of cleaning for shared/common areas and educate staff and inmates on appropriate use.
- Implement a cleaning audit/checklist tool to demonstrate compliance and improve safety.
- Use the 2-step process to clean and disinfect commonly used/touched items as per GEO procedure.

Standards

- PPE red zone staff factsheet
- GEO infection control procedure

Others

- There are risks associated with potential cross transmission with aerosol generating procedures and extra mitigating precautions required, e.g. CPAP and nebuliser
- The issue of ventilation for protection against COVID-19 more broadly including density limits for Infection Prevention is an important aspect however was reviewed by another party of the review group

PREVENTATIVE MEASURES

COVID-19 vaccination program

Findings

- GEO does not use the Australian Immunisation Register (AIR) to verify the COVID-19 vaccination status of patients on entering custody.
- GEO currently has only one accredited immuniser whose workload covers the verification, tracking, administering and recording of the vaccinations.
- The register of GEO staff vaccinations indicate that few staff received a booster shot.
- GEO is under-resourced to support ongoing vaccination including the commencement of the booster doses for qualified patients.

Supporting information

- Interviews with GEO Immuniser, A/HSM and RN
- PAS COVID-19 vax activity as at 7 Feb 22
  - 1,241 – total vax given
  - 6 – booster doses given
  - 220 – potential boosters due
  - 626 – COVID-19 fully vax in custody alerts
  - 50 – COVID-19 fully vax in community alerts
  - 161 – active COVID-19 respiratory alerts
- Dec 2021 - last reported vaccination blitz run

Recommendations

- Arrange AIR access
- Offload administrative tasks from Immuniser to allow for vaccinations to re-commence.
- Encourage staff to receive booster vaccination – especially for health services staff
- Continue to prioritise the recruitment of vacant clinical positions.
- Increase number of accredited immunisers
- Reoffer unvaccinated patients COVID-19 vaccine
- Commence booster program

Standards

- ATAGI guidelines
- Important Notice – PAS Alerts and Codes for COVID-19 vaccinations (4 Nov 21)
- IN – Vaccination 3rd dose and coding (6 Dec 2021)
- IN – COVID-19 Fully Vax in Custody Alert in PAS (27 Jan 2022)

Others

- TP/LDJ to discuss with Network and other private centres to try and ensure transfers out to Junee are up-to-date with their COVID-19 vaccinations
- Organise CAS ‘Train the Trainer’ sessions with the Network
- Provide CAS Tip Sheets

MITIGATING MEASURES

Management of COVID-positive patients

Findings

- GEO does not use JHFMHN COVID-19 Business Rules for monitoring COVID-positive patients.
- GEO staff does not use COVID-19 Clinical Pathways.
- GEO staff unfamiliar with COVID-positive patients Clinical Risk Categories.
- GEO does not follow Process of transfer of COVID-19 positive patients.

Supporting information

- Interview with GEO MO and RNs in the Health Centre

Recommendations

- Follow Network Business Rules, Clinical Pathways and Clinical Risk Categories available on the intranet.
- Recommended to all staff involved in clinical care to familiarise themselves with COVID-positive patients care.
- Liaise with Network COVID MO Team when required.
- System in place to update procedures with any changes.

Standards

- *Business Process* - Monitoring COVID-19 positive patients
- *BP* - Guidelines for the Clinical Care of COVID-19 positive patients
- *BP* - COVID-19 Guidelines for care of patients in isolation
- *BP* - COVID-19 Process for the transfer of COVID-19 patients in custody
- Important Notice – PAS Alert for COVID-positive patients (25 Aug 2021)
- *IN* – PAS Alert for risk categories (12 Oct 2021)

Others

- TP/NH to arrange Skype meeting with all relevant staff to discuss the management of COVID-19 positive patients
- TP to confirm that updated business process are being sent to partner agencies
- TP to confirm that important notice changes are being communicated to partner agencies.

MITIGATING MEASURES

Patient and staff cohorting strategies

Findings

- GEO is conducting surveillance using a combination of PCR and RAT testing – schedule and timeframes require clarity.
- Inmates appear to be appropriately isolated and quarantined according to risk and exposure; possible improvement.
- Zoning of facility as whole as a high risk RED ZONE compliant with GEO and statewide corrections guidance.
- Ability to zone and align with non-COVID, recovered, suspected, and confirmed would improve controls for infection prevention; universal and high level application of PPE based on this zoning potentially contributes to breaches and cross contamination.
- Local implementation not consistent with written guidelines.

Supporting information

- Facility is in lockdown during outbreak and movement of inmates is permitted only by exception, e.g. workers
- New inmates are appropriately quarantined for 14 days
- Inmates who test positive to COVID-19 are isolated in a designated block
- Robust regime of RAT and PCR testing in place

Recommendations

- Implement triaging to create a more streamlined approach and zoning areas according to risk.
- Clear understanding and process of early case identification through surveillance and screening to contain risk of onward spread.
- Streamlining of application of PPE and review zoning: Priority protection for all staff is respiratory protection (mask/respirator) and additional eye protection. Gloves and gown only if in direct contact (touching) inmates; environment- reducing use to appropriate use increases compliance
- ✓ This is consistent with the Commissioner's Instruction 01/2022 below.

Standards

- PPE red zone staff factsheet
- GEO Infection Control
- CEC
- TGA
- NSW Health
- JHFMH

Others

- Inmates positive to COVID-19 are generally transferred out of the facility regardless of the severity of illness; containment rather than movement could be considered. Increase to movements of cases has been shown to increase risk of spread - Moving of inmates can increase potential exposure points and persons. Consideration where condition permits and given the community prevalence how to contain and prevent spread on existing site
- Approach to zoning – see next slide

MITIGATING MEASURES

Patient and staff cohorting strategies cont'd

RECOMMENDATIONS: Cohort / Zone planning

Consider five zones:

Zone	Description
Green zone	Individuals who have met the release from isolation criteria against COVID-19. Note: in the initial stages of an outbreak all inmates/detainees are usually considered close contacts and will be in quarantine.
Yellow zone	Unvaccinated individuals who have been released from quarantine following a risk assessment (includes those who are not close contacts). Fully vaccinated individuals who are not close contacts.
Amber zone	Individuals who have met the close contact or suspected case definition and are in quarantine. This may include new inmates/detainees when there is COVID-19 in the community.
Red zone	Individuals who have confirmed COVID-19.
Blue zone	Buffer areas between potentially contaminated and non-contaminated zones. For example, staff security points, corridors, staff lunchrooms, meeting rooms. Blue zones also include transition points from one zone to another where staff must don or doff PPE.

When setting up zones

Consider:

- Amber and red zones should be
  - geographically separated
  - decluttered to make cleaning and decontamination easier
  - assigned dedicated staff
  - include single rooms/cells with their own bathroom.
- All zones should have
  - limited entry/access
  - sites for PPE and hand sanitiser
  - staff break areas, spacious to enable physical distancing to prevent spread
- Ideally implement zoning after the first round of testing is completed and be flexible to adjust zones as individuals recover. Anything that moves between zones such as food service or linen pathways should move from green to red zones i.e. from clean to contaminated.
- Consistent with Commissioner's Instruction 01/2022 when P2/N95 masks and face shield/googles worn in all zones. Gloves/long sleeve to be worn in amber/red zones.

MITIGATING MEASURES

Patient and staff cohorting strategies cont'd

Commissioner's Instruction

PPE- Statewide RED ZONE – (CI01/2022)

If sites have adequate PPE and are able to comply with this Commissioner's Instruction immediately, they should do so. For sites who require additional PPE, they should place their orders on **4 January 2022** and implement RED ZONE PPE compliance by **8 January 2022** at the latest.

Red zone PPE

P2/N95 mask	Face shield/safety goggles*	Disposable gloves	Long sleeve gown
AT ALL TIMES	AT ALL TIMES	ONLY when working in reception/intake, quarantine, isolation, staging areas, court cells locations and with COVID 19 positive inmates (including transport/escorts)	ONLY when working in reception/intake, quarantine, isolation, staging areas, court cells locations and with COVID 19 positive inmates (including transport/escorts)

MITIGATING MEASURES

Surveillance testing and utilisation of infection information

Findings

- Process are in place for COVID-19 testing in accordance with Commissioners Instructions and CSNSW Coronavirus Command advice.
- Inmate/ patient COVID-19 testing results are recorded on a spreadsheet; this is distributed to CSNSW Coronavirus Command Post, the Health Services Manager and GEO Corporate. Centre Management refer to the information contained to plan further testing and containment measures in consultation with CSNSW Coronavirus Command.
- GEO forward patients/ inmate test results to Corrective Services NSW (CSNSW) Coronavirus Command for assistance with their COVID-19 response.
- CSNSW is not linked to NSW Health surveillance network, nor does in play a role in clinical or public health governance, as such health data is being sent to a non-health entity.
- GEO is not following established pathways for Surveillance Data Collection.
- It is unclear if GEO are using the JHFMHN COVID-19 Emergency Public Health Response, Advice, and Risk Matrix for management of staff exposures as sent to GEO.

Supporting information

- Interviews with centre management on day of site visit
- Junee Correctional Centre. COVID-19 Pandemic Plan Effective: 2 September 2021-Rev.19

Recommendations

- GEO Health Centre staff receive education regarding the process of notification and documentation of testing and results to facilitate accurate surveillance data collection by JHFMHN and therefore influence best practice decision making.
- A member of the Health Care staff participate in all Containment Meetings.
- Business Rules regarding data collection of staff testing, exposures and positive case notification are developed and distributed to key stakeholders.

Standards

- JHFMHN COVID-19 Emergency Public Health Response, Advice, and Risk Matrix
- COVID-19 Patient Screening and Escalation Process
- Business Rules. COVID-19 Results Management
- JHFMHN COVID-19 Clinical Pathway
- NSW HEALTH Population Health Surveillance Strategy NSW 2011 to 2020

Others

- Nil