Inquiry into the Queensland Government's health response to COVID-19

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Queensland Health written submission to Committee

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's Inquiry into the Queensland Government's health response to COVID-19

Contents

Introduction

In lodging this submission, it is important to acknowledge the context in which Queensland finds itself today – the State continues to be in the grips of a global pandemic. This submission is being lodged on a day that sees the number of global cases of COVID-19 exceeding 8,000,000 and the number of deaths related to COVID-19 exceeding 400,000 (including the deaths of 102 Australians).

In December 2019, a new coronavirus emerged in Wuhan City, in the Hubei Province of China, with the World Health Organization (WHO) confirming evidence of human to human transmission. Coronaviruses are a large family of viruses that can cause illnesses ranging from the common cold through to Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). The disease caused by the new virus is known as COVID-19.

The Queensland Government acted early and decisively to respond to the threat of COVID-19. The State Health Emergency Coordination Centre (SHECC) was activated to respond to the COVID-19 pandemic on 25 January 2020.

SHECC is stood up as an emergency coordination centre focused on ensuring an effective, coordinated response by Queensland Health, which comprises the Department of Health and the 16 Hospital and Health Services (HHSs), during any disaster or event that affects one or more of the Hospital and Health Services, or to support major events of significance like the Commonwealth Games and G20. SHECC functions include coordination of information, reporting, planning and logistic support to operations.

SHECC also embedded Liaison Officers from several other government agencies, including representatives from Queensland Ambulance Service (QAS), Queensland Police Service (QPS), Queensland Fire and Emergency Services (QFES), Department of Education (DoE), Department of Communities, Disability Services and Seniors (DCDSS), Department of Agriculture and Fisheries (DAF), Local Government representatives and the Australian Defence Force (ADF).

Furthermore, the State Disaster Coordination Centre (SDCC) was activated to coordinate the whole of government response in support of Queensland Health as the lead agency for the pandemic. Queensland Health is the lead agency for the response functions of public health, mental health and medical services under the Queensland State Disaster Management Plan, and the primary agency for four of the nine specific hazards listed in the plan: pandemic, biological, radiological and heatwave.

On 29 January 2020, the Honourable Steven Miles MP, then Minister for Health and Minister for Ambulance Services declared a public health emergency (COVID-19 emergency) for all of Queensland, under section 319 of the *Public Health Act 2005* (Public Health Act) due to the outbreak of COVID-19 in China, its pandemic potential due to cases spreading to other countries and the public health implications within Queensland. A declared public health emergency activates a range of powers and functions under chapter 8 of the Public Health Act. Queensland was the first State or Territory in Australia to declare this public health emergency, several other jurisdictions did so under their respective legislation shortly after. A Queensland Health Public Health Incident Management Team was established to support the COVID-19 emergency.

Under the Queensland disaster management arrangements, when a state-wide disaster is declared, the SDCC is stood up, led by the State Disaster Coordinator under the direction of the Queensland Disaster Management Cabinet Committee. The SDCC and State Disaster Coordination Group (SDCG) were mobilised following the declaration of the public health

emergency to support Queensland Health as a response lead and to ensure whole-of-government awareness and coordination in planning its pandemic response.

On 30 January 2020, the WHO declared COVID-19 outbreak as a public health emergency of international concern.

On 1 February 2020, the Prime Minister of Australia, based on updated health advice from the Commonwealth's Chief Medical Officer and the Australian Health Protection Principal Committee (AHPPC), introduced entry restrictions on foreign nationals who had been in mainland China from 1 February 2020 onwards. On 5 February 2020, Queensland Health introduced screening at Queensland's international airports (Brisbane, Cairns and Gold Coast) and required all travelers who had been in mainland China from 1 February 2020 to self-quarantine for 14-days.

On 26 February 2020, AHPPC recommended that surveillance should be maintained to facilitate COVID-19 testing in symptomatic returned travelers from South Korea, Iran, Japan, Italy, Hong Kong, Thailand and Indonesia. On 29 February 2020, the Australian Government announced entry restrictions on foreign nationals who had been in Iran from 1 March 2020 onwards. On 5 March 2020, the Australian Government announced entry restrictions on foreign nationals who had been in South Korea from 5 March 2020 onwards.

On 11 March 2020, the Director-General of the WHO declared COVID-19 a global pandemic.

The *Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020* (Public Health Emergency Act) was urgently passed by Parliament on 18 March 2020. Among other amendments, the Public Health Emergency Act amended the Public Health Act to strengthen powers of the Chief Health Officer and emergency officers for the COVID-19 emergency to implement social distancing measures, including regulating mass gatherings, isolating or quarantining people suspected or known to have been exposed to COVID-19 and protecting vulnerable populations, such as the elderly. In particular, the Chief Health Officer was empowered to make a Public Health Direction if they reasonably believe the Direction is necessary to assist in containing or responding to the spread of COVID-19 within the community.

The impact of the restrictions being imposed has been significant both for individuals and businesses. While essential services have been maintained, individuals have had their movement restricted for non-essential purposes and non-essential businesses have been unable to operate. Looking forward, as discussion turns to the easing of restrictions, the suppression of the virus means that Queensland is now well-placed to reopen our economy while also effectively manage any increased cases or localised outbreaks of COVID-19.

At the national level, the National Cabinet has provided an overarching governance mechanism for coordinated decision-making and nationally consistent responses across all Australian jurisdictions. Led by the Prime Minister and First Ministers from each state and territory, the National Cabinet has worked to enable a coordinated national response with input from all jurisdictions on the pandemic response, while allowing for flexibility so that responses are tailored to each jurisdiction's unique circumstances. National Cabinet decision-making is strongly informed by advice from the AHPPC, which is chaired by the Australian Chief Medical Officer and comprised of all jurisdictions' Chief Health Officers and a comprehensive panel of multi-disciplinary experts.

The COVID-19 pandemic had and continues to have the potential to be catastrophic for Queensland if not managed correctly. The restrictions that have been put in place in Queensland have meant that the uncontrolled outbreaks seen in some overseas jurisdictions have been avoided. Queensland has had time to consider and develop our health system to

be able to respond to any outbreaks, to meet the needs of unwell Queenslanders and to ensure the safety of front-line staff. Our health system has continued to respond to emergencies and address the needs of those most unwell in our community, including urgent non-COVID-19 related cases.

Queensland Health's early preparedness, ongoing leadership and investment in technology to improve health service outcomes meant that it was well positioned to rapidly upscale and support virtual models of care and alternate working arrangements in response to COVID-19 restrictions and distancing requirements.

Queensland Health has established clear processes to source Personal Protective Equipment (PPE), establish urgent additional space and equipment for COVID-19 cases, if required, and to support contact tracing when cases do occur. These baseline requirements are a result of the early and ongoing efforts of the health system in responding to the COVID-19 pandemic.

Governance Structures for Queensland Health's COVID-19 Response

The effective coordination and collaboration across all levels of government, Queensland government portfolios, within Queensland Health and HHSs and the health system more broadly, has been central to our ability to determine strategic priorities and rapidly mobilise resources to enable swift and targeted action. This was enabled by the establishment and Queensland Health's contribution to several governance mechanisms that bring together clinicians, multi-disciplinary experts, senior public and health care administrators and government leaders at the national, state, local and Queensland Government's intra-departmental levels. These are in addition to our 'Business as Usual' governance arrangements.

These groups have to date successfully operationalised Queensland's State Disaster Management Plan and the Queensland Health Disaster and Emergency Incident Plan (QHDISPLAN) and the Australian Government Australian Health Sector Emergency Response Plan for Novel Coronavirus (the COVID-19 Plan) to respond the COVID-19 Pandemic and will play a leading role in Queensland's Roadmap to Recovery.

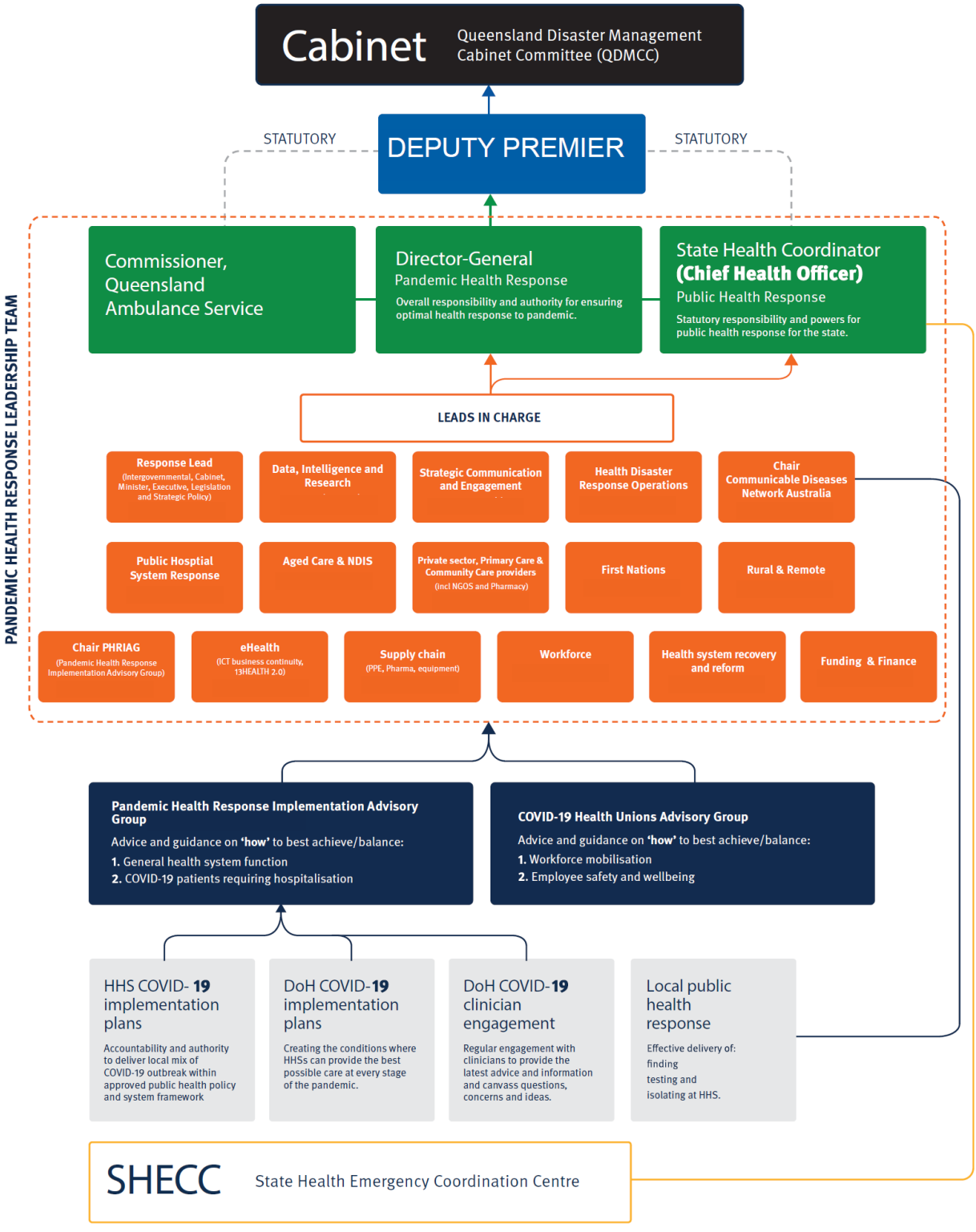
In responding to COVID-19 Queensland Health has been leading the public health response and also responding to the impact of the pandemic on the delivery of health services. The public health response includes but is not limited the finding, isolating and testing of cases and contacts, and monitoring and advising on the appropriate response to the pandemic. The pandemic health response include but is not limited to the health systems capacity to support the public health response, and surge planning ensure capacity to treat and manage cases and to ensure continued delivery of essential health services, including emergency care, cancer treatment and obstetric services.

Queensland Health established two internal key governance mechanisms, the Pandemic Health Leadership Response Team (PHLRT) and the Pandemic Health Response Implementation Advisory Group (PHRIAG), that harnesses the diverse set of expertise across the Department and HHSs to develop and guide the implementation of our tactical response to the COVID-19 Pandemic.

PHRLT members were each assigned a portfolio lead area of accountability. Health Services Chief Executives (HSCEs) nominated a partner HSCE for each PHRLT member in an advisory and support capacity.

In the early stages of the COVID-19 response, PHLRT meetings and meetings between PHLRT and HSCEs were held daily to discuss issues impacting on the broader system, particularly the hospital preparedness activities. As matters were resolved and planning activities continued, the frequency of these meetings has decreased.

These groups were supported by the creation of a comprehensive administrative machinery articulated under various streams to support the demanding strategic and operational functions of our COVID-19 response. For example, the Office of Rural and Remote Health Establishment (ORRHE), leveraging off the priority planning for Remote Discrete First Nations communities, in partnership with the Aboriginal and Torres Strait Islander Health Division (A&TSIHD), developed a community preparedness planning document, *COVID-19 Rural and Remote community planning resource and checklists*, to provide a strategic outline of a community's responses to the COVID-19 pandemic.



Note: Roles and responsibilities of PHLRT members were subject to change over the course of the response to address emerging issues and priorities.

Legislative and regulatory response

Queensland was the first State or Territory to declare a public health emergency, with most States and Territories not declaring an emergency under their respective legislation until early or mid-March 2020. Declaring a public health emergency under the Public Health Act enabled emergency officers and others to commence issuing quarantine notices and take measures to control the spread of COVID-19 before it became unmanageable.

Following the declaration of the public health emergency, urgent legislative measures were taken to strengthen the ability of public officials to contain and respond to the spread of COVID-19 within the community.

On 30 January 2020, the *Public Health (Coronavirus (2019–nCoV)) Amendment Regulation 2020* was made. The regulation prescribed COVID-19 (then referred to as 'coronavirus 2019-nCoV') as a controlled notifiable condition and a condition requiring immediate notification. The purpose of the regulation was to ensure that Queensland Health was able to understand the epidemiology of the virus and manage any potential outbreaks in Queensland.

On 5 and 6 February 2020, regulations were made to extend the period of the declared public health emergency until 12 February and 19 February 2020 respectively. On 7 February 2020, the *Public Health (Declared Public Health Emergencies) Amendment Act 2020* was enacted to allow the period of the declared public health emergency to be further extended by regulation for periods of up to 90 days. The declared public health emergency was subsequently extended to 19 May 2020 and again to 17 August 2020.

On 18 March 2020, Parliament passed the *Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020* (Public Health Emergency Act) to strengthen powers of the Chief Health Officer and emergency officers appointed under the Public Health Act to implement social distancing measures, including regulating mass gatherings, isolating or quarantining people suspected or known to have been exposed to COVID-19 and protecting vulnerable populations such as the elderly and remote communities with a high Aboriginal and Torres Strait Islander population. In particular, the Chief Health Officer was empowered to make Public Health Directions that are reasonably necessary to assist in containing, or responding to, the spread of, COVID-19 within the community.

Several regulations were also made to prescribe police officers, fire service officers and harbour masters as additional categories of persons who may be appointed as emergency officers (general) under section 333 of the Public Health Act.

On 22 April 2020, building on the initial legislative response, Parliament passed the *COVID-19 Emergency Response Act 2020*. This Act established a modification framework of general application across the Queensland statute book. Under the modification framework, government departments, courts and other entities may make statutory instruments and/or propose 'extraordinary regulations' that directly modify Acts of Parliament with respect to statutory timeframes, proceedings of courts and tribunals, and provisions relating to physical documents or physical attendance at places or meetings. The powers may only be exercised to the extent necessary: to protect the health, safety and welfare of persons affected by the COVID-19 emergency; to facilitate the continuance of public administration, judicial process, small business and other activities disrupted by the COVID-19 emergency; or to achieve other specific purposes of the COVID-19 Emergency Response Act.

In reliance on these powers, several extraordinary regulations and statutory instruments were made to support Queensland Health's ability to respond to COVID-19. These extraordinary powers and any regulations and instruments made under them are subject to safeguards and will sunset on 31 December 2020.

On 18 May 2020, the *Health (Drugs and Poisons) Amendment Regulation 2020* was made to streamline service delivery and reduce physical contact for vulnerable patients during the COVID-19 pandemic. Specifically, the regulation allows certain drugs to be prescribed and dispensed based on a digital image of a prescription in accordance with the *National Health (COVID-19 Supply of Pharmaceutical Benefits) Special Arrangement 2020* (Cth).

On 21 May 2020, as a further legislative response to the pandemic, Parliament passed the *Justice and Other Legislation (COVID-19 Emergency Response) Amendment Act 2020* (COVID Amendment Act). This Act addressed matters that could not be dealt with under the modification framework established by the COVID Act.

Significantly, the Justice and Other Legislation (COVID-19 Emergency Response) Amendment Act amended the Public Health Act to:

- clarify that public health directions can be given to a parent on behalf of a child;
- clarify that public health directions can commence after they are published;
- authorise additional delegates to share information for contact tracing (including information from the Notifiable Conditions Register); and
- extend certain timeframes that apply to detention orders from 96 hours to 14 days, consistent with the powers of emergency officers to detain persons for up to 14 days under amendments made by the Public Health Emergency Act.

The Justice and Other Legislation (COVID-19 Emergency Response) Amendment Act also amended the *Private Health Facilities Act 1999* to allow the Chief Health Officer to waive license fees incurred by private health facilities that furnish assistance to the State during its response to COVID-19 and amended the *Mental Health Act 2016* to ensure continuity of care for mental health patients and to enable mental health patients to comply with public health directions, including orders to isolate or quarantine at particular places.

The changes provide that the Chief Psychiatrist may approve the absence of particular involuntary patients from an Authorised Mental Health Service if satisfied the absence is necessary to comply with an order or direction given under the Public Health Act. In order to approve an absence, the Chief Psychiatrist must be satisfied that the treatment and care needs of the person can be met in the community for the period of absence and that the absence will not result in an unacceptable risk to the person's safety and welfare, or to the safety of the community.

In addition, to expedite current administrative processes and enable continuity of treatment to involuntary patients during the COVID-19 pandemic, the Justice and Other Legislation (COVID-19 Emergency Response) Amendment Act has been modified to allow the Chief Psychiatrist to declare an Authorised Mental Health Service or appoint an administrator of an Authorised Mental Health Service via publication on a Queensland Health website, rather than being required to utilise the Government Gazette process.

The Justice and Other Legislation (COVID-19 Emergency Response) Amendment Act expires on 31 December 2020, except for the amendments to the Public Health Act in relation to detention orders, which will expire on 19 March 2021.

Understanding and mapping COVID-19

Since late 2019, Queensland Health had been closely monitoring the situation and spread of COVID-19 internationally and assessing the risk to Queensland which led to advice being provided to the Honourable Steven Miles MP, then Minister for Health and Minister for Ambulance Services, to declare a public health emergency under the Public Health Act on 29 January 2020.

Queensland Health's initial intelligence on COVID-19 was informed by announcements by the WHO, and advice from the AHPPC, who was in turn advised by the Communicable Diseases Network Australia (CDNA). On 21 January 2020, WHO issued its first situation report on COVID-19. On 30 January 2020, WHO's Director-General declared the outbreak of COVID-19 a Public Health Emergency of International Concern. The WHO issued recommendations that "all countries should be prepared for containment, including active surveillance, early detection, isolation and case management, contract tracing and prevention of onward spread." On 24 February 2020, WHO's Director-General affirmed that COVID-19 had pandemic potential, and that "this is a time for all countries, communities, families and individuals to focus on preparing."

Using Commonwealth modelling and partnering with the Commonwealth Scientific and Industrial Research Organisation (CSIRO) Collaborative, Queensland Health has developed its own modelling which is made available to approved stakeholders, in particular Hospital and Health Services, on the internal System Performance Reporting (SPR) platform and via daily reports. This modelling has been independently assured and validated by the University of Western Australia and includes forecasting of:

- the effective transmission rate (R0)
- hospital bed and Intensive Care Unit (ICU) capacity requirements (including ventilators) with a linkage to Queensland Health's COVID Response Framework
- medication needs for COVID-19 patients and maintaining business as usual services
- COVID-19 cases by Hospital and Health Service and what this means for Queensland's public health system.

Queensland Health has actively monitored key information to inform its response to matters relating to the COVID-19 pandemic, including supply and availability of PPE and other consumables such as disinfectant, availability of ICU beds, number of COVID-19 cases including the source of infection, locations and recovery, deaths from COVID-19. This was enabled through rapid development of data analytics and dashboards that integrated data from multiple, existing health systems and new patient management and tracing tools developed for COVID-19.

On 16 April 2020, the Australian Government released modelling outlining the impact of COVID-19 in Australia. Nowcasting uses Australian data from the previous 14 days to more accurately understand the present state of the epidemic. Model forecasts can be projected to estimate what the next fortnight will bring based on the current rate of epidemic growth. These forecasts can be used to review the effectiveness of current measures, inform future response strategies and predict the likely course of the pandemic over time.

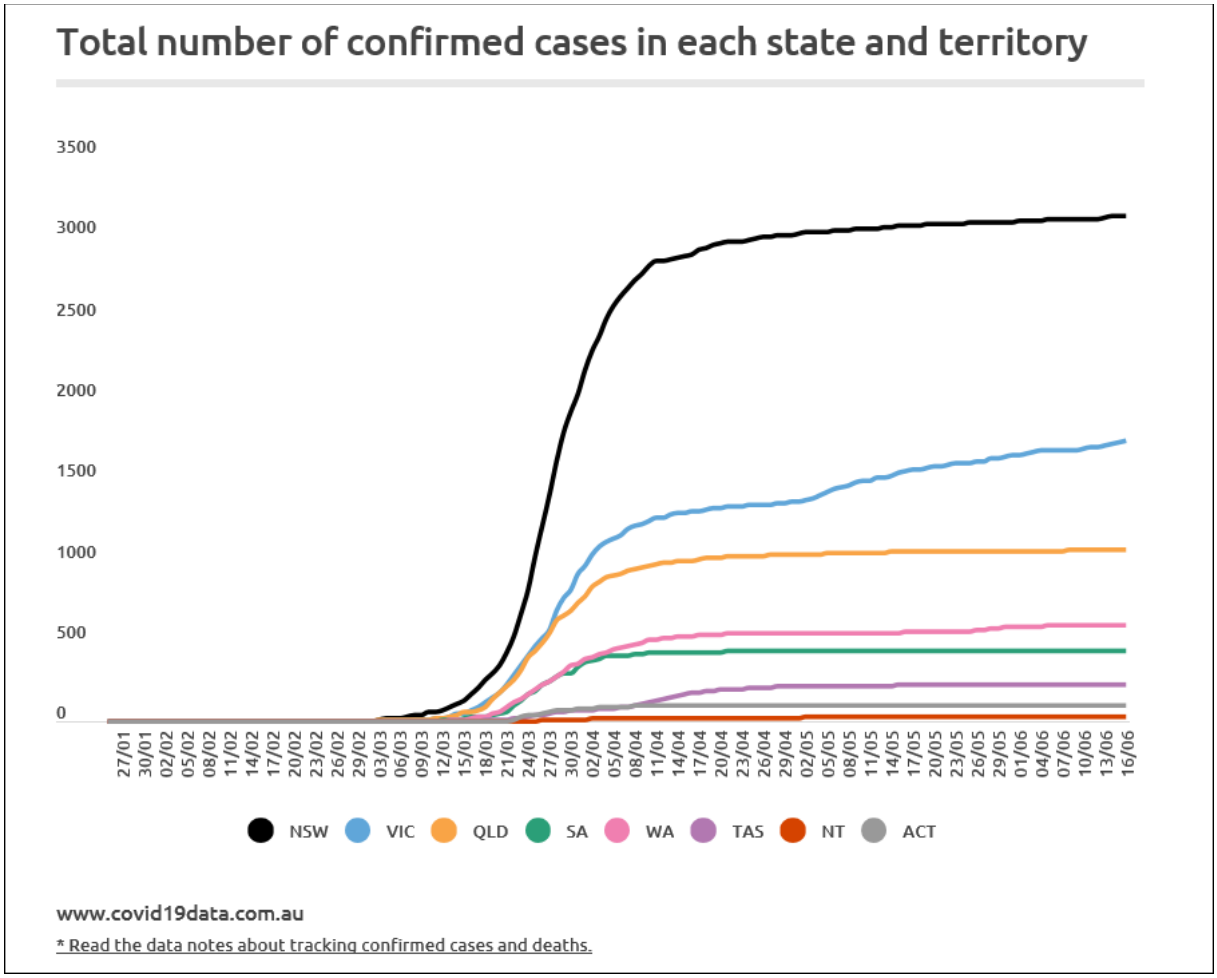
To support the strategy of suppression of COVID-19, the Australian National Disease Surveillance Plan For COVID-19 (Surveillance Plan) was developed and released on 29 May 2020 to guide the collection of comprehensive health data to enable us to understand the characteristics and time-trends of COVID-19 in Australia.

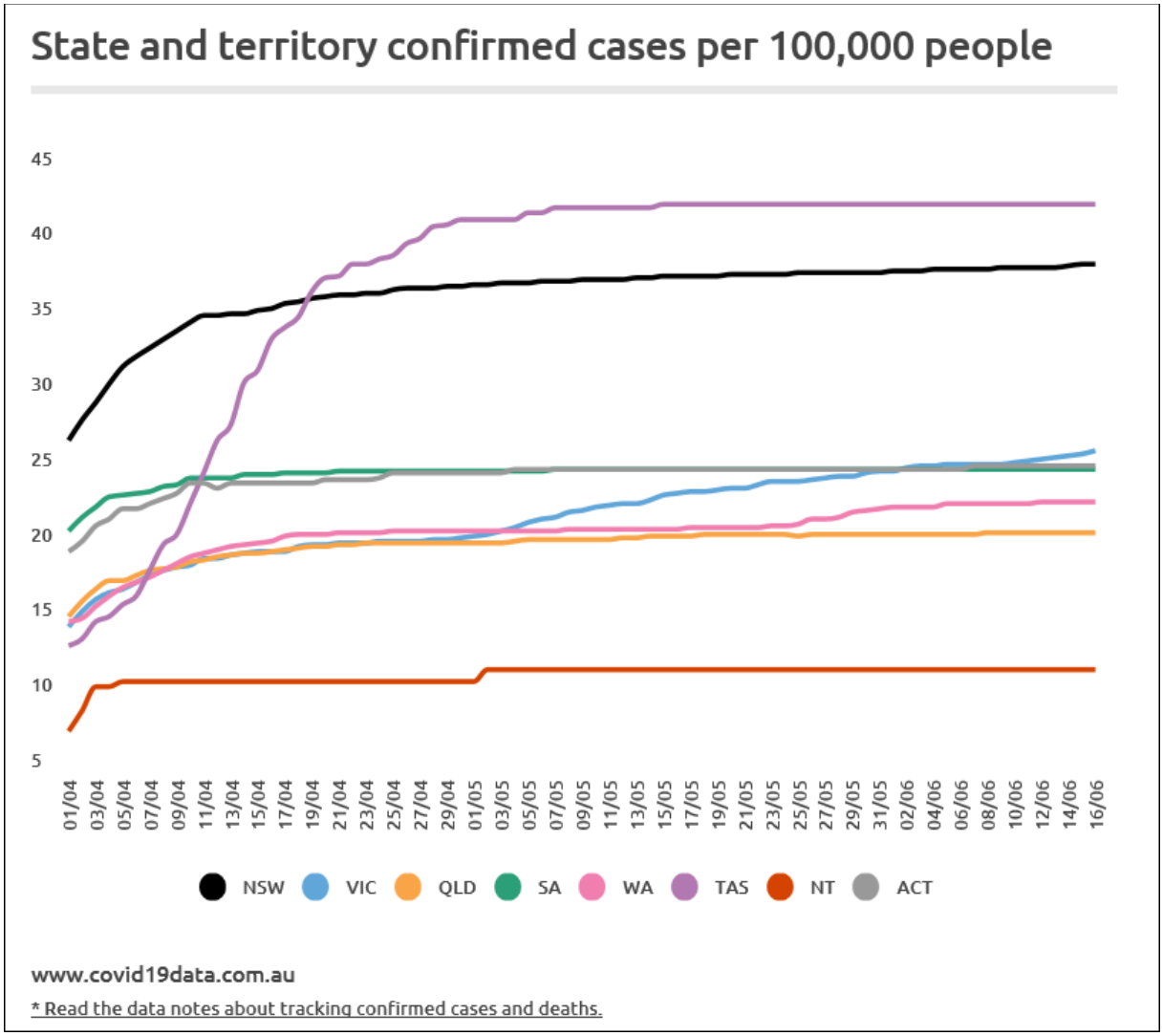
For national COVID-19 suppression strategies to be effective, effective reproduction rate (Reff) must be less than one. This means that every person who contracts COVID-19, on average, will transmit the virus to less than one other person. It is expected that the health system will be able to cope with projected peak/increases in cases if strategies to contain and trace cases are continued, as well as physical distancing and good hygiene practices are maintained.

The Australian Pandemic Health Intelligence Plan (Intelligence Plan) works in parallel with the Surveillance Plan providing pre-determined metrics to evaluate readiness to adjust measures and the outcomes of these adjustments.

Combined, these two plans provide a consistent and evidence-based framework for decision-making around easing restrictions and future measures as the pandemic progresses. It also enables states and territories to track progress against set goals and adjust strategies through the different stages of the pandemic in a gradual and safe manner.

As depicted in the following graphs, actions taken by Queensland and other States and Territories have seen the curve of the number of cases flatten over recent times.





Preparedness for a pandemic

Australia is one of a handful of countries around the world that has been, and remains, very successful in flattening the curve and having measures in place to continue to address the COVID-19 pandemic, with Queensland leading the way in Australia.

Queensland Health has a dedicated Health Disaster Management Unit, which leads state-wide policy and planning with HHSs and QAS, leads multi-agency planning and exercises, and operationalises SHECC. The all-hazards and all-agencies approach, adopted under the State Disaster Management Plan, ensures that the regularly exercised multi-agency responses for natural disasters such as cyclones and floods are utilised for less regular hazards such as pandemics. The Queensland Health Disaster and Emergency Incident Plan (QHDISPLAN) aligns with a similar all hazards approach.

SHECC is activated for natural disasters, emergency incidents and major events and alongside SDCC) for several months each year. Most recently, Queensland Health was the lead agency for the heatwave response in the 2018 bushfires, air and water quality in the 2019 bushfires, and for the contaminated strawberries public health event of state significance in 2018.

Queensland Health has had a Pandemic Influenza Plan in place since 2006 in response to the threat demonstrated by H5N1 avian influenza virus. The Queensland Health Pandemic Influenza Plan provides an effective health response framework to minimise transmissibility,

morbidity and mortality associated with an influenza pandemic and its impact on the health sector and the community. While focused on influenza, the plan outlines that it "may also be applied to the management of other highly transmissible respiratory infections associated with significant morbidity or mortality, including severe seasonal influenza". 'Winter Bed' strategies are also in place with private hospitals to ensure health system capacity.

The Queensland Health Pandemic Influenza plan was activated at the beginning of the COVID-19 response for use until a specific COVID-19 pandemic plan could be developed. At the commencement of the COVID-19 pandemic, the Queensland Health Pandemic Influenza Plan has been revised several times in response to previous learnings, having last been updated in 2018.

Queensland Health has developed and published COVID-19 specific public health and infection control guidance for health care and community settings, consistent with and supplementary to Australian Government Department of Health guidance.

Queensland Health also has in place a Health Service Directive (HSD) for the management of public health incidents of state significance, which requires the Hospital and Health Services to follow the directions of the Chief Health Officer on activation. This HSD was activated on 20 January 2020 to support the COVID-19 response. Each Public Health Unit (PHU) has Business Continuity and Emergency Incident Response Plans (EIRP) with annual exercises to test response capability. The EIRPs are closely aligned with and informed by State Public Health Disaster Planning documents.

In early March Queensland Health and DPC also undertook modelling-based scenario assessments on the likelihood of the health system and the pandemic response effort as a whole to be overwhelmed by a significant number of outbreaks and new cases as it was being experienced in other countries at the time. These scenarios included various potential variables relevant to the Queensland context:

- Concurrent outbreaks at multiple locations across the state including regional inland centres (i.e. Toowoomba), Northern Queensland regional centres close to discrete Aboriginal communities (i.e. Cairns and Yarrabah, respectively), remote areas with shared overseas borders (i.e. Torres Strait Island and Papua New Guinea, respectively) and heavily populated areas in Southeast Queensland (i.e. Brisbane).
- Multiple outbreaks across various settings in these locations such as schools, childcare centres, universities, aged care facilities and hospitals.
- A significant proportion (10%) of essential workers such as police and health professionals being required to self-isolate.
- A severe weather event occurring at the same time (i.e. cyclones in Northern Queensland)

On 10 March 2020, Queensland Health convened a forum which included the participation of the Minister for Health and Minister for Ambulance Services, Queensland Health Leadership Board, HHSs Chief Executives and key Executive Directors and Clinical Leads, consumer representatives, union delegates, to enable critical hospital planning to ensure preparedness for the Pandemic. The forum sought to:

- Inform participants of the likely timeline, stages of the COVID-19 response in Queensland and potential impact on the health system workforce and the broader community.
- Explore systems considerations for COVID-19 such as hospital thresholds and triggers, funding and workforce.

- Ascertain the status of hospital preparedness plans to double intensive care capacity and triple ED capacity.

The matters considered at this forum were complex, wide ranging and impacted on all of parts of the health system in Queensland, with focus on hospital capacity (particularly ED and ICU), health system funding and the health workforce. This focus was not at the expense of other important issues, but rather recognised that planning for other parts of the system, such as aged care, primary care and First Nations health, required specific inputs from lead areas within Queensland Health and conducted focused planning separately.

During this period, joint-planning and extensive consultation such as this occurred across the whole health sector and enabled the development of the Queensland Health COVID-19 Surge Plan (Surge Plan) to ensure patients could continue to access the right care, at the right time and in the right setting.

By early March, HHSs implemented strategies to ensure pandemic preparedness and lift capacity in the health system. This included establishing COVID-19 response plans, commissioning COVID-19 specific theatres and wards, split staffing to avoid potential infection, clinical hotlines, overflow clinics, increased staffing to support increased Intensive Care Unit and Emergency Department capacity. Some HHSs also commenced capital works and non-urgent category 2 and 3 elective surgeries were suspended. These measures were supported by a refocusing of the system onto emergency and urgent planned care in line with both national and state policy decisions on how to respond to the COVID-19 pandemic.

With an initial forecast that there would be a major peak in COVID-19 cases towards the end of April 2020, on 24 March 2020, the Queensland Government provided a funding boost of $1.2 billion to increase the capacity of Queensland's health system to respond to COVID-19. This included the expansion of the health system to:

- double intensive care capacity
- triple ED capacity
- employ more paramedics, ambulance services
- deliver more acute care services
- expand fever clinics
- deploy new infrastructure and better utilise our existing hospitals
- expand community screening and contact tracing services
- expand Health Contact Centre services including establishing self-quarantine health and compliance checks and doubling the capacity of the 13 HEALTH nurse triage and general information
- resource backfilling of health staff who are unwell
- continue non-urgent elective surgery in the private sector
- deliver more support for regional health services
- provide more aeromedical services for regional and remote communities
- expand suppliers to source and secure PPE
- deploy new infrastructure and better utilise our existing hospitals
- upscale information and communications technology capacity and support levels to increase health services delivery flexibility across the state (including telehealth) and supporting alternative working arrangements for up to 40,000 staff

- prepare to rapidly deploy information technology to support intensive care, ED, fever clinics and other hot spots as they occurred
- prepare for an increase in cyber security attacks targeted at healthcare organisations experiencing major disruptions due to COVID-19

Primary Health Networks/Primary Care

Active consultation has occurred with representatives from the primary care sector throughout the COVID-19 response throughout the pandemic. This included consultation for the development of the Surge Plan and response to ensure patients can continue to be supported to access primary care services in the right settings.

Through established disaster management arrangements, HHSs have well practised collaborations with their local Primary Health Networks (PHNs) in preparedness and disaster responses. Queensland Health has regularly engaged with PHNs and other key stakeholders to advise on the public health response and decisions regarding health service provision that impact primary care.

On 20 March 2020, Queensland Health met with PHN's Chief Executives to discuss the then draft Surge Plan and the accompanying service modifications that would occur as required to expand rapid public hospital capacity. Formal communication occurred with relevant stakeholders in the primary care sector on 27 March 2020, advising of the determination to trigger the first Surge Plan response that occurred on the 22 March 2020, and advising of the service modifications that would occur across the public system.

Since 28 January 2020, daily Chief Health Officer teleconferences involving public health units, hospital and health service emergency operations centres and other stakeholders, specific primary care meetings were established between SHECC and Queensland PHNs as a mechanism to directly share information on the progression of Queensland Health's response with the sector and to respond to arising concerns. This was in addition to the local communication and partnerships established between HHSs and their PHNs and local general practices.

To alleviate capacity constraints on hospitals, a community management pathway for mild COVID-19 cases in rural and remote communities was developed by the ORRHE and the Statewide Rural and Remote Clinical Network. The pathway is in the process of being published to the Queensland Health website. The community management pathway was developed with input from other statewide clinical networks, metropolitan and regional hospitals, consumers, GPs and other clinicians across Queensland. The community management pathway incorporates elements of Hospital in the Home and Virtual Ward models to enable a shared care of a patient with mild COVID-19 by a GP, visiting medical officer or rural generalist and the relevant hospital in circumstances where the patient can be safely monitored and cared for at home or in another appropriate setting in the community.

Preparedness in prison

The Office for Prisoner Health and Wellbeing (OPHW), Queensland Health has been working closely with Queensland Corrective Services (QCS) and Prison Health Services in HHSs on COVID-19 preparedness and the implementation of strategies to reduce the risk of a COVID-19 outbreak in correctional centres. Queensland Health has facilitated health and temperature screening for prisoners and staff in correctional centres. To date, there have been no confirmed cases of COVID-19 for prisoners within correctional centres.

A QCS COVID-19 Taskforce was established in February and Queensland Health has supported this Taskforce with clinical information and advice. The Taskforce developed *Guidelines for the Prevention, Control and Management of COVID-19 Outbreaks in Corrective*

Services Environments in Queensland in consultation with the OPHW. A weekly COVID-19 meeting for the operational management teams of prison health services and PHUs has been established to provide an update from a state-wide perspective, discuss issues and share information and resources.

Hospital and ICU capacity

The Statewide Intensive Care Clinical Network (SICCN) has supported and guided the local expansion plans of Intensive Care Units (ICUs) across Queensland. A significant procurement exercise has been undertaken to ensure Queensland has enough ventilators and associated medical equipment to manage a substantial increase in demand for ICU beds. A project to pilot a telemedicine intensive care support service is underway to ensure regional and rural clinicians have access to expert intensive care advice.

The SICCN undertook an initial scoping of current ICU capacity and stock take of ICU equipment. Appropriate areas within hospitals were identified as possible ICU expansion areas. Re-skilling of clinical staff was also undertaken to support the current ICU workforce. A daily survey of ICU demand and capacity was commenced to enable early identification of areas of need that may require redeployment of equipment or clinical staff. The SICCN met twice a week to update on resourcing and share learnings regarding the clinical course of COVID-19 patients within ICUs. The Guidelines for the provision of intensive care services during the COVID-19 pandemic was reviewed and updated by the SICCN.

Utilising a tiered framework, the Surge Plan provided direction to all HHSs to prioritise care, deliver vital healthcare services to all Queenslanders and facilitate rapid increases to maximise hospital capacity in response to escalating COVID-19 outbreak scenarios. The framework included surge planning modelling for intensive care unit beds and the required equipment for invasive and non-invasive ventilation. All HHSs had individual contingency and emergency plans tailored to their local situation. Key stakeholders were also able to monitor modeling and forecasting of system wide bed and ICU capacity, system triggers linked to the framework and potential private Emergency Department diversions by using internal dashboards published on SPR.

The tiered framework creates capacity through escalating levels of reducing non-essential services in the public system while simultaneously increasing capacity through utilising both public and private options. It maps out how Queensland Health can continue to provide vital care during an increased surge to the public health system while minimising health service disruption to prevent harm related to non-COVID-19 related conditions.

The planning process was supported by HHSs to determine the technology requirements and rapidly deploy information technology to support intensive care, emergency departments, fever clinics and respond to hot spots as they arose. Utilisation of telehealth through virtual care and outpatients also reduced the number of minor presentations at hospitals reducing the risk of spreading the virus and maintaining bed capacity.

To further ensure capacity, Queensland entered into a National Partnership Agreement (NPA) with the Australian Government that confirmed the arrangements with private hospitals to assist with COVID-19 cases. Under this NPA, the Australian Government funds COVID-19 related activity in private hospitals in a 50:50 split with states and territories. It will also fund the 'viability gap' for private hospitals to account for their reduction in private surgery and other activity.

Queensland's rapid health response and management of the COVID-19 pandemic has been effective in reducing transmission and has resulted in consistently low reported cases, averting

the scenario where extreme pressure would have been placed on the health system and frontline workers.

Hospital and Health Service staffing

The Human Resources Branch, Department of Health, worked with the HHS executive directors of workforce on the supply mechanisms of a contingent workforce. The following steps were taken to build a contingent workforce for Queensland Health:

1. Existing Queensland Health staff were reassigned internally to support additional work emerging as a result of COVID-19. For example, HHSs were able to re-assign staff in services which had been reduced or paused.

2. Utilisation of the Public Sector Workforce Mobilisation Service coordinated by the Public Service Commission. HHS workforce requirements, provided by the EDs of Workforce, formed the basis for matching employees from other public sector agencies to essential roles in Queensland Health.

3. The Human Resources Branch coordinated a COVID-19 Expressions of Interest (EOI) campaign, effective from 18 March 2020. Queenslanders were invited to express interest in temporary employment with Queensland Health should demand arise. In addition, some HHSs conducted their own EOI recruitment processes.

Public Sector Workforce Mobility

Queensland Health identified critical workforce requirements and sourced available mobilised public sector employees through the rapidly established Public Sector Workforce Mobilisation Service, with 100 employees mobilised to areas in Queensland Health such as HHSs, the State Health Emergency Coordination Centre and associated areas.

External Expressions of Interest

Queenslanders were invited to apply for roles in the following workforce streams:

Medical	**311**
Nursing and Midwifery	3390
Allied Health	3530
Administration Support	14887
Operational	10345
Dental	529
Contact Tracing Officers	220

**Figures as at 7 May 2020*

Individuals registering for these opportunities were categorised into talent pools identifying locational preferences and professional registrations. A newly formed COVID-19 recruitment network was established to ensure recruiters from across all HHSs had access to EOI respondent information. To support the need to rapidly onboard a surge workforce, new conditional employment processes were developed to allow new temporary employees to commence in roles while finalising pre-employment screening outcomes and preventable disease vaccine requirements.

Contact Tracing

Contact tracing roles were filled through the reassignment of existing HHS employees. In addition, the Department of Justice and Attorney-General led a taskforce which looked at building a standby contact tracing workforce. The Public Service Commission invited

approximately 1057 public sector employees to undertake contact tracing training to support Queensland Health in the event there was a surge in cases. As of 3 June 2020, 560 public sector employees have completed the contact tracing course and remain on standby.

Health Practitioner

A sub-group of the Australian Health Practitioner Regulation Agency Jurisdictional Advisory Committee with Queensland representation was formed with the first meeting on 8 March 2020. This group supported the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards formation of the Pandemic Response sub-register which has been established for up to 12 months (or less if the Pandemic subsides) to assist with fast-tracking the return to the workforce of experienced and qualified health practitioners to the national register.

The sub-register came into effect on 6 April 2020 including medical practitioners, nurses, midwives, and pharmacists and is an opt-out basis with eligible practitioners added to the pandemic sub-register automatically. There is no obligation for persons added to the sub-register to practice or remain on it. Eligible diagnostic radiographers, physiotherapists and psychologists were added to the register from 20 April 2020.

From mid-July, it is anticipated that previously registered Aboriginal and Torres Strait Islander Health Practitioners will have the opportunity to opt-in to a specific sub-register. This has been negotiated by Queensland, Northern Territory and South Australia. AHPRA provided the Department of Health with an excerpt from the sub-register for all practitioners identified as having a principal place of practice in Queensland.

This information has been held by the Clinical Chiefs for the relevant professions to support the recruitment process for the surge workforce. The relevant National Boards are preparing transitional pathways for practitioners on the sub-register to return to general registration if desired following the 12-month period.

To further specific clinical workforce capacities across the Queensland HHSs, including the utilisation of the Pandemic response sub-register, a series of options papers were produced for consideration and utilisation of the respective Clinical Chief as members of the PHRIAG:

- Nursing and Midwifery surge workforce options – finalised 6 April 2020
- Pharmacy, Physiotherapy and Diagnostic Imaging surge workforce options – finalised 15 April 2020
- Medical surge workforce options – finalised 20 April 2020
- Aboriginal and Torres Strait Islander Health workforces' options – finalised 27 April 2020.
- ICU nursing specific workforce surge options - finalised 3 June 2020.
- Aged Care nursing specific workforce options – to be finalised 12 June 2020.

These options were scenario based and can scale up and down depending on the levels of clinical response and optimum skill mix required to deliver services. Options included potential utilisation of capacity within private and not-for-profit sector workforces as clinical activity such as elective surgeries were scaled down.

Reports also modelled the impact of vulnerable workers (for example Aboriginal and Torres Strait Islander person who is 50 years and older with one or more chronic medical conditions – as per the Queensland Health guideline) and potential loss of skilled clinical workforce due to sickness from contracting COVID-19 and isolation requirements, such as when awaiting testing results.

Nursing and Midwifery Staff

Potential pools of nursing and midwifery staff were identified in March and April through:

- Remaining graduates that had applied for the 2020 Graduate Nursing and Midwifery Campaign that had not secured a placement by the beginning of March (2,700 candidates),
- EOI for nursing and midwifery staff to assist as part of the COVID-19 response was advertised on 18 March 2020 and closed 18 May 2020 (over 4,000 candidates).
- AHPRA Sub-Register which includes re-registered nurses and midwives that had cancelled their registration within the last three years and had no suspensions or outstanding complaints or sanctions and were not subject of a conduct, performance or health notification at the time they were removed from the register.

Each HHS developed COVID-19 Contingency Plans, which were supported by workforce planning tools to provide insight into the potential increase in FTE that could be achieved through internal staff strategies and external strategies such as:

Internal staff strategies

- Reallocating the current indirect or enabling nursing workforce, that is those who are not currently frontline into frontline nursing roles
- Increasing the hours of the current part time and casual workforce
- Recalling staff currently on annual leave

External staff strategies

- Mobilise agency nurses or deployed staff from other non-impacted HHSs through SHECC request
- Employment of Nursing Talent Pool – Registered nurses, enrolled nurses and assistants in nursing expressed interest in working for Queensland Health
- Employment of registered nurse graduates who are not currently employed and have expressed interest in working for Queensland Health
- Re-registering registered nurses whose registration has lapsed in the last 3 years that are on the AHPRA Sub-Register
- Employing registered nurse students undertaking year 2 and 3 of their studies temporarily to support frontline nursing staff

Other options that could be considered

- Use of private health organisations under contract agreement with Queensland Health
- The use of registered midwives holding dual registration as midwife and registered nurse
- Increased use of current nursing workforce using overtime.

Rural and Remote

To help with surges in rural and remote areas, HHSs agreed to a process whereby the ORRHE, Human Resources Branch and the Medical Advisory and Prevocational Accreditation Unit (MAPAU) could identify Queensland Health medical practitioners (predominately from metropolitan health services) who would be prepared to deploy to rural and remote communities to assist with medical service delivery during a surge period. These metropolitan doctors would, in turn, be backfilled by the significant number of EOIs received for metropolitan

services. The same approach may also be utilised for nursing and Aboriginal and Torres Strait Islander Health Practitioners and Workers who may be needed to augment workforce capacity in rural and remote communities.

Modelling of Workforce Requirements

Queensland Health developed a centralised information solution to support workforce management during the COVID-19 response. It was expected that an increase of people in the community being impacted by COVID-19 would lead to an increased demand for HHSs, while managing higher rates of absenteeism rates within the workforce. On 17 March 2020, a system-wide workforce dashboard was implemented to assist in workforce decision-making. This facilitated the recruitment of employees to support an increase in demand and the deployment of the right skilled staff, while protecting vulnerable employees. The dashboard supports:

1. Protecting vulnerable employees who are at higher risk from the effects of COVID-19 in accordance with the COVID-19 vulnerable employee guidelines.
2. Monitoring the number of employees who are unable to work due to testing positive to COVID-19, being in isolation or COVID-19 related caring responsibilities
3. Identifying employees who have critical skills and experience to respond to COVID-19, including employees who have worked in ICUs, emergency services, aged care services and PHUs.
4. Assessing a potential impact of school closures by identifying employees with caring responsibilities.
5. Assessing a potential impact of international and domestic travel bans by identifying employees who are non-citizen or non-permanent residents or employees who live interstate
6. Monitoring COVID-19 temporary positions.

Employment Relations

Queensland Health's rapid engagement with its workforce and stakeholders allowed for immediate workforce capacity and capability uplift to meet the clinical requirements of COVID-19. Centralised leadership in the human resources response allowed for clear and consistent messaging and leveraging of existing partnerships with the various public health unions and ensured the workforce was empowered to meet public healthcare needs. This was accomplished through a tiered framework of engagement to ensure the ongoing and constant transmission of communication between Queensland Health, its workforce and public health unions.

In addition, there were weekly meetings held with the executive directors of workforce from HHSs which again allowed for the urgent transmission of information involving the workforce. The development of a single webpage as the conduit and repository of COVID-19 workforce specific information supported the human resources communication strategy.

On 16 April 2020, the Director-General, Queensland Health, released the *COVID-19 Industrial Relations Principles* which were used to provide clarity and certainty on important key aspects of the employment relationship for the duration of Queensland Health's response to COVID-19. The principles formed an overarching framework and provide the ability for rapid consultation processes to be agreed and implemented and supported the development of safe and responsive rules of engagement in partnership with unions. They also set the expectations on how staff would be managed throughout the pandemic.

Safety and Wellbeing

During the COVID-19 pandemic crisis the Human Resources Response Team (HRRT) developed supporting information and guidelines to support employees and their line managers. This included developing the *COVID-19 vulnerable employees guidelines* which assisted in identifying employees that are at a higher risk from the effects of COVID-19 due to existing health conditions and/or circumstances and identifying ways employees can continue to work with suitable adjustments to ensure their safety and wellbeing. The HRRT worked closely and engaged internally with key COVID-19 response teams within Queensland Health to provide regular feedback from stakeholders on the development of versions of the *Interim infection prevention and control guidelines for the management of COVID-19 in healthcare settings*. This document included information on the safe fitting and removal of PPE for healthcare staff. The HRRT developed a four-point summary of the statewide mental health and wellbeing support for staff:

- The *COVID-19 Wellbeing Strategy* provides tiered support to sustain employee wellbeing during the phases of COVID-19.
- All dimensions of wellbeing are considered in the statewide provision of COVID-19 specific wellbeing resources published to the Queensland Health intranet, QHEPS.
- Statewide distribution is achieved via broadcasting and publishing of COVID-19 wellbeing supports and resources for all staff on QHEPS, inclusive of an HHS index to HHS-specific COVID-19 information, statewide Employee Assistance Services details and available counselling support, wellbeing resources, fact sheets and FAQs.
- Further resources continue to be developed to meet changing staff needs through the various phases of the COVID-19 pandemic: Rapid Change – During – Recovery – New Normal.

In addition, the Human Resources Branch developed several wellbeing fact sheets and a COVID-safe workplace transition plan for Queensland Health employees to support the safe return of employees to the workplace. The plan was developed in line with Public Health Directions, Workplace Health and Safety Queensland guidelines and the *National COVID-19 Safe Workplaces Principles*.

COVID-19 testing and fever clinics

Testing regime

Queensland Health's testing regime for SARS-CoV-2 has been undertaken in line with advice from CDNA, which is continually reviewed and regularly updated in the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for PHUs.

Testing criteria was initially focused on returned international travelers with fever and/or respiratory symptoms, and close contacts of these returned travelers. The testing criteria in Queensland was expanded on 25 April 2020 to include anyone who presents with a fever or history of fever, or acute respiratory symptoms. On 4 June 2020, the latest COVID-19 Public Health Alert No. 14 was issued which further expanded testing to include anyone who met clinical or epidemiological criteria as well as anyone who presented to a fever clinic, including those with atypical symptom presentations for COVID-19.

Pathology Queensland, together with Forensic and Scientific Services, now has six different test platforms for COVID-19 testing, up from the original two available in January 2020. Five of these are polymerase chain reaction (PCR) instruments used for front line testing. The sixth uses a serology-based test, which detects the presence of antibodies to the virus in the blood and can be used to assist contact tracing.

Queensland has current capacity to undertake up to 10,000 tests per day. This has provided Queensland with the ability to undertake urgent COVID-19 tests on site at 29 public hospitals. High volume testing can now be undertaken at the Forensic and Scientific Services Coopers Plains Laboratory and at Pathology Queensland laboratories at Cairns Hospital, Townsville Hospital, Sunshine Coast University Hospital, Royal Brisbane and Women's Hospital, and Gold Coast University Hospital. High volume testing capability is also planned for Toowoomba and Rockhampton Hospital laboratories, with these instruments expected to be brought into production over the course of June and July 2020. Private pathology laboratories are able to test for COVID-19 with laboratories in Brisbane and Sydney.

As a result of this expansion the results for routine COVID-19 testing for most Queenslanders are available on average within 24 hours. Turnaround times for non-urgent results from remote communities can take up to 3 days because of the distance to their nearest laboratory, but the results of urgent testing in small Queensland hospitals like Mount Isa and Thursday Island with laboratories on site can usually be delivered within two hours of receipt in the laboratory.

Australian Department of Health Point of Care Testing (PoCT) Program

Queensland Health has been working closely with the Australian Department of Health and the Kirby Institute as those organisations continue the rollout of Point of Care Testing (PoCT) for SARS-CoV-2 in remote and isolated communities across Australia. On 4 June 2020, the national group, Aboriginal and Torres Strait Islander Advisory Group on COVID-19, approved an additional 18 Queensland sites for inclusion in the program. This included five sites in Queensland nominated by Queensland Health in consultation with internal stakeholders.

Fever clinics

Fever clinics are operated by HHSs and are set up as specialist clinics for people who may be infected with COVID-19. All HHSs have established a fever clinic, and over the course of the pandemic, as at 16 June, there have been a total of 125,071 presentations across Queensland.

These clinics can be in an emergency department or in a separate area and help keep people who may be contagious away from other areas of hospitals or health services to minimise risk to other patients and staff. This was supported through planning of technology requirements with HHSs to rapidly deploy information technology and maintaining capacity (infrastructure and support resources) to support fever clinics and other hot spots as they occurred.

The Australian Government has also set up fever clinics across Australia with a number of clinics in Queensland.

Ventilators, personal protective equipment and other equipment

Prior to the declaration of the public health emergency, the sourcing of sufficient PPE and other equipment and supplies was of high priority to Queensland Health to ensure the wellbeing and safety of staff and to ensure COVID-19 patients could be appropriately cared for. An intensive care bed requires a ventilator as well as critical supporting equipment and medication. For this reason, efforts to access, source and supply ventilators was closely monitored from early 2020 through centralised online monitoring mechanisms and modelling tools developed by Queensland Health. Dashboards were made available to key stakeholders to provide statewide visibility of equipment required, including forecasting of PPE requirements by HHSs and facility, and the reporting of current status of available ventilators and types available.

PPE is crucial for Queensland Health's response to the COVID-19 pandemic. In early 2020, as COVID-19 began to transcend borders and be identified as a worldwide pandemic, local

and international supply chains progressively became volatile as panic ordering and demand far outstripped supply. In Queensland, the impact of global infection rates started to be realised for supply and procurement from mid to late-January and progressed to include restriction of supply and notification of forced allocation from key suppliers. These market conditions worsened over time, making it increasingly difficult to source PPE and other critical items, leading to a fundamental change in the way sourcing, procurement and supply teams operate in order to ensure surety of supply.

Queensland Health has partnered with other Queensland Government departments and agencies to provide opportunities for Queensland businesses to address supply shortages arising from international and state border closures.

In March 2020, Ministers convened an Executive Governance Oversight Committee for PPE procurement led by Directors-General from Queensland Health, Department of State Development, Manufacturing, Infrastructure and Planning (DSDMIP) and Department of Housing and Public Works (HPW), supported by the Department of the Premier and Cabinet (DPC), to solely focus on demand and supply of critical PPE items and emerging critical items. This included diverse purchasing arrangements to optimise the opportunity for current supplier and manufacturers to meet existing and future demand, the provision of specifications for critical PPE items for manufacturers, and support for fit testing and clinical appropriateness aligned with Therapeutic Goods Administration (TGA) approval.

Queensland Health directly received or was forwarded by other agencies offers to supply PPE. To manage initial offers, Queensland Health established a register of individuals and organisations interested in providing PPE. All leads were logged, and contact made with prospective suppliers. On 20 April 2020, a COVID-19 supply portal was launched by Queensland Health to inform and manage potential suppliers and streamline a due diligence process. Referral pathways were established with DSDMIP, HPW and DPC to ensure offers of supply could be redirected as appropriate across agencies.

In April 2020 the interim COVID-19 Supply-Chain Surety Division within the Department of Health was formalised to oversee and bring an end-to-end process for the Department's supply chain surety response. The interim division consolidated demand planning and forecasting, supply planning, procurement, purchasing, supplier payments and warehousing and logistics into a single coordinated stream from across various Department Divisions.

A COVID-19 PPE demand planning and modelling tool was developed to forecast PPE usage across Queensland Health, based on actual and predicted data. Extensive clinical engagement took place during the development of the model to determine and validate the appropriate use of PPE in the pandemic environment, including with the Infectious Diseases and Infection Control Clinical Network, the PHRIAG, and HHSs clinicians and Chief Executives.

The demand modelling was used to inform risk adjusted ordering of PPE and the supply of PPE to HHSs in line with the disease profile. The modelling also included the ability to forecast PPE usage in the event of an outbreak.

Daily reporting on pandemic and non-pandemic PPE stock levels was established to enable early identification of supply challenges and equitable distribution of available supply based on need. This reporting includes tracking of available stock, forecast days of coverage of existing stock and the status of orders (i.e. total quantity of orders, percentage of those fulfilled and quantity of items still to be delivered).

Rapid and streamlined procurement processes were put in place to enable procurement teams to secure critical goods in a highly competitive market. Existing (traditional) suppliers of PPE

were contacted to confirm their capability to fulfil existing and to expedite the supply of new, large volume orders.

Queensland Health worked with Trade and Investment Queensland (TIQ) to investigate opportunities for sourcing PPE using their international presence to understand what's was occurring in local markets i.e. China and how best to access freight and airport options to move stock to Australia.

Queensland Health has also worked closely with DSDMIP to support businesses in Queensland to retool and refocus manufacturing opportunities for the supply of PPE. Manufacturing opportunities that Queensland Health has supported to date include face shields, face masks, hand sanitiser and reusable gowns. To date, over 120 clinical assessments of product samples have been undertaken and feedback provided on the assessments.Queensland Health made early contact with the Australian Government Department of Health to access PPE from the National Medical Stockpile (NMS). On 23 March, 6 April and 17 April 2020, the Chief Health Officer wrote to Professor Brendan Murphy, Chief Medical Officer, Commonwealth Department of Health requesting access to the NMS for masks, face shields and gowns. This relationship has been maintained and strengthened to enable Aged Care Facilities to be provided with PPE from the NMS through Queensland Health.

The Relationship and Demand Management Team was established to manage relationships with HHSs and problem-solve supply issues as they arose. This includes the identification and supply of appropriate alternatives or substitutions, to manage any shortages of items.

Elective surgery and cancer screening

In line with National Cabinet's decision to suspend elective surgery on 26 March 2020, Queensland Health suspended non-urgent category 2 and 3 elective surgery. Category 1 and urgent category 2 elective surgery continued to be delivered in public hospitals.

Since the National Cabinet decision, Queensland Health has undertaken extensive negotiation with private providers to develop agreements to ensure capacity across the whole health system to respond to COVID-19, as well as pass on the Australian Government's viability payment to support the ongoing operation of private hospitals. Queensland Health will utilise its existing Surgery Connect contracts with private hospital providers to enable elective surgery and Gastrointestinal Endoscopies to be delivered to more Queenslanders.

On 30 March 2020, the Director-General, Queensland Health, wrote to HHSs Chief Executives concerning the temporary statewide suspension of the BreastScreen Queensland program. This position was informed by expert clinician opinion, falling rates of client attendance at screening appointments, and continued escalation of the COVID-19 pandemic.

Temporary service suspension protected the health and safety of clients and staff and allowed for the release of HHS staff and facilities to respond to COVID-19 healthcare demand. Readings, assessments and referrals for existing BreastScreen Queensland clients were concluded to ensure completion of the pathway and fulfil the program's duty of care. Approximately 9,000 existing appointments from April to June 2020 were cancelled. The temporary service closure decision was consistent with breast screening suspension for all states and territories.

In late April 2020, the Director-General, Queensland Health wrote to HHSs requesting they recommence service delivery in line with advice from National Cabinet, including:

- Expansion of Category 1 and 2 Elective Surgery (1 in 4 theatre lists which were closed due to COVID)
- Acceleration of Category 1 and 2 specialist outpatient services, with a focus on virtual/telemedicine care models
- Reactivation of BreastScreen Queensland
- Expansion of endoscopy and colonoscopy (focus on category 4) and
- Expansion of dental services to Level 2 restrictions.

From 28 April 2020 to 12 June 2020, across Queensland there were 14,947 elective surgeries performed. This was made up of 5,928 Category 1 elective surgeries, 6,904 Category 2 elective surgeries and 2,115 Category 3 elective surgeries. On 15 May 2020, elective surgery also began to recommence in private hospitals.

On 14 June 2020, the Queensland Government announced that $250 million would be provided to support increasing capacity within the health system to reduce the number of people who had their surgery postponed as a result of COVID-19. The delay was considered necessary to ensure that the health system could increase its capacity to address any potential outbreak of COVID-19.

As at 1 June 2020, there were 52,240 patients on elective surgery lists, with more than 90 percent of those waiting within clinically recommended timeframes. However, modelling indicates that more than 7,000 people have been waiting outside of clinically recommended timeframes as a result of the delay due to COVID-19.

This additional funding will support both the public and private sector to address the health needs of Queenslanders who have been impacted as result of COVID-19. The additional funding will enable elective surgery waiting lists to be reduced and allow people to receive their elective surgery within clinically prescribed wait times.

On 27 April 2020, Queensland Health recommenced a staggered recommencement of the BreastScreen Queensland program. By 1 June 2020, 10 of 11 services across the state had resumed service provision. Screening resumption focused on clients who had their screening appointment cancelled during suspension, clients in the target age group, clients on an annual rescreen due to higher risks, and clients who called during the suspension for an appointment.

The health system continues to refocus in a gradual and planned manner; this approach will continue to ensure the system balances the clinical needs (and potential harm caused by delays in access to care) of non-COVID-19 related healthcare with the ongoing need to respond to COVID-19.

Mental health and wellbeing

The COVID-19 pandemic and response strategies have created significant disruptions to social connections, community activities, employment and everyday life. These changes may result in an increased risk of community members developing mild to moderate mental health issues, exacerbation of existing severe mental illness, development of or increase in alcohol and other drug (AOD) problems. Across this spectrum, other vulnerabilities (for example, homelessness, domestic and family violence) may place individuals at increased and heightened risk of impacts to their mental health and wellbeing. There is also some data to indicate that suicide rates increase in response to economic recession.

The impact on people's social and emotional wellbeing is particularly evident for older people in residential aged care facilities, where visitation has been restricted. These restrictions, as well as clinicians' and patients' perceptions of factors including COVID-19 transmission risk,

system capacity constraints, and PPE availability and supply chain reliability, have contributed to a significant decline of hospital care for non-COVID-19 related needs.

Following a meeting of Mental Health Ministers from the Commonwealth, states and territories, all Ministers agreed to the critical importance of supporting mental health and wellbeing in response to COVID-19 impacts while beginning to plan for the post-pandemic recovery phase. Ministers agreed to establish an ongoing State, Territory and Commonwealth Ministerial working group to coordinate responses and share ideas.

Preliminary national and international evidence is already indicating increased levels of psychological and emotional distress resulting from COVID-19. In Australia, agencies such as BeyondBlue, Headspace, Lifeline and Kids Helpline have reported a 30-60 per cent increase in demand for phone and online support services related to mental health, alcohol and other drugs (MHAOD), and suicidality during the early stages of the pandemic. It is anticipated there will be increasing pressure on publicly funded MHAOD services as well as those funded and provided through the private and primary health care sector.

In mitigating the impact of COVID-19 on individual mental health and at a population level on community wellbeing has necessitated the provision of immediate responses as well as putting in place medium to longer term measures.

Immediate response

Immediate measures put in place across Queensland Health and Hospital and Health Services focused on ensuring continuity of care for known consumers of public mental health bed based, community treatment and community support services including:

- Supporting use of information sharing mechanisms between HHSs including weekly MHAOD Services COVID-19 Planning and Response meetings and establishment of a SharePoint site to share locally developed information and approaches to treatment and care of consumers of MHAOD services in the context of the public health emergency relating to the COVID-19 pandemic.
- Utilising telehealth options for clinical contacts, including screening, assessment and treatment, for consumers, including specifically those in quarantine, self-isolation, experiencing anxiety regarding clinic/hospital-based appointments and other consumer groups as clinically appropriate through different modalities including:
    - telephone and messaging: consider screening calls prior to community contacts
    - videoconferencing via appropriate modalities.
- Implementing comprehensive screening procedures, practices for consumers (including identification of vulnerable groups such as older people, those with pre-existing physical health conditions, Aboriginal and Torres Strait Islanders, homeless and prison populations), staff and visitors.

Mortuary Capacity Planning

Based on COVID-19 death rates in other countries, additional body storage capacity would be required in the event of a rapid and significant escalation in the level of community transmission of the virus. While the number of COVID-19 deaths is currently relatively low in Australia, Queensland recognised that the capacity of funeral directors to collect and store deceased persons may be impacted during the pandemic.

Queensland Health leads the Mortuary Surge Capacity Working Group established by the State Disaster Co-ordination Group (SDCG) and is responsible for developing plans for additional temporary mortuary storage. The Queensland Mortuary Surge Capacity Plan –

COVID-19 was endorsed by the SDCG on 5 May 2020, outlining a tiered approach to scaling-up temporary mortuary storage capacity. The plan makes provision for:

- Optimisation of existing hospital mortuary capacity and supplementary storage;
- Engagement with funeral directors to monitor preparedness and business continuity;
- Rapid deployment of pre-assembled and self-sustaining refrigerated storage containers anywhere in the State;
- Establishing a temporary mass storage facility to support hospitals in major population centres in South East Queensland; and
- Deploying additional storage capacity at Queensland Health's Forensic and Scientific Services Campus in Coopers Plains.

Older Queenslanders, Queenslanders with Disability and Culturally and Linguistically Diverse (CALD) communities response

A hallmark of the Government's health response to COVID-19 is that it meets the specific needs of all Queenslanders, including those most vulnerable to the virus. Queensland Health has worked collaboratively with the Australian Government and aged care peak bodies to ensure that older Queenslanders are safe, and that hospitals are supported to respond, and residential aged care facilities are supported for service continuity. Queensland Health has worked closely with community partners and across government to develop COVID-19 policy and actions plans for Queenslanders with disability and CALD communities, to ensure that the health response is appropriate to these groups and that it minimises the risk of any unintended consequences of public health messaging and changes in service delivery.

Older Queenslanders

The Queensland Government's response to COVID-19 in residential aged care demonstrates a commitment to healthy ageing and targeted prevention strategies. A Rapid Response Plan to the COVID-19 outbreak was developed, which has been refined since the North Rockhampton Nursing Centre incident where Queensland Health actively learnt from the response. The Rapid Response Plan is currently with stakeholders for further refinement and comment.

Extending the hours of operation for the Residential Acute Support Service program into residential aged care across the state is another highlight demonstrating a commitment to effective, person-centred care and in-reach support into aged care settings. The Department also instigated an assurance process for the Director-General as the Approved Provider of Queensland Health residential aged care services under the *Aged Care Act 1997*. The Commonwealth Aged Care Regulation Branch has since invited Queensland Health to share this process so it can consider its applicability and benefit to private sector providers.

Queenslanders with Disability

One of the nine priorities in the *COVID-19 Policy and Action Plan for Queenslanders with Disability* is the discharge of patients with disability who are medically ready for discharge from hospital to safe and supported accommodation in the community. As intended under the National Disability Insurance Scheme (NDIS),discharging this cohort of patients from hospital to community living has been a longstanding and intractable problem faced in all Australian jurisdictions participating in the NDIS. In the COVID-19 environment, hospital discharge is important in reducing the exposure of this vulnerable cohort to the possibility of infection in a hospital environment and has created valuable additional hospital capacity alongside work to flatten the curve.

Through a concerted effort by Queensland Health, partnering government agencies, and the National Disability Insurance Agency (NDIA), transformational change has been achieved, with 273 long-stay patients discharged between 25 March and 27 May 2020. Flexibility in the implementation of scheme policy by the NDIA has been a major input to the success of this hospital discharge strategy..

This critical discharge work is ongoing with a further 199 long-stay younger patients that are medically ready for discharge in Queensland public hospital beds. To support this work, Queenslanders with Disability Network (QDN) has been engaged by Queensland Health to provide independent support and advocacy for patients, their families and guardians, and the Metro North Hospital Hearings Project has been expanded to expedite Queensland Civil and Administrative Tribunal (QCAT) guardianship hearings to other HHSs.

CALD Communities

The *Policy and Action Plan for CALD Communities* focuses on developing culturally appropriate COVID-19 messaging and translated material and ensuring that people from CALD backgrounds can access appropriate COVID-19 information, screening and treatment. It also aims to ensure that people from CALD backgrounds continue to access healthcare for their ongoing needs.

The priority of establishing and engaging with a COVID-19 CALD Working Group, comprised of government and non-government representatives, ensured that messaging and translation work is highly targeted, and that communities can access timely advice on Public Health Directions. COVID-19 information has been translated into 31 priority languages in a combination of written and audio translations, which will continue to be updated with information. Departmental officers continue to attend community networks to share information about COVID-19 restrictions with community leaders, bi-cultural workers and support agency employees, recognising that for some languages in new and emerging communities, there are no accredited translators in Australia.

First Nations preparedness and response

Understanding and mapping COVID-19

The Aboriginal and Torres Strait Islander Health Division (A&TSIHD) have represented Queensland Health on the National Aboriginal and Torres Strait Islander COVID-19 Advisory Group. Queensland's First Nations response has also been informed by key national guidelines including the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) – Management Plan for Aboriginal and Torres Strait Islander populations, *COVID-19 Communicable Diseases Network Australia National Guidelines for Public Health Units and the Interim National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19*.

The A&TSIHD has worked to develop specific outbreak modelling for remote and discrete communities, drawing upon the national work undertaken by the Doherty and Kirby Institutes, to inform the development of a COVID-19 Testing Strategy for Queensland Aboriginal and Torres Strait Islander people and communities and Public Health Guideline for COVID-19 Outbreak in First Nations Communities.

The A&TSIHD's epidemiology team has undertaken work to ensure adequate transparency of access to testing for First Nations people and notifications of COVID-19 and has developed ongoing surveillance benchmarks for COVID-19 testing for First Nations people.

Legislative and regulatory response

Aboriginal and Torres Strait Islander Mayors – as Chairs of the Local Disaster Management Groups (LDMGs) – supported the Queensland Government's decision to request the inclusion of remote and discrete First Nations communities under the *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements for Remote Communities) Determination 2020* (Biosecurity Determination) made under the *Biosecurity Act 2015* (Cwth), with effect from 26 March 2020. There are currently 20 communities under this declaration (as at 9 June 2020).

In line with the Queensland *Roadmap to easing access restrictions for Queensland's remote communities*, Queensland Health has worked in partnership with the Department of Aboriginal and Torres Strait Islander Partnerships (DATSIP) and LDMGs to develop the Chief Health Officer Public Health Direction - Restricted Access to Remote Communities, to replace the Commonwealth Biosecurity Act declaration for these communities. The Queensland Government worked with the Australian Government to meet the requirements of the Australian Government's *Remote Framework – Conditions for easing remote travel restrictions*.

On 12 June 2020, the Restricted Access to Remote Communities Direction commenced and the Biosecurity Determination ceased to have an effect on the remote and discrete First Nations communities in Queensland.

Preparedness for a pandemic

In line with the above, on 16 March 2020 the A&TSIHD established a First Nations COVID-19 Response Team and, in partnership with the ORRHE, has continued to work with DATSIP to engage with First Nations Queenslanders, including the Mayors of Queensland's remote and discrete communities. This has involved providing Aboriginal and Torres Strait Islander people and communities with key resources, on an ongoing basis, which included tools and flowcharts to support local decision making and resources to support their overall preparedness.

As at 16 June 2020, there had been nine Aboriginal and Torres Strait Islander COVID-19 cases in and no COVID-19 deaths of First Nations people in Queensland. No COVID-19 cases have been recorded in the remote and discrete communities in Queensland.

The A&TSIHD and ORRHE have worked in partnership to develop and facilitate input into a number of planning and information documents to ensure the Queensland Government significantly increased its capability to handle the impacts of COVID-19 and respond to emergent outbreaks for First Nations people. These include:

- *Local Pandemic Plans for Remote Communities*
- *COVID-19 Protection and Containment Considerations for First Nations Communities: Information Resource*
- *COVID-19 HHS preparedness checklist for Queensland's First Nations people*
- *Queensland Government Roadmap to easing access restrictions for Queensland's remote communities*
- Chief Health Officer Direction – *Quarantine within Designated Areas* (superseded)
- Shared asset library of communication collateral from across the health sector
- Chief Health Officer Direction – *Restricted Access to Remote Communities*
- Draft Public Health Guideline for COVID-19 Outbreak in First Nations Communities
- Draft COVID-19 Queensland Testing Framework: Enhanced Testing Strategy

- Draft COVID-19 Testing Strategy for Queensland Aboriginal and Torres Strait Islander People and Communities.

A funding boost of more than $21 million has been made available to support the health and wellbeing of First Nations Queenslanders and communities during COVID-19. This investment is already delivering for First Nation Queenslanders and will help:

- facilitate partnerships between HHSs and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) to support local COVID-19 responses
- bolster the frontline health workforce to help people remain connected and continue their healthcare during this time
- roll out innovative models of healthcare in the home, from the home and close to home
- enable a surge workforce capacity to respond in the event of community outbreaks.

Queensland's First Nations people are particularly vulnerable to experiencing poorer health outcomes from COVID-19 infection due to a higher burden of disease, complex co-morbidities and a range of social determinants (e.g. remoteness, overcrowding). During the Biosecurity restrictions the First Nations COVID-19 Response Team worked closely with HHS's and A&TSICCHO's to help facilitate continuity of healthcare solutions.

The A&TSIHD and ORRH also engages on a regular basis with the Queensland Aboriginal and Islander Health Council (QAIHC), the peak body for Queensland's ATSICCHOs and other key stakeholders, to support sharing of information, communication resources and facilitation of local partnerships.

Surge Workforce

Queensland Health has developed surge workforce capacity plans to meet the demand for increased services due to the COVID-19 pandemic response. The plans detail the potential surge capacity of the Medical, Nursing and Midwifery, Allied Health Professional and Aboriginal and Torres Strait Islander Health Worker and Liaison Officer workforce in Queensland. The plans also detail response options based on modelling and offer recommendations for HHSs to further contextualise locally including the ability to mobilise a registered Aboriginal and Torres Strait Islander Practitioner workforce.

HHSs will continue to work with A&TSICCHOs to utilise the First Nations workforce at a local level where possible and where there is capacity. Collaboration between HHSs and A&TSICCHOs will provide the best healthcare solution to contain and manage any COVID-19 outbreak in their communities and creates enhanced opportunities for scaled up testing and assessment.

Contact Tracing

Queensland Health has the capacity to commence contact tracing and outbreak response within four hours of a first confirmed case being notified to the relevant jurisdictional authority. Public Health physicians are available 24 hours per day to assist with contact tracing. Queensland Health and primary health services have telehealth/video conferencing capabilities to support an outbreak response. We have trained additional staff to ensure there is sufficient capacity for contact tracing in the event of an outbreak.

HHSs and A&TSICCHOs have been training Aboriginal and Torres Strait Islander Health Workers in contact tracing in an endeavour to provide culturally appropriate contact tracing. We have encouraged our staff to use the Australian National University training and resources on COVID-19 infection control and contact tracing for Aboriginal and Torres Strait Islander Health Workers or health workers in remote settings.

Testing regime

In all, 30 Queensland Health laboratories can perform SARS-CoV-2 testing using a GeneXpert or other PCR instrumentation. Fourteen of these laboratories are located in rural or remote sites, including Rockhampton (can service Woorabinda), Kingaroy (can service Cherbourg), Mt Isa (can service Bourke and Doomadgee), Cairns (can service Yarrabah, Cook Shire and Wujal Wujal), Townsville (can service Palm Island) and Thursday Island (can service Torres Strait Islands).

Additional sites are proposed in priority locations with GeneXpert Point of Care Testing (subject to approval) in Cloncurry, Cooktown, Normanton and Weipa. There are additional sites that have testing capacity as part of the TTANGO initiative (Bamaga, Aurukun, Doomadgee, Townsville, Wuchopperen (A&TSICCHO in Cairns)).

The development of the COVID-19 Queensland Testing Framework: Enhanced Testing Strategy and COVID-19 Testing Strategy for Queensland Aboriginal and Torres Strait Islander people and communities will guide an increase in surveillance capability in remote and discrete communities to detect COVID-19 cases early and respond rapidly to any positive cases. This will provide an envelope of both symptomatic and asymptomatic testing with further advice in community and surrounds sentinel surveillance.

Queensland Health is working with QAIHC to ensure A&TSICCHOs have priority access to Queensland Health laboratories to expedite a timely turn around for test results in Aboriginal and Torres Strait Islander communities.

Chief Health Officer Public Health Directions

A specific roadmap to easing COVID-19 restrictions for Queensland's remote communities is outlined in a three staged approach—the Roadmap to easing access restrictions for Queensland's remote communities. Stage 1 came into effect on 1 June 2020 allows quarantining in community where there is suitable accommodation. Stage 2, which came into effect on 12 June 2020, introduces Declared Travel Zones for each designated area eliminating the need for quarantine for residents and enables travel further afield for healthcare, schooling and a range of other reasons outlined in the Direction , and Stage 3 will come into effect as declared by the Chief Health Officer in consultation with LDMG Chairs. Under stage 3, remote and discrete communities will be subject to the same provisions as other Queenslanders.

Queensland Ambulance Service preparedness and response

As part of its standard operating model, the QAS maintains an ongoing, flexible, and scalable readiness capability to respond to disaster events and major incidents using an all-hazards approach. This model includes planning for and the ability to respond to significant health events such as pandemics.

For the COVID-19 Emergency, the QAS leveraged its existing, well-practiced disaster management arrangements to develop and implement plans designed to ensure that the QAS could maintain service delivery as well as manage a potential demand surge as a result of COVID-19.

These plans translated to several successful initiatives that increased QAS frontline response capacity, enhanced the safety of QAS staff and patients, and ensured effective communication, coordination, and leadership during the response phase of the pandemic.

Context

The QAS is an integral part of the primary health care sector in Queensland. The QAS's mission is to deliver timely, quality and appropriate, patient-focussed ambulance services to the Queensland community. The QAS delivers ambulance services through 15 Local Ambulance Service Networks (LASNs) which are aligned to Queensland's HHSs. A 16th statewide LASN comprises the Operations Centres (OpCens). There are eight QAS OpCens throughout Queensland responsible for emergency call taking, operational deployment and dispatch, and coordination of non-urgent patient transport services.

QAS Disaster Management Capability

The QAS has a defined role under the Queensland State Disaster Management Plan, namely to:

- Provide, operate, and maintain ambulance services and service delivery during rescue and other related activities, notwithstanding protecting persons from injury or death, whether or not the individuals are sick or injured; and
- Provide transport for persons requiring attention at medical or health care facilities, to participate with other emergency services in counter disaster planning and to coordinate all-volunteer first aid groups during the disaster.

In this regard, the QAS forms part of the Queensland Disaster Management Arrangements and maintains an ongoing capability at both a LASN and state level, consistent with its broader role within Queensland Health, to prepare for and respond to events, as defined under the *Disaster Management Act 2003*. This capability includes, without limitation:

- The *QAS Statewide Major Incident and Disaster Plan* outlines the strategic, operational and tactical roles and responsibilities of the QAS response utilising LASN, state and external resources to support incident management during a major event or disaster;
- A permanent Emergency Management Unit based at the QAS Fleet and Emergency Management Precinct at Geebung to provide emergency management leadership and a scalable response capacity supporting the QAS during major incidents and events;
- A State Incident Management Room (SIMR) can be scaled up (i.e. activated) to provide statewide coordination, operational intelligence, information to QAS personnel involved in an event, liaison with other agencies and assurance around the effectiveness and efficiency of the QAS's response to events;
- The capability to stand up Local Ambulance Coordination Centres at a LASN level to enable LASN Incident Management Teams to coordinate the response to large-scale or complex incidents or events, either solely within the LASN or as part of a broader QAS response; and
- Representation at disaster management committees at a state, district and local level.

The QAS also maintains a high level of Emergency Management Training through the initial tertiary education program, initial induction period and regular annual training for all QAS staff involved in emergency management activities. As at 31 May 2020, 653 officers have been trained in the Emergency Management Course/Australasian Inter-Service Incident Management System (AIIMS).

The above capabilities are maintained permanently within the QAS operating model to provide a scalable and flexible response capability to major incidents, events, emergencies, and disasters, taking an all-hazards approach consistent with the Queensland Disaster Management Arrangements.

QAS Pandemic Planning

As a part of Queensland Health and the broader Queensland Government, the QAS falls within the scope of the *Queensland Health Pandemic Influenza Plan*. In this plan, the QAS recognises Queensland Health as the lead agency for pandemic management, with QAS supporting Queensland Health as part of the Queensland Emergency Medical System.

To give further effect to the QAS role under the *Queensland Health Pandemic Influenza Plan*, the QAS has developed the *QAS Pandemic Influenza Response Plan*, which was first established in 2007 and has had the most recent version released in March 2019. This plan acknowledges that a severe influenza pandemic event would have a significant impact on QAS operations, and its ability to maintain normal service delivery. The plan reiterates the importance of early preparation and considered planning for such events. In response to COVID-19, the QAS formally enacted this plan on 30 January 2020.

The purpose of the *QAS Pandemic Influenza Response Plan* is to outline the strategic arrangements for the QAS response to pandemic influenza situations in Queensland and to ensure an effective and sustained response to an increase in service demand. This plan also focusses on strategies to maintain the health and welfare of QAS staff and volunteers in conjunction with supporting Queensland Health's response as part of a whole-of-government approach.

Through the development of the *QAS Pandemic Influenza Response Plan*, the QAS ensures that it is well-positioned to respond to a pandemic event. In particular, the *QAS Pandemic Influenza Response Plan* describes how the QAS would leverage its existing disaster and emergency management capability, systems, and governance to establish a flexible and scalable approach, a sustainable command and control structure and guidelines for the conduct of ambulance operations during a pandemic event.

QAS Planning – COVID-19

The QAS commenced additional planning for the potential impact of the COVID-19 disease in January 2020, based on the advice of Queensland's Chief Health Officer.

The QAS recognised that the COVID-19 Pandemic Event posed a significant threat to its ability to achieve its mission to provide timely, quality, and appropriate, patient-focussed ambulance services to the Queensland Community. A pandemic event in Queensland would likely cause a significant surge in demand for ambulance services and potentially impact the availability of QAS's frontline workers, namely paramedics, patient transport officers, and emergency medical dispatchers responding to this increasing demand.

In response to advice from Queensland's Chief Health Officer concerning the likelihood and consequence of a potential pandemic event caused by COVID-19, the QAS immediately commenced a rapid strategic planning process. This process further assessed the risk that a demand surge event would pose to QAS operations and identified the necessary preparedness activities required to augment or enhance business as usual arrangements should a significant demand surge eventuate.

A dedicated, cross-disciplinary Demand Surge and COVID-19 Planning Team was developed to undertake this strategic planning process. The Planning Team brought together QAS expertise in emergency management, ambulance operations, human resources, onboarding, education, communications, service planning, and governance to develop a Concept of Operations to provide strategic direction to the QAS response to a potential demand surge event. The purpose of the Concept of Operations is to:

- Deliver an agile and scalable approach ensuring that ambulance service delivery capacity is maintained on a statewide basis; and
- Support the Whole-of-Government COVID-19 response through the continued delivery of the QAS Mission.

The Concept of Operations complemented the *QAS Statewide Major Incident and Disaster Plan* and the *QAS Pandemic Influenza Response Plan* and is consistent with the approach to pandemics taken by Queensland Disaster Management Arrangements.

Importantly, the Concept of Operations established a command structure that described how the QAS would lead and manage the response to a demand surge event. The structure utilises the Australasian Inter-Service Incident Management System, which is a central tenet of the QAS emergency management capability and reflects the Commissioner's accountability under the *Ambulance Service Act 1991* to manage the QAS's operations.

The Concept of Operations, using Queensland Health modelling and advice regarding COVID-19 applied to the QAS demand profile, described a range of considerations for the QAS to assess and implement solutions to as required, depending on the scale of impact of any demand surge experienced. Further detailed planning commenced utilising the strategic intent described in the Concept of Operations and resulted in the development of a series of sub-plans or new arrangements covering critical areas including:

- Demand surge operational requirements;
- Establish a sustainable command and control structure;
- Rapid recruitment, onboarding, and induction of frontline personnel including Emergency Medical Dispatchers, Paramedics, and Patient Transport Officers;
- Enhanced staff and patient safety, with a focus on infection control;
- Revised service delivery model options;
- Communications;
- Operations Centres;
- Business continuity planning;
- Continuing professional education;
- Winter seasonal demand surge; and
- Personal protective equipment supply.

Through these plans and together with existing disaster management capability, the QAS successfully implemented a range of initiatives to ensure organisational preparedness for a potential surge in demand for ambulance services due to COVID-19.

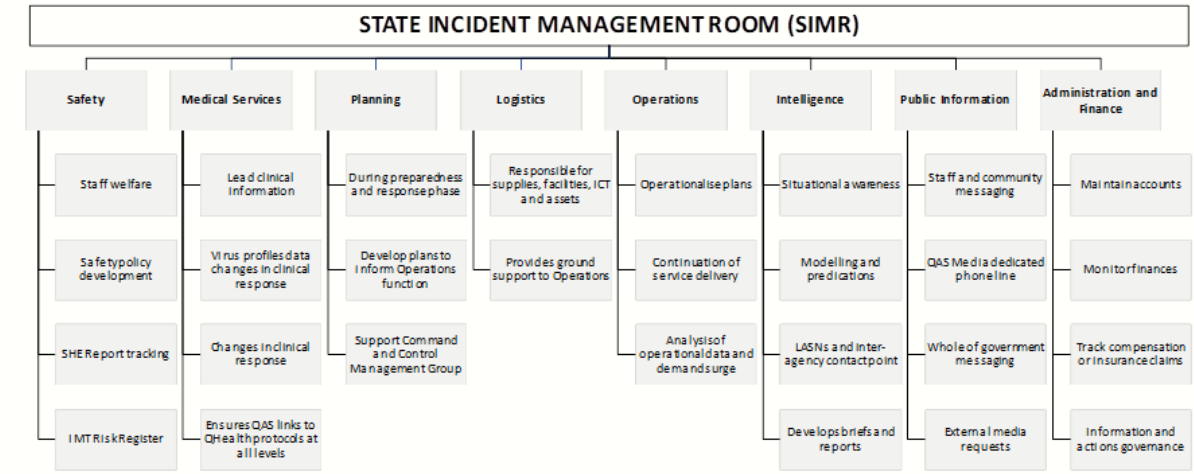
Coordination

The QAS understands that its activities form part of a broader Queensland Health and Queensland Government response to the COVID-19 threat, under the auspices of the Queensland Disaster Management Arrangements. It also recognises the importance of ensuring that all activities undertaken in support of the QAS response were well led and coordinated across the organisation, including at a local level via the QAS LASNs. Initiatives implemented in this regard include:

- Representation on the Queensland Disaster Management Committee, State Disaster Coordination Group and district and local level disaster management groups across Queensland;

- Maintaining an around the clock presence in SHECC to enable greater operational intelligence and contribution to health system planning, with established and regular communication links to the QAS State Incident Management Room;
- Daily executive management meetings to provide real-time leadership and oversight during the emerging response;
- Daily briefings between the QAS Incident Controller and LASN Managers;
- Enhanced coordination and oversight of the organisational response to COVID-19 via a scaled-up State Incident Management Team, with dedicated cells focused on Operations, Intelligence, Planning, Logistics, Administration, Medical Services, Public Information, and Safety;
- Contribution through weekly teleconferences with the Council of Ambulance Authorities, the peak body for the Australian and New Zealand ambulance sector, to ensure cross-jurisdictional information sharing;
- Maintained regular briefings of key external stakeholders, including the United Workers Union;
- Merged the local planning and management of the QAS response to the likely winter period demand surge in South East Queensland with the COVID-19 specific arrangements to ensure appropriate coordination;
- Connections to the Department of Health and HHS forums;
- Active participation and involvement in exercises with the State Disaster Coordination Group (SDCG) and the SDCC;
- Enhanced engagement and dedicated briefings through United Workers Union on a routine basis;
- Stronger links with Health Disaster Management Unit;
- Fast tracked health planning information and response options;
- Commissioners involvement at departmental leadership team meetings;
- Deputy Commissioner and Assistant Commissioner involvement at Chief Health Officer briefings;
- Coordination and communication through the Health Emergency Operations Centre; and
- Embedded QAS liaison in SHECC to ensure timely information source and linkages with public health.

The Commissioner, QAS led the Central Office Executive (COSE) and ensured alignment with the QAS strategic direction and delivery of outcomes and benefits identified in the Concept of Operations. To support the Commissioner in achieving the QAS business outcomes, the COVID-19 response was provided with an Incident Controller (Deputy Commissioner) to oversee all elements of the response, and to ensure objectives were met through the State Incident Management Room (SIMR). The table below demonstrates the cells utilized in the co-ordination of the QAS response within SIMR.



Service Delivery

As indicated above, the QAS, through its pre-existing pandemic planning and in its detailed assessment of the potential demand surge impact of the COVID-19 event, recognised that it would need to plan for and potentially respond to a significant increase in demand for ambulance services. The considerable spread of disease in Queensland, coupled with the social and economic disruptions caused by the disease and associated policy responses (e.g. schooling changes), were identified in the planning phase as potentially impacting the availability of QAS frontline personnel to continue to work.

In response to this risk, the QAS implemented a range of actions designed to increase the workforce's capacity and implement innovative service delivery models to ensure more effective and efficient utilisation of resources. These initiatives included:

- maintained operational efficiency through streamlining processes;
- operational and syndromic intelligence capabilities enhanced utilising technology platforms to provide additional oversight and assurance of critical workforce and logistical requirements;
- The establishment of Surge Response Teams and vehicles at various Brisbane, Gold Coast, and Sunshine Coast Ambulance Stations providing a specific response capability to supplement existing service delivery arrangements;
- clinical hub enlivened alternate models of service delivery including:
    - clinical review of all potential cases;
    - increased advice to QAS crews attending potential cases and members of the public/Patient Transport Service; and
    - implementation of COVID-19 response vehicles.
- paused or cancelled planned activities, functions, and events to redirect resources to rapid recruitment, onboarding, and induction of new operational staff;
- newly recruited and trained frontline personnel deployed to localities requiring additional resourcing; and
- identification of existing QAS personnel who were appropriately trained and qualified in other roles and could be redeployed to meet demand.

In response to the emerging threat posed by COVID-19, the QAS established a liaison presence in SHECC on 29 January 2020 and stood up a State Incident Management Team at its Fleet and Emergency Management Precinct at Geebung on 30 January 2020.

The QAS expanded its State Incident Management Team in response to the scale, complexity, and risk to service delivery posed by the COVID-19 Pandemic Event. This expansion incorporated the Demand Surge and COVID-19 Planning Team into the pre-existing State Incident Management Team. Importantly, given the nature of the COVID-19 Pandemic Event, the QAS activated (for the first time) dedicated incident management cells to deal with Safety, Medical Services, and Public Information aspects of the QAS response.

Staff and Patient Safety

A significant strategic intent of the QAS preparedness for a potential demand surge caused by the COVID-19 Pandemic Event was ensuring that the health and safety risks to QAS personnel and patients were well-managed. This required a series of new initiatives and adaptations to existing practices. Safety initiatives implemented by the QAS as part of the Demand Surge (COVID-19) planning include:

- implementation of Emerging Infectious Disease Surveillance (EIDS) questions for Triple Zero (000) callers to identify potential COVID-19 cases and enable enhanced interrogation of Triple Zero (000) calls;
- activation of "Protocol 36 (Pandemic)" in the Operations Centre environment to help identify and manage suspected COVID-19 patients;
- establishment of a 'Clinical Hub' to facilitate the assessment of Protocol 36 incidents and provide enhanced advice to frontline officers attending cases and to provide greater coordination of resource deployment to suspected COVID-19 cases;
- restrictions to non-essential visitors entering critical work locations;
- careful monitoring of PPE statewide to ensure sufficient supplies were available to frontline staff providing ambulance services;
- regular and consistent messaging to staff to ensure awareness of and compliance with Personal Protective Equipment requirements;
- increased surveillance of health trends identified in the community;
- staff health screenings at QAS facilities and changes to business processes (e.g. paperless offices and social distancing) to reduce the risk of infection;
- the ongoing evolution of a clinical risk assessment matrix according to current evidence-based research and Queensland Health guidelines;
- a 24hr medical services advice line established in the State Incident Management Team;
- a dedicated Safety Cell as part of the State Incident Management Team;
- implementation of social distancing and sanitisation practices at QAS facilities;
- assessment of staff identified as vulnerable persons based on health guidelines, with appropriate advice and support provided as required;
- staff welfare checks by the QAS Flexible Work and Inclusive Practice Network, as requested by staff;
- continued operation of the QAS employee assistance service, Priority One, with increased messaging around staff mental health and welfare;
- whitelisting of the COVIDSafe app onto operational iPads; and
- specific plans for staff entry into remote Aboriginal or Torres Strait Islander communities to comply with Australian Government and Chief Health Officer requirements.

Public Information and Employee Communication

The QAS recognised that, given the rapidly changing situation, enhanced communications with both employees/volunteers and external stakeholders, including the general public, would be integral to an optimal response to the COVID-19 threat. In this regard, the QAS implemented the following new or improved communications approaches:

- Establishment of a Public Information Cell as part of the State Incident Management Team, to coordinate QAS stakeholder communication activities;
- Use of QAS social media accounts to promote or reiterate key Queensland Government and Queensland Health messaging;
- Twice daily all staff emails to provide key organisational messages around issues such as safety and patient care, and situational awareness of the status of the COVID-19 Pandemic Event in Queensland; and
- a dedicated COVID-19 page on the QAS internal web portal to disseminate relevant information and resources to staff.

Operational Response

Utilising the plans and initiatives developed (as described above), the QAS continued to maintain ambulance service delivery during the response phase of the COVID-19 Pandemic Event. As is the experience across many parts of the health sector in Queensland, due to the success of government and community action with respect to COVID-19, the anticipated surge in demand for ambulance services did not eventuate at the end of March and into April and May 2020. This was estimated to be due to a series of factors such as:

- restrictions in economic activity (including the closure of many workplaces);
- changes to social behaviours (including the closure of hospitality venues, changes to schooling arrangements, travel restrictions and restrictions on leisure activities like sports); and
- reduced need for scheduled patient transport services.

However, while overall demand did not experience significant growth, it is the case that complexity in the delivery of ambulance services increased during this period. Due to the risk of infection caused by COVID-19, the QAS undertook enhanced screening of patients both at the point of request for services (e.g., Triple Zero (000) call) and at the scene before treatment of patients. In many cases, this prompted enhanced use of personal protective equipment and increased staff health surveillance.

Significantly, while the overall demand for ambulance services did not surge, the QAS experienced an increase in demand relating to mental health cases. The QAS received an approximate 19% increase in Triple Zero (000) calls for assistance to mental health cases.

Conclusion

The QAS approach to the COVID-19 Pandemic has been through the delivery of a well-practiced, scalable disaster management model that continues to evolve. The implementation of a dedicated COVID-19 Planning Team and the State Incident Management Room activation has ensured the QAS could support statewide coordination with Queensland Health and adapt as required to support the Queensland community, in the dynamic environment confronted.

Through the application of a lesson's management framework, the QAS will ensure learnings from this event can be implemented into future event and exercise management and provides a tried and tested level of formal assurance in shaping the COVID-19 recovery plan.

Chief Health Officer Public Health Directions

On 18 March 2020, the Public Health Emergency Act was urgently introduced, debated and passed by Queensland Parliament. The amendments made to the Public Health Act provided the Chief Health Officer with powers to make a Public Health Direction, they deemed reasonably necessary to assist in containing, or responding to, the spread of COVID-19 within the community.

The explanatory notes to the Public Health Emergency Act provided that a Direction can commence once it is published on the department's website or in the gazette. In practice, the Directions have been published on the Queensland Health website. As soon as reasonably practicable after the Direction is given, the Chief Health Officer must take reasonable steps to notify people who are likely to be directly affected. This has primarily occurred through online communications channels such as fact sheets, Q&As, social media and email updates to subscribers, as well as direct engagement with relevant industry stakeholders.

Queensland Health is the agency responsible for drafting and publishing the Public Health Directions in accordance with the requirement of the Public Health Act. Throughout the development of the Public Health Directions, Queensland Health has engaged with the Department of the Premier and Cabinet to ensure whole-of-government co-ordination policy input into the Public Health Directions. Consultation has also been undertaken across various government agencies to ensure that key policy and operational matters are addressed. In addition, the Public Health Directions were provided for comment and input by the Queensland Government through standard government decision-making processes to support input on issues raised by the public directly with members of Parliament, Ministers within the Government or the Premier and Minister for Trade.

While consultation with affected agencies forms a critical part of the operational and policy responses to the COVID-19 pandemic, the final decision about the content of Public Health Directions is made by the Chief Health Officer. This ensures that while government departments, business sectors and members of the public have been able to raise concerns relating to the Public Health Directions, the decision to implement restrictions has been made with a view to the overriding need to manage the public health risks of COVID-19 across Queensland.

As at 16 June, the Chief Health Officer has given 63 Public Health Directions and 3 Notices. There are 17 Directions and 2 Notices currently in force and 46 Directions and 1 Notice have been superseded. The Public Health Directions have been refined and updated throughout the COVID-19 response, as additional information about health risks became available, to reflect consultation with industry and to implement decisions and advice from National Cabinet and AHPPC.

On 8 May 2020, the Queensland Premier released Queensland's Roadmap to Easing COVID-19 restrictions. The Roadmap outlines a staged approach to giving Queenslanders more freedom to travel, participate in more activities and hold more gatherings.

Stage 1 of the Roadmap commenced on 15 May 2020, allowing 5 visitors to a residence, gatherings of up to 10 people in a range of settings, reopening of a range of businesses, activities and undertakings for up to 10 people (or 20 people for restaurants, cafes and pubs in the Outback), funerals with a maximum of 20 people indoors and 30 outdoors, and recreational day trips up to 150km within your region (or 500km within the Outback, including overnight stays).

Stage 2 of the Roadmap commenced on 1 June 2020, allowing unlimited travel and overnight stays within Queensland, gatherings of 20 people inside and outside the home,

reopening of additional businesses, activities and undertakings, and the ability to have more customers or patrons with a COVID Safe Plan approved by the Chief Health Officer or a delegate. The list of permitted purposes for leaving home were removed, allowing Queenslanders to leave home for any reason.

Enforcement of health measures

Queensland Health's contact tracing officers have worked tirelessly to conduct contact tracing for every case of COVID-19 identified in Queensland. In instances where confirmed cases have been able to be treated outside a hospital environment, they have been issued isolation directions requiring them to remain at a nominated address and not interact with others until they are deemed to be clinically recovered. Identified close contacts of confirmed cases have all been issued with quarantine notices, requiring them to remain at a nominated address and not interact with others for 14 days.

To bolster national border entry restrictions, on 5 February 2020, Queensland Health introduced health screening at Queensland's international airports (Brisbane, Cairns and Gold Coast) and issued quarantine notices to all persons arriving from, or who had transited through, mainland China from 1 February 2020 onwards.

As the spread of COVID-19 moved across the world, Queensland Health increased health screening and the issuing of quarantine notices to international arrivals from other COVID-19 hotspots. This included arrivals from Iran (from 1 March 2020), South Korea (from 5 March 2020) and Italy (screening for health care workers from 5 March, quarantine notices for all arrivals from 11 March 2020).

13 HEALTH continued to operate to provide health advice and information for Queenslanders while in quarantine or self-isolation. Between 21 January 2020 and 13 June 2020, the Health Contact Centre has received approximately 174,310 distinct calls regarding COVID-19 related matters, including travel and entry restrictions, testing and test results, people experiencing symptoms and self-quarantine requirements. Since 4 February, staff at 13 HEALTH have had mechanisms to register consumers for practical support from Community Recovery and/or emotional support from Red Cross. The service gathers details from callers of suspected non-compliance with quarantine and isolation orders and health directives passing the information to the relevant authority to investigate and take the necessary actions. For individuals in self-quarantine or isolation who call 13 HEALTH with symptoms or deteriorating health, they are assessed by Registered Nurses and if needed, connected to the treating hospital or to the QAS.

From 11 February to 19 March, the Health Contact Centre delivered an outbound call service to individuals issued a Public Health order to self-quarantine – Self-Quarantine Monitoring Service. Calls and SMS messages were made about every 3 days during the 14-day period and checked-in with consumers, identified emerging symptoms/health concerns and ensured the person understood and encouraged them to comply with the requirements of quarantine. This service was then modified and redirected for delivery by the Department of Justice and Attorney-General and Smart Service Queensland (SSQ). The Quitline Service has supported individuals required to self-quarantine in hotels who smoke with counselling sessions and free supply of Nicotine Replacement Therapy.

From 29 March 2020, Queensland Health, in conjunction with other Queensland Government agencies, served quarantine notices on all persons arriving in Queensland from overseas and required them to complete their 14-day quarantine period in a government funded hotel. Quarantine requirements have also been extended to domestic interstate arrivals where the person is moving to make Queensland their permanent state of residence or for certain people who had visited identified COVID-19 hotspots.

Queensland Health has maintained a database of all persons subject to quarantine notice since 5 February 2020. This was supported by the rapid development of an application to capture and store data relevant to travelers entering Queensland to assist with self-quarantine tracking and contact tracing.

Since 5 February 2020, a total of 66,614 self-quarantine notices have been issued across Queensland. A total of 3,198 people are still subject to the requirements of a quarantine notice (as at 16 June 2020).

Queensland Health has worked closely with several agencies to ensure quarantine notices are adhered to. The model of compliance monitoring has been modified over time to best utilise available resources. The initial response model included daily calls from 13HEALTH (to determine health status and compliance with quarantine movement restrictions), regular calls from the Red Cross (to address any welfare concerns) and ad-hoc compliance visits from QPS and staff of Queensland Health's 11 PHUs.

The current model of compliance for persons subject to quarantine notices, which was announced on 31 March 2020, is a collaborative partnership between Queensland Health, DJAG, HPW and SSQ, and QPS. The Service was mobilised on 7 April 2020, and as of 6 June 2020, over 19,000 calls have been made, 15,000 text messages sent with an overall compliance rate of 94% with the quarantine requirements. On 20 April 2020, QPS undertook a random blitz for those individuals on day 10 of their 14-day quarantine. Approximately 150 visits were made across the state and there was found to be 98% of compliance with the direction.

In addition to the services outlined above, the compliance model also incorporates services of the Queensland Government's Community Recovery Hotline. The Hotline is available to assist people who have been advised to quarantine at home by a medical professional, Queensland Health or through government direction and have no other mechanisms for support. Community Recovery works with partner organisations to arrange non-contact delivery of essential food and medication to people in quarantine with no other means of support. 13HEALTH continued to operate to provide health advice or information for Queenslanders while in quarantine of self-isolation. Staff at 13HEALTH connect people through to a local PHU and other health support services.

Queensland Health, with assistance from QPS, has co-ordinated a multi-agency enforcement campaign in relation the Chief Health Officer's Public Health Directions. This has involved activity from virtually all Government Departments. A significant focus of this campaign has been to police compliance with the *Queensland's Roadmap to easing of restrictions*.

A hierarchy of enforcement options exist when it is identified that there is non-compliance with either a quarantine or Public Health Direction. These include verbal advice/education, warnings, penalty infringement notices and prosecution. The emphasis for supporting the Public Health Directions are verbal advice and education. An enforcement matrix has been developed to promote consistency between agencies and enforcement officers and to ensure enforcement decision making appropriately considers public health risk.

To assist with interpretation of Public Health Directions, Queensland Health has published extensive web content and question and answer documents. In addition, to ensure the public fully understand the measures, restrictions and penalties there has been an extensive media campaign. This has involved regular press conferences hosted by the Chief Health Officer, the Premier and Minister for Trade and the Deputy Premier and Minister for Health and Minister for Ambulance Services, webinars and daily social media posts. These actions have been supplemented by similar activities undertaken by Queensland Police and other Government Agencies.

In addition, an online portal has enabled the public to submit enquiries in relation to Public Health Directions and to request exemptions where the opportunity exists. As at 16 June 2020, the Service responsible for addressing submissions to the online portal had received in excess of 15,000 queries. To assist in response to these queries, in early June 2020, the 134 COVID phone line was established and DCDSS activated their COVID Safe Ambassador program, dispatching Queensland Ready Reserves to major shopping centres to provide compliance advice to businesses.

In the context of easing of restrictions, businesses, activities and undertakings identified by the Chief Health Officer as having a high risk of transmission are subject to a range of restrictions. This may include a restriction on the number of people they can accommodate and a requirement to complete a COVID Safe checklist and training. High risk activities include, but are not limited to:

- restaurants, cafes, pubs, RSLs clubs and hotels
- beauty therapists, nail salons tattooists, tanning and spas
- concert venues and theatres
- social sporting clubs
- boot camps, personal training and social sporting-based activities
- caravan and camping parks
- places of worship.

Businesses and organisations may be able to have more than the current limit of people in their venue as prescribed in the Roadmap for that specific stage, provided they are in complete compliance with the applicable COVID Safe Industry Plan (Industry Plan) and the relevant Public Health Directions, including social distancing requirements and floor space limits, which vary by business venue.

A number of Industry Plans have been developed by key industry groups, in consultation with the Queensland Government, to allow for the variations of business and assessing the requirements for the business to operate safely by following the COVID Safe principles of social distancing, hygiene and cleaning. As at 16 June 2020, 15 Industry Plans have been reviewed by Queensland Health and approved by the Chief Health Officer to ensure they meet the compliance requirements. It is important to help local businesses get up and running and their staff back to work again safely, a vital step in the State's economic recovery.

Once plans have been approved, Queensland Health is encouraging business and organisations to work within their industry to promote the plan and improve compliance. Any business or organisation in an industry with an approved industry plan is also encouraged to download and follow that plan and complete a Statement of Compliance to demonstrate they are undertaking best practice as a COVID Safe Business.

Industry Plans are not mandatory. If a business chooses not to opt-in to the relevant Industry Plan it can continue to operate under the relevant conditions listed under the Roadmap and Chief Health Officer public health directions. This may include completing a mandatory COVID Safe Checklist and training.

Eligible high-risk businesses that have completed and displayed a statement of compliance with an approved Industry Plan will no longer be required to complete and display the mandatory COVID Safe checklist.

In some cases, a site-specific COVID Safe Plan can be developed by eligible operators that are larger in scale due to the unique aspects of their business, such as complexity and size.

Only businesses identified by the Chief Health Officer as suitable for site-specific plans are considered. Under such plans, details of customers/participants need to be recorded and kept in a secure location on the premises for at least 56 days if contact tracing is required to be undertaken.

No Health Direction or Industry Plan is able to provide specific instruction on every possible scenario. Queensland Health encourages all businesses – whether they undertake activities that are deemed as essential or non-essential – to reduce the risk to staff and patrons by following the basic principles of social distancing, hygiene, cleaning and keeping records to support contact tracing. The intent of the easing of restrictions is to gradually increase the circumstances in which people might gather for non-essential activities (as opposed to essential activities like shopping, health care, manufacturing, construction) and gradually increase the number of people that might gather at a time for non-essential reasons.

Communications

Actionable, timely, transparent and engaging communications are a bedrock of Queensland Health's response to the COVID-19 pandemic. The commitment and determination of Queenslanders in seeking out, understanding, respecting and following public health advice is a huge part of the State's success in combatting the pandemic. The quality of communications was a vital part of the public health response – it was one of the primary factors in ensuring responsiveness.

In January 2020, Queensland Health began comprehensive communication planning for the then unnamed novel coronavirus. Key planning actions included:

- developing a living communications strategy which is refined regularly in-line with the evolving national and state pandemic plans;
- establishing a COVID-19 communications hub that was connected with SHECC;
- scaling up the health communications workforce with communications staff from across Queensland Government.

Planning involved working closely with communication experts from around Australia and across the Queensland health system, including with a range of community and non-government organisations. This engagement helped ensure coordination and consistency in messaging across jurisdictions and that the communication needs of vulnerable groups, such a culturally and linguistically diverse communities, were being met.

The public response was overwhelming, with COVID-19 generating higher levels of engagement and interest than any other topic in the history of Queensland Health. Between January 2020 and 10 June 2020, Queensland Health's Strategic Communications Team had:

- Created and posted 722 COVID-19 social media posts
- Developed advertisements that appeared 11,592 times
- Answered 14,732 media calls and email inquiries
- Received 128,414 social media comments and 35,589 private messages, many of which received individual responses
- Created and updated 298 web pages
- Posted 25 COVID-19 blogs
- Facilitated 328 media conferences and media releases.

When the first case was identified in Queensland, Queensland Health issued a public health alert across various channels including online, traditional and social media to inform the Queensland community of the local active case. Since then, Queensland Health has reported daily on the case data. This reporting has been in-line with the agreed national reporting standards and is done to provide them as much information as possible to the Queensland public without compromising patient privacy and confidentiality. Due to the rapidly evolving nature of the pandemic, Queensland Health swiftly expanded the communications to focus on:

- health advice and support for travellers, vulnerable population and the wider Queensland community
- information about the pandemic and public health response, including the latest health advice and any outbreak information
- information on Queensland Health's system response, including any changes or disruptions to services
- information for clinical groups and frontline healthcare workers
- advice and support services for managing physical and mental health throughout the pandemic.

On 29 January 2020, Queensland Health also launched a dedicated online COVID-19 information hub to ensure the community had a single source of credible Queensland specific public health information. The hub, which has evolved throughout the pandemic, outlines all the relevant COVID-19 information including information and statistics about the outbreak in Queensland, latest public health advice and regulations, and information for vulnerable groups. This hub receives about 1 million views each week and has had approximately 26 million views since it was created.

Since January 2020, a significant amount of content is produced daily to ensure useful, relevant and timely information is being delivered through an extensive range of channels. Key communication activities include:

- Development of communication materials to support the changes to Public Health Directions, including a wide variety of question and answer documents to help the Queensland community understand the changing requirements
- Developing a series of paid advertising campaigns across print, TV, radio – including content and creative development
- Social media management including posting, advertising, monitoring and responding to public enquires across a number of platforms
- Daily content monitoring and updating to the Queensland Health platforms and channels, such as websites, social media platforms, intranet. This includes responding to online enquiries
- Management of media and communications protocols across the health system
- Develop media releases, media responses, talking points and other media materials.
- State-wide media briefing and engagement
- Press conferences and media interviews.
- Liaison with public relations and media teams in affected external organisations that have been affected by direct contact with the known COVID-19 case
- Regular teleconferences and meetings with communications teams from across government, the health system and with NGOs

- Develop and distribute of shareable, downloadable creative content (such as newsletter articles, posters, social media tiles, videos, screen savers)
- Creating and distributing newsletters, email updates and other internal communications collateral to staff and clinical networks
- Coordination of translating of materials
- Social and market research and insight gathering
- Communication activity evaluation.

In closing, Queensland Health continues to acknowledge that Queensland remains in the grips of a global pandemic. Queensland finds itself in a fortunate position at a time when countries around the world are facing increasingly large numbers of cases and deaths as well as second waves of community transmissions. Actions taken by Queensland have seen the curve flattened whilst also demonstrating an ability to respond to critical emerging issues.

Appendix 1 – List of Abbreviations and Acronyms

ADF	Australian Defence Force
AHPPC	Australian Health Protection Principal Committee
AHPRA	Australian Health Practitioner Regulation Agency
AIIMS	Australasian Inter-Service Incident Management System
ATSICCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
A&TSIHD	Aboriginal and Torres Strait Islander Health Division, Queensland Health
CDNA	Communicable Diseases Network Australia
COVID-19 Plan	Australian Health Sector Emergency Response Plan for Novel Coronavirus
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DAF	Department of Agriculture and Fisheries, Queensland Government
DATSIP	Department of Aboriginal and Torres Strait Islander Partnerships
DCDSS	Department of Communities, Disability Services and Seniors
DoE	Department of Education
EIRP	Emergency Incident Response Plans
EOI	Expressions of Interest
HSD	Health Service Directive
HHSs	Hospital and Health Services
HSCEs	Health Services Chief Executives
ICU	Intensive Care Unit
Industry Plan	COVID Safe Industry Plan
Intelligence Plan	Australian Pandemic Health Intelligence Plan
LASNs	Local Ambulance Service Networks
MAPAU	Medical Advisory and Prevocational Accreditation Unit
NMS	National Medical Stockpile
NPA	National Partnership Agreement
OpCens	Operations Centres
OPHW	Office for Prisoner Health and Wellbeing
ORRHE	Office of Rural and Remote Health Establishment
PHLRT	Pandemic Health Leadership Response Team
PHNs	Primary Health Networks
PHRIAG	Pandemic Health Response Implementation Advisory Group
PoCT	Point of Care Testing
PPE	Personal Protective Equipment
QAIHC	Queensland Aboriginal and Islander Health Council
QAS	Queensland Ambulance Service
QCS	Queensland Corrective Services
QFES	Queensland Fire and Emergency Services
QHDISPLAN	Queensland Health Disaster and Emergency Incident Plan
QPS	Queensland Police Service
Reff	Effective Reproduction Rate
Roadmap	Queensland's Roadmap to Easing Restrictions
R0	Effective Transmission Rate
SDCC	State Disaster Coordination Centre
SHECC	State Health Emergency Coordination Centre
SICCN	Statewide Intensive Care Clinical Network
SIMR	State Incident Management Room
SPR	Systems Performance Reporting
SSQ	Smart Service Queensland
Surge Plan	Queensland Health COVID-19 Surge Plan
Surveillance Plan	National Disease Surveillance Plan For COVID-19

HRRT	Human Resources Response Team
TGA	Therapeutic Goods Administration
TIQ	Trade and Investment Queensland
WHO	World Health Organization