HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP
Dr MA Robinson MP

Staff present:
Dr J Dewar—Committee Secretary
Ms A Groth—Assistant Committee Secretary

PUBLIC BRIEFING—QUEENSLAND HEALTH

TRANSCRIPT OF PROCEEDINGS

MONDAY, 22 MARCH 2021

Brisbane

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The committee met at 9.38 am.

CHAIR: Good morning everyone. I now declare open this public briefing of the Health and Environment Committee. I start by acknowledging the traditional owners of the land on which we are meeting and pay my represents to elders past, present and emerging. I would like to introduce the members of the committee. I am Aaron Harper, the member for Thuringowa and chair of the committee. Mr Rob Molhoek, who is on his way, is the member for Southport and our deputy chair. The other committee members are: Mr Stephen Andrew, the member for Mirani; Ms Ali King, the member for Pumicestone; Ms Joan Pease, the member for Lytton; and Dr Mark Robinson, the member for Oodgeroo.

The purpose of today's briefing with Queensland Health is to assist the committee with its oversight of the Health and Ambulance Service portfolio. The committee would appreciate the department providing an overview of the management of Queensland's public health system. The committee also proposes to examine the department's reports. Before we begin, I remind everyone that the briefing today is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. I ask that mobile phones are switched off. Hansard will be recording the proceedings and a copy of the transcript will be provided.

BOWLES, Commissioner Russell ASM, Commissioner, Queensland Ambulance Service

STEELE, Mr Nick, Deputy Director-General, Healthcare Purchasing and System Performance Division, Queensland Health

WAKEFIELD, Dr John PSM, Director-General, Queensland Health

YOUNG, Dr Jeannette PSM, Chief Health Officer, Queensland Health

CHAIR: I now welcome from Queensland Health Dr John Wakefield, Dr Jeannette Young, Commissioner Russell Bowles and Mr Nick Steele. Before we commence the briefing, on behalf of the committee I would like to thank all of Queensland Health staff and ambulance staff for their outstanding work in managing COVID to date. We know there is a lot going on in the vaccine space. We look forward to getting an update on that today from Dr Young. Given that the pandemic is far from over, we appreciate you giving time from your very busy schedules. We also have flooding going on, which I am acutely aware of. We are very thankful to the department and Ambulance Service representatives for being here today. Dr Wakefield, I invite you or one of your colleagues to provide an overview.

Dr Wakefield: Thank you and good morning, Chair, Deputy Chair and committee members. I start by respectfully acknowledging the traditional custodians of the land on which we meet this morning, the Jagera people and the Turrbal people, and pay our respects to their elders past, present and emerging. I am Dr John Wakefield, the Director-General of Queensland Health. I would like to thank the committee for the opportunity to brief you on the responsibilities and activities of Queensland Health.

The Queensland public health system: health services in Queensland are delivered through a range of healthcare professionals and organisations in both the public and the private sectors. Queensland has a world-class public health system and one that I am proud to lead every day as director-general. The Hospital and Health Boards Act 2011 provides the overarching framework for the delivery of publicly funded health services in Queensland and it sets out the key responsibilities and functions of Queensland Health.

Queensland Health comprises the Department of Health, the Queensland Ambulance Service and 16 independent hospital and health services situated across the state. The Department of Health, as the system manager, provides strategic leadership and direction to the public health system in Queensland. It is responsible for the overall management of Queensland's public health system at a statewide level. This includes commissioning $16.57 billion worth of services from the hospital and health services and setting and monitoring performance metrics for those services.

Hospital and health services are responsible for the delivery of public sector health services as independent statutory bodies governed by their own board and managed by a health service chief executive. Queensland's public health system governance aligns with the principles and objectives of the National Health Reform Agreement to deliver safe high-quality care in the right place at the right time whilst ensuring the future sustainability of the health system. Queensland achieves this through its governance structure by strengthening local decision-making and accountability, enhancing clinician-consumer engagement and providing for statewide health system management. This allows the system to balance the benefits of local and also system-wide approaches. I think our management of COVID really demonstrates the strength of that system approach.

The establishment, structure and functions of the Queensland Ambulance Service is subject to the Ambulance Service Act 1991. Both the Hospital and Health Boards Act and the Ambulance Service Act were amended in 2019 to recognise that the Queensland Ambulance Service and the hospital and health services must collaborate to manage the interaction between the services they provide. This collaboration ensures services are delivered in the best interests of the system as a whole and, of course, to the Queenslanders we serve.

Turning to COVID-19 governance, COVID-19 has and continues to be a huge challenge for health services all around the world. Queensland Health's response to COVID, I believe, has been world class. We have demonstrated our ability to adjust and pivot very quickly as an organisation and as a result we have seen some of the lowest case numbers in the country and indeed worldwide. Queensland Health's COVID-19 public health disaster governance includes two key accountability lines. The Queensland Chief Health Officer manages the public health response—that is, the public health measures that need to be put in place to protect the whole of the Queensland community, whether that be through a regulatory response such as the Chief Health Officer's public health directions or through general advice, public alerts and our contact tracing and compliance activities. As the director-general, my role is to manage the health system response to the pandemic. That is how the department and the hospital and health services adjust and react to the evolving situation—for example, ensuring that we have been able to mobilise fever clinics across the state as well as vaccine hubs, and have the bed capacity to treat COVID-19 patients at the same time as continuing to deliver the day-to-day health services, outpatients and elective surgery that our community demands and deserves.

The Chief Health Officer and I both report jointly to the Minister for Health and Ambulance Services on our respective responsibilities. The effective coordination and collaboration within the Queensland government, Queensland Health and the broader health system has been critical and integral to Queensland's ability to determine the strategic priorities and rapidly mobilise resources. Governance structures have been established to enable collaboration across all levels of government, the health sector, business and industry and allow for the constant review of changing circumstances to ensure public safety.

The health system interfaces through the COVID System Leadership Forum, what we call the CSLF, which meets weekly, scaled up and down as required through the pandemic. In the early stages of the pandemic we had a daily briefing of all of our chief executives and my executive team. That forum, which I chair, includes the department's executive leadership team, the 16 health service chief executives, the Mater Hospital chief executive and clinical and consumer representatives. It determines strategic and operational solutions to the challenges and opportunities that face the Queensland health system during the COVID-19 pandemic. As a group we continue to actively manage the health system's capacity whilst responding to significant increases in demand and identifying, treating and managing COVID-19 cases.

The Queensland government allocated an additional $1.2 billion over the 2019-20 and 2020-21 financial years to support this health system capacity increase. This included tripling our emergency capacity and doubling our intensive care capacity. We have also worked hard to ensure significant supplies of personal protective equipment were available to our frontline staff at a time of critical international shortage as well as increasing the number of ventilators available across the hospital and health network. It has also allowed us to expand our public health network of contact tracing and, of course, to look after over 3,000 hotel quarantine beds.

Whilst Queensland Health continues to play a critical role in infection control and outbreak management, much of our strategic work has now moved to support the rollout of the vaccines. The Queensland COVID-19 vaccination task force has been established to oversee the planning and implementation of the rollout of COVID-19 vaccination. The task force is working closely with the Australian government on Queensland's COVID-19 vaccination program implementation plan and is also working very closely with hospital and health services across Queensland to facilitate their

readiness to implement the COVID-19 vaccination program safely and efficiently. Queensland now has 37 vaccine sites in operation across the state and we expect 12 additional sites to come online this week. In addition, 261 Queensland general practitioners are planned to also start vaccinating this week. With more than 37,000 vaccines administered to date in Queensland, our vaccine rollout is proceeding as we had planned.

Finally, to the annual report 2019-20: I understand the committee has reviewed the department's annual report for 2019-20 and intends to use this time to ask questions about that report. There have been many highlights driven by our public health response to the COVID-19 pandemic, including bolstering Queensland's supply of personal protective equipment by using locally based manufacturers and doubling our emergency medical stockpile and fast-tracking the rollout of the state's telehealth virtual clinics to enable Queensland to continue to access safe and high-quality health services. Whilst COVID-19 dominated Queensland Health's priorities during 2020, we also delivered a number of other significant achievements throughout the year and continue to deliver world-class health care for Queenslanders. In 2019-20 we invested $3.2 million to further support specialist care for cardiac services by further expanding the networked cardiac services model of care across the state. In January 2020 we also launched Queensland's first ever positive mental health and wellbeing campaign, Dear Mind, encouraging Queenslanders to prioritise their mental health and wellbeing, particularly at this difficult time.

We also continued to improve access to health services for those in Indigenous and rural and remote communities by establishing our first ever Aboriginal and Torres Strait Islander Health Division and the office of rural and remote health. I am proud to say that in January 2020 Queensland was the first Australian state or territory to implement human rights legislation that specifically includes a right to health services.

We are also continuing to manage unprecedented demand for our healthcare services. Between 1 July 2020 and 28 February 2021, Queensland's public hospitals received over 1.58 million presentations to their emergency departments. That was 163,593 more presentations—that is 11 ½ per cent—compared to the same time last year. During this period there were also over 446,300 ambulance arrivals, which is an increase of over 8,600 or two per cent more arrivals compared to the same time last year. Good progress is also being made to restore our planned care services following the national suspension of non-urgent elective surgery early last year in response to COVID-19. As at 1 March 2021, there were 49,492 referrals ready for surgery on our elective surgery waiting list, 95.9 per cent of which were waiting within the clinically recommended time frames. Whilst there are countless more achievements I could share, I will not take up any more of the committee's time by doing so.

In conclusion, I take this opportunity to personally thank every Queensland Health employee for their hard work and commitment as we continue to fight this global pandemic. We as an organisation can be proud of the work we have done to keep Queenslanders safe and healthy. Dr Young, Queensland's Chief Health Officer, will now provide a brief opening statement and then we will be happy to take any of the committee's questions.

Dr Young: I would also like to acknowledge the traditional owners of the land on which our parliament is, the Turrbal and Jagera people, and pay my respects to their elders past, present and emerging. One fact that I am incredibly proud of is that here in Queensland we have now had 1,421 confirmed cases of COVID, 11 of them have been in First Nations people and none of them in any of our remote First Nations discrete communities across the state. That is due, I believe, to two reasons: firstly, the mayors of those communities and their elders; and, secondly, the appointment of Haylene Grogan. I think that it was a fantastic appointment by the previous director-general of Queensland's first Chief Aboriginal and Torres Strait Islander Health Officer.

Thank you very much, Dr Wakefield. Thank you also to the committee and chair for the opportunity to talk with you this morning. I was asked to speak about the role of the Chief Health Officer. The role of the Chief Health Officer and Deputy Director-General of the Prevention Division in the Department of Health is multifaceted and includes a whole range of things—normally: health disaster planning and response; aeromedical retrieving services; licensing of private hospitals and schools of anatomy; policy regarding organ tissue donation, blood, medicines and poisons; cancer screening; surveillance and control of communicable diseases; environmental health; preventive health; and medical workforce planning and leadership.

However, since January last year, when we first became aware of this virus circulating from China, my responsibilities pivoted to focus on managing the public health response to the COVID-19 pandemic. That has been all encompassing. It is not a role that I believe I could have achieved if I had continued with my usual responsibilities so I was very grateful to the director-general that he put

in place a person to take on my usual role. Professor Keith McNeil is a senior leader in Queensland Health. He was appointed as Acting Deputy Director-General of the Prevention Division and Chief Medical Officer. I continued the Chief Health Officer role in terms of the statutory responsibilities of the Chief Health Officer and I focused on managing the pandemic. For instance, I am still responsible for licensing of private facilities because that is a statutory responsibility.

I was delighted that last November I could release the CHO report. I want to remind everyone that one of the most important facts out of that report is that daily smoking by adults in Queensland is now down to nine per cent, which I announced last November, but I think it got a bit lost in everything else that was going on. That is fantastic. As you heard from the director-general, of course, we are continuing to do normal business although it is getting subsumed in many places by COVID-19.

Going back a little into the history of the pandemic, in early January last year we became aware of this threat. We took it very seriously, of course, and I declared a public health event of statewide significance. On 25 January I stood up the State Health Emergency Coordination Centre, SHECC. The then minister, now the Deputy Premier, declared a public health emergency under the Public Health Act on 29 January last year. We were the first state to take that action. I believe that proactive approach, which Queensland is known for in so many different ways, has absolutely stood us in really good stead because it was only on 11 March 2020 that the Director-General of the World Health Organization declared COVID-19 a global pandemic and we already had everything in place to manage that. We were ahead of the game.

As you have heard, we had already initiated the planning to triple our emergency department capacity and we have needed that, to double our intensive care capacity and to introduce early expanded testing capacity for COVID-19, which has proven absolutely critical. Imagine asking people to stay home if they have a sniffle. You could never have got people to do that, but you can task people to stay home, get tested if they have a sniffle, wait for the result and, if it is negative, to continue their lives. In the last pandemic 10 years ago we were asking people to stay home for seven days. With this one we would have had to ask people to stay home for 14 days. Our pathology testing capacity has been absolutely critical to our ability to manage this pandemic. We introduced screening at our international airports—and to date more than 75 per cent of our cases have come in through our international border—because we knew that was critical.

I am very grateful, of course, that on 18 March the Queensland parliament passed amendments to the Public Health Act to ensure that we had the legislative tools to effectively respond to this pandemic. New part 7A, chapter 8 of the act includes particular powers for this emergency, including the power for the Chief Health Officer to make public health directions. As of now I have made over 160 public health directions of which 19 are currently in force and that has been critical to our ability to manage the pandemic. Those directions have allowed us to respond rapidly to any emerging threats and issues that have arisen. Without them we would not have been able to implement things like our physical distancing measures. We would not have been able to rapidly protect our most vulnerable populations and we see that all the time in aged care, hospitals, disability services and corrective services. It has been critical to be able to protect them.

Early in our response to the pandemic, governance structures, as you have heard from the director-general, were established or broadened in scope to ensure there was good, solid, consistent public health advice that was enabled for all our hospital and health services. At the national level, the national cabinet has provided an overarching governance mechanism for coordinated decision-making and nationally consistent responses across our country.

National cabinet decision-making has been informed by the Australian Health Protection Principal Committee, chaired by the Australian Chief Medical Officer, and comprises all of the states' and territories' chief health officers or their equivalent and a comprehensive panel of multidisciplinary experts. The AHPPC receives advice from a range of expert committees, most importantly the Communicable Diseases Network of Australia, which includes the senior communicable disease expert from every state and territory and is chaired by our own Deputy Chief Health Officer, Dr Sonya Bennett, which is another critical reason Queensland has done so well. Other key groups that advise AHPPC include: the Infection Control Expert Group, which sets the standard for utilisation of personal protective equipment; the National Health Emergency Management Standing Committee, which sets the standards for aeromedical retrieval and disaster response; and the Public Health Laboratory Network of Australia, which sets the standards for pathology services.

For the majority of last year, and indeed through into this year, AHPPC has met daily, seven days a week, to discuss all current issues related to COVID-19, and that has been critical. It has been incredibly important in ensuring that information could be distributed effectively across the country. Queensland Health then established several internal governance mechanisms to harness the diverse

set of expertise across the department and our HHSs to develop and guide the implementation of our tactical response to the COVID-19 pandemic. One of those includes, as you have heard from Dr Wakefield, the COVID system leadership forum which would met every Thursday morning at 7.30. It was critical, and often additional meetings would be called. That was our mechanism to get consistent information out through all of our 16 hospital and health services.

Today in Queensland, we are in an enviable position in terms of case numbers. We had four new cases overnight, all from Papua New Guinea, and we are doing our bit to support Papua New Guinea while ensuring that Queensland is safe. You would have seen that we started the rollout of the vaccine program throughout the Torres. That is in place. They have already done those islands closest to the Torres and they are spreading through the whole Torres area. That has been critical. We are now at 1,421 cases. Fifty-eight of those are active and one of them is in ICU, and that is probably the highest number we have seen in our hospitals to date. We are very fortunate that our hospitals have the capacity to manage every single one of these cases.

The rollout of the vaccine is fantastic and brings so much potential going forward. We will be able then to rapidly remove those restrictions. Once our entire adult population has been offered the vaccine and hopefully taken it up—and that is our job: to get people out there understanding the need for the vaccine—we will be able to pull back on the restrictions in place. That is the discussion of course that AHPPC has been having so that we can advise national cabinet.

The vaccination task force, as you have heard, has been established and is working with our hospital and health services to facilitate the rollout of the vaccine and we are absolutely on track. One month to the day since our first vaccine was delivered to Zoe Park, a nurse in the COVID ward at the Gold Coast University Hospital—that happened on 22 February—the director-general said we would have vaccinated over 37,000 people and we have done 37,002 vaccinations to date. It is brilliant. We are right on track as to where we need to be. Today we saw the start of phase B, with GPs getting access to the vaccine and starting to roll it out. It is working beautifully. Our aim is to have that first cohort of the most vulnerable in terms of getting the disease—our aged-care and disability-care residents and their staff and the people most at risk of getting the disease and transmitting it to other people, so people at the borders, people in our hospitals, people who are managing the hotels—those 125,000 people, vaccinated by the end of March, and we are right on track.

We cannot totally relax yet. I do not expect any Queenslander thinks they can. We still have a significant risk to Queensland, given what is happening in the rest of the world. We are now at over 2.6 million deaths—and they are continuing to happen—and we have started to see a little bit of increase in the numbers of cases being reported around the world. We are seeing some really good rollout of vaccination in some other countries but not all. We need to maintain our progress and we need to maintain our vaccination program. We will have to maintain our quarantine arrangements at the international border until the vast majority of our adults have been vaccinated or at least offered the vaccine.

I hope people understand that this is a vaccine to be selfish about. This is a vaccine that each one of us needs as an individual, because if you are vaccinated your risk of dying is vastly decreased. Your risk of going to hospital is vastly decreased. You could still get the disease but it would be very mild. That means you can still give it to other people. Individuals have to be vaccinated, unlike with so many other vaccines. In fact, if you get 95 per cent of the population covered you will stop transmission and people who are not vaccinated are safe. In this case, to be safe you have to be vaccinated. That is a very complicated message to get out there, but it is a very important one.

We have recently seen some transmission in our quarantine hotels. We have seen that happen in states that are taking travellers. At the moment it is really only Sydney and Brisbane that are taking the majority of these international travellers. That is where we have seen these transmission events. That is why we need all of those people working in those hotels to continue being tested. I feel terrible that I am still asking them to be tested on a daily basis, although they have been vaccinated, because they can still get infected and they can still spread it if we have a transmission event in our hotels, as we saw most recently in the last fortnight. All of those things are continuing. Vaccination gives us another layer of protection but it does not totally mitigate the requirement for quarantine and for increased surveillance testing.

We need to continue to balance the role of our restrictions on our communities—and you would have seen that they have gradually been released and removed. Hopefully we will be able to have a normal Anzac Day as much as possible, at least for outdoors, and I think that is critical to start signalling the move back to a normal way of life here in Queensland. That is really important. We are fairly rapidly removing restrictions for outdoors. We know that indoors is such high risk that we need to keep some of those restrictions going forward until more of the population is vaccinated. That is

important. Where we can manage it, where we have seated ticketed events for instance indoors, we are going back to 100 per cent capacity. It is really where we have people who are standing, moving around and engaging with a lot of different people that we have to keep those restrictions of one person per two square metres. You would have seen that we have removed density restrictions on campgrounds and caravan parks, so people can enjoy our beautiful climate here in Queensland as we go into Easter and it is very safe outdoors. That is the message. We are going into the best time of year in Queensland in terms of our weather. Let's take full advantage of it.

I also acknowledge those within Queensland Health and the Queensland Ambulance Service and across the whole of government who have just worked tirelessly to support the development and implementation of everything we have done to keep Queenslanders safe. Our success to date, I believe, is absolutely due to the work of every single one of our healthcare workers across the state—what they have done individually, to go and work together then as a team and to get messages out so that the community understood what they needed to do. Thank you very much for the opportunity to speak this morning.

CHAIR: Thank you very much, Dr Young, for that update. I was very happy to see our vaccine hub in Townsville open up just recently. That is starting to roll out. Commissioner, did you want to make an opening statement?

Commissioner Bowles: I start by acknowledging the traditional owners of the grounds on which we sit here today. I also acknowledge our frontline workforce—our paramedics, our emergency medical dispatchers, our doctors, our nurses and all of the people we interact with each and every day—for the great work they do each and every day under what can be at times some very difficult and quite challenging circumstances. To see this you only have to look at the weekend and the environment in which our people were working, especially around the Gold Coast and later in the day in Brisbane. Experience tells me that there is nothing worse than being wet and going from case to case, trying to stay positive and trying to work with the community as they come through the door.

The Ambulance Service this year is very well funded—to the tune of almost $1 billion with capital, so about $989 million. We employ roughly 5,000 staff. Like any mid-sized health system, we are confronted by challenges. They can be challenges around demand or around a changing workplace, as we all would have seen. To go back to when I started some 40 years ago—I was probably the youngest person in the organisation at that time, as you can probably tell!—there was no female part to the workplace back in those days. If you look at our profile now, we have about a fifty-fifty workplace for our frontline responders, and that continues to grow. The person in this role in around 15 years will probably see roughly a 60 per cent to 65 per cent feminised workplace because, as we look at our data and at what is coming into the system, it is pretty much 70 per cent female and 30 per cent male. Those numbers are exactly reflected in university students.

With such change in a workplace, culture also presents its challenges because you do have some lags. Not only have we been faced with the changing demographic of our workplace; we have also gone from being an emergency service to being an emergency health service. Two years ago we were the 15th nationally health registered profession. Again, that is about that ever-evolving culture and about making sure we keep up with that health culture as we change from that emergency service culture into this new world. Again, I acknowledge the work that our people have done in this ever-changing environment, because ambulance services, for what we do these days, have come onto the scene very late in health systems. We work very closely with the medical profession to make sure we are able to deliver a service that is appropriate to the community's needs.

The other thing I touch on is that we sometimes seem to focus in on demand but, if you go back to 2014-15 and come through to now, we have had some pretty unprecedented growth in facilities. We have had 12 new ambulance stations in that period—additional new ambulance stations—and 15 replacement stations for stations that no longer were fit for purpose due to the ever-changing workload. We are continuing to grow. In 2019-20 we put in 122 new and replacement vehicles. We hope to do 135 this year. Whilst demand is coming, we are also doing lots of infrastructure and other initiatives to make sure we keep pace with our growth. That is just a brief overview of where the Ambulance Service is at today.

CHAIR: Thank you very much, Commissioner. We very much appreciate the update. Before I move to questions, one of the alarming numbers I heard Dr Wakefield give—there are just over five million people in Queensland, and are you saying that a quarter of the population, 1.5 million of us, went to emergency departments in the last year? Was that the figure you gave? It was 1.58, I think.

Dr Wakefield: We have around about two million emergency department presentations per year.

CHAIR: Wow!

Dr Wakefield: In fact, it is probably more like 40 per cent of the population.

CHAIR: That is incredible. The increase of 11 per cent is a significant impact on our public hospitals, and this would relate to the 346,000-plus ambulance presentations. That is almost 1,000 a day, for goodness sake. That is incredible! Are there people in our emergency departments that should not be there? Are there people that should be going to GPs? Is the low acuity case increasing? That is a significant increase on our public emergency departments.

Dr Wakefield: A simple answer to a complex problem is usually wrong. It is complex and I think we need to be careful not to speculate too much around this. Clearly, we have been asking the question: why is it? Why is it that there is so much growth in emergency demand across our system? When you look at those sorts of numbers, that eight, nine, 10 per cent, and obviously acuity comes into it as well—the more acuity you have, the more resource consumption per case. We have done detailed analysis work on that to understand what was related to population growth and what was related to increased utilisation per person. Really the facts are that there are both. About a third of it is related to population growth and around two-thirds is related to increased use per person. That is not surprising when you look at what has happened over the past 20 or 30 years with this growth. People are living a lot longer. An extra year of life expectancy is gained every four years since the beginning of the last century. Just think about that: one year of life expectancy increase for every four years since the beginning of the last century. We thought that would stop in the 2020s. In fact, it has not. It has slowed down a little bit, but our life expectancy is increasing.

During those ageing years, people have chronic disease. The people who we are treating are a lot sicker and they get sick more frequently. Part of this is absolutely understandable and expected. It is not a surprise, and it requires us to gear up to that. It also requires a shifting health system response across the broad health system; it is not solely about hospitals. The work to really change how primary care responds to age care, mental health, disability care and so on is really critical because those cohorts of people are very different to what they used to be. The royal commission has highlighted some of those things.

As a final response to that question I say that we provide services 24/7 that are free, that are accessible, that have great confidence of the community, and everything is done in the one place. When you compare that to other alternatives that families and people have in terms of accessing health care, in some respects the quality of that service really draws people in. Those are some of the factors which I think impact on demand. We have done an enormous amount of work to mitigate that, both pre hospital, in the ED and in the hospital, but it is a constant job.

Mr MOLHOEK: I should start by again passing on my congratulations to Queensland Health for the COVID responses that we have seen in the last year. There is absolutely no doubt that the response has been outstanding and that Queensland can hold its head high in terms of how we have responded as a state and also how we have responded compared to other nations around the world.

I wanted to raise some other questions. Commissioner, you mentioned that we have increased our capacity; we have new ambulance stations—15 replacement stations. But what we have seen in recent weeks and months is an increase in ambulance ramping. I think you said that there is nothing worse than being out in the wet and the cold and having to deal with very challenging circumstances. Is the system failing ambulance officers in terms of when they get to the hospitals, they are having to wait so long?

Commissioner Bowles: I think John opened up before when he said these are very complex issues and there is no single answer to that, I suppose. The first thing I will say, post patient-on-stretcher times are a challenge to ambulance services, not only here in Queensland but also nationally and internationally. In the North American states you can see people on beds for two and three days, and thank God we are not there in any way, shape or form in this country. From a community viewpoint, a lot of people feel that COVID has now gone and we are into the phase of putting a needle in someone's arm. However, we respond to a range of cases that have flu-like symptoms, especially in the aged, the elderly and a whole range of other people. They need to be streamed differently into the emergency department, so that creates some challenges. PPE is now used on pretty much each and every patient, especially where there is any concern. Post is a challenge and the less that the post is, the more able we are able to respond.

I will say that if we go to our response performance, especially our sickest patients which are what we call a Code 1a, they are patients that need an ambulance as soon as you can get one to them. Our response times for 2019-20, the year of the report, was 7.5, at the 50th percentile against

a target of 8.2, so we are doing quite well with our sick patients. If we have a look at this year, whilst we have the challenges as we have gone through COVID and the challenges that COVID has thrown up to us in this space, we are still at 7.7 minutes at the 50th percentile against a target of 8.2 minutes.

To suggest that the system is failing us would be wrong. Do we need to work together as a system to improve post so that paramedics can arrive at a hospital, unload their patients and go and get another patient in a timely manner? Yes, we do. We work together each and every day. Look at some of the things we have put in place over the last couple of years to shore up those processes. Once upon a time, our CAD systems—computer-aided despatch systems—would only be in a big room. Now we have them in our patient access coordination hubs. That is a shared facility that we have at the major hospitals, especially in the south-east of the state and Cairns, where we coordinate patients amongst a network. We have put our CAD system into those facilities so that we can coordinate and get a much more seamless way of delivering patients around the network.

We have put in place mental health co-responders. Going back to the chair's question before about who should be in an ED and who should not, if you look at the places where we have mental health care responders—and we hope to keep rolling those out over time—we have non transport to a public ED of 60 per cent. These are all the things that we have to do to be able to work with our health systems so that we do not have patients in hospital who do not need to be there and that in the first place the paramedics are not going there.

Looking at our data around what we do not take to a hospital that we respond to, we do not take in now about 120,000 patients a year that we respond to. Through our low acuity units, we distribute those into general practice or—once upon a time we would go out and find a GCS4 or 8 or somewhere like that diabetic, for example. We would put the person on a bed, give them some glucose, put up an IV and take them to hospital, but they would be conscious by the time we get there. We do not do that anymore; we go, treat and refer them into the diabetes system. We just started to do the same with falls in the Metro South HHS.

Mr MOLHOEK: Based on what you are saying, there are actually less acute people being taken to the hospitals. Going back to my original question: at the time that the paramedics and ambulances arrive at the hospitals—it sounds to me, from what you are saying, you are only taking the more acute cases—is the system at that end not coping and is it letting people down? That is really the question.

Commissioner Bowles: It is probably not for me to talk on behalf of—

Mr MOLHOEK: Perhaps if I can redirect my question to the director-general. You mentioned earlier we have the COVID System Leadership Forum. I am wondering if that deals with some of these broader external issues. What performance initiatives are in place to improve ambulance ramping and waiting times at hospital once the ambulance has arrived?

Dr Wakefield: The system is always responding to find greater efficiencies and better flow. Certainly the system is under pressure. You cannot have that amount of growth of demand without that. As has been stated already, this is not just a Queensland problem, this is a national problem and beyond.

We have a range of initiatives, including pre-hospital, and the commissioner has spoken about some of those which are very effective. We have solutions within the emergency department. For example, the TIN nurses who actually accept the patient and look after them to allow the paramedics to go and leave and respond to the next case—that is just one example. There is a range of examples there. Within the hospital itself, one of the things that we have been working hard on is to reduce the elective surgery cases that really flush through from the slowdown period when COVID hit. We have also had beds full of patients where we have been working extra evenings and weekends to catch up.

So it is a finally tuned balance of the capacity of the system. Certainly for the past few weeks we have been under a lot of pressure, so we go back and we completely work through all of those and make sure all of those things are working. As the commissioner has said, the system is under pressure, it is under strain, but our performance and the experience of patients, by and large, remains very good in terms of our time limits.

Ms KING: I just want to begin by acknowledging the incredible work of the Health staff. I know that in my area they are doing an exceptional job. I want to reiterate from the committee that we could never, ever—under any circumstances—think they were letting Queenslanders down.

My first question is to the commissioner. You have talked about some of the measures that have been taken to address the unprecedented demand, but I know that the Queensland Ambulance Service has also received a record budget. Can you please outline how that record budget is being applied?

Commissioner Bowles: Obviously the first thing I would start with is our growth in staff. If you have a look at this year's record budget, as you put it, we will take on 100 additional ambulance operatives into our system. We will also pull some forward, probably from next year, so we could end up with about 110 to 120 additional staff this year. As you would all know, staffing costs are an incredible part of any service delivery system.

I mentioned before the building of new stations. Out of the recent commitments over the period of this term we will build additional new stations at Caloundra, Burdell—Burdell is just north of Townsville, that growing area up there that the chair would know all too well—Morayfield, the growing area in our northern and western corridors, and also Ripley.

Queensland prides itself on its fleet. In our organisation if someone asked me what I thought our greatest risk was, it is kilometre reach—how far we go each year. We do 44 million kilometres a year. I think it is something like 50 times to the moon and back, if you want to put it into perspective. There is a lot of risk in that because, as I said, you have seen the weekend weather and you have seen these adverse conditions that we drive around in. We need to make sure that our paramedics have the best fleet available to them. In 2019-20 we put on 122 new and replacement vehicles. This year we will put on 135 new and replacement vehicles. As a system, our average fleet age is around four years. That would be the envy of pretty much any ambulance service. If I go back to my days on the road—which are a long time ago, but I try to stay across what is still happening—in 1990 you would be driving a 1977 F100, and now they drive state-of-the-art Mercedes that are pretty much, in the main, low kilometres and new.

There are a whole range of things, even the things that we introduce into our workplace. Health care can be quite expensive. We introduced pre-hospital thrombolytics to our critical care paramedics in 2006, but in 2016 or 2017 we introduced all of our advanced care paramedics to pre-hospital thrombolytics. If you are in Aramac or—obviously go to a cath lab if you are in Spring Hill—you can get them. Some of these things cost a lot of money. For example, for ampules of tenecteplase, all of the new versions, you are looking at $1,300 to $1,500 for a single vial, but you look at the downstream costs that you save when you do not have people in coronary care units for seven nights and they are in there for two nights, or whatever the case may be.

I often say that we are the David Attenboroughs of the health system: we are just out and about in what is going on in the community. We are always looking for ways to contribute, and being the well-funded ambulance service that we are has allowed us to continue to employ paramedics. In total for this annual report period we employed 312 graduate paramedics out of university. I spoke before about culture, the renewal of young people coming into our system and then getting the benefits of this very experienced workforce, they are all the things you grow and develop a system around. As you have quite rightly pointed out, you need funds to do that.

Ms KING: My question is to Mr Steele, the deputy director-general. We heard from the director-general about some of the factors that are leading to this unprecedented increase in demand. I wonder, Mr Steele, if you could please detail the actions that Queensland Health has been taking to increase bed capacity across the HHSs in order to respond to this increase in demand?

Mr Steele: We have been working in partnership with hospital and health service chief executives and the ambulance commissioner on a range of initiatives to try and free up capacity in our hospital sector. There are a number of actions. We have been opening additional beds in some of our public hospitals. Where we have wards that are not fully open, we have been funding the expansion of those wards. We have been looking to partner with local private hospitals as a way of trying to access additional beds within the private sector, whether that be for planned care or for medical patients. We are also looking to try and utilise beds more efficiently within our hospitals. We are looking to put in place models that will reduce length of stay. We have models like Eat Walk Engage for our frail and elderly patients where we are looking to accelerate discharge back to home and a range of things like that to try and improve utilisation.

The next sort of thing we are working on now is satellite hospitals and a way of trying to bring those seven new satellite hospitals on to try and manage some of the demand issues that we have in the system. A lot of that will be around some of the minor injuries and illness type case mix that we see come through but also, as the DG said, a lot of the focus around chronic disease and mental health. We will look to try and utilise those for that as well. There are a range of issues that we work on every day with the ambulance commissioner.

Mr ANDREW: Thank you all for the services that you provide. Dr Young, I have a question. Could you provide details on what independent analysis will be undertaken with regard to any very adverse reactions or injuries as a result of COVID-19 vaccines in Queensland?

Dr Young: We saw that happen the other day. That is the role of the TGA, the Therapeutic Goods Administration, which sits within the Commonwealth Department of Health. It is their role to check every single vaccine, drug and therapeutic device before it comes into Australia and give approval for it. You would have seen that over the weekend they announced they have now approved the CSL-made AstraZeneca vaccine, so they have approved that for release. They do all of that prior to the release of any new drug, vaccine or therapeutic goods device. After any of those are introduced into the population they do post-surveillance screening. Whenever there is an adverse event, that is then immediately sent through to the TGA and they review it.

The other day when we had four severe reactions to the AstraZeneca vaccine over a 24-hour period we notified—we had already notified the TGA. I spoke to them and said, 'We've now had four. Could you do a very urgent review?' which they did. They brought together a group of very senior expert clinicians from across the country to review all four of those events and work through whether there was anything to be particularly concerned about. They said no, that it was almost coincidence. We had four in our first 2,986 deliveries and we have had none since then, so it was just a matter of coincidence—and that happens in life—with four in those first deliveries. They reviewed all of those, came back to us and said, 'No, we don't think there is a signal here that we need to do anything with, so you can go back,' and we immediately notified all of our vaccine deliverers and so forth. That is what they do. That is the job they do every single day all the time for any drug, any vaccine and any therapeutic device like IV lines et cetera.

We are very fortunate in Australia that we have a very proficient TGA that is very good at doing this. Every country has something similar—for example, the FDA. That is how it works in Australia. The most important thing, though, is that people must tell us about events. It is really important. Of course all of our healthcare professionals know that they need to notify of any adverse event. We also need people in the community to notify. If there is a delayed event, they must let us know. There are processes in place to remind people when they have their vaccine that, if anything happens, you need to let us know. Even if you do not think it is anything, we still need to know about it.

Ms PEASE: Thank you very much for coming in. Like my colleagues, I would like to acknowledge all of the great work by all of the frontline health workers and also all of the workers in the background who are quite often not mentioned. I know that it takes a lot of people to get to the point we are at during our COVID response, so thank you very much each and every one of you.

Dr Young, could you please provide some components about who was responsible for the vaccine rollout in terms of the Queensland jurisdiction and also the Commonwealth jurisdiction?

Dr Young: It is a joint response. The Commonwealth's role was to find and procure vaccines that would work and that could be delivered, and they delivered. The Commonwealth delivered beautifully, so we now have two vaccines. They have two more on order and we will see what happens with those. The two that they first procured, the Pfizer and AstraZeneca vaccines, have proven to be excellent vaccines. They did that very early on. There are now 260 vaccines in various stages of trials around the world. For them to have chosen the two out of the four they put orders in for, which have been really successful, was excellent. That was the Commonwealth's role, and they did that.

The next is to then roll those out. They are responsible for accessing those vaccines and distributing them throughout the country. They have done that with the Pfizer vaccine. The 20 million doses they ordered are now coming through into Australia and are being delivered throughout the country. They ordered 53.8 million doses of the AstraZeneca vaccine. Just over three million of those are to come to us from Europe, but there have been some delays in that because of the enormous problems that Europe has. They are starting to see increased case numbers, so of course they want to keep that vaccine for their own use, which is understandable. They worked with the CSL, and that was the exciting news over the weekend—for the CSL, our own country—to produce 50 million doses of that AstraZeneca vaccine, so the Commonwealth has been responsible for that. The Commonwealth has paid for all of those vaccines and organises them to be delivered to the point where they will be delivered out into the community.

Our role here in Queensland Health was to vaccinate the critical first cohort of people who are most likely to get infected—that is, people at our international border where cases are coming in because that is where the vast majority of cases, indeed all of our cases, now come from and then the hotel quarantine workers. That is all of the support staff, the cleaning staff, the hotel staff, the ADF, the police, all of those people and the health staff who are supporting those quarantine hotels. We have had up to 30 hotels through the state, so that is the second part of that cohort. Then the third part of that cohort are our workers in our hospitals who are treating confirmed cases. They are

the workers in our COVID wards, the workers in our intensive care units and the workers in our emergency departments, so people who are actually seeing confirmed positive cases. That is a cohort of 37,000 people in Queensland, and it was the state's responsibility to vaccinate them.

The Commonwealth's responsibility was to roll out vaccine to the most vulnerable, which is the residents in our aged-care facilities. We are so fortunate in Queensland that we did not have an outbreak that progressed in any of our aged-care facilities. We had a number of staff who developed infections, but they did not spread it to residents so we were protected, but going forward we know they are the highest risk group. Once COVID or flu, any of those infections, gets into aged care it is really difficult to manage. The Commonwealth is responsible for that and they have already started that a month ago, rolling that out to aged-care facilities, the residents and the staff. Rolling it out to disability- care facilities, to the residents and the staff, is the Commonwealth's responsibility and they are on track. They are doing that for every aged-care and disability-care facility in the state, public or private. That is happening. That adds up to 125,000 between the state responsibility and the Commonwealth responsibility and we are on track by the end of this month to achieve that cohort total of 125,000 Queenslanders.

Then we move into phase 1b, which we started today in Queensland. That means all healthcare providers, public and private. The state will be responsible for public, of course, and the Commonwealth for private. It will be all healthcare providers, whether in hospitals, in GPs, in allied health clinics, all of those. They are in 1b. Then also there is anybody who is 70 years of age or over. They will be able to start going to their own GP, if their GP provides the service, as of today. They need to make appointments, remembering that we have now got several hundred GP surgeries that have received vaccine this week. More will get it next week, but they are only getting 50 doses a week because we are still waiting on that AstraZeneca vaccine to roll out from CSL. They should be able to produce around 1 million doses a week, but it will take a little while to get there, to be able to get it out. The numbers are quite small. We know that now we have got most of our 1as done, which are the people at risk of getting it, everyone else is so much better protected. There is not really a need for rush. People do not need to panic and feel they need to get vaccinated tomorrow. They can wait. It is over the next few weeks that it is important that people start to get vaccinated. It is wonderful to see that people are so desperate to get vaccinated and want to be there immediately, but there is not that necessity. We are not in the stage that the UK or Europe or America is. We can do this slowly and methodically.

1b will be Queensland Health staff and staff in other agencies that are critical to the response such as police and other workers. That is where the Queensland government response will be. Then the Commonwealth will be responsible for aged care, disability care and also for GPs. They are standing up across the country 100 clinics for people to come to to get vaccinated. People should, wherever possible, if they have a GP, be going to their own GP to get vaccinated because their own GP knows their history, knows whether they have got a history of severe allergic reactions, for instance and knows what the risks are. That is the aim.

2a will be the next phase after we have done the over 70s, all of the healthcare workers, all of our critical workers and First Nations people over age 55 who are all in 1b. Once we are finished with those we then go to 2a. For that stage the plan is for community pharmacies to be able to start to vaccinate. I would see them vaccinating people who do not have GPs because they are probably the healthier people and those who do not have significant histories, do not have chronic disease, do not have cancer and malignancies that the GPs would be treating. They are the more well people and they will be able to go to pharmacies. That is the plan at the moment. It is still being worked through. Then we will go through 2a and 2b and at that point we will hopefully have vaccinated around four million Queenslanders and then the process will be to look at whether or not we need to vaccinate children. We know children rarely get severe disease—very rarely—and there have been very few deaths worldwide of children, which is totally different to the flu, absolutely. This is a very different disease and causes different results in different people. We will be looking at whether it is important to vaccinate children because they then can still, of course, get the infection and spread it to other people, but that work has not been done. The Pfizer vaccine is currently accredited down to age 16, the AstraZeneca to 18. We will need more trials to be done before we would go out and start vaccinating children.

It is quite clear who has responsibility for the rollout of the program. The Commonwealth is responsible for choosing and purchasing, putting in place contracts and buying vaccine and distributing it to point of delivery. Then the states are responsible for those key first groups of border workers, hospital workers and hotel workers and then after that the state is responsible for those critical workforces, those public servants who are absolutely critical and critical for their own patients

that are seen in hospitals. There are some patients who do not have a GP because they are such that they are seen in our transplant clinics and those sorts of areas. The Commonwealth is responsible for getting the vaccine out and delivering it through GPs and then, if the decision is made to go through pharmacies, for managing it through pharmacies.

Ms PEASE: Thank you, Doctor.

Dr ROBINSON: Commissioner Bowles, the media is reporting an Indooroopilly woman tragically died on 15 February waiting for an ambulance to respond to her 000 call. Can you explain what prevented an ambulance arriving in time in that case?

Commissioner Bowles: I may need to take some advice. We have actually notified the coroner about that specific case so it probably would be inappropriate for me to discuss that here today.

CHAIR: Do you have another question, member for Oodgeroo?

Dr ROBINSON: Yes, I have a question for Dr Wakefield. In terms of Redlands Hospital and ambulance ramping there, it has been reported recently that up to 18 ambulances were seen by local people ramped at the Redland Hospital. In my 12 years as a member of parliament I have never heard the figure being that high. Is the system slipping and what specific measures and assurances can you give that would give confidence to the people of the Redlands that this is going to be fixed?

Dr Wakefield: I have not heard the particular comment that you made—and I cannot confirm it—about the number of ambulances at Redlands. I think I have addressed in previous questions the demand on the system. There is significant demand on the system and my colleagues have outlined a range of interventions that we are putting in place to reduce that demand and manage waiting, particularly where it pertains to clinical outcomes for patients. I am not sure it would be useful for me to repeat all of those, suffice to say that the system is under pressure. We continually work through pre hospital in the ED, in the hospital itself, to make sure that we appropriately triage patients and make sure that those who need time critical care get it when they need it. That does sometimes mean that patients with lower acuity problems wait. In fact, in spite of that growth in demand, our performance and our wait times for emergency care are exceptionally good. I might get my colleague, Nick Steele, to outline those. What matters to people when they get to hospital is how quickly can they access care, particularly related to the acuity of their condition. I might ask, through the chair, my colleague Nick Steele, to give some of those numbers around our performance.

CHAIR: Yes.

Mr Steele: A couple of areas we look at is, one, how quickly patients are actually seen on their arrival at an emergency department. We call that the seen-in-time performance. For the first six months of this year that is at 80 per cent overall for all categories. That is nearly four per cent higher than it was for the previous six months last year. The other area of performance that we look at is what we call ELOS, emergency length of stay, which is where we are trying to ensure that all patients are seen, treated and either discharged or admitted within four hours. That has actually improved for the first six months from just shy of 74 per cent last year to just over 76 per cent in those first six months. The one area that we probably do not talk a lot about is emergency surgeries and that is where we are starting to see a really significant growth in. As well as those ambulance arrivals and the growth in ED attendances, we are also seeing a nearly seven per cent increase in emergency surgeries in those first six months. Now that is a fairly significant increase and all those patients are going to need admission and they are all going to need a hospital bed as well. We are starting to see that pressure come through all parts of the patient pathway.

Dr ROBINSON: Can I ask a quick supplementary in terms of Redland Hospital. My question was very specifically in terms of the operation of Redland Hospital. The statistics that I have seen in the report is 32 per cent of patients have waited longer than the recommended 30 minutes, and that represents a 13 per cent increase over December 2019. I do not see how that is an improvement. It looks like a system that is slipping. Do you have any comment?

Dr Wakefield: Again I would have to take on notice the specific data for Redland Hospital, unless my colleague can bring that forward. We are all working exceptionally hard in health care to deliver the best possible performance of our system, and that includes the timeliness of care. For our most vulnerable group, which are those in need of urgent care, time critical care, I think our record actually, in spite of the significant increase in demand, bears out that we are keeping people safe, we are delivering care to many more people on time and within time and I stand by that.

The other thing that I would say, and this is more by way of a broader consideration of what is happening in the system at the moment which is different to usual, is because we have done so well as a health system and as a state in basically eliminating COVID and getting our lives back to relative

normality—I am not suggesting that many people have not suffered because of this, but when you compare what has happened in other countries it is really stark—the downside to that for us is that I think people think, 'Well, it has gone. There is no impact on our health system.' We are a people business. It is a fairly confined group of people. You cannot produce them in five minutes. They are not available off the supermarket shelf. They are a confined group. Right now even though it seems like COVID is not there and our system should be all hands on deck with normal health care, we have a number of things which I would just like to point out which I think the community will understand about the fact that in some cases this means that for non-urgent care they have to wait a little longer.

We have fever clinics running with 5,000 to 10,000 samples a day. I do not know whether you have had a sample, but you know what is involved in a single sample and all the testing behind that. That takes staff. We have 3,000 to 3,500 quarantine hotel rooms occupied every day that we are supporting with both clinical care, in-reach and infection control across the state. We have the elective surgery recovery, as I said before, with a whole lot of additional work on top of our normal work, often evenings and weekends as well, where our staff are working really hard to get Mrs Smith that operation that she has waited longer for because of the backlog due to the COVID situation. We have our public health units working incredibly hard with additional staff in their testing, tracking, tracing, and now we move into—and as I say this is our greatest priority this year, not from a health perspective but from a social and economic perspective for the nation and the state—having eight million jabs to do between now and the end of the year. That is eight million appointments—occasions of service. General practitioners are probably going to do three quarters of those. What is that going to do to demand and access to services for general practice and the impact that that will have on our system as well?

From my perspective as director-general, probably one of the things that I would ask is that we are going to need some recognition. Whilst we have created what is I think an amazing outcome for our community, there is an enormous additional workload as well as what we normally do. Yes, we have to work as hard as we can to minimise the impact on patients in the community around that, but it is vital that we have understanding and support because this is a people business and our staff are stretched very thin and we need to support them.

CHAIR: On that point, Dr Wakefield, thank you very much. We are at the end of our hearing. We very much value the time of everyone who has appeared here today. It has been very helpful for the committee to hear you. There was one question on notice from the member for Oodgeroo regarding Redlands. If we can have the answer back by 29 March. On behalf of the committee, we thank the hardworking men and women right across the state in Queensland Health. I think I saw there were 94,000 people working in the system, 5,000 of those with the Queensland Ambulance Service. We know how hard they are working. We know the additional impact rolling out the vaccine will have on the service. There is no doubt it is about keeping people safe. We thank you for your time today and I declare this briefing closed.

The committee adjourned at 11.02 am.