HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Mr AD Harper MP (Chair)
Mr MF McArdle MP (via videoconference)
Mr MC Berkman MP (via videoconference)
Mr MA Hunt MP
Ms JC Pugh MP (via videoconference)
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Ms A Beem (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE QUEENSLAND GOVERNMENT'S HEALTH RESPONSE TO COVID-19

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 3 JULY 2020

Brisbane

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The committee met at 12.32 pm.

CHAIR: I now declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I start by acknowledging the traditional owners of the land on which we are meeting today. Today's proceedings are being conducted using Zoom and I do ask that all participants or anyone watching the live broadcast please bear with us if we encounter any technical issues. I am Aaron Harper, chair of the committee and member for Thuringowa. The other members joining us today are Mark McArdle, member for Caloundra and deputy chair; Michael Berkman, member for Maiwar; Marty Hunt, member for Nicklin; Jess Pugh, member for Mt Ommaney who is substituting today for Barry O'Rourke, member for Rockhampton; and Joan Pease, member for Lytton.

The purpose of today's briefing is to assist the committee with its inquiry into the Queensland government's health response to COVID-19. The briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath. I remind anyone that intentionally misleading the committee is a serious offence. Hansard will record the proceedings and you will be provided with a copy of the transcript. The briefing is being recorded and broadcast live on the parliament's website. Provided you are not joining us via Zoom or on your mobile phone, I ask everyone participating today in today's proceedings to please turn your mobile phones off or on to silent. I also ask that you please place your microphones on mute unless you are speaking. This will prevent any audio interference and background noise.

CRIDLAND, Mr Mark, Deputy Director-General, Policy, Department of Premier and Cabinet (via videoconference)

MARTYN, Mr Paul, Lead, COVID-19 Response and Recovery Taskforce, Department of Premier and Cabinet (via videoconference)

McGARRITY, Ms Rebecca, Executive Director, Social Policy, Department of Premier and Cabinet (via videoconference)

STEWART, Mr Dave, Director-General, Department of Premier and Cabinet (via videoconference)

CHAIR: I now welcome officers from the Department of Premier and Cabinet. In view of today's briefing being broadcast via Zoom and given the absence of name plates and more limited visual cues, I ask that you please identify yourself by name when speaking, particularly when speaking for the first time or when speaking other than in response to a direct question. Committee members will endeavour to ensure they clearly identify themselves when asking questions to minimise any confusion for yourselves. Mr Stewart, I now invite you to make a brief opening statement on behalf of the department after which committee members will have some questions for you.

Mr Stewart: Thank you. Good afternoon, chair, and members of the committee. Thank you for this opportunity to provide this briefing regarding the Queensland government's health response to COVID-19. I, too, would like to begin by acknowledging the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. This is a valuable opportunity to provide the committee with an overview of Queensland's interaction and coordination with the federal government in relation to the health response to COVID-19. The Queensland government has acted swiftly and decisively in response to the COVID-19 pandemic and the substantial health challenges it has presented. In Queensland, the health response to COVID-19 has been led expertly by Queensland Health and informed by advice from Queensland's Chief Health Officer, Dr Jeannette Young. I understand that Dr John Wakefield, the director-general of Queensland Health, and Dr Young were witnesses before the committee last week and have outlined Queensland's preparedness and the health response activities in great detail.

Queensland Health has been supported by a whole-of-government approach which has drawn on Queensland's existing disaster management arrangements. These existing arrangements have provided a solid, practised and scalable framework for guiding the Queensland government's

response to COVID-19. The early declaration of a public health emergency in Queensland on 29 January this year and the rapid activation of Queensland's disaster management arrangements have been instrumental in ensuring a coordinated whole-of-government approach to supporting the health response to COVID-19.

The Queensland Disaster Management Cabinet Committee was created to strengthen existing disaster and management arrangements in recognition of the significance of the pandemic and the potential for widespread impacts. This cabinet committee involves ministers and their directors-general, ensuring a whole-of-government consideration. This approach has also ensured leveraging of the expertise in and networks of each agencies to provide a comprehensive response to the pandemic.

Queensland has also coordinated very carefully with the Australian government and other state and territory governments, mostly through the national cabinet which first met on 15 March this year. The deliberations and decisions of national cabinet have been guided by the health response to COVID-19 across all jurisdictions in Australia. Throughout the pandemic, national cabinet has been and continues to be informed by the expert health advice of the Australian Health Protection Principal Committee, AHPPC, of which Dr Young is a member. One of the key successes of national cabinet has been the flexibility for states and territories to consider and act upon their local circumstances. While decisions made at national cabinet have established the health response to COVID-19, the Queensland government response has been tailored based on the status of the pandemic in Queensland and the advice from Queensland Health, most notably from Dr Young.

The coordinated and contemporary relationship between the Queensland government and the Australian government throughout the COVID-19 pandemic has ensured that Queensland's health system has been able to prepare for and respond to COVID-19 and now retains capacity and capability to respond to any future COVID-19 outbreaks. While the health response to COVID-19 has been led by Queensland Health and supported by a whole-of-government effort, the Department of Premier and Cabinet has played an important role in leading the interaction between the Commonwealth government and the Queensland government to guide the response to COVID-19. Several examples illustrate the work of the Department of Premier and Cabinet in facilitating this federal-state collaboration. These include—advocating for the implementation of restrictions on foreign nationals entering Australia; the process of easing restrictions; the development of COVID-safe plans for workplaces; and the coordination of protections for remote communities. Each of these initiatives has enhanced and complemented the Queensland government's health response to COVID-19.

In addition, the Department of Premier and Cabinet has supported the Premier in her attendance at national cabinet and the Queensland Disaster Management Cabinet Committee meeting through the provision of briefing materials and in the case of the health response has been informed by advice from Queensland Health. Queensland has acted swiftly and decisively as the global pandemic has unfolded. The strong health response means that Queensland has not experienced the devastating outcomes witnessed in other parts of the world and ensures that the state is well positioned for recovery. Thank you for this opportunity to make an opening statement.

CHAIR: Thank you, director-general. Only 42 minutes ago we in Queensland commenced stage 3 easing of restrictions. I do understand that it is Friday afternoon and that a lot of people will have Friday on their minds as we allow more people into facilities throughout Queensland. We did indeed have the Chief Health Officer and Dr John Wakefield in front of us a week ago providing information on the outstanding health response. Queensland is in an enviable position, there is no doubt, in terms of allowing us to bring on these restrictions earlier. Was there an earlier request from the Queensland government to form national cabinet prior to 15 March?

Mr Stewart: There was not a request to form national cabinet but there certainly was significant interaction between Queensland and the Commonwealth. You can imagine that at the political level there were COAG interactions, but certainly at officer level I had considerable discussions with my federal and Commonwealth colleagues and my state and territory colleagues. We were in contact quite early on in relation to the discussions around what was happening in an Australian context. It is fair to say that the Premier certainly wrote on many occasions to the Prime Minister outlining some of what we saw as some of the early impacts of COVID. If you look back in time—and I know Dr Young and John Wakefield spoke about this—as soon as we were aware of the health issues happening in China in Wuhan we became very alert to the fact.

CHAIR: From your perspective, has the Queensland government been satisfied with the level of clarity that has been provided by the federal government?

Mr Stewart: There have been a number of mechanisms put in place and it certainly has been a very collegiate process. At all stages though it has certainly been informed by the health advice. We have had access to very good health modelling by the AHPPC. A lot of that modelling I think you will now find on the AHPPC website or institutions like the Doherty Institute. My director-general of policy might want to comment, but one of the things we set up very early on was what we called the national coordination arrangements where we looked at particular instances or particular issues that we had to address in a national context. One example is incoming flights that we have seen occur since the closure of the borders, so we have been working very closely with the Australian government on those issues and others such as quarantining. Mark, I do not know if there are any other issues you want to raise there specifically.

Mr Cridland: Yes. The National Coordination Mechanism that Dave refers to was set up by the Prime Minister on 5 March and it was essentially to establish a mechanism to coordinate the response to non-health issues arising from the COVID-19 pandemic. Since that was established, there have been 77 National Coordination Mechanism meetings held across 23 different sectors. I will not go through all of them, but examples are education, agriculture, public safety, emergency management, resources, supply chain and telecommunications. The main aim of the National Coordination Mechanism, which is facilitated by the Department of Home Affairs but involved all first ministers' departments, was to maintain key functions within the community while the health response was being dealt with and also to reduce the overall severity outside of the health response. That was quite an effective mechanism that is still operating today.

Mr Stewart: I think it is fair to say that there is a very good information flow, so we do have very good processes of understanding what is happening across the country and internationally.

CHAIR: Yes, I think that has been demonstrated with the coordination of all government departments with that whole-of-government response. It has been outstanding from the departments that we have had in front of us to date. I want to turn to the road maps and the process of developing the road map. Who was consulted during the drafting in terms of government and non-government agencies?

Mr Stewart: The road map development has been a very carefully considered process and, as you say, today is a very significant day in a road map context. If you go back to where we started, the fundamental premise of a road map is taking the health advice and a lot of that health advice—particularly things like density, gatherings, those sorts of things—was clear advice from the AHPPC. Dr Young probably would have spoken about that—and I have read that transcript—but the fundamental premise was work done by the task force led by Paul Martyn, who is in the room today, but certainly taking on that health advice. The health advice has been the basis of those road maps.

I will let Paul maybe answer this, but the Premier was also very keen in getting the view of key stakeholders. One of the key stakeholder mechanisms we have at the moment is an alliance group of key industry, a key stakeholder union and those peak agencies and peak organisations that provide very clear feedback on how they would like to see, in a health context, those road maps and those restrictions and how we have moved. Very early on you would have seen on the very first road map 'subject to health advice', and that has always been the fundamental premise. I do not know if Paul Martyn would like to say anything more, but I think there has been a very extensive consultation process across government and with stakeholders.

Mr Martyn: If I could just elaborate a little bit on what the director-general has outlined in two key ways, so I will elaborate on two key areas in the development of the road map which I think go to the question. The first is around engagement with the business community on the implementation of the road map. The government developed the COVID safe business framework which was designed to provide businesses with certainty around what they were able to do and not able to do as the road map was implemented. This involved extensive consultation with a whole range of industries and the development of 58 COVID safe plans that covered industries.

What the development of this framework allowed the government to do was to explore with industry the practical implementation of restrictions. What we were conscious of was that, in order to get customers back to businesses, customers needed to be sure if businesses were operating in a safe way. Equally, businesses wanted to know they were doing the right thing. These COVID safe plans were developed for industries and checklists were developed for individual businesses. This process enabled us to get feedback from business about how they were experiencing the restrictions being implemented and that feedback then enabled us at each stage of easing to understand what practically could be done to achieve both health objectives but also the reopening of businesses.

The second point I want to pick up in terms of what the director-general outlined is that the Premier has formed the Queensland Industry Recovery Alliance which consists of key leaders across 24 sectors of the economy. This alliance has met three times and its members are providing direct feedback to the government on the circumstances in which their industry is placed both economically and in the context of restrictions and providing feedback which again is used to help in the implementation of the health advice.

Mr Stewart: I also want to note one other issue. The Australian government road map—you have probably seen it, and I am happy to get one tabled at some stage—is a staged process not dissimilar to our own road map. Again going back to the basics, our health response and the outcomes that we have managed to achieve in Queensland have allowed us, as has been the case in other states and territories, to implement easings sooner or later, whichever may be the case. Another thing I want to raise is that you would also see that we have a remote communities road map as well. One of the key groups that we have been consulting with is our Indigenous communities, particularly the discrete communities. Those consultations have been quite regular and ongoing but again based very much on that health advice.

CHAIR: That goes to my final question before I open it up to other members. I was going to ask what feedback your department has received not from industry—you have clearly articulated the stakeholders that you engaged with—but more the general public. As a local member in Thuringowa, I have contacted—as I am sure other members have—a lot of people in my area, particularly during phase 1 of restrictions when we were asking people 65 to 70 and over to stay home or for essential travel only. The feedback I got was that they felt safe, that they were informed daily with that messaging. I think that that is commendable and it should be passed on to the Department of the Premier and Cabinet—that is, there was a lot of positive feedback. From a public perspective, can you comment on that?

Mr Stewart: I again want to emphasise that we would not be where we are today without the tremendous support of every Queenslander. I think Queenslanders have taken this issue seriously and they have really comprehensively understood the implications. Obviously we are going to get different levels of feedback from different stakeholders in different communities, and again national cabinet does get a report nearly at every meeting or certainly every month around the acceptance of the community in relation to restrictions and then the easing of restrictions. We have seen those results in quite positive terms, and again it has also allowed us to make adaptions and amendments. I would again thank Queenslanders. I think they have done an outstanding job and on the whole I think people have been very responsive and understanding of the importance of those restrictions.

Mr HUNT: Thanks very much for your time today. I have some questions around the road map and the process as well. From my research this afternoon, I think the road map was released on 8 May; would that be right?

Mr Stewart: The first road map, yes.

Mr HUNT: On that road map I want to turn your attention to the border opening indications in phase 3, I think it was, and the 10 July date. Who would have come up with that date and how was that date arrived at on 8 May or leading up to 8 May?

Mr Stewart: In terms of the point I made just before with regard to the Queensland road map, we followed very closely the advice from the AHPPC, and if you go back and look at the Australian government road map, which is in three stages, they are not dissimilar stages. This work was always premised on health outcomes and health advice. Again, if I step you back to the Australian government road map, it was under a raft of categories over a raft of times, not dissimilar to the timings that we have here.

One of the things that we were also very keen on—again, I think Dr Young could answer the issues more technically from her public health background—was that there was a whole pile of things around the time between making and easing a restriction and then the ability to review that over an incubation period or a number of incubation periods and then make an adjustment based on that. The dates were what we projected to be our dates, but as you would have seen on that road map, particularly the one you have just talked about released on 8 May, every month it depended on COVID safe plans and it certainly had a whole pile of issues around reviewing the health impacts. As you probably recall, at that stage we also had biosecurity measures in place. In those early days we were also still seeing a lot of international travellers coming back to Australia, mainly Australian residents of course being quarantined, so there was constant vigilance and constant review of border dates and border restrictions.

Mr HUNT: I understand that the road map is a fluid document that was always intended to be reviewed at the end of the month and that those things were always under review, and I draw on comments from Mr Martyn earlier about providing certainty to business as much as you possibly could. As you said, it had to be reviewed at the end of each month and readjusted but, to your knowledge or to anyone's knowledge, between 8 May, when it was released, and 18 May did anything change in relation to health advice that would have had an impact on that date?

Mr Stewart: The health advice was changing. The health advice was being given very regularly. We were looking obviously at what was happening not only in this state but also in an Australian and national context. We get daily reports from Queensland Health in relation to what is happening. I would have to go back and review those daily reports, but that health outcome and what was happening in a health context moved every day. There was a requirement to consider that advice and there was certainly very regular contact with the Chief Health Officer, as in national cabinet.

With regard to the discussion at national cabinet—whilst I cannot go into those deliberations in detail—the Chief Medical Officer from the Commonwealth would update us very regularly on what was happening not only in Australia but also internationally and I think they were starting to understand the pandemic and particularly how COVID was manifesting within people in the community. It has been a very constant, vigilant process. I go back to the point that we are where we are today because of the management of the health response in this state in particular but also nationally and in an Australian context, but you cannot estimate how much work has happened in this state.

Mr HUNT: I appreciate that. I draw your attention to comments made on ABC radio by the Premier on 18 May, outlining concerns with infection rates in New South Wales, I believe she said, in relation to border openings that things would look more positive towards September. That created a lot of confusion in the community and certainly a lot of public debate. To your knowledge, in that 10-day period was there anything specific that would have changed the date on the road map to a date later in September?

Mr Stewart: The Premier was very clear that she would take health advice. In the context of what has happened most recently in Victoria—and I am sure that Dr Young may have talked to you—one of the greatest concerns of the AHPPC, Professor Murphy and our Chief Health Officer was the level of community transmission. At that stage, from my recollection—I would have to go back and look at the data, so I am using my memory—there was significant community transmission happening in New South Wales. There was transmission happening in other states. What we have seen in the past couple of weeks is community transmission occurring in Victoria, which we have been very mindful of. It is not only Queensland that has been mindful of that community transmission; it is states such as New South Wales, South Australia, Western Australia and the Territory. On the advice I have, I understand the ACT is equally concerned about it. This has been a constant issue of vigilance and the Premier has very clearly—and she said this herself—taken the advice of Dr Young.

Mr HUNT: Between 8 May and 18 May, from my research and from the graphs, during that period in New South Wales there were 21 cases or around about two per day, which did not look like a significant increase in community transmission during that period. Was there anything specific to your knowledge that would have required that—

CHAIR: Member for Nicklin, I think the director-general—

Mr Stewart: All I can reiterate is that the Premier was taking advice from the Chief Health Officer, as has been the process throughout this. Again, I am fortunate to sit in national cabinet meetings. The advice from Professor Murphy is also well regarded and taken. I think the road map has been very clear that they have been based on good assessments—the process that Paul Martyn has mentioned—and clearly on health advice. In fact, you would see the most recent road map also has that proviso in relation to taking health advice.

Mr HUNT: I draw you to the most recent road map and the announcements—I think today—on the ability for somebody to have 100 people at their house. The road map says 'friends and family', but the Chief Health Officer's directive does not mention 'friends and family'. I guess that is very difficult to define in law, if you are looking for a breach in that regard. How is the number of 100 at a person's private residence arrived at?

Mr Stewart: Again, it is based on health advice. That is the health advice. Queensland Health has given advice in relation to densities. Quite frankly, that is where we have got that number from, from the road map.

Mr HUNT: I am trying to compare licensed premises, for example, that have COVID safe plans, a lot of restrictions around the number of patrons per square metre, et cetera. We are opening it up to the possibility of young people, who cannot go dancing at nightclubs, having house parties at home, which can get out of hand in terms of social media and inviting people they do not know. Was any of that considered when coming up with the number to have at a private residence?

Mr Stewart: To be very clear, there is the health advice and then, in a regulatory context, of course that was taken into account. As we see with border measures and other measures, we have a number of regulatory agencies within the Queensland government, most notably the Queensland Police Service and they are able to manage responses to those issues that you raise, as we do with the Office of Liquor and Gaming Regulation and the like. Every time we have a response in a road map, you can imagine there are a lot of matters that we then go and talk to our regulatory agencies about as well, to make sure that we have an enforcement process.

Ms PEASE: I echo your words and congratulate Queenslanders for the great effort that they have done, working together as we unite against COVID. I know there has been a lot of discussion around the road map. One of the things that I am really interested in hearing from you is about the sort of parameters or boundaries the federal government set when they were talking about the road map. What flexibility did they give the Queensland government, if we wanted to do something different to their road map?

Mr Stewart: That is a great question. Again, one of the processes with the road maps—and, again, I keep pointing people back to the Australian government road map. I will make sure that I get a copy for you to table, Chair. One of the clear messages was around the principles of what could happen under certain health scenarios and health outcomes. They were things such as density measures, gambling activities and those sorts of things. At every stage there was that premise of how we can ease restrictions to actually manage the health response, but also to encourage economic activity. That has been a constant focus, not only in the Commonwealth government's road map but also the Queensland government's road map. That is something that we pay close attention to, but it has all been based on health advice.

Ms PEASE: You also mentioned the Queensland Industry Recovery Alliance. Can you give us some information about who is on the alliance?

Mr Stewart: I will hand over to Paul Martyn, who probably has more details. The good news is that I sit in those alliance meetings and the contribution is outstanding. Paul probably has a very detailed list of who is there.

Mr Martyn: The Queensland Industry Recovery Alliance provides a forum to facilitate ongoing direct engagement with industry peak bodies on the future stages of the government's unite and recover approach. The key roles of the alliance are to provide advice to the government on priorities for recovery, up-to-date intelligence on the current business climate and key trends, perspectives on how to best position Queensland nationally and internationally in the changed environment, inputs to the development of future stages of recovery, advice on how to encourage private sector investment and growth to help drive recovery, and advocacy to the federal government on behalf of Queensland in the preparation of national approaches to recovery. There have been three alliance meetings to date.

I can advise that the members include the leaders of AgForce, the Australian Industry Group, the Australian Medical Association, the Australian Petroleum Production and Exploration Association, the Chamber of Commerce and Industry Queensland, the Civil Contractors Federation, Clubs Queensland, the Housing Industry Association, the Infrastructure Association of Queensland, the Local Government Association of Queensland, Master Builders, the National Retail Association, the Property Council of Australia, the Queensland Conservation Council, the Queensland Council of Social Service, the Queensland Council of Unions, the Queensland Farmers' Federation, the Queensland Hotels Association, the Queensland Resources Council, the Queensland Tourism Industry Council, RAPAD—which is the Remote Area Planning and Development Board, based in Longreach—the Real Estate Institute of Queensland, the RACQ and the Smart Energy Council.

You can see that the recovery alliance covers an enormous span of Queensland's economic activity and provides perspective, from both the south-east and from regional Queensland. The three meetings to date have proven to be very useful. The Premier and the Treasurer have attended those meetings, together with the Deputy Premier and the Chief Health Officer. The group continues to provide advice to the government on priorities going forward.

Ms PEASE: Did the alliance participate in the road map development?

Mr Martyn: The feedback of those groups helped to inform the considerations around impacts on business and industry for the road map.

Mr BERKMAN: Thank you all very much for your time this afternoon. A couple of times you have referred to the way the national cabinet functioned and the reliance on advice from the AHPPC. I am curious as to how you dealt with an issue, for example, like the health advice coming around the borders, which at times was inconsistent if we look at what was being said by the national Chief Medical Officer and Queensland's Chief Health Officer. Is it simply a case of the DPC going with the Queensland Chief Health Officer's advice? How did you deal with any conflicting health advice that was feeding into that process and then back to the Queensland government?

Mr Stewart: One of the things about national cabinet was there was a very clear message and a clear process that it was national advice, but states could take their own decisions in relation to those issues. At the end of the day, obviously, the states were accountable for the decisions that they made as states and we have seen that response across the country. There is a strong view of consistency, where possible, but at the end of the day states are accountable for the decisions to their community and that is what happened. We strongly took the advice and noted the advice of AHPPC, but at the end of the day our Chief Health Officer was the person whom we took note of.

I think you would see that the advice from AHPPC has also changed over time. If you go back and look, the 1.5 metre social distancing spacing has not changed, but most recently we started off with five people gathering and then 20 people gathering, then 50 and then the view was 100, and now we have gone to the four square metre rule. You would have seen other states adopt, much earlier on, the two square metre rule. Quite frankly, that was in relation to what was happening in their state and their observation of what was happening in neighbouring states or other states of Australia. The national cabinet process was a very collective and collegiate process, but very clearly noting that, at the end of the day, states were accountable for the actions and the measures that they put in place.

Mr BERKMAN: Indeed. I will preface this question by saying that I was almost surprised, as I think many were, at just how collegiate and collaborative national cabinet was and how apolitical the decision-making appeared to be from the outside. We have tested the limits of that more recently, I suppose, particularly around the border issue, playing off that slight conflict in the health advice that we have seen over past months. Are there other issues that you think the committee should bear in mind, where there has been tension in the health advice that has the potential to play out in political discord?

Mr Stewart: I do not know about tension, but certainly there was a lot of discussion very early on around international borders and managing the movement of people. I think one of the key achievements we have made in containing or getting the results that we have had in this country and in this state is around the international border issue. That has been paramount. There has been a very good discussion on quarantining and a very good discussion on contact tracing and how important that is. There was a lot of discussion under the intelligence planning on the capacity of the health system to respond.

We did a lot of early work, particularly with the State Disaster Coordinator and Queensland Health—and we did this in partnership with our Tasmanian colleagues—around rapid response, so the ability for us to respond and have a plan to respond to outbreaks. I think we have seen good measures. There has been amazing cooperation from the Australian Defence Force. We have seen that posture change in recent years through natural disasters—bushfires, floods and cyclones. The posture of the ADF has been outstanding in supporting, in particular, our Police Service to deliver those outcomes.

I cannot think of key areas of conflict. Certainly there have been strong opinions voiced on particular issues, but at the end of the day the states have taken health advice—the national health advice and the advice of their own chief health officers—to make decisions, as we have. It is not unique. We see those decisions changing as we speak. We have seen what has happened with us providing resources and support to Victoria, because it is in our interests, as it is in everyone's interests, to make sure that our colleagues in Victoria can respond to the issues that they are facing at the moment.

Mr BERKMAN: I am very interested in the government's response around domestic violence. There were obviously really grave concerns about the consequences of isolation and lockdown in terms of the impacts on domestic violence, relationships and concerns about an uptick in that. There are two facets to my question—what have been the key government responses in terms of increasing resources for DV support sector? Alongside that, is there really capacity in a circumstance like this just to flick the switch and increase those supports? Do we really have the capacity in the DV support sector to meet that increased need so quickly?

Mr Stewart: There is no doubt that domestic and family violence has a profound and tragic impact. We have seen some very notable cases in recent times, including a couple of days ago. No doubt, we know that this happens every day. Again, the Queensland government's response has been very well measured and very proactive. Not only have we seen an increase of funding but we also have seen the ability to boost services. I think the department has done a very good job in working with the NGO sector to ensure that we deliver additional service. I believe that is occurring. It is certainly front of mind in a lot of discussions that happen within government.

I am confident that additional resources have been provided to domestic and family violence not only through the relevant department but the police in terms of being very focused in the response to domestic and family violence. I do not want to trivialise the issue at all; it is a very important issue. We have seen the tragic consequences of what has happened in our community. One of the things that we have seen in domestic and family violence is a bipartisan approach across all government agencies and government departments to manage and address these issues. I am confident that we have the resources and the ability for services to respond.

Mr BERKMAN: That goes some way to answering the second part of my question. I am interested in any feedback you have had from the sector about its capacity to deal with the uptick in the need for its support services. Has it been in reality and on the ground possible for them to respond as rapidly as the circumstance has required?

Mr Stewart: The advice I have received from my director-general colleagues—because as you know it is across a number of agencies and departments—is that the extra funding and the resources being applied has been able to at least manage the upsurge in domestic and family violence.

Mr BERKMAN: Any possibility of those resources—

Ms McGarrity: You might recall that we had the first virtual summit on DV in May this year. On 6 May Minister Farmer, the minister for domestic and family violence, held a virtual summit which was attended by various ministers and sector representatives as well as victims of domestic violence who spoke. There were a number of different breakout groups where we discussed how we are responding in the COVID space. It was specifically held to deal with the COVID response. That gave us an opportunity to think a little bit differently about how we are responding and how we are getting the message out there. It certainly informed the campaigns that were being rolled out under the *Not Now, Not Ever* program of work. We directly fed that in. We are conscious of how the directions have had an impact as well. We have worked very closely with our colleagues in Queensland Health as the directions were being planned to make sure that there was that ability for people still to get access to help and to still seek that help if they needed it.

Mr McARDLE: Thank you for being here today and for your documentation as well. Mr Stewart, can I ask Mr Martyn a question? I note that his CV refers to 'response and recovery task force' which I assume that he is a member of. When did that body first meet, how many times since then has it met and who is on the task force?

Mr Martyn: The Queensland government's agencies and disaster recovery and response groups remain in the frontline of COVID-19 crisis management. On 23 March 2020, the Department of Premier and Cabinet stood up the COVID-19 response and recovery task force to build on the state's disaster response and recovery capability in this new and unprecedented environment. The task force supports the state by enhancing coordination of efforts across the government on a range of issues, including economic recovery strategies, easing of restrictions, supply of personal protective equipment and improving public communication. The task force has worked closely with Queensland Health to deliver Queensland's initial road map to the easing of restrictions on 8 May and subsequent road maps. The task force has also worked to support the government's work on easing of restrictions most recently at noon today.

In addition to the health response to COVID-19, the task force has also supported the Queensland government's economic recovery response, including establishing the industry recovery alliance that I talked about earlier. The task force developed and released stage 1 of the Unite and Recover Jobs Strategy on 19 May and stage 2 on 16 June. The task force is an operational unit within the Department of Premier and Cabinet. It is staffed by officers seconded from 10 different agencies across government and it works closely with other parts of the department and with Queensland Health and it reports to the director-general.

Mr McARDLE: How many times has it met since 23 March 2020?

Mr Martyn: Because it is an operational unit of the department which I head, it is a physical unit of public servants working and supporting the Premier and director-general and working across government. It is a task force in the sense that it is a mobilised group of officers with a dedicated task.

Mr Stewart: It is not dissimilar to a division of DPC. It is not like it is a group of people who come to meet. They are there in situ dealing with operational issues. They are like one of my divisions. It is a permanent cohort of seconded officers.

Mr McARDLE: The COVID-19 response and recovery task force has not derived from COVID-19; it has always been in a form, i.e., a subset of DPC that was given a title?

Mr Stewart: No. I think what Paul Martyn said is that this is a group that was formed specifically to deal with COVID and that it has been formed by a group of officers seconded from across government.

Mr McARDLE: Surely there would need to be some sort of ongoing meetings to discuss the next level of work, the source of information, the outcomes trying to be obtained? There were no formal meetings? Who was in charge of it?

Mr Martyn: I am in charge of the task force.

Mr McARDLE: How did it function, Mr Martyn? Did you simply issue directions?

Mr Martyn: I have 28 staff. We meet regularly to discuss priorities. I meet with my colleagues in this department and with colleagues in other departments. I conduct briefings of ministers and meet with stakeholders on a regular basis.

Mr McARDLE: I ask again in a formal sense—on how many occasions post 23 March did the COVID-19 response and recovery task force meet?

Mr Martyn: I would say hundreds offhand.

Mr McARDLE: Who is on the task force?

Mr Martyn: The task force consists of officers seconded from up to 10 different agencies. They are public servants.

Mr McARDLE: I do not want their names; I accept that. Could you please give me the agencies from which they are derived?

Mr Martyn: The task force has officers from the Department of Premier and Cabinet, the Department of State Development, Manufacturing, Infrastructure and Planning, Queensland Treasury, Trade and Investment Queensland, the Department of Housing and Public Works, Queensland Treasury Corporation, the Department of Transport and Main Roads, the Department of Environment and Science, and the Department of Natural Resources, Mines and Energy. That is the current mix of staff.

Mr McARDLE: They never met in one room together at any one time?

Mr Martyn: We have met online virtually, obviously because of social distancing requirements, but the group initially was meeting as a singular group every day. We meet as an entire task force three times a week.

Mr Stewart: You have space within the building.

Mr Martyn: Yes, we are located within 1 William Street on level 16. That is where the task force is based.

Mr McARDLE: Three times a week since 23 March 2020 would be a fairly accurate assessment?

Mr Martyn: Five times a week initially as an entire group, but obviously areas within the task force have been meeting much more often, together with a range of meetings with staff from this department, other agencies and external stakeholders.

Mr Stewart: It is also fair to say, just to give you an example, when we were visiting and going and meeting stakeholders in Longreach and Barcaldine a week or so ago, specific issues were identified by some of the key stakeholders out there. The task force was asked to go and look at COVID-safe plans to deal with those industry groups and sectors and to work with health and other agencies to try and find solutions to improve and enhance the operation of those businesses. It is very task-oriented as well.

Mr McARDLE: It appears to be—and they all were of course—a very important body that, in essence, was directing the recovery through COVID-19 and will go on for a lengthy period of time yet. Did the Premier ever attend these meetings?

Mr Stewart: The Premier is briefed regularly from the task force lead and other members of the task force. Those briefings happen quite regularly and, of course, they often involve stakeholders like the Chief Health Officer as well.

Mr McARDLE: Can you advise me—and maybe you cannot—of the state spend in the health sector for COVID-19 since it became obvious in January that we were facing a problem? That may not be your bailiwick, but I do know that you are working together with Queensland Health and that you may have that data available for us.

Mr Stewart: Again I will double-check, but my recollection is that $1.2 billion was assigned to Queensland Health to respond to the issue. If you go to page 13 of our report, on 19 May the Premier announced $50 million to develop and expand manufacturing and production capacity for health consumables, devices and PPE. This was in addition to the $1.2 million committed on 5 April.

Mr McARDLE: What is the breakdown of that $1.2 billion?

Mr Stewart: I do not have that information.

CHAIR: A question for Health.

Mr McARDLE: Are you able to get a hold of the information? Can you take it on notice?

Mr Stewart: I can go and talk to Queensland Health and find out whether they have that information available.

Mr McARDLE: Can you take that on notice then?

Mr Stewart: Yes, I am happy to take it on notice.

Mr McARDLE: Thank you very much. I do appreciate that. I do not mean to be disrespectful to the capacity of departments of government to know all issues across all frontiers, but often we find that consultants will be brought in to assist. Has that happened here in relation to the Queensland government's COVID-19 response in terms of engaging consultants?

Mr Stewart: Let's talk about coordination across governments, to start with. We outlined very quickly in my opening address that one of the strengths of the Queensland government has been its ability to use the Queensland Disaster Management network. It is unfortunately a well-practised network, whether it is for outcomes of fire, for flooding or for cyclones.

One of the things we did very quickly was to instigate that—in fact, the first meeting of the Queensland Disaster Management Committee was on 30 January. The recognition very soon was to turn that into a specific cabinet subcommittee which allowed, as I said in my opening address, for ministers and directors-general and the commissioners to meet on a regular basis. That disaster management subcommittee has been meeting on a regular basis. It then was able to look very closely and understand the implications not only from a health perspective but also the ability to then coordinate across government in relation to the pandemic and our response in relation to the pandemic. There has been a very strong coordinating process across the Queensland government, as the national cabinet has been the process for coordinating across Australia. It is a fine coordinating process.

Mr McARDLE: I appreciate the comment. Were consultants engaged by the Queensland government—outside agencies?

Mr Stewart: Yes.

Mr McARDLE: How many consultants were engaged, can you tell us that, and who they were?

Mr Stewart: Within the Department of Premier and Cabinet, I would have to double-check the number, but it is a very small number. I will give you a defined number.

Mr McARDLE: Could you take that on notice for the committee as to the number and who they were?

Mr Stewart: Yes, I am happy to take that on notice.

Mr McARDLE: This may be a question outside your province: are you aware of Queensland's health engagement of consultants, or should I ask the director-general?

CHAIR: Deputy Chair, that might be a question more appropriate to the Queensland Health DG.

Mr McARDLE: I agree entirely with that; it is not a problem at all. On page 10 of your submission to the committee, you talk about the national partnership and COVID-19 response, Mr Stewart. Then on page 11 you outline that payments from the federal government fall into three categories: upfront advance payment, hospital services payments, and state public health payments. The Commonwealth provides one half of contribution. Are you able to provide details of what that funding amounted to from the federal government under those three headings?

Mr Stewart: Again, I would have to consult with the Director-General of Queensland Health. I do not have that number at hand. It is an appropriate question for Dr John Wakefield, but I am happy to make that inquiry of him. It is fair to say, as you can imagine, given the way the pandemic has been managed in a health response across the country, that that national partnership agreement is under review by the Australian government.

Mr McARDLE: Can you take that on notice, sir?

Mr Cridland: The NPA is available online with the funding amounts after the upfront payments included. For Queensland it is not exactly 20 million, but 20 million. It is available online.

Mr McARDLE: That is the upfront payment. What about the hospital services payments and the third one, are they referred to in that document?

Mr Cridland: No, they are different. They are not fixed amounts, so they are not in that document, no.

Mr McARDLE: If you could take that on notice, director-general, I would appreciate that, thank you very much. On page 12 of your document, you refer to the National Medical Stockpile being axed in relation to drugs, vaccines, antidotes and PPE. You make the comment that they are limited in their number and their quantity, and I accept that. You also say it was accessed by the state government. You then say, 'enabled aged-care facilities to be provided with PPE from the NMS through Queensland Health.' Did Queensland Health also access, for their own use, that is in the HHSs, supplies from the National Medical Stockpile?

Mr Stewart: On my understanding, you have taken that question on notice from Dr Wakefield and Jeannette Young, I thought.

Mr McARDLE: No, I haven't.

Mr Stewart: I thought there was a specific question around the stockpile and what had been used.

Mr McARDLE: No, what I had asked was: what was the number that they had at a certain time or a certain date. What I am simply asking now is: did Queensland Health access the National Medical Stockpile as part of gathering the PPE and other items required?

Mr Stewart: Yes.

Mr McARDLE: They did?

Mr Stewart: That is my understanding.

Mr McARDLE: Do you have any idea of the amount or quantity that they obtained?

Mr Stewart: I do not, sorry. I do not have operational responsibility for the—

CHAIR: These can be supplementary questions for the Director-General of Queensland Health, Deputy Chair.

Mr Stewart: I understand there were some questions on notice around PPE.

Mr McARDLE: That there were but they were about the number, not about the source?

Mr Stewart: The clear message is that the national stockpile was there for the use of states to deal with the pandemic. In fact, I recall seeing truckloads arriving at various stockpile sites in Queensland from the national stockpile.

Mr McARDLE: Thank you very much. Chair, I will leave it there for the time being. Another member may wish to ask questions.

CHAIR: Taking on that point, on page 12—and I was going to move to that—the federal government has responsibility for general practice and residential aged-care facilities for PPE. We have the PHN in front of us later on today. Very briefly, just whilst we are on that, before I move to the member for Mount Ommaney, the PHN's submission highlights some issues in relation to getting stockpile to—they are responsible for the GP network and those private residential aged-care facilities, certainly in Townsville. With our connections with the PHN, there were issues that we were getting from GPs that they were not able to access as quickly. That going forward—and we will ask the PHN—they are indicating that there needs to be a more collaborative approach. I do not know if you can comment on that. Perhaps the committee can ask the federal Department of Health because a lot of that seemed to be coming in late, from our experience, certainly in Townsville. Do you have any comment on that?

Mr Stewart: Certainly I can add that very early on the whole issue of PPE was of very high importance to our response to health. Given some of the modelling in the scenario planning that was before us, we recognised how important PPE was. In fact, the Premier appointed Minister Dick at the time, who is now obviously the Treasurer, to specifically focus on PPE. There was a considerable amount of work done on modelling PPE usage.

As you appreciate—and which I did read in the response from Dr Wakefield and Dr Young—there was a whole pile of management issues like elective surgery, dental—there were a whole pile of responses to managing PPE stockpiles and PPE access. I know the AHPPC had very informed views on protocols around the use of PPE. It was given very significant attention at the beginning, and that attention has not changed, whether it was PPE, sanitiser, as was hospital capacity. One of the things we now see in our reporting from national cabinet, from the AHPPC, is on this whole issue of intelligence around hospital capacity. PPE is one of those areas, so it was something that was very closely monitored.

Ms PUGH: I am curious to ask about quarantining in hotels. Obviously that was a significant policy shift. It seems like it happened at a national cabinet level and that was certainly adopted by Queensland, New South Wales and Victoria, to name just a few. I am interested to understand what factors, without going into too much detail, or certainly the national cabinet process, led up to this decision, and what benefits has it had for Queensland and potentially for the rest of Australia?

Mr Stewart: It has been a very interesting discussion around the importance of quarantining in-hotel and the importance of quarantining in-home. The view certainly was that with people crossing our borders internationally, it was important that we were able to manage those people, and managing them in hotels was considered probably the most appropriate way. You would see that that posture has changed over time. International people arriving into Australia have been quarantining in hotels and will continue to be quarantined in hotels for 14 days. You have also seen the change in response where with people who are not willing to be tested, then that quarantine period is also extending. You would have also seen the most recent border measures that have been introduced today is people coming from hotspots will also be quarantined.

One of the things that the Premier made a very early decision on around the quarantining was that the Attorney-General had a specific focus on making sure that people were abiding by quarantining, so we put a number of processes in place to manage that quarantining, whether it be in hotels or at home. It has been one of the most important aspects of managing the containment of COVID. We have seen how important quarantining has been and the results that we have achieved. I can give you specific numbers around hotel quarantining and quarantining at home, but I cannot give you what the direct epidemiological contact or connection has been. It certainly has been very strong.

Mr McARDLE: Can I correct the record, Mr Chair? When the director-general and I were speaking about PPEs, I made the comment that my question related to the number of items. That was incorrect. I asked how many days PPE were held at a certain date. The answer provided certain numbers, so I want to correct the record in that regard.

CHAIR: Thank you. That being the time, Mr Stewart, Mr Cridland, Mr Martyn and Ms McGarrity, thank you very much for your appearance today before the committee. It has been very informative. You have taken three questions on notice. We would appreciate the responses be provided by Friday, 10 July. In saying that, you have just moved to another stage; if there needs to be any extensions, we welcome the department to write to us to consider extending responses. I am very cognisant, as is the committee, that we do not want to overburden departments, and I have no doubt there will be close monitoring of Queensland after this implementation today of Stage 3. I wanted to preface that. We appreciate the departments are doing an enormous amount of work and the information has been appreciated. I thank you for your time and attendance today. I now declare this part of the hearing adjourned and we will come back at 1.50 pm. Thank you very much.

Proceedings suspended from 1.43 pm to 1.51 pm.

CHAIR: We will continue our public inquiry into the COVID-19 response from a health perspective. I now welcome officers from Queensland Health, Queensland Mental Health Commission and Queensland Ambulance Service.

ALLAN, Associate Professor John, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

BOWLES, Commissioner Russell ASM, Queensland Ambulance Service

EMERY, Deputy Commissioner Craig, State LASN Operations, Queensland Ambulance Service

FRKOVIC, Mr Ivan, Commissioner, Queensland Mental Health Commission

REILLY, Dr John, Chief Psychiatrist, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

CHAIR: I will begin by inviting the Mental Health Commissioner to make an opening statement, after which we will have some questions. We will then move to the Queensland Ambulance Service.

Mr Frkovic: I would like to begin by acknowledging the traditional owners of the land on which we meet and pay my respects to the Jagera and Turrbal people.

The COVID-19 pandemic is affecting all Queenslanders in a variety of ways. Can I suggest that we are all in continual vulnerability—all of us. Queenslanders have extensive experience when it comes to responding to disasters. We have a lot of knowns in terms of responding to disasters such as cyclones, floods, fire and drought, but when it comes to COVID-19 there are a lot of unknowns. The evidence would suggest that it is the difference between the knowns and the unknowns that is causing major psychological distress for the entire community across Queensland and Australia.

We have enough information, data and research around that recovery response cycle. For example, if you think it in terms of a cyclone, in that early heroic stage we wait for the cyclone, we are ready for it, we are prepared, we know it is coming across a particular part of Queensland, we know the wind speed and we know a whole range of things, but when it comes to COVID-19 we do not know that. Then after the cyclone passes we have the honeymoon period where we have survived, there has not been too much damage et cetera, but then we go into a phase of frustration, exhaustion, delay and then the whole reconstruction phase where we start to pick things back up.

As I said earlier, I would suggest that we are all on the vulnerability spectrum or continuum. If you think about it, prior to COVID-19 approximately 60 per cent of the Australian population was psychologically strong and well. Those people are now, like all of us, becoming more vulnerable. We also had people who were vulnerable prior to the COVID-19 virus. Those were people such as the homeless and unemployed, and I can go on. We also had people who had been directly impacted by COVID-19, particularly people who were impacted by the virus itself but who also lost their job and a whole range of other things. Then we had people with severe and complex enduring mental illness who lived prior, during and hopefully soon post COVID-19 and their families and carers. In that continuum everybody will swing up and down from that vulnerability. We are all more vulnerable in this new environment.

We also know some of the early signs of distress and stress. I can talk more about these, but my colleagues here have clinical insight and are dealing with this every day. We have emotional signs, physical signs, cognitive signs and behavioural signs—all of these things. It is not one issue but a combination of those things that impacts on the psychology of our society. We also know what the key considerations should be during this particular COVID-19 pandemic. One of the things that has helped a great deal and that we really need to be clear on is our messaging and communication. The communication of our leadership at the national and state levels—our Prime Minister, the premiers, ministers, deputy premiers and chief health officers—has helped people psychologically with this particular issue in a better way than where communication is not very articulate. They have provided facts, and remember that facts reduce fear. I think all levels of leadership across the country have provided that, and that is why Australia and Queensland are in such a great place.

We were also very quickly able to adapt and adopt our service delivery system to operate quickly in a different way. We did that in mental health and beyond mental health. We were also very clear about needing to support our workforce if we are going to continue to respond to people's needs. We put a lot of effort immediately into supporting the workforce by dealing with people who were infected but also generally in health care and other workforces in child safety, corrections et cetera

by supporting the workforce to continue to provide the services they do. What was also really interesting is that we have realised that we cannot think about mental health in terms of just the immediate response. Mental health has to be thought about as the immediate response, short term and long-term, and we need to keep an eye on that.

COVID-19 has also further emphasised the nexus between personal, social and economic circumstances and mental health. Social and economic circumstances will certainly impact on mental health. I would suggest that the mental health and wellbeing impacts of COVID-19 are not yet fully realised, and I thank the committee for looking at mental health issues. Things will change over time from our immediate response to medium- to long-term responses depending on a range of factors, for example, JobKeeper and JobFinder. All of those things are critical aspects. The economic aspect is so critical.

From my perspective as an independent statutory function, governments at all levels have rapidly responded—and I underline positively—when it comes to mental health, both directly in terms of mental health services but indirectly through a whole range of other responses that have had an impact on mental health. COVID-19 has also focused us to rethink and redesign aspects of our systems generally—mental health and other systems—within health and beyond. We have been more creative and flexible in the way we conceive, commission and deliver services. We have overcome barriers, which has been an historic issue in this sector, in terms of information and data sharing to embed informed real-time decision-making. We have overcome those barriers that we struggled with for a number of years. We better coordinate, collaborate and cooperate within and beyond the mental health, AOD and related sectors. We have been able to prioritise—and this is a really important point—the need to support people with appropriate, quality and timely supports—and the word here is in situ—in community in their own home rather than relying on the hospital system and all roads leading to inpatient care.

Finally, we have to consider the importance and need to rebalance the system within and beyond the health sector. When I talk about rebalancing the system I mean pushing more services into the community where people live in situ rather than just relying on the hospital system. That has certainly been part of the system reform agenda for a number of years, and we have seen that start to happen during COVID-19. Overall, COVID-19 has increased our literacy about the benefits of prevention. When you do not have treatment or a vaccine, prevention is your best option. We have seen that with COVID-19. That similarly applies to mental health. For many historical reasons we have struggled to move the whole system upstream—to say, 'Let's not wait until people get unwell.' How do we prevent or intervene early so we do not get people at that severe end? I think literacy in the community now about the benefits of prevention will also help in moving the mental health system up in terms of preventative thought.

I will just give you some quick examples of both federal and state governments working together to respond. There are many, but I will just highlight a few. They include: no-gap Medicare relief for GPs and psychologists to provide support to individuals, both face to face and via digital platforms; funding for universal phone and digital support services through Beyond Blue, Lifeline, Kids Helpline et cetera; and funding for the immediate enhancement of psychological psychosocial support through the community mental health and AOD sectors. Dr John Allan can address that if you need more details because that was funded through Queensland Health. These immediate mental health and AOD responses have been complemented by funding through broader social programs which have also had an impact on mental health; for example, the Queensland government response around housing and homelessness, domestic and family violence, Aboriginal and Torres Strait Islander services, and services for people from culturally and linguistically diverse backgrounds. All of those have also impacted on mental health even though they are not mental health specific.

Concurrently, though, while these immediate responses were being rolled out state and federal governments commenced work on the development of a cross-jurisdictional National Mental Health and Wellbeing Pandemic Response Plan which was endorsed by cabinet, including our Premier here in Queensland, at a meeting of the national cabinet. It is simultaneous and we have all had input into that plan from a jurisdictional perspective. Other things are also occurring. Ministers for mental health are meeting regularly and commissioners like myself and the Mental Health Principals Committee—which John sits on—meet regularly. We met regularly to ensure there was national consistency. We were getting state, national and local collaboration and cooperation. We were trying to do all of that.

Through the Queensland Mental Health Commission we also convened public, private and NGO service providers and peak bodies to come and talk to us around how they were tracking on a weekly basis and developments and issues so both John and I could be across that. John and his branch convened weekly meetings with executive directors of mental health services in the hospital and health services, so we were doing all of this in parallel as these things were occurring.

I will just give you a bit of insight. What do we know about the impact of COVID-19 on individuals, families and communities? We know that intense, unpredictable, prolonged stressors such as risks to physical safety—which we know—unemployment, disruption to education, and economic hardship can contribute to a sense of helplessness, distress, anxiety and depressive symptoms. There is evidence that there has been an increase in the level of psychological and emotional distress in the community as a result of COVID-19. In the early stages of the pandemic agencies such as Beyond Blue, headspace, Kids Helpline and Lifeline have all reported a 30 to 60 per cent increase in demand for phone and online services. All of these requests for services were related in the main. The majority related to mental health, alcohol and other drugs, but also suicidality. During the immediate response phase, activity data indicates that mental health and AOD related ED presentations were lower than would usually be observed, but it must be noted that these numbers are reportedly starting to approach pre-pandemic levels. Dr John Allan and Dr John Reilly can talk more in detail around that.

Trends in drug use are often impacted in times of crisis and can fluctuate. A recent National Drug and Alcohol Research Centre study found that cannabis and alcohol use during this period was the most common increase in terms of utilisation, while the use of MDAA, MDMA, cocaine and ketamine had most commonly decreased and that the unique nature of COVID-19 and its associated impacts on our society poses challenges in the way we prevent suicide as well. That is an important issue to keep in mind here. It is important for us all to monitor suicide data very closely. We do know that there are always multiple contributing factors when it comes to suicide. It is not one factor.

The Australian Institute for Suicide Research and Prevention currently provides regular reports to the branch, government and me with respect to suspected deaths by suicide. Triggers for suspected suicide are being monitored specifically around unemployment and financial problems. AISRAP notes that the data does not currently identify—and I need to repeat this—does not identify any geographical locations with specific concerns, although specific groups are being monitored because we know their rates are generally higher when it comes to Aboriginal and Torres Strait Islanders, young people, males, and LGBTI community members.

In conclusion, COVID-19 has reinforced the need for us all to focus our efforts on service responses to people in need. Equally, we need to focus on preventative strategies particularly targeted at known high-risk groups. For example, this includes young people who have been impacted, those impacted through loss of employment particularly, and older Australians. Sustained efforts with ongoing emphasis on the social determinants of mental health and wellbeing, including, as I said earlier, economic security, employment and housing will be required to minimise the potential impacts of COVID-19 on the mental health of Queenslanders and Australians.

CHAIR: Thank you, Commissioner. We will come back to you after we hear from Commissioner Bowles. Your opening statement has certainly articulated very well the broad impact that COVID-19 has had on Queenslanders. It is no surprise to hear about the increase to those services. I commend the work that your department has done in engaging broadly with those non-government organisations.

Just to preface questions later, I do want to try and understand how you engage with the PHNs who offer some mental health but also the impact on those people who have been isolated early, so our elderly, older Australians. We certainly reached out in local electorates to a lot of people 70 and over who felt it was the right thing to do in terms of easing restrictions, because we got a good health response and now we are seeing the benefits of that. Was there any particular impact on that group? You have touched on remote Indigenous communities as well. I would certainly like to see if there is any increase in suicide rates, which is a good segue to our next speaker. There is so much being done in the mental health space that it just needs to be commended. There has been ongoing work now for a long period of time.

I will come back to some positives, because it is not all negative. We have seen that the response has been quite positive—and maybe you can comment on this later—in terms of the Care Army, for example, which is a great initiative to engage with Queenslanders. Telehealth, as you mentioned, enables people who were restricted in their community to pick up the phone and talk. There is no doubt that the impacts of losing your job are being felt. We will do a bit of a deeper dive and see where that goes. That is where I would like to end up.

I now welcome Commissioner Russell Bowles of the Queensland Ambulance Service to make an opening statement.

Commissioner Bowles: Thank you very much, Chair, for the opportunity to come along and present here today. I would like to begin by acknowledging all of the frontline health workers and other emergency services who have played such a significant role in our response to the COVID-19

pandemic. There is an old Australian adage that tough times bring out the best in people, and I do think we have seen that through this whole process. Today I want to acknowledge some of their great work.

Last week Dr Young, our Chief Health Officer, spoke in depth and gave a very significant opening statement outlining the response of the department and her role in the national response. Following on from Dr Young's comments here last week, the Queensland Ambulance Service has a very clear role in providing a response. Whether it is a pandemic, cyclone or flood, that role is pretty much divided into a couple of subsets. Under the Public Health Act we have a support role in a pandemic situation. Basically, we support the Chief Health Officer in the delivery of the response to the pandemic, and that is covered off in public health legislation.

Further to that, the Queensland Ambulance Service responds each and every day to somewhere between 3,000 and 4,000 patients, depending on the day; for example, depending on weather conditions, what events are happening and so on and so forth. We provide support no matter whether there is a pandemic, cyclone or some type of other natural event. In this case, where the health agency is the lead, we fall in and provide support to them. It should also be noted that support is basically about 24 per cent of everything that we do as an organisation—the logistics of the health system—the joining up of the health system and transporting patients within Queensland which, as you would be aware, is a very vast network.

As the Mental Health Commissioner said, we have had a slight decrease in general workload over the period of the pandemic. If you look at it in terms of where we sit in past years, it is somewhere above 2017-18 but somewhere just below where we were heading on our 2019-20 trajectory up until this year. There is one standout in that. There are lots of ways in which ambulance services look at data. Being quite a simple creature, you often go to what are some of the blunter, simpler things to look at and understand. That is about taking into account what the community tell us when they dial triple 0 and what they believe is their emergency, although obviously due to their level of training and expertise paramedics may have a different view after they arrive.

As I say, we have had a slightly decreasing workload but we have had a 19 per cent increase in what we bluntly refer to as card 25s; that is, when someone rings up and says that they are having some type of abnormal event and are feeling suicidal as a result. That has been one of the anomalies. The Mental Health Commissioner, Professor Keith McNeil—who has been the acting deputy director-general up until recent times—and I have had significant discussions about what we are seeing and putting that into the overall planning. As late as last week I had discussions with Associate Professor Allan about mental health and impacts within the community.

Based on the Chief Health Officer's statement last week and where we are at today, I am happy to conclude my opening statement. I am happy to be asked anything about our response, our preparedness and any lessons learned from it.

CHAIR: Thank you very much, Commissioner. I think that is an excellent way to begin questions on the Queensland Ambulance Service's response to COVID-19 with regard to preventing the transmission of cases. No doubt your staff would have treated some of the people who arrived from overseas or who have been transported or quarantined or transported to hospital if they were sick or and unwell. Obviously, one of our big pluses in terms of the health response has been getting people tested.

Before I do that I will just declare—so there is no perceived conflict of interest, because I can see the member for Nicklin and deputy chair—that my role with the Queensland Ambulance Service ended in 2018.

Ms PEASE: No!

CHAIR: Yes, that is correct.

Mr McARDLE: I had no idea!

Ms PEASE: Me neither. Did you know that, Mr McArdle?

Mr McARDLE: I had no idea.

CHAIR: This is what we normally get. I put on record that I am very proud to have served with the Queensland Ambulance Service in that capacity and it has been an excellent foundation for doing this role in parliament. However, during COVID, particularly in the early months, I reached out to the Queensland Ambulance Service because we did not think that we would be coming back to parliament for months and months and months based on the modelling, so I will declare for my fellow committee members that I did rejoin the Queensland Ambulance Service in an honorary capacity.

I just want to say thanks, particularly to the Townsville LASN. I have spent some days back in the classroom and am now attached to Kirwan Ambulance Station. I have had to do a fair bit of catch-up work in the last couple of years. One of those—and I think you can probably talk to it in relation to what we are talking about today—is pandemic training. I had to do an online component for pandemic influenza training. Can you talk to that in relation to maybe informing people who are listening what that means in terms of prevention and preparation for handling what is a global pandemic at the front line?

Commissioner Bowles: The first thing I would start off with, as you and everyone else would be aware, is that there is nothing more important than the workplace health and safety of our people. The way in which we prepare them for this and then look after them through this is always our No. 1 priority. That is easy to say, but what I would like to do now is go through how we do that. These days, as many would be aware, it even starts before our staff get to us. It starts in the universities. They go and do their Bachelor of Paramedic Science at the various universities throughout the state and nationally and a part of that is how we respond to disasters, natural disasters, pandemics. If you go back 10 or 15 years ago, everything was taught within the system and now our people come to us with not only undergraduate qualifications but also a good understanding of the environment they are coming into in that space and they are a little bit more prepared than what would have happened previously. That is a great thing for us now that we are the 15th registered health profession, so I think that is a good thing.

The other thing that we have to be able to do is we need to be able to train our people and make sure that it is not only our frontline people who receive the training—and I will come to that in a moment—but supervision is very important in any natural disaster or any response in a pandemic. Over the last few years within our establishment we have trained in excess of 600 supervisors in disaster management and their role in setting up for disaster management and also pandemic management. We have a very in tune supervision structure that is also able to provide that health and safety for our frontline responders, because we do have all different levels of experience. It is very important that we have that in place because, as we have noticed with this, the situation changes rapidly and it changes daily. As a response organisation, we need to be able to respond to that changing environment as to what we know and as the evidence changes as the Chief Health Officer tells us more about PPE and the appropriate types and all of that type of stuff. It is a very rapidly changing situation that frontline services like ambulance services are confronted with.

The secret to—and experience tells me—rapidly changing situations is to make sure that you keep those who are responding on the front line well informed—that is, they have to be well informed. They have to know what is the information that is new and at hand. Because of the broader departmental structures that were set up very early in this, that was made easier for me as the commissioner of the Ambulance Service in keeping our staff up to date. We went to daily teleconferences between the executive leadership team and the chief executives responsible for the 16 HHSs. Jeannette and the director-general would open that and Jeannette would give an update on what the latest information was, what was happening locally, what was happening in the state and what was happening nationally and internationally.

That information is much too valuable than to be with one individual who sits on a teleconference in the morning, so we decided to up our communications with our people very early on in this process. We went to a whole range of different ways, but one of the key planks we went to was a twice daily email. No matter what was changing or what was new, we sent out a 10 o'clock and a 4 o'clock email that was very wideranging. Personally, I met with the whole statewide executive once a week but the central office executive every day and went through what was changing and what was going on and we communicated that to that broader staff group twice daily.

We then got a repository for that information, so we developed a page on our portal for COVID-19. No matter what was happening, what went out or what was new, we put the information on that portal. If you work in an 8/6 station, for example, and you had your six days off and you came back and you wanted to know what was going on—because, as I said earlier, things changed very rapidly—you could go to this page and bring yourself up to date and you would have all of the latest information on what was happening and what was going on.

With regard to when you were on the road, Aaron, or in the air in the helicopters, the medical director, Dr Steve Rashford, sends out medical circulars. That was pretty much daily at the start and then just continued that rhythm. We sent out as much as we could and we spoke to as many staff as we could. I am quite fortunate in that I live near one of the ramps that pulls a lot of people into the south-east of the state and it is a very easy place to go and have a chat on your way home to find out how people are finding the communication and what they believe they are getting out of it, and the way in which we set that up was received very positively to say the least.

It is more than that. We also have to communicate with our staff. As you would know, Chair, we have a very well-established Priority One employee assistance scheme that looks after our staff. That program has been put into other countries and other states and has been 27 years in the development, so the messaging from that is very important from Todd Wehr, who is the executive in charge of our Priority One program, and then that multilevel network that exists out there was also kept informed through this process. As you know, we have that peer level of support for our staff and then we have our psychological network. This year we have just added another eight psychologists to that program, and that has come at a very good time.

You also referred to the online stuff that we do. We have mandatories that also cover this. During this we have developed videos on how to clean a car. Everyone knows how to clean a car, but we thought we should refresh it and make sure that some of those basics are very much covered off on. We developed videos around that. We developed videos around PPE and how to use it. Our people are very experienced. They are used to responding to very contagious cases that exist in the community now such as measles or even in the southern states at the moment we have had an outbreak of tuberculosis. We prepare for that, but these are the times when you just want to refresh that. You just want to bring it to the fore and you want to make sure that everyone is as good as they can be because once you have walked in, as you would know, you do not get the chance to walk out and go and put your PPE on. You have to do it right and you have to do it at the right time.

With regard to part of our planning for this, we introduced two cells. One was into our communication room, and that had a mixture of very senior ambulance clinicians and also senior medical officers. Basically, in the communication room when we triggered a case that we believed might be suspect due to the early EIDS reporting, they would then call that household back or the patient or the caller and ascertain more information about that and then that information through our communication structures would then be passed on to the vehicle that is responding to give them a much more in-depth update about what they will be presented with there but also to provide advice on what is the best type of PPE to use.

The other cell that we started was in our state incident management room that was set up—that is, the ambulance version of the state health check. We put a cell in there, too, because at the start of COVID we had in excess of 100 staff who were overseas at the time and a whole range of other things that were impacting within the environment, so we put a cell in there. That was able to provide 24-hour advice to our people about what are the requirements based on the Chief Health Officer's directives and everything else that was going on just to make sure that they were safe. I think it is very important that we have those one-stop shops where you can go to or call and be provided advice as to how you should behave.

We deliver from over 290 locations, of which about 229 of them are permanently staffed with advanced care paramedics or communications rooms. We stopped non-essential visitors and then in our critical infrastructure like our communications room a whole range of testing occurred before you could go into the room to make sure that we kept our staff safe but also you do not hurt any of your critical infrastructure. With regard to call answering, if you look at any review into any major event anywhere in the world, the way in which you answer your calls up-front and the way in which you are able to deal with excess load is often the way that you are judged. It is not necessarily how you responded; it is about how you answered the call, because that is when people believe that they are entering the health system.

CHAIR: Thank you very much. Commissioner, we did see that in practical terms. We were with the Deputy Premier and Minister for Health and Minister for Ambulance Services and we undertook a tour recently into the comms and it was test, test, test before we could even enter. Only yesterday I spoke with a newly minted paramedic—been in since April. This question might have to go on notice before I move back to the Mental Health Commissioner, but how many additional paramedics did we see? I knew that there was an initiative to get some of those people, similar to police, out early. I just wanted to land on a number there in terms of that increase in staff—from memory there was an announcement of bringing those staff on early—and maybe a breakdown of where they went throughout the state.

I have a question that is related to the Mental Health Commission also, but have you seen an increase since January in call-outs for increased mental health calls for service and/or anxiety related issues, suicides or anything like that? That might have to be taken on notice. There is a link between them and having you both here is very important, and I am sure that the Mental Health Commissioner will be very happy to hear that you have put on the extra additional psychologists in that Priority One program. You indicated Card 25. Is that a co-responder model similar to police?

Commissioner Bowles: No, it may stimulate a co-response, but basically, as you would be aware, it is an internationally used system called Clawson and it is a series of algorithms that emergency medical dispatchers use to come out with the most appropriate response to a patient. A Card 25 is abnormal psychological and threatening suicidal behaviour. In terms of the number increase in this year, if you compare it from mid-March until the end of this financial year and you do the same period last year, there is just over a 19 per cent increase in the use of that Card. We did bring on extra additional staff for this—both EMDs, emergency medical dispatchers, and we also brought on additional paramedic frontline staff. They have been distributed all over the state.

The south-east will always attract a lot because that is where a lot of the population live. We did distribute 153 staff throughout the state. I do have the exact numbers by LASNs. I will start with Townsville. We put 13 additional front-line staff into Townsville; 46 into metro north; 17 into the Gold Coast; 12 into West Moreton; 27 into metro south. That is basically done on a needs basis. I think one of the other things of note is the onboarding. It would normally take us six weeks to onboard. They would do their three-year degree and they would spend about 30 weeks on our trucks during that period as a requirement for their graduation. We did take that from a six-week induction to a three-week induction and then an induction back in the LASN.

CHAIR: That is a great segue back to the Mental Health Commissioner. We did touch earlier on what it meant to those more isolated people in the early response to COVID, with people only going out for essential shopping, those types of things. Did you get an increase in calls for service? What is your position on that at the moment?

Mr Frkovic: I want to clarify that we tried to get the message across, the Premier and everybody did, that when we talked about social distancing we did not mean social disconnection. We still wanted people to be more socially connected than ever. That is a really important thing because from a mental health perspective social connection is one of your biggest protective factors. Going specifically into your question, when people did become more socially distanced and had to stay within their homes and not go out as much, obviously you could see, and this is just a correlation, an increase in some of the calls to some of the support lines because people did not have enough physical support around them. You could see that spike. As I said, there has been a 30 to 60 per cent increase depending on the service in terms of Beyond Blue, Lifeline, Kids Helpline et cetera. We do not have the hard evidence to say that is the case, but there seems to be a correlation between those increases and people staying much more at home and not being able to go out.

To pick up your point around suicide—suicide ideation, rather than suicide—the data that I spoke about and the stuff we are monitoring is really about suicide. We could generally as a country and also as a state do better in terms of suicidal ideation, because we know that the data suggests that people who end up taking their life, probably 30 per cent of that group at some point have attempted. I think that is a really important group that we have to keep an eye out for. It is useful to have the data that I think Queensland Ambulance has to be able to keep abreast of that to ensure that we are monitoring people who are having suicidal ideation. That sort of, as you call it, abnormal event—we call it in mental health a situational crisis, something that has happened, a relationship breakdown, financial problems, drug and alcohol problems, whatever it is—the data is not conclusive, but you would also think, because again it is hard to read data over a two or three-month period and say this is the case and to compare it to what.

We can compare it to previous years, but you do not have enough data to be able to make some of these conclusions, but again making the association, as I did earlier, there would be some increase in some of those situational crises, as we have heard, as a result of some of that lockdown and people staying at home. I know that you have had discussions around family and domestic violence and some slight increases in that and increases also, as I said, in terms of purchases, particularly purchasing of alcohol. I think they are the things where you can make the association that there has been an impact, but I would certainly like to ensure that Health and us and the Ambulance Service work on monitoring people who are self-harming because they are a high-risk group.

CHAIR: Thank you very much. We might open up to questions. Can I start with the member for Nicklin?

Mr HUNT: Thank you, Chair, and thank you very much for your time today. A special cheerio to Mr Emery who I met some 32 years ago at Oxley. It is great to see you again, Craig. I just want to move to Mr Frkovic. You mentioned prevention being important around mental health. I think the messages around COVID-19 prevention—social distancing, coughing into your elbow, all the strategies that were communicated to us through television advertising, radio advertising, newspaper advertising—were certainly clear. I think it is clear to all of us how to prevent COVID and that was done quite well. In terms of the vulnerability of people in this sort of a crisis to mental health issues,

and the fact that inquiries like this would seek to see where we can do things better in the future, would you like to see more resources put into communicating preventative measures in a time like this for mental health issues?

Mr Frkovic: I would never say no to more resources. I think that is a pretty general response, but can I say that particularly in the Queensland context, and you will also see it in the national action plan for mental health and wellbeing in terms of the pandemic, having broad based community campaigns that actually help people to think about their mental health in a positive sense is on the agenda.

Specifically in Queensland, and I think this is what we need to also highlight here, we have a campaign in Queensland that started before COVID-19 called Dear Mind? This was run by Queensland Health. You might have seen it. This was a multifaceted campaign: it is on TV, it is on social media, it is written campaigns, it is community activities. It is really about how do I look after my mind and all the things you need to do. I can talk to you for hours about things that I should be doing, which I do not do well, to look after my mind, things like physical health, diet, sleep, exercise, all of those things that we have got to do—social connection, et cetera. That campaign was primarily designed around that. I think Queensland, to be fair, has been on the front foot with that.

Can I also let the committee know that only recently between the commission and Queensland Health we have decided to re-fund and continue that campaign for another period but with additional vignettes that focus around the COVID-19 response and how do you look after your mental health in this particular time, not so much about where do you go to get treatment for mental illness. That is the difference. I am hopeful that some of those campaigns, and I can certainly see it now, even with the earlier campaigns with some of the positive feedback that has been received particularly by Health which has collected this data, which has been that people have started to now equate looking after their mental health to how they look after their physical health. That is the shift we want to try to make. The answer to your question is, yes, I would never say no to more resources, but I also have to acknowledge that Queensland is already down this path a fair way.

Mr HUNT: Moving on to increased alcohol purchasing, any of us on social media would have seen during the height of the isolation period that as a culture we tend to make light of increased drinking and joke memes, et cetera, in relation to alcohol use. I was interested to hear the statistics from the ambulance commissioner in relation to a decreased level of calls for service. You would think increased alcohol use would increase accidents and violence, et cetera, but I guess that increased alcohol use within the home may lead to family and domestic violence but not necessarily street violence, street accidents et cetera. Do you draw any conclusion from that, Commissioner Bowles, in terms of alcohol use and how it related to ambulance calls for service?

Commissioner Bowles: As I say, one of the blunt things that we use is the cards. One of the cards that comes in and goes into the algorithms is assaults. It has actually decreased during this period to which you have alluded to, but there are obviously some reasons. You are asking my view on that. There are things such as pubs and nightclubs and those types of venues—in the Valley, to localise it even—which have not been open and people have not been out and about. They have been much more confined to their residence. If we remember, at the start it was only a couple of visitors that you could have into your house. Obviously that has grown now. You can draw any conclusion, but one of the things we noticed was that as things started to open up the workload starts to come back. We noticed it when schools opened up because there is more traffic on the road, there is much more activity and activity is a big driver of ambulance services especially in such a vast state as Queensland.

Mr Frkovic: Can I add that we do have some data that says that the 24/7 alcohol and other drug support service that we have in Queensland called Adis had a 15 per cent increase. I think people are reaching out to get the support, which I think is a good thing. Even though it is an increase I think it is a good thing that people are reaching out, which may be reflected in some of the numbers, maybe a bit lower for you, because people are getting a sense that they have got somewhere to go and can get some advice on where to go for treatment and what can I do to minimise my intake, what is problematic drinking in a sense. People can do that. We have seen an increase in that service, which I think has helped in terms of dealing with some of these issues.

Mr HUNT: In relation to traffic accidents, Commissioner Bowles, any increase in callouts to traffic accidents? I think I saw on the news there were decreases in traffic generally but not a decrease in accidents, maybe related to police decisions not to do roadside RBTs or increased alcohol use; did you see any evidence of that?

Commissioner Bowles: No. In fact, I cannot remember the period now, but it would be from 22 March to about the end of May, mid June data, there was actually quite a significant decrease in our response to motor vehicle accidents. This is a little bit anecdotal, but you get in your email devices these days notifications, what we call PSDU, Patient Safety Distribution Unit, and they will send notifications out. What we did see is the nature of some of the traffic accidents were a lot more severe, I suppose would be a fair comment, but the actual percentage of motor vehicle accidents did actually decrease. That makes sense. In the early days we were not able to drive long distances and we had to be close to home so obviously there is going to be less accidents for us to respond to. As I say, and it is anecdotal at this point, but over time we are just trying to work out from all of our different datasets what was the experience so that we make sure that that is a learning for us and can drive our legacy into the future in this response.

Ms PEASE: Thank you very much for coming in and thank you for the great work that you all do. I would like to make a comment to Ivan. I have spoken with a friend of mine who works for Yourtown and Kids Helpline and she mentioned the increase in calls for service and you have actually confirmed that with a 30 per cent increase for Kids Helpline and other help services online. It has been a very difficult year, and even the end of 2019, with the fires, the floods in the beginning of the year and now COVID.

For children and young people it has been a frightening time. We have had lots of things going on that they do not understand and they are scared about, and it is not just children but all young people, and that their future is looking bleak. I am wondering if you can talk about how the Queensland government supported community based mental health and alcohol and drug services. You talked about how important it was doing it in place rather than having them come in. Given the way, with COVID, that we do have all those restrictions so we cannot actually travel, how have you responded to provide that support?

Mr Frkovic: As I said in my introduction, Queensland Health and the Queensland government had responded immediately with $28 million to look specifically at services in the community sector: mental health, drug and alcohol, Indigenous primary health care and palliative care and a few others. Some of those services, in particular mental health, also deal with younger people in a whole range of family type environments. Rather than talking to you about the details of that, Dr John Allan knows the details and I would like to hand to him.

Even in the national pandemic plan, one of the things we could have strengthened—and I think your point is right—is around the impact of COVID on those zero to 12-year-olds and families. There is some work happening at the moment around how we address some of that, particularly, as you say, with schools being disrupted: they cannot see their friends or people in their social networks and all those things. There are things in train to try to particularly focus on that group.

From where I sit as a commissioner I am certainly raising that now very clearly at both state and national levels about not forgetting this group. We did put out some clear information through the commission about how to talk to your kids about this particular virus, what does it mean, be honest with them, continue to have a routine et cetera. I can go on about things we tried to give families to do that. Dr John Allan can give you an idea about what was actually funded through that $28 million, and that targets particularly some of those things.

Ms PEASE: Even the responsibility for all of us to take on board the social distancing, the washing of hands and all of that would be quite confusing for young children.

Mr Frkovic: Correct.

Prof. Allan: I will add a couple of comments to what Ivan has said. One is that education was quite disrupted, so kids being at home had good and bad effects. Kids were there more with their parents, and that often depended upon the nature of the relationship with their parents as to how it went. Obviously, we saw issues for kids when there was not a good parental relationship. For many kids a lot of that anxiety was actually soothed by good parental behaviour and the fact that there was so much contact and they really had nothing to do but interact with each other. That was a really good thing. We have had quite a lot of discussion with Education and have been working through our child and youth services around this as well. We actually have mental health officers who work with schools and work in Education. We have had reports about kids who have had issues during the disruption and when going back to school as well. That is the concern.

In terms of community response, I think it is really important to point out that one of the things Ivan and I did was to start taking the barometer of services. We actually met with PHNs, with the peak bodies—drug and alcohol bodies, mental health bodies—and a number of service providers every week and thought about what was happening. One of the first things that happened when we started

to talk to the NGO providers was their concern about, 'What happens if I cannot visit someone at home who needs support? How will we change our practices? We do not have the right kind of telephones or computers to do telehealth. We need to change all of that. How do I deal with PPE? My staff are asking these kinds of questions.' There was a whole lot of that. In response to a lot of those questions, we thought the best thing to do was, one, to give a lot of advice around how to do, but the other was a program in terms of support.

That $28 million had three arms. One was organisational support, which was around, 'If all my staff got sick and I had to employ other people and I had to do other training, how would I make my service run?', or, 'My phones don't work properly. I need to get new phones.' The other was about enhancing existing services. When you had to change your practice, if it was that you were expecting to see people in one place but you had to change your method of doing it—you might need more staff to enhance that—and then to have a different service offering new services that people needed. For example, because of the lockdown restrictions a lot of the support services went from five days to seven days because they felt that was a better way of doing things, and people really appreciated that support.

In the end, of that $28 million, some was sent out as direct grants to the services that we already work with. There was a number of services with whom we had already done recontracting work to rationalise and have services linked between the NGO service and the HHS directly in that partnership. We did all of that. Then we had some money that was set aside for them to give us novel ideas that could be done straight away without any impediment that would enhance what they were doing. In the end it actually came to $30.3 million that was given out because there was such a weight of things. There were actually 212 separate grants. Of that, $12.6 million went to mental health services, 89 different grants; $2.2 million to drug and alcohol services, 20 different grants; and $7.3 million to Indigenous health services—and I have the number as well; I can give you that. The follow-up we have had is that they have been really happy because they have actually been able to flex and innovate. They have said, 'We never knew you were this flexible, that you could actually do that for us.' I think that has been really important in that way.

Ms PEASE: This question is possibly to both of you. John, you were talking about Indigenous communities, and we have some discrete communities. How did you work with those communities from a QAS perspective and also from the mental health perspective? Either of you can begin.

Mr Frkovic: We made a conscious decision very early on that there was infrastructure already starting to be established in Health, which John can talk about. It was between DATSIP, Health and a whole range of agencies to look at those Indigenous communities. We supported that rather than us taking a lead on that because that was the best option to go with—having Indigenous people and Indigenous agencies to look at that. John and certainly mental health were a part of that. There was a whole range of issues that were addressed and put in place to ensure that those Indigenous communities were safe in this particular process, and John can talk to you more about the details. What I did not want to do as commissioner—because I brought the whole sector together—is duplicate what was already happening but link with that.

Prof. Allan: There are 19 discrete communities with lockdown biosecurity, which I am sure you are aware of. There are issues around the alcohol management plans for those and concerns about drug and alcohol use and concerns about suicides. We have been working together with the Aboriginal and Torres Strait Islander health branch as well as with DATSIP to, at a high level, make sure that those services are not disrupted and we do our best. We have worked with all of our health services in terms of understanding what the restrictions have meant for them in terms of where they had a fly-in fly-out service, how they have replaced that with telehealth; what people they have on the ground; what supports they are getting; what happens if there is a crisis and you need to contact the other base and how do you supply those things. I think there have been challenges with that because of the issues of biosecurity, but we have tried to maintain that service and respond.

We have also had a lot of feedback from the communities about what they want and what they need to do. Obviously they want more community control and we are working on community control with health organisations as well in that part. It is an ongoing piece of work that we will continue to do. There have been some issues. There have been some communities where there have been some issues and incidents for people, but in general that has actually gone quite well. Again, it is one of those things where it is early days. We need to continue that work with them.

Ms PEASE: That was something I was going to ask. Some of the initiatives and activities may well continue on?

Prof. Allan: There is a task force that is being led by Chris Sarra, the DG of DATSIP. We are a part of that and we are really reconsidering the models of care, how that works and how those communities are involved. I have had recent discussions with the chief executives of Torres and Cape, and Mount Isa just in the last week. They have some fantastic ideas and a real commitment to doing that. We need to continue that work.

Ms PEASE: Commissioner Bowles, would you like to comment on how the QAS has responded to working with the discrete communities?

Commissioner Bowles: As you would be aware, we provide 24/7 responses in a number of identified communities within the state. I think it is fair to say it is not when the pandemic hits that you want your relationships to start in communities; you want long-established relationships within our Indigenous communities.

The first thing I would start with is I had the privilege earlier this week of welcoming four new Indigenous paramedics into the Queensland Ambulance Service. They are going to communities such as Cunnamulla and Charleville. Obviously we have a range of Indigenous paramedics dotted throughout these small communities throughout the state. They are recruited from within those communities. There is no better person to have on the ground than someone who knows the community and has all the ties and relationships into the community. As I say, we use that network and also the formal networks of our Indigenous reference groups and things like that. Of course, in Queensland we are very fortunate to have had a chief Indigenous health officer employed by the health department that sits on the executive leadership team. We are in a good position in that space. It is just those foundations to keep on growing and adding and growing programs like the Indigenous cadet program.

CHAIR: I know the deputy chair is waiting very patiently. We have approximately 30 minutes to go. I might go to Mount Ommaney and then finish with you, Deputy Chair.

Ms PUGH: My question follows on from the question asked by the member for Nicklin and that is around alcohol. At the beginning of the lockdown period we saw that there was an increase in the purchase of alcohol. As the member for Nicklin said, there was a lot of jokes about hoarding and panic buying. What I recall from those media reports is that alcohol consumption was reported not to have gone up, but I am sure that for some people the mental health effects of COVID would have led to an increase in alcohol consumption. I am wondering—and either of you may answer, particularly you, Mr Frkovic—what the plan would be to deal with alcohol consumption that has increased as a result of COVID-19 stresses, things like losing jobs; let's be frank, having children at home more; all of the factors that may have led to mental health stresses? Are we concerned about an ongoing increase in alcohol consumption in some people?

Mr Frkovic: I might ask my colleague Dr John Reilly to also add to my answer. Clearly, if we look at that question from another angle, if we can address some of those things like JobKeeper, JobSeeker and a lot of those things that people are saying in a positive way, that will also have an impact on alcohol, people not losing jobs et cetera. We have to look at alcohol in the context of the bigger picture. Yes, as we saw, we have had an increase to our services at the state level. People are ringing and getting advice, so that would give you some correlation maybe that there is an increase.

What will help in terms of managing alcohol consumption and reducing the potential increase is ensuring there is a whole range of other supports provided to people including jobs, being able to pay for their housing and for their schoolkids—all those things that are really critical. Unless we address those, I think all of our services will struggle because people will look for that. Also we will have fallouts in other areas such as domestic violence, potential accidents on the roads and a whole range of things. We have to look at alcohol particularly in a broader social context. Fortunately or unfortunately, in Australia it is part of our social DNA. We have to address it at that larger level. Do you want to add to that, John?

Dr Reilly: No, I do not think so.

CHAIR: Do you have a further question, member for Mount Ommaney?

Ms PUGH: No. I might follow up if we have time. It is unfortunate; you are right about that. Alcohol is such a widely accepted part of our social fabric. It is unfortunate.

Mr McARDLE: Commissioner Bowles, there is a QAS pandemic influenza response plan that you would have activated sometime earlier this year. Is that a public document? I cannot locate it. If it is not, could you undertake to table that document for the committee's consideration?

Commissioner Bowles: I am not too sure if it is a public document, but there would be no issue from my point in publishing that document. It is quite an in-depth document about how we strategically respond to events such as this.

Mr McARDLE: Could you also advise when that plan was last updated, if not now, then on notice?

Commissioner Bowles: We update that plan on a regular basis every year.

Mr McARDLE: So it would have been done in 2019 then?

Commissioner Bowles: That is exactly right.

Mr McARDLE: Are you aware of a document entitled business continuity plan?

Commissioner Bowles: The business continuity plan of—

Mr McARDLE:—of the QAS that covers when situations escalate to a point where staff availability becomes critically compromised?

Commissioner Bowles: We are a 24/7 operational system, and not to be flippant in any way, but we have a lot of business continuity plans and a whole range of plans, some of them being things like should the offices where the administrative arrangements play out not be habitable, we have an alternate site where you would go through that type of business continuity in the aspects of the pandemic response. We have the overarching plan that you just referred to—you would have seen it in the document tabled at this committee hearing—and then we have our operational plan or how we actually operationalise the strategic plan. That ConOps, as we call it, then has a number of subplans that exist within that. Those subplans are vast and are listed in here. These are all BCP type plans. There is demand service—

Mr McARDLE: That is fine. Do you have a business continuity plan that would have come into play if there had been a critical staff shortage as a consequence of a fallout from the pandemic, particularly in relation to paramedics and EMDs? Do you have such a plan?

Commissioner Bowles: Yes, we do. It is called a concept of operations.

Mr McARDLE: Can that document be tabled before the committee?

Commissioner Bowles: It is quite a comprehensive document. It outlines our response to this, and I believe it would be a very valuable document for the committee to have as part of their deliberations.

Mr McARDLE: You will undertake to table that?

Commissioner Bowles: It would be a pleasure to table that for you.

Mr McARDLE: Thank you. Commissioner, you made the comment earlier that between mid-March and the end of the last financial year there were 153 additional EMDs and paramedics employed throughout the state. You then outlined a certain number being placed in LASNs. I wonder if you could take on notice where the paramedics, by LASN, were appointed and where the EMDs were appointed by LASN—not today, just on notice?

Commissioner Bowles: I could table a document where they actually are—

Mr McARDLE: Even better.

Commissioner Bowles:—or I could talk to it. It is not in the format that you would normally have. It is 33 patient transport officers, 99 advanced care paramedics and 21 emergency medical despatchers. The total was 153. They have gone pretty much throughout the state. I am happy to table that. There has been a lot of press around them in little communities.

Mr McARDLE: Can you also give information to the committee as to which LASNs they went into?

Commissioner Bowles: I have all that. If that is something that you require, I am more than happy to share that information.

Mr McARDLE: Can you take it on notice, please, Commissioner Bowles?

Commissioner Bowles: Yes, no problems at all.

Mr McARDLE: Was the recruitment of the paramedics undertaken through the QAS recruitment human resources section of your office?

Commissioner Bowles: Yes, it was under the Deputy Commissioner for Corporate Services. That is where the HR branch sits. They are responsible for onboarding the recruit paramedics, EMDs and patient transport officers.

Mr McARDLE: They would have been the subdepartment of your office that would have engaged the paramedics you referred to just recently?

Commissioner Bowles: For their onboarding, or after they got to us?

Mr McARDLE: There were 153 paramedics and EMDs. Of the paramedics that were brought on under that program, would the QAS human resources subdepartment been responsible for the engagement of those men and women?

Commissioner Bowles: Yes, that is right.

Mr McARDLE: The other point I want to raise is this: in terms of the 153 can you break that down into paramedics, that number only, and can I ask you to advise what the parameters were of a person making application to be accepted by the QAS as one of those paramedics going forward?

Commissioner Bowles: There is a range of selection processes that take place. The first thing that you have to do to be a paramedic is you have to have an undergraduate degree in paramedic science to come through the graduate recruitment program. Then there is a range of pre-testing that we would do. Some of that is face-to-face. Don't get me wrong, during the pandemic we have had to alter some of the ways we onboard people because of the social distancing requirements and the number of people you can have in one location. We have had to adjust.

As importantly—and we have some very learned people in the room here—a significant part of how we bring paramedics into the system is through a range of psychometric testing, and a range of processes that have been built up over many years, and many years of finding what is the best employee in that space. It is not just a matter of, 'Did you get a GPA of greater than 5? Blah, blah, blah. You are welcomed into the system'; it is a whole range of testing that takes place.

As you would be aware, even to go to Bunnings has been difficult. You have to queue up at the start. That is exactly the same as when you are trying to onboard people and you want to test a thousand applicants for bringing them into the system. It creates many, many challenges, but we have been able to do it. I met with our latest induction group earlier this week. I can tell you, if that is the people that we have for the future of the Ambulance Service, we are in very good hands.

Mr McARDLE: I refer to page 13 of the document provided by Queensland Health. It said that in early March Queensland Health and DPC undertook modelling based scenario assessments on the likelihood of a health system and the pandemic response in the event that it was overwhelmed by a significant number of outbreaks in new cases. Were you or your office involved in those discussions?

Commissioner Bowles: Yes, very much so. If my memory serves me correctly, that was the same document that was referred to at the last committee hearing last week or the week before. It was taken on notice as to whether it would be cabinet in confidence, I think, was what the discussion was around. We use modelling. We are an integral part of the health system. The community think they are entering the health system when they dial triple 0, so it is very important that we are in such scenarios.

Mr McARDLE: My question more related to the fact that the quote referred to Queensland Health and did not refer to QAS. It was a matter of clarifying your involvement in that process, and you have done that.

Commissioner Bowles: Thank you.

Mr McARDLE: Commissioner Frkovic, the COVID-19 pandemic is a unique situation to Australia. We have had fires, we have had floods and we have had cyclones. For anything of this nature we have to go back to 1918 to understand what may have taken place. Earlier disasters have been of a physical nature—that is, you can see the outcome; you can see the fires, you can see the floods and you can see the cyclones. Here we are dealing with a silent and invisible issue—that is, the COVID-19 virus. How much more difficult does that make your work in trying to get across to people in the community the necessity to be cautious and to be well aware of their own mental health issues?

Mr Frkovic: Always it has been difficult in terms of particularly when you talk about mental health. I will take it slightly offline. Stigma with mental illness has been around for a long time. What we have done more recently through initiatives such as Beyond Blue and the work, as I have said, that we have done in Queensland through Dear Mind and a whole range of campaigns would suggest—and I am sure that my colleagues here would confirm—that there is enough evidence to say that the level of stigma around some of the high prevalence disorders such as depression and anxiety has decreased. People are more likely to seek and get assistance for those types of illnesses,

and to even talk about them. We are seeing that workplaces are now picking up mental health. When you start to talk about, 'I am living with schizophrenia,' or, 'I am living with bipolar,' we still have a level of stigma and a not in my backyard type of attitude. I still think we have got a long way to go. So getting the message across around mental health, at the same time as when you are talking about the virus, in fact has not been as difficult as I thought it would be. You saw that being done at the national level. You saw here the Premier, the minister, the Chief Health Officer and myself talking about mental health.

There seems be to a general acceptance that in these situations when particularly you have a level of lockdown, you have a level of uncertainty, fear around the virus, not having any treatment or cure, that obviously people are going to be worried. I think there is a greater level of appetite—at least that is my understanding—and I do not have empirical data to back this up, but at least from where I sit and the people that I talk to, and the access to services and supports which I have talked about would indicate that there has been a greater acceptance of looking after your mental health, particularly during this time, than we have had historically in this country.

Mr McARDLE: One of the points that has been raised, Commissioner Frkovic, is that if you are 70 years or older, you are advised not to leave your home bar for a few very tightly controlled matters. If you are 65 and have a chronic disease, you should also be in that same category. If you are Indigenous, it is about 50 or 55 years of age. Nursing homes were in lockdown for a long time. There were weeks that went by where—my mother is in one, so I make that declaration now—I could not see her. Older people are going to be impacted more dramatically because the message was targeted to them and they were told repeatedly, 'Don't go out.' Nursing homes were locked down for very good reasons. Do you expect a spike in mental health concerns and questions in that cohort because of what we had to do?

Mr Frkovic: I suspect we will see some level of increase in terms of mental health. I cannot give you the details of that. I am not sure whether my colleagues here would have any indication from a public health perspective whether there has been an increase in terms of presentations by older Australians, but you would think that the rates of isolation that people have had to experience—I have in-laws also in a nursing home—would make it much more difficult for people to keep that social connection. Certainly, as I said, social connection is a protective factor, and when you reduce that, in whatever state, you going to impact on the mental health of that individual or that family. I suspect there will be an impact. I do not know to what extent. I think we will start to see that over time in terms of responses from services both online and also direct responses from general practitioners who may see these people from nursing homes themselves or from some of the specialist mental health services.

Prof. Allan: I will make some comments from a professional point of view rather than a Queensland Health point of view. A number of the medical professions have been very concerned about a couple of things in nursing homes, one being around people not being able to attend their regular appointments or doctors not seeing them for their regular appointments. There has been quite a lot of lobbying and information from various medical groups and I think that that has changed so that people are getting their care properly now. In the initial phases that was actually a fear of exposing people to unnecessary physical risks and not understanding that situation. That lobbying has changed that. Also I think the lobbying has changed some things around the visiting.

I do agree with Ivan that obviously support for people has to be balanced against the physical need to protect them. There will be a range for people because some people will understand the need for that. Speaking personally, people I know are actually very happy about the isolation advice if you are older because it protects you and you know you are going to be well versus people who are champing at the bit to get out. There will be a range of reactions from people. What we need to do is make sure that any response that we give is not a blanket one but one which is tailored towards what that person needs at that time. We need to be able to make sure we listen to what they are saying and what they are doing. If we stop that voice, then that will be a problem.

Mr McARDLE: My final question is twofold. We really still are in the early days of this pandemic and globally it is still raging across the world. We are 'lucky' in Australia. I do not mean to put this in a cold-hearted fashion, but should a study be undertaken into the mental health impacts of this pandemic that follows through from the studies undertaken in Victoria with the bushfires and what happened down there in relation to the mental health of so many people and families?

Mr Frkovic: I can make some general comments. We do not have anything firm and hard on the table, but there have been discussions, particularly with the National Mental Health Commission et cetera, about how we capture the learnings from this particular pandemic and the impact on mental health. We saw some modelling come out of New South Wales and out of a Victorian university and

we had some come out from a Queensland university. I think there is a level of appetite and interest. From where I sit as the commissioner, I certainly would be very supportive to see particularly the research institutions do some work in helping us better understand what has been the full impact of this virus on the mental health of Queenslanders.

Prof. Allan: There is a national research fund into mental health. Some $10 million has been made available just recently for further research into COVID, of which some has gone to a number of specific groups to look particularly at parenting, suicide prevention—another one which I just have to take on notice as I cannot remember—and about $3½ million for grant funding to do work into the effects of COVID on the community. I should declare a conflict of interest because I am part of one, but I am aware of a number of Queensland studies that have applied for grant funding. There is one looking at the health of children. There has been one looking at the modelling of services and change. I am also aware from World Psychiatric Association contacts I have internationally that there is considerable research interest in this work. I think you will find that there will be particular groups that take an interest.

I believe that it will be the kind of research focus of the moment. It is a very hard thing to sit in the middle of and think about that research. It is probably also very important to note that, as well as research, there is the collation of data. One of the key features of the national pandemic and wellness response plan is around the collation of data and about how we have gone—national suicide data, the stresses of the community, the service levels and responses. There are plans and moneys to support the collation of data through the Australian Institute of Health and Welfare. Queensland is very strongly supportive of that. We are contributing to that in a particular way, and we are collecting our data for sure.

CHAIR: Are we able to access that data or can you table that data?

Prof. Allan: I cannot table the suicide data because that is from the coroner. It is unverified and we have that on the basis that we do not table it. I would be happy to arrange a discussion with you, but not to table it.

CHAIR: Just to take on the deputy chair's point, the impact of outbreaks internationally continues. Is any of that research available to compare Queensland with Australia? Given that Victoria is going backwards, do you suspect there will be increased mental health issues because they have had to wind back restrictions?

Mr Frkovic: We do not know exactly—and I think John's point is that we do not know—but the reality is that the situation we are in is certainly having a more positive impact when people compare Victoria or internationally. The psychology of the population is that our leadership, our state, has done well and so that is certainly a positive thing. It is the other bits that I think are the challenge. Can we as a result of doing positively in the health sphere also rebuild the economic sphere because that will impact on mental health as well?

Prof. Allan: The experience in Australia and New Zealand is very different to the rest of the world and a few other countries like that. It will be very important that we study what we have done because the international research will not reflect our experience. When I search the web and look at the guidelines from my colleagues in the UK, the US and others, they are talking about different things to us.

Ms PUGH: My key concerns were really around alcohol usage. That was well covered by both the mental health commissioner and the head of ambulance. That is fine, thank you.

CHAIR: If there are no supplementary questions, we might conclude this session. There were questions taken on notice. Could we have those responses back, if possible, by Friday, 10 July? We appreciate both the Queensland Ambulance Service Commissioner and the commissioner for mental health being here today. You have informed the committee greatly on the work we are undertaking in looking at the health response, and both form a very important part of that health response. I commend both organisations.

Proceedings suspended from 3.21 pm to 3.32 pm.

BOSEL, Mr Mike, Chief Executive Officer, Brisbane South, Queensland Primary Health Networks

HUDSON, Ms Pattie, Chief Executive Officer, Central Queensland, Wide Bay, Sunshine Coast, Queensland Primary Health Networks

STROHFELDT, Ms Merrilyn, Chief Executive Officer, Darling Downs and West Moreton, Queensland Primary Health Networks (via videoconference)

CHAIR: I thank representatives from the primary healthcare networks for being here. In view of the health committee being requested to look at the health response, it is very important to look at the PHN response and how it has affected the seven PHNs across Queensland. In Townsville, where I am from, we deal with the Townsville PHN. It has been interesting to see the collaboration and some very good things come out of the work both the state and the feds have done in the health response such as telehealth. I have had a lot of feedback about that in a positive light, but I still think that there are some challenges that I will raise as we go through—work that could potentially improve the response going forward. I invite you to make an opening statement before we ask questions.

Ms Hudson: I would like to acknowledge the traditional custodians on whose land we meet today and pay our respects to elders past, present and emerging and acknowledge the resilience of our First Nation people to keep their culture and traditions alive for future generations. Thank you very much for the opportunity to share our learnings and experience. We represent the seven PHNs and hope that we are able to share with you what we have done in working in collaboration with Queensland government departments, in particular local, state and national disaster coordination, hospital and health services, GPs and primary healthcare providers during many natural disasters and, more importantly, the current COVID-19 pandemic.

The focus of PHNs is on primary care, particularly through support of general practice and working with a range of government and community organisations, service providers and the community to develop better integrated health and community care services. We aim to improve access to service with an emphasis on the most vulnerable people at risk of poor health outcomes and to improve equity of access for primary health care. Through our health needs assessment and the richness of the data that we collect from our local general practitioners and health service providers, we aim to ensure that our communities optimise their health and wellbeing and remain well and reduce the burden of disease and the pressure on our hospital system. As we know, we cannot continue, as a state or a nation, to afford a very expensive hospital system. PHNs are local system integrators. We are partnership brokers and coordinators with well-established relationships. Due to our significant commissioning activities, PHNs have a deep understanding of place based needs of our local primary healthcare providers and also our communities. We work very closely with our community control organisations. Our consumers, carers and people with lived experience are central to the co-design of healthcare services and delivery that meet their needs. We are able to rapidly collaboratively engage across otherwise unconnected organisations and groups.

The key activities during COVID-19 were surgical masks and PPE distribution—we did not know we were good at logistics, but we sure do now; rapid establishment of our GP respiratory clinics, which were done in just over a month to six weeks; support for education to primary healthcare and community services around infection control, which was rolled out in the second or third week across all of our service providers; and an up-to-date source of truth on all aspects of COVID management via HealthPathways. HealthPathways comes from Canterbury in New Zealand. We have been using it in Queensland for around seven years. It gives GPs and health service providers access every day in Brisbane. The COVID-19 management was updated because, as you know, lots of information comes out, so that became the source of truth. HealthPathways is funded jointly and managed jointly by Queensland Health and the PHN and we are looking now to add a patient platform on to that as well, so it is a very unique system. Other activities were infection control education, as I mentioned, and residential aged-care preparedness. We did a very efficient assessment of all the residential aged cares across Queensland through our PHNs and were able to look at their preparedness, their pandemic plans, their flu vaccinations and also ensure that they knew the fact that on 1 May visitors were not allowed to go in unless they were vaccinated. That was able to be put out quite quickly.

The commissioning of new mental health services was very much a part of looking at where were the greatest needs, and I do not think we have seen the impact yet, as our learned colleagues have mentioned previously. The success of managing the spread of COVID has not been achieved by one individual or an organisation; it has been through open, honest and transparent collaboration with no barriers of which side of the fence you sit on or which government department you work with.

It was for the common cause of keeping our community safe. We brought our shared resources to the table, our best clinicians and leaders to ensure the whole system of holistic care was delivered. PHNs are very keen not to lose this momentum. We have gained collectively to build stronger, healthy Queenslanders for now and into the future—a person centred system which works to address the social and emotional determinants of health in our communities, including our First Nation people, older people, people with disabilities and young children. Thank you very much.

CHAIR: Thank you very much for your opening statement. I do welcome the work that the PHN has done broadly, and thank you for your submission as well. You do make some recommendations at page 8 of 12. It might be a question on notice that you cannot answer now, but what was the funding the PHNs had per those seven PHNs? Are you able to articulate that in the COVID area of response? That might be in the mental health response or I am not sure, but was there a portion of funding from the federal government given to each PHN to respond?

Ms Hudson: Yes, there was.

CHAIR: Are you able to table those or take it on notice?

Ms Hudson: They all go on our website, so yes.

CHAIR: I am always interested to see what the comparison is obviously across Queensland. I am flying my regional flag, being from Townsville.

Ms Hudson: I think you will be pleased to know that our funding is based on rurality and Aboriginality, so we do get a particular loading the further regionally we go.

CHAIR: Okay. That will be very interesting for us to look at. With regard to the PPE, I want to read from—and you will not have this document—a document from DPC or the Department of the Premier and Cabinet, and they also provided a submission. They go on to say—

The federal government has responsibility for ensuring that general practice, residential aged-care facilities, Aboriginal and Torres Strait Islander community controlled organisations and other non-government health services have access to PPE.

Would the PHNs be solely responsible for ensuring your GPs get that PPE and those residential aged-care facilities?

Ms Hudson: What happened was the term 'PPE' was used very early in the distribution. It was masks. P2 masks and surgical masks were the ones that we were given.

CHAIR: And gloves.

Ms Hudson: No gloves in the initial stages. When the respiratory clinics came on board, we then looked at the PPE—that is, they were the clinics that were testing. In terms of a lot of our PHNs in Queensland, because the national stockpile was low and we were concerned about our residential aged cares and our health service providers, we purchased additional PPE and we have been able to help general practice and healthcare providers—pharmacists, radiographers, specialists—in that case, and we still now will carry that stockpile that we have individually through till more likely early in the new year because we do not know.

CHAIR: We should clarify that PPE is personal protective equipment, and I would have thought that P2 masks and gloves would have been in the same area as standard PPE.

Ms Hudson: I think that general practices were, as part of their core business, to have gloves. Most health professionals have gloves at hand, but the masks were something that were not as plentiful. In the early days I think that primary health was left off because of the importance of ensuring that our hospitals were ready for whatever happened, but we very quickly picked that up.

CHAIR: Some of the GPs in my area of Thuringowa were contacting us saying, 'We can't get access to PPE. We need to get access to PPE,' and they included gloves and masks, so we formed a weekly catch-up session with our PHN up there and the HHS and brought people together. I hope that goes some way in terms of working in collaboration, and it is one of your recommendations of working closer together. Do you think there might have been some barriers at a federal level—take aside the national stockpile—of getting either the funding or whatever was needed to each PHN?

I will preface that with my experience. I welcome to the Upper Ross, in my area, a GP respiratory testing facility. I welcome it, but it arrived in June. If we were going to do early testing—we were out there saying, 'If you are sick or unwell or returned,' we had our HHSs already established mobile testing facilities—from my perspective that came a little late in the piece. It is still there and we welcome it because we are going to have to keep testing people for a long time to come. However, I was wondering where the lag might have been in terms of timing?

Mr Bosel: Could I just clarify one point in terms of PPE? In terms of residential aged-care facilities, that came through a Commonwealth branch here in Queensland. We as PHNs were tasked with distribution to GPs and then latterly pharmacies or pharmacy staff—not for resale—and then latterly allied health. Obviously with the respiratory clinics, which I am happy to come on to now, when you consider that from a standing start of zero across the country as a whole to 120-plus respiratory clinics being set up in a period of six weeks—and there is a process to go through; not every GP premises suits a respiratory clinic. They must have a separate entrance, separate air conditioning and separate staffing. Those had to be inspected to ensure they complied. Training had to take place to ensure that all the staff were aware of what they needed to do. That all took a period of time.

We had a company called Aspen that was running around like a headless chicken all across the country, and that is probably the reason there was a lag. Given that and given clearly there were some areas where we did not see the respiratory clinics arrive until fairly late in the day, I believe we still undertook across all of those respiratory clinics 10 per cent of all testing in Australia from a standing start. In certain areas like Metro South, we were able to stand down an existing fever clinic that Metro South were running because we had one next door, so they could reallocate their resources elsewhere.

I do not think over a six-week period it is a particularly bad time scale. I know there were certain areas where, due either to distance or to prior commitments of Aspen, they may have been late in the day. We opened one clinic as recently as two weeks ago on Stradbroke Island for a particular reason. That was outside the normal Commonwealth response. That is a response of the joint partnership between ourselves and Metro South. I do not think it was a bad run, but clearly I think the lags were naturally inbuilt to the system.

Ms Hudson: I think also we have to congratulate our general practitioners because I know across-the-board they had their practices set up for COVID. If you had flu-like symptoms you stayed in the car park and rang. They did some amazing work in doing testing as well. Whilst it was an afterthought in thinking, 'What about the primary healthcare?', the majority of people go to their GP first. I really congratulate ACRRM and RACGP and our GPs for their fast action in doing that work.

CHAIR: I think I need to do that as well and put it on the record. I visited my GP a number of times through having to do a medical for the Queensland Ambulance Service and getting the vaccinations and all the rest of it. They were incredibly good. I had my first telehealth consult as well. When I was talking with a lot of those people who were restricted early, can I feed back the overwhelming response that people were telling me in my electorate—I am sure other members can say the same thing—they actually thought it was a new way of doing business. There are advantages in that rural remote setting of being able to do a telehealth conference with your GP. Whilst we might have had a bit of a lag in that particular spot in my area, I have to say on the whole the GPs did a great job in having that foundational support around the HHSs. We did not want to overwhelm our hospitals, of course, but we have a strengthened network as a result of that. I will pull it up there and go to other members for questions and come back with any supplementaries.

Ms PEASE: We had a briefing at the height of the pandemic. It seems like a lifetime ago, but it was only six weeks ago apparently. Thank you so much for coming in. I know it has been a bit of a trial in unchartered waters for everyone. Thank you very much for everything you have done. Pattie, you talked about HealthPathways, which is an information package. I take it that it is online?

Ms Hudson: It is. It is web based. It came from Canterbury in New Zealand. In New Zealand when they had the Christchurch earthquakes it was Canterbury HealthPathways that enabled them to mobilise their health services across that whole region because they had a database of where every specialist is, where every GP is and every disease profile. We used that HealthPathways across our state to enable our GPs and health service providers to have an up-to-date source of truth—they could go online—because things did change. Certain things changed every day.

Ms PEASE: I guess that is what I am leading to. I know my local GPs worked really hard to have all the testing, have all the people outside et cetera. Often they would contact my office for up-to-date information. That is a concern to me, that there was information available somewhere for them. Were all GPs made aware that this access was available to them?

Ms Hudson: In our patch and across most of Queensland we are up to about 87 per cent of engagement with our GP practices. Yes, there were multiple ways out. We had briefings with our hospital and health service, ourselves and our GPs, so those briefings took place. I think it was a little bit hard in the beginning because one organisation would put some information out and then it would change. Then a national one would come in. I think it took a couple of weeks for that to normalise and then I think we saw the benefits.

Ms PEASE: My community is an older community. The doctors are the gods of the community, so they are the font of all knowledge. As a consequence, my constituents would be given information that sometimes was not accurate—and that was of concern to me—nor was it up to date. You talked about it being from New Zealand. I am assuming that it was updated with Australian information?

Ms Hudson: Certainly.

Mr Bosel: If I could respond for that area, we have about 14 GP practices there that amongst all of our region have the highest take-up of that engagement. I am concerned as the CEO of that area that that information stream was not as failsafe as I thought it was. We certainly spent an inordinate amount of time working with Metro South to make sure there was a consistent message, clear, unambiguous and current. What we found was that within a 24-hour period, as we have all admitted, there were changes but ensuring that that happened.

Ms PEASE: Further to that, was that information just available to the GPs or was it available to their staff and nurses?

Ms Hudson: To the practice, to the nurses and we put it out to allied health practitioners. It is a website with a password.

Ms PEASE: It would be interesting, because a lot of the misinformation or lack of clarity was due to out-of-date information. It was often not necessarily the GP—it could have been the GPs; I am not sure. It is of interest that you have that service already going. One of the other things that I wanted to raise was in relation to the aged care and the issue around access for families to aged-care facilities. There was a bit of consternation around people not being allowed to be seen by their family even if they had received the immunisation. Do you have any comment on that? How did that come about? Were aged-care facilities making a determination because it was protecting their patients and their residents and so, therefore, it was safer for them not to have visitors, full stop?

Ms Strohfeldt: I am happy to answer that. This came from Chief Health Officer advice to residential aged care. It was about stopping visitors to aged care during that period and that was to reduce the risk of infection.

Ms PEASE: Was that the national Chief Medical Officer?

Ms Strohfeldt: It came from both. It came from the state Chief Health Officer and it came from the national Chief Medical Officer as well.

Ms PEASE: Is that with or without a flu vaccination?

Ms Strohfeldt: It was not in regards to the flu vaccination; it was in regards to the COVID outbreak. The flu vaccination came in as a requirement from 1 May.

Ms PEASE: Some of my aged-care facilities were letting people in and others were not.

Mr Bosel: I sit on the Queensland Health residential aged-care facility COVID response committee, and there was a period of time when there was a great deal of confusion as to who was allowing who in, and that was clarified at a state level. Then subsequently very clearly it was documented to all residential aged-care facilities that post 1 May if a person had a flu vaccination or indeed had a medical reason why that flu vaccination could not be had, they were allowed in. If it was a palliative situation or end of life, clearly all rules were off and that was down to the discretion of the residential aged-care facilities. I am aware of at least three instances through that committee where there were some issues, and I think that that was more of a clarification process than anyone purposely failing to admit family members. Hopefully now that situation is clear.

The other thing I would add is that I know our focus necessarily is on those residents in residential aged-care facilities. I have five times as many of my population who are actually cared for in their own homes with home care packages, and 10 times that number who actually have no Commonwealth funding whatsoever. Whatever statistics you see—and I have seen a whole raft of them—it is certainly no more than 25 per cent of our elderly who live by themselves. Therefore, the isolation that they must have felt through this process would have been more acute, and we seem to have glibly ignored that throughout this process. It is a flag that I wish to fly very clearly. Certainly in your electorate there is a high proportion of elderly, more so above the average. It is a worry and it continues to be a worry.

Ms PEASE: Having said that, like the chair, I know that our local practices have been operating and providing telehealth and it has been very successful. In the course of COVID I myself have had to go to the doctor three times—I have not had to go to the doctor for years—and it was a telehealth process. I have been ringing around and have made phone calls twice for people over 75 in my electorate, and most of them have been contacted by the Care Army already. A lot of people have

been out there, so it would be great to see that those sorts of pick-ups continue. The Community Visitors Scheme is a really great example of that that has been ongoing for some time. It is very successful in my electorate and the Red Cross is doing the work as well.

Mr Bosel: You have the opportunity with the PHNs because we are that interface.

Ms PEASE: I will be in touch.

CHAIR: I will comment only before we go to the member for Nicklin, Mr Bosel. This committee is very familiar with the 469 aged-care facilities and the 16 state-run facilities. It is very difficult to get communication across every single one. Also, as you have just noted, there are those older Australians who are still waiting, and we made a number of recommendations in our previous work in the aged-care, palliative care, end-of-life inquiry around aged-care supports. There is still more work to be done, but we are awaiting our government response on that.

Mr HUNT: A lot of what I wanted to cover was covered by the member for Lytton. In relation to aged care, when the pandemic and the restrictions first arose and the Chief Health Officer's directives came out we were all in it together. We all realised we had to isolate and our movements were restricted. There were a lot of community restrictions. Moving on from that, as restrictions started to ease, the calls to my office started to change. Older people started to contact my office, particularly from residential aged-care facilities. I recall getting a lovely handwritten letter, as our seniors are wont to do, about feeling not only isolated but also trapped as prisoners because they were not allowed out, and a lot of these residents did have the capacity to go out. Could you unpack for me if you are able to provide any support to people feeling that and what, if anything, you were able to provide?

Ms Hudson: In our area we have 109 residential aged-care facilities. We now have regular updates and were able to put telehealth in in some of those residential aged-care facilities to allow relatives to actually chat with their loved ones. We had care packages that went out from local organisations. They are just small things but we have kept those programs going. We have regular meetings with all of our residential aged-care facilities. We have three HHS areas. We have a newsletter that goes out for the resies and for the staff about what is happening in the outside world and some nice little things that they can do. I think it is just ensuring that there is contact there and then making sure that the residential aged-care staff have the right information to be sharing with their residents and with their carers and their loved ones. We have started that journey.

We have always had strong connection, but, like Mike has said, it is the other elderly people who are living at home with care as well. We see a lot of the churches and a lot of really good hearted people reaching out. I think that the PHN is able to understand our communities and people will call us and say there is a gap or this is not happening in this place and how can we look at that. Usually communities get together after you make that initial consultation with them and they have the resources they just did not know they had them.

Mr HUNT: I suppose I was getting more at getting these people out and about rather than providing support in-house. The frustration that was expressed to my office was that they could not go out. Obviously the higher risk prevented that, but were there any efforts made to support outings or COVID safe outings for people in residential aged care?

Mr Bosel: I think the response to that was that the government had initiated through a grant through to the PHNs in terms of psychosocial support which we had run to put in place. I have been involved in nursing homes for about 35 years, both here and in the UK, and over the course of that 35-year period we have seen the dependency of residents increase exponentially. What we used to have in 1985, which was very similar to the *Fawlty Towers* two sisters approach, who would dress for dinner and come down and have a glass of sherry, is not the type of client that we now have in residential aged-care facilities. In essence we have 205,000 registered operating beds in this country. They are at the peak of that journey towards the end of their lives. Unfortunately it is a sad truth, but it is a truth nonetheless, that a large majority of our residents are actually bound within the confines of that residential aged-care facility. We as PHNs have a series of schedules. When the government funds us and the Commonwealth funds us we have particular schedules that may address mental health and suicide. We as PHNs fund our residential aged-care facilities out of our core and flexible funding and some other funding called out-of-hours. That is something that the PHNs are addressing with the Commonwealth, that we need to be specifically funded to be able to address some of these social and psychosocial support mechanisms in residential aged-care facilities. We also need to be extending the end-of-life care planning.

What we have seen in Brisbane South, particularly through a couple of initiatives, is that a lot of people who are transported to hospital in the last week of their lives actually do not want to be transported to hospital in the last week of their life. The reason that happens is there is a disconnect

between what that resident wants and the residential aged-care facilities themselves which may not feel comfortable in addressing that, and again that is something that we have spent the last 18 months on and we are very, very pleased with the results on that, but more importantly I think the prospect is that, as we have done in Metro South, which is connected with the hospital and health service, there is a lot that we can do to support residents in these facilities. I do not think there is any PHN within Queensland that would not put its hand up to say we want to work with our HHSs to ensure that happens.

CHAIR: You say you fund activities within those resi care facilities. Can you take it on notice and break that down as to what funding you currently receive?

Mr Bosel: We can provide that on notice.

CHAIR: Across-the-board.

Mr Bosel: Again what I would add to clarify that is what we do in Brisbane South is not necessarily what Townsville or the Far North would do because we use our flexible and core funding, which is not a schedule that is specifically primed for any one particular cohort or activity.

CHAIR: Is it per capita? Is it per resident?

Mr Bosel: No. Basically we have used our out-of-hours funding, which was a particular grant, and we have looked at supporting obviously residential activities, staff training to ensure that they understand the psychosocial needs of our clients and also this end-of-life planning. That is a specific set that we as a PHN believed there was a need for. Other PHNs would do things differently.

Ms Hudson: I think there are some wonderful programs, especially in Western Queensland, from the old 60 and Better Program called Healthy Ageing and I know that Charleville has been running one out there for probably about 24 years now. I had the privilege of being the district manager for the health region out there when it first began. I visited a year ago and I saw people who probably should be in nursing homes riding pushbikes in a street parade and being younger than they looked when I saw them. I think there are some beautiful, Healthy Ageing programs that do not cost a lot of money. They are run by volunteers. They are people helping each other out. I think that we forget, in our lack of extended families these days, that older people get together and they have fun. It is really important that we look at those beautiful community based activities that help people get out: tai chi, water aerobics, mahjong.

Ms PEASE: I think that is what the member for Nicklin was saying: that all of those things just stopped and so they were trapped inside, whether they be living at home or in a residential aged-care facility. Those people who were living at home are isolated and those people in an aged-care facility are trapped. That was just a product of COVID.

Ms Hudson: Yes, and I hope now with restrictions lifting we can get them back out.

CHAIR: Member for Nicklin, did you have another question?

Mr HUNT: That is all from me at this stage.

CHAIR: We might move to the member for Mount Ommaney. Do you have a question?

Ms PUGH: Thank you very much, Chair. We have heard a bit about telehealth. I have had the opportunity to have a few telehealth appointments myself and I have to say as a consumer I found them absolutely fantastic. I am interested to know what the feedback has been from other stakeholder groups and if there is a general consensus from other stakeholder groups that this might be something that we can continue post COVID? I see them as a great example of a potential learning that has come out of COVID. I would also be interested to hear if there are any other potential learnings or efficiencies that we have found that we have been able to achieve through this COVID period that we may want to look at continuing post COVID?

Mr Bosel: Certainly Minister Hunt's announcement two weeks ago or a week ago that telehealth will extend beyond September is welcomed. The response we have had from most of our stakeholders is positive. There are some fears from our GP practices that this would lead to some telehealth only, dare I say it, cowboys—not wanting to use the Townsville vernacular. If it is properly regulated and properly run then telehealth will become a valuable tool in our arsenal. Many of our HHSs responded with a virtual health approach to many of the things they do. If we could marry those two up my God what a wonderful system we would have. That is really what we are very keen to make sure goes forward.

Ms Hudson: I think probably too in rural and remote areas where people have to travel to the south-east for their major surgery or for major appointments and then they go home and then they have to travel all the way back for that five-minute check-up. We were discussing it with our clinical

counsel the other night and I said as a rural person it would be fantastic if you could have the patient and the GP and the specialist on a virtual meeting and they did not have to leave their town. Can you imagine the cost of our Patient Travel Subsidy Scheme, the cost to families having to leave their families and come away, stay away from work et cetera. I think there are some really wonderful opportunities there in that clinical handover and also that exchange of knowledge between specialist and GPs in knowing that the care plan for that patient has been discussed with the patient.

Ms PUGH: I feel that telehealth has been a bit of a revelation for a lot of people in the community. It has been convenient. It has been responsive. I had my doctor get back to me at 6.30 on a Friday night and she was able to bill me. It was an appointment with some test results that I was waiting on quite urgently. I found that absolutely fantastic. I am wondering if there is anything else that has come out of COVID that we have been able to learn that has been similar to telehealth in that regard?

Mr Bosel: I think from Brisbane South's perspective and working with Metro South it was actually the first time the hospital and health service, the PHN and stakeholders engaged together. This has not been something that has happened in the past. We have a large number of vulnerable communities in our area. Communities felt empowered because they were not only talking to the PHN they were talking also to the HHS at the same time. I think that possibly, other than telehealth, one of the most remarkable things that has come out of COVID is actually the HHSs and the PHNs were almost forced to engage together rather than disparately.

CHAIR: I wanted to explore that a little bit more towards the end if we have time because one of your recommendations goes towards that. Can we go to the deputy chair for now.

Mr McARDLE: Thank you very much and thank you for being here today. Ms Hudson, you made the comment in your opening statement or in answer to a question that in the early days we were looking at modelling that showed an horrendous outcome for Queensland. I think up to 10,000 to 30,000 people were to die in the first wave commencing in April and then peaking further on. It does not surprise you in those circumstances the need to resource and man HHSs and hospitals was the first priority of the national and state government.

Ms Hudson: Yes, most certainly. That was not a criticism. I think it was that the first point of contact for most people was to GPs and I understand totally, in modelling from what was happening overseas, that the government in Australia has done an amazing job in ensuring that our hospitals were ready and they very quickly, within a couple of weeks, picked up. We had a whole primary healthcare committee with SHECC to ensure that we were communicating with each other, we were feeding back to the State Emergency Service, we were working with the nationals. If the lesson is learnt, it is about that communication and coming together.

Mr McARDLE: I think the decision to focus on the HHSs was borne out by the figures that were coming through, but also the unknown factors because there is no vaccine for this virus, there is no historical data behind it so we had to work on what was to be the worst-case scenario and therefore man and resource the primary line of defence if the pandemic got out of control?

Ms Hudson: That is very true. As I say to her, I take our hats off to the primary healthcare sector working with our HHSs and the Queensland government in ensuring that we had a continuum of care during this pandemic.

Mr McARDLE: You are probably in a very unique position with the PHN because you function on a state basis but you also have a cohort in the Commonwealth sector as well. Would you say that the relationship between the state, the PHNs, the federal body, GPs and other health providers was good during the early stages—even up to today—with regard to the pandemic? Did they work together well?

Ms Hudson: Most certainly. After my 35 years in health, in the last five years I have seen a huge difference in the environment in relation to working together. We cannot continue to build more hospitals. We have to start really focusing on keeping people well, and I think the environment is right there. We work very closely with our HHSs.

One of the examples I would like to give you from a policy area is with the fifth mental health plan that was set down. The PHNs and HHSs were asked to develop regional plans. We not only developed regional plans but we have governance with Queensland Health, Dr John Allan, and we work collectively. Using the mental health service planning framework tool to assess where the gaps are in that mental health area and working with Ivan and the commission has been a prime example to me where policy and implementation and resourcing have come together.

We are seeing early good results. There is more work to be done, but I think that just shows there is an opportunity there when we look at the 10-year primary healthcare strategy to build that from national through to state and continue this collaboration and work together.

Mr McARDLE: I think you are a member of the state COVID-19 response and recovery task force; is that correct?

Ms Hudson: Yes.

Mr McARDLE: Mr Bosel, when you were talking about the mental health of people who are aged and in nursing homes, at home or in isolation through the pandemic, I got the impression that you are quite concerned about what that impact would be on their mental health. When I posed a similar question to the Mental Health Commissioner he did not seem to be as stridently concerned as yourself. Is there a difference of opinion, or really the language means the same outcome but there is a difference of emphasis?

Mr Bosel: I think it is more a difference of the groups that we are dealing with. Typically, our first concern is those within the community who are first in primary care, whereas the Commissioner himself is probably dealing with those coming into that acute care. Unfortunately, we do not have any evidence or data to suggest that there is a tsunami coming. What we are hearing is anecdotes coming from our GPs, who are telling us very clearly that there is a problem. Health is often associated with your mental state, and if your mental state is not good then obviously that health suffers. I think that we are talking about the same thing but from different aspects.

It would be good if we could join both of those aspects together, and it would also be good if we could align what it is that we are doing and when. Often state funding goes this way and Commonwealth funding goes that way and never the twain shall meet. Or if they do meet, they pass in the night like ghost ships. I think there is a clear situation that we could join those dots up and we could actually take someone's journey through being supported in their community through that process right up until end-of-life planning. I think that is probably, in terms of numbers, one thing that Australia as a whole could stand out for. Because our population base is quite small in comparison to the rest of the world, I think we should be bold and brave in trying to achieve that.

Mr McARDLE: I certainly agree with you and the committee would as well. Mr Bosel, we are in the early stages of this pandemic in Queensland, Australia and across the globe. It is horrendous overseas. The problem I see is that this is a silent killer that could arrive at any time. It is not a fire, flood or cyclone. Are we going to be living with this anxiety until a vaccine is developed? I know it is a very difficult question, but how long will it be before we get some sort of clarity as to the full impact of this virus on Queensland citizens in terms of mental health?

Mr Bosel: I think that the anxiety will never go away. What we are seeing every year is a repetition, so every time there is a flu season we are going to go back to, 'Is it COVID-19?' That is the first response. We have had swine flu and we have had avian flu, so it appears that every so often we have this pandemic. This is probably the worst one we have had since the Spanish flu at the turn of the last century, but we have to prepare ourselves for it so the next time we are more prepared than we are now. Residential aged-care facilities, as an example, are not going to go away and the needs of our elderly are not going to go away, so we have to plan for that. I think that the anxiety can be reduced if we can show that we are prepared for it and we have learned our lessons from here. Already, as we have seen in Victoria, they are stepping back from the brink and what is happening is that they are seeing a significant re-emergence and second wave. I think it is an obligation of Queensland to make sure that we do not get that second wave and anxiety should reduce.

Yes, I am concerned about mental health and I am also concerned about the other unseen factors that are going on. Domestic and family violence is another issue and childhood development, particularly across the backdrop of children having to remain confined in home for a period of time. There are a whole different myriad of issues. I think there is an opportunity to look at these jointly and to target these jointly rather than relying on it being done at the primary level—that we go through this and then the hospital and health service picks it up at the end of the day. I know that every state is different. From talking to my colleagues in other states, I would say that the relationship we have with Queensland is more encouraging and far better than some of the other states, and I would use that as a basis to move forward rather than looking backwards.

Mr McARDLE: Would you agree that there should be a national study undertaken at some point in time because although we are different there are certain key basic factors that exist in every state?

Mr Bosel: We would absolutely agree with that. I think it is actually an important task to undertake.

Mr McARDLE: Thank you very much. Thank you, Chair.

CHAIR: Thank you, Deputy Chair. Before I go to my next question, in the few minutes remaining I need to procedurally ask that you table the submission because we have not formally accepted it yet.

Ms Hudson: I seek leave to table a submission from the Queensland Health PHN.

CHAIR: Is leave granted, members?

Mr McARDLE: Yes.

CHAIR: Leave is granted. You made some recommendations and you have touched on a number of important aspects going forward. In terms of the learnings of how we have managed the health response, I see opportunities to remove silos and work in a collaborative fashion going forward. It is good to have heard that you are (a) on a COVID response task force; and (b) that you are embedded within the state health emergency centre. One of your key recommendations talks about the role and scope of the PHNs to be clarified and embedded into the state disaster planning and response processes. One would think that should be occurring now. I am going to go back to what the autonomy of each PHN is. Do you operate under the umbrella of the Commonwealth Department of Health?

Mr Bosel: We are funded by the Commonwealth. We are individual stand-alone companies in our own right where our members are our stakeholders. We are initiatives rather than an agency of the Commonwealth.

CHAIR: Does the federal Department of Health play a role in linking PHNs with the state at all? Do they have any coverage?

Ms Hudson: We have just recently seen it under the National Health Reform Agreement for the next five years. There are some recommendations in that health reform around the relationship between state health departments and the PHNs, and I think that we can further build on those. There are recommendations from the inquiry into aged care once again where PHNs will be asked by the government to lead certain bodies of work. The most important thing there, as I said with the mental health planning, is coming together and working together to ensure that we get the best outcome.

CHAIR: We worked on a very broad 18-month inquiry into aged care, palliative care and end-of-life care, and not everything was forthcoming from the Commonwealth Department of Health that we might have hoped for. I was trying to get clarification around what their role might have been. You mentioned recommendations, and there were a number that you spoke to. Can you table those for the committee?

Mr Bosel: Those were signed at national cabinet, so it is the new reform agreement that every state has now signed up to. Within that the PHNs have their own schedule. It specifically now names how the PHNs will work with the HHSs with the states, which has never happened before. I would hope that this gives us the framework, not necessarily the guardrails, to work more closely together. If there is one advantage that has come out of this pandemic, it is working together.

CHAIR: Absolutely. Then trying to get it embedded within the state disaster planning framework is a common-sense move going forward so that you have a seat at the table and everyone is on the same page in terms of mapping out planning and ensuring the community has PPE, GPs or whatever. Is that happening now or in some HHSs and not others?

Ms Hudson: No, we are all involved as primary health care. We have an SHECC meeting once a week, not once every day. What we were aiming for there is to say, 'We have done it now. We need to embed this into future disaster management planning' so that we are on equal footing and from the very beginning of a national disaster we can be at the table. I think that then takes in primary health and acute care, aged care, and brings us all together. There were a few missing. I think pharmacy was missing and allied health was missing from the table. It is about saying, 'What did we learn and who else should be at that table to ensure that we all have a role?' I think in disaster management—and I have done quite a bit—it is about the role that each organisation plays, so you know your role. 'This is our role in this big picture,' and then nobody is falling over each other and we get good outcomes.

CHAIR: I think you have touched on a couple of good points. The health committee conducted a pharmacy inquiry and we made a number of recommendations. It is up to the government to accept them. Having a network where you can deliver vaccines was one of them. The 77 recommendations that the committee made have not yet all been responded to because of COVID-19, but it goes to the end-of-life care issue that you raised. We actually received some data from the Queensland

Ambulance Service relating to the number of transports from residential aged-care facilities. You were absolutely accurate before when you said that not everyone wants to end up in an ambulance going to a tertiary hospital: they want to remain within their community or in their home. I know the member for Lytton is going to correct me if I am wrong, but we have seen some very good models of care in Metro South. At a Wynnum residential aged-care facility the HHS has a palliative care—

Ms PEASE: Camellia Court.

Mr Bosel: If it would help, I am very proud of a piece of work we literally released last night working with Metro South, Our End of Life, which is an evaluation and the methodology working on that framework that you mentioned and the actual physical impact it has had on residents' end of life. It is a phenomenal document that actually goes to not only the reduction in the numbers of people being transported to hospital against their wishes, probably against the needs of that client, to even when they end up in hospital for a short stay of four, four and a half days. I am happy to table that.

CHAIR: We will accept that. Again, we are waiting for the outcome of our 77 recommendations to see that some of those actually align with that piece of work you have obviously done. That would be greatly appreciated. There are two minutes remaining. Are there any supplementary questions, members?

Ms PEASE: With the SHECC meetings, was each PHN representative there?

Ms Hudson: Yes, all seven of us. It has been really good because it is important—

Ms PEASE: You all have different needs.

Ms Hudson: Exactly. Our communities have different needs—

Ms PEASE: You all do different things. In our travels we found that all PHNs are autonomous and do completely different things in different areas to meet the needs of their communities, also the people on the PHNs.

CHAIR: That is demonstrated in the different programs that have happened in each one. Thank you so much to all three of you for being here and contributing to our inquiry. It has been informative. It has been valuable for us. We look forward to receiving responses to the questions taken on notice. We would ask that they come back by Friday, 10 July. If that is not possible, please write to the committee and we will undertake to extend the time. That will conclude today's hearings. We appreciate you being here. I now declare this hearing over.

The committee adjourned at 4.31 pm.