

COVID-19 Reflections

An evaluation on the health system
response to COVID-19 in First Nations
people in Queensland



Queensland
Government

Acknowledgement of Country

Queensland Health acknowledges the Traditional and Cultural Custodians of the lands, waters and seas across Queensland, pay our respects to Elders past and present, and recognise the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia. We also acknowledge the more than 500 people who shared their ideas and hopes for a more equitable future for Aboriginal and Torres Strait Islander peoples

Terminology

Throughout the report, the terms 'First Nations peoples' and 'Aboriginal and Torres Strait Islander peoples' are used interchangeably. Acknowledging First Nations peoples' right to self-determination, Queensland Health respects the choice of Aboriginal and Torres Strait Islander peoples to describe their own cultural identities which may include these or other terms, including particular sovereign peoples (for example Yidinji or Turrbal) or traditional place names (for example, Meanjin Brisbane).



*COVID-19 Vaccination Team with Johnathan Thurston at Aurukun
(Source: QH Asset Library)*

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Foreword

Since early 2020, when the COVID-19 virus first threatened our shores, we have been on a journey to protect the Aboriginal and Torres Strait Islander peoples of Queensland.

As we move to a new phase of the COVID-19 pandemic it is timely to reflect on our actions over the past two and a half years. To identify the lessons; what we have done well, and what could have been done better, and work to positively influence our future health care delivery for First Nations people with these lessons.

It has been my honour to lead the Aboriginal and Torres Strait Islander Health Division through these unprecedented times and I am proud of our staff, across Queensland Health, Aboriginal and Torres Strait Islander Community Controlled Health Sector, Primary Health Networks and our other multiple partners, and what they have contributed to #keepmobsafe.

Our First Nations staff across the State have shown true leadership and commitment, and I have been heartened by the innovation and co-design of care delivery that has occurred in many places across our State. Not once did we think we would be sitting in parks and on beaches providing vaccinations to our people. The relationships that have been built across communities, with our health care partners, and other agencies, cannot be understated and have led to better outcomes for our people. We have also learnt the value of flexible local decision making and how we should lean on this when we make decisions such as Biosecurity, Directions and delivery of vaccination.

At the time of releasing this report we have had over 50 First Nations deaths in Queensland due to COVID-19. We need to remind ourselves of the loss of these individuals and the impact on their families and communities. In health we should also try to keep improving, and my hope is this report will provide Queensland Health, our Hospital and Health Services, and our partners in health care delivery suggestions on how we can do business better to care for our communities.

I would like to acknowledge the stakeholders who participated in this review, from our Queensland Health and Hospital and Health Service staff to the leaders in the Aboriginal and Torres Strait Islander Community Controlled Health Organisations, the Mayors and Chief Executive Officers from the Aboriginal and Torres Strait Islander Shire Councils, and our partners across other government agencies. Without your frank and honest discussions, we would not have this report. Thank you.

Ngulkurr warngku

Haylene



*Haylene Grogan
Chief First Nations Health Officer*

Acronyms

Acronym	Definition
A&TSICCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
AIDR	Australian Institute of Disaster Resilience
AIR	Australian Immunisation Register
AMS	Aboriginal Medical Service
BAU	Business as Usual
C3	Command, Control and Coordination
CHHHS	Cairns and Hinterland Hospital and Health Service
CHO	Chief Health Officer
CHQ	Children's Health Queensland
CSRG	COVID-19 System Response Group
CQHHS	Central Queensland Hospital and Health Service
DDHHS	Darling Downs Hospital and Health Service
DDMG	District Disaster Management Group
DSDSATSIP	Department of Seniors, Disability Services, and Aboriginal and Torres Strait Islander Partnerships
EOC	Emergency Operations Centre
HEOC	Health Emergency Operations Centre
HHS	Hospital and Health Service
HITH	Hospital in the Home
IGEM	Inspector General Emergency Management
IHLO	Indigenous Health Liaison Officer
IMT	Incident Management Team
IUIH	Institute of Urban Indigenous Health
LDMG	Local Disaster Management Group
MoU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
OILL	Observations, Insights, Lessons Identified, Lessons Learned
P ² OST ² E	People, Process, Organisation, Support, Technology, Training, Exercise Management
PHU	Public Health Unit
PHN	Primary Health Network
PoC	Point of Care
PPE	Personal Protective Equipment
QAIHC	Queensland Aboriginal and Islander Health Council
QCVMS	Queensland COVID-19 Vaccination Management System
QDMA	Queensland Disaster Management Arrangements
QFES	Queensland Fire and Emergency Services
QPS	Queensland Police Service
RAT	Rapid Antigen Test
SHECC	State Health Emergency Coordination Centre
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 (COVID-19)
STI	Sexually Transmitted Infection
TCHHS	Torres and Cape Hospital and Health Service
TGA	Therapeutic Goods Administration
WHO	World Health Organisation

Introduction

In December 2019, China reported cases of viral pneumonia caused by a previously unknown pathogen that emerged in Wuhan, China. The pathogen was identified as a novel coronavirus (named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)), which is closely related genetically to the virus that caused the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). SAR-CoV-2 is commonly known as COVID-19.

Many Aboriginal and Torres Strait Islander peoples experience substantial health disparities compared to other Queenslanders, and as a population group, First Nations peoples have poorer health compared to any other population group in Australia¹. The 7.3-year life expectancy gap (7.8 years for men and 6.7 years for women)² between First Nations peoples and non-Aboriginal and Torres Strait Islander Queenslanders is evidence of the avoidable, unfair and remediable race-based health inequities that still exist in Australia. As a result of this, First Nations people were identified as being at risk of being disproportionately impacted by COVID-19 if an outbreak were to occur in a community.

Since early 2020, the Queensland Department of Health, Hospital and Health Services (HHS), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHO), Commonwealth Department of Health and other agencies in the Queensland Disaster Management Arrangements (QDMA) have worked together to support the COVID-19 response across the Aboriginal and Torres Strait Islander communities of Queensland. In March 2020, the Queensland Department of Health, First Nations COVID-19 Response Team was established to support the COVID-19 system response across the state.

In March 2022, the Queensland Department of Health, First Nations COVID-19 Response Team undertook a review into the COVID-19 response for First Nations people and communities. This report provides the outcome from the analysis of the data collected. The review captured data from face-to-face interviews, surveys, written statements, and document analysis. It presents the data methodology, chronology of the response, analysis of data and the emerging themes, and the resulting 29 Insights and nine Lessons Identified.

Many opportunities exist for the Queensland Department of Health to use its responsibilities as health system manager to embed equity across the policy, legislative and funding environments governing Queensland's public health system. It is anticipated that the outcomes of this review will enable the Department of Health and other agencies to include the recommendations for improvement and acknowledgement of the positive and successful practices to inform other areas of First Nations health, with a focus on Health Equity and Closing the Gap.

¹ Australian Institute of Health and Welfare (2018). Australia's Health 2018, page 48

² Australian Bureau of Statistics (ABS), Life Tables for Aboriginal and Torres Strait Islander Australians, 2015-2017, Cat. No. 3302.0.55.003.

Overview of Insights and Lessons Identified

Insights

First Nations Leadership

- i. The Mayors and Councillors of Aboriginal and Torres Strait Islander Shire Councils know their communities and showed strong leadership and advocacy throughout the pandemic response. As leaders, they have the rapport and respect of community, and this was evidenced throughout the response. Elders and other local leaders (such as the Yarrabah Leadership Forum, and similar) were integral to community engagement, advocating for community, modelling behaviours, supporting the vaccination rollout and leading the local response for their communities under the Queensland Disaster Management Arrangements. Integration of this leadership into the health response enabled the recognition and leveraging of existing Social Capital, Human Capital and Cultural Capital within local communities which lead to more effective pandemic responses within these communities.
- ii. Where there was strong integration of the Aboriginal and Torres Strait Islander executive lead into the Hospital and Health Service executive team and COVID-19 response teams, there was evidence of stronger integration and consideration of First Nations health and representation in the pandemic response operations. In some areas, the converse was identified, with Aboriginal and Torres Strait Islander executive leads not being well integrated and so there was less focus and consideration for the health and needs of Aboriginal and Torres Strait Islander people.
- iii. The Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General was a strong First Nations voice in the Queensland Department of Health, advocating for First Nations Health Equity in the response to the COVID-19 pandemic. Their phrase “First Nations First” is now known and used across the department.
- iv. Where there was a strong Aboriginal and Torres Strait Islander Health Worker workforce, or staff from other disciplines (e.g., nursing), presence and integration in the front-line response, stronger connection and integration with community was seen. First Nations workforces are known and trusted by the communities they work with and where there was First Nations leadership and presence in vaccination teams, outbreak management teams etc. there was increased vaccination rates, increased compliance, increased testing, increased connection with health services, and increased First Nations staff satisfaction.

Consideration and Integration of First Nations Perspective

- v. When the response actions acknowledged and honoured the diversity of health response needs of Aboriginal and Torres Strait Islander peoples and communities, and incorporated First Nations ways of knowing, being and doing into co-designed health care which met community needs, better outcomes were seen. This was evidenced in increased vaccination rates, increased testing, increased compliance, and increased engagement with health services. Examples of meeting communities needs included door-to-door testing and vaccinations, bringing vaccinations out of clinics and delivering them at common meeting places, and having First Nations staff deliver care to First Nations people.
- vi. Remote Aboriginal and Torres Strait Islander communities were provided specific focus by health services due to their remoteness and vulnerability of their populations. Urban areas, where the majority of Aboriginal and Torres Strait Islander people reside however, with not as high a percentage of the population, were not provided with the same concentrated focus, despite the population having a similar vulnerability profile as the remote communities.

Role of First Nations Staff

- vii. The Hospital and Health Services generally had low employment rates of Aboriginal and Torres Strait Islander Health Workers, and where these positions did exist, their clinical capability was generally underutilised, with their focus being more about cultural capability support. Where Aboriginal and Torres Strait Islander Health Workers were empowered and utilised to their potential, good outcomes were seen, including increased vaccination rates, increased connection to community, increased integration with health services, and increased First Nations staff satisfaction. It was generally accepted that this underutilisation was because of a general lack of understanding of the clinical governance of Health Workers, and that Health Workers often opted to work in the Administration Officer stream as Indigenous Health Liaison Officers due to pay disparities and a lack of clear pathways for career progression. Aboriginal and Torres Strait Islander Health Workers in Aboriginal and Torres Strait Islander Community Controlled Health Organisations are utilised more in their clinical capacity. There are disparities between the roles and responsibilities between Health Worker positions in Aboriginal and Torres Strait Islander Community Controlled Health Organisations and Hospital and Health Services.
- viii. The implementation of the Emergency Order Pandemic Response to Coronavirus Disease (COVID-19) and inclusion of the Aboriginal and Torres Strait Islander Health Workers to be able to provide the COVID-19 vaccine was a welcomed step in increasing the scope for Aboriginal and Torres Strait Islander Health Workers. This increased scope reduced strain on the greater workforce, to enable business as usual services to continue, and reduced the need for 'fly-in, fly-out' workforces in some areas. The training that was developed and delivered for Health Workers by Queensland Health was comprehensive and provided the required baseline knowledge. What was initially missing was additional mentoring and support to increase Health Worker confidence and the uptake of Health Workers delivering the vaccine after completing training. The Aboriginal and Torres Strait Islander

Community Controlled Health Organisations workforce were the primary Health Worker workforce that attended and implemented the use of the training, where Hospital and Health Service Health Workers were more likely to be engaged in a cultural liaison role, even after completing training.

- ix. When Aboriginal and Torres Strait Islander staff (across all disciplines) were integrated into teams and included in decision-making there was a strong First Nations focus, culturally responsive health care was provided, and better outcomes seen for communities. Where the Aboriginal and Torres Strait Islander workforce was not engaged, they felt like they had to “jump up and down” to be included and be able to co-design and deliver culturally appropriate and safe health care for their communities. Once engaged, outcomes such as increased vaccination rates, increased testing, and increased engagement with health services were seen.

Health Service Integration with other Agencies

- x. Some Aboriginal and Torres Strait Islander Community Controlled Health Organisations felt that they didn't have a “seat at the table” within the health system, and that it is not an integrated health system but rather a group of different systems. It was generally felt that Hospital and Health Services didn't understand or trust the capability that exists in Aboriginal and Torres Strait Islander Community Controlled Health Organisations and so didn't always utilise this. Where relationships between organisations already existed, there was a higher level of collaboration and integration of services. As relationships grew and solidified, so did the ability for a coordinated response for communities with less duplication, more streamlined approach to service delivery, and increased outcomes to communities.
- xi. Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) are generally well known and respected within the communities they serve, particularly in the remote Aboriginal and Torres Strait Islander communities. A&TSICCHOs generally just ‘got in and delivered’ for the communities, stepping up for the safety of their staff and clients, even when funding arrangements were not clear, and this was noticed in the continued and/or increased delivery of services provided by the A&TSICCHOs. The pandemic response highlighted the lack of services and resources in some areas, particularly where an A&TSICCHO works with a ‘fly-in, fly-out’ workforce.
- xii. There was often confusion around what and how much data (such as names and addresses of positive cases) could be shared by Queensland Health and the Hospital and Health Services (HHSs) with other organisations involved in the pandemic response, such as Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), Queensland Police Service (QPS), Aboriginal and Torres Strait Islander Shire Councils etc. to support the provision of care to the community. Where data sharing arrangements were established between the HHS and other organisations (as evidenced in Yarrabah, Woorabinda, and Cherbourg), a more streamlined and coordinated approach to patient care and safety was evidenced. This included A&TSICCHOs and councils being able to access information to be able to deliver welfare packs and undertake welfare checks with people who were isolating.

- xiii. There was a general lack of coordination and understanding of resource sharing between agencies, such as Queensland Health and Hospital and Health Services (HHS) with other government departments or Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs). Queensland Health policy generally outlined that certain resources would not be distributed (e.g., Rapid Antigen Tests (RAT) and Personal Protective Equipment (PPE) to organisations outside of Queensland Health or the HHS, however HHSs often made local arrangements with their A&TSICCHOs and provided some resources. Where this occurred it was appreciated, however the different approaches across HHSs caused some confusion. Individual Local and District Disaster Management Group areas and agencies in some cases had different arrangements for the access of state agency housing and other resources and these different processes often caused confusion and delays in access.
- xiv. The Queensland Department of Health, First Nations COVID-19 Response Team initiated and coordinated meetings between Hospital and Health Services (HHSs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), and other relevant agencies, some of which had never collectively built ongoing engagement mechanisms previously, and provided a level of Departmental policy and clinical support to First Nations HHS leads, A&TSICCHOs and HHS COVID-19 response teams that hadn't been experienced before. This additional coordination and support was generally well received, particularly regarding outbreak management, vaccination support and resourcing, however not all stakeholders understood the role of the Team, how they fit in the disaster management or business as usual structures, what they required from the HHSs or A&TSICCHOs, or what support they could provide. The Team was not always well linked into the Queensland Health disaster management arrangements (i.e., with the State Health Emergency Coordination Centre (SHECC).
- xv. Queensland Department of Health and Queensland Aboriginal and Islander Health Council (QAIHC) initially worked closely for the development of the [Make the Choice](#) vaccination campaign. Queensland Health provided funding and support to develop the concept, marketing materials, distribution, and advertising, however as the campaign was nearing release, there appeared to be differing opinions and goals on the campaign as QAIHC were less engaged with its release and ongoing engagement. Whilst the campaign was identified as a success and Queensland Health continued the rollout, this breakdown had an impact on the ongoing rollout and potentially the overall success that could have been seen with this branding.

Alignment with the Queensland Disaster Management Arrangements

- xvi. The Queensland Disaster Management Arrangements (QDMA) was a well trusted and established framework for the multi-agency coordinated response required for the COVID-19 pandemic response. The QDMA places local government as the lead for their communities, enabling a community-led and informed response, supported by the other agencies of the QDMA. Local Disaster Management Plans, whilst not pandemic-specific, provided well-tested plans to enact a coordinated response. What impacted this response was that it was more of a top-down approach, rather than the traditional bottom up, meaning Local Disaster Management Groups (LDMGs) were enacting policy provided from above, rather than being able to inform requirements from community. Where there were strong relationships across Local Disaster Management Groups and District Disaster Management Groups (DDMGs) a more coordinated and community-focused response was evidenced.
- xvii. Queensland Health (both in the Hospital and Health Services and Department of Health) generally struggled to understand their Lead Agency role in the Queensland Disaster Management Arrangements. This then had downstream impacts on their engagement and collaboration with Local and District Disaster Management Groups, and trust-building and relationships with the other agencies.
- xviii. Not all representatives of the health system (e.g., Primary Health Networks (PHNs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), Aged Care etc.) are represented on all Local or District Disaster Management Groups (LDMGs/DDMGs). This has led to a poor understanding of this greater health system and the role that Queensland Health and the Hospital and Health Services play as the only health system representative, their requirement and/or ability to coordinate the whole of health system representation, and that they cannot represent on behalf of the other organisations without authority being provided to them. Where representation of the greater health system (e.g., PHNs and A&TSICCHOs) existed on LDMGs and DDMGs there was greater sharing of information and coordination of response.

Community Engagement and Communications

- xix. Much of the communications and related messaging developed centrally by Queensland Health was generally focused on metro areas (and in particular the context of South East Queensland) but expected to be used for all of Queensland. This centralised messaging was often out of sync with other areas of Queensland and therefore not relevant at the time of distribution, and the conventional communication strategies and the content was not (and was not always allowed to be) contextualised for regional or remote areas or take into consideration the context of Aboriginal and Torres Strait Islander culture, family dynamics, local resources and infrastructure, and consumption of information. There were significant delays in providing Aboriginal and Torres Strait Islander targeted messaging (e.g., the Make the Choice vaccination campaign was not released until August 2021, when the vaccine had been available since March 2021). When Hospital and Health Services and Aboriginal and Torres Strait Islander Community Controlled Health Organisations were able to develop and deliver community-informed

messaging, taking into account the needs of individual communities and locations, the messaging was better understood and applied.

- xx. Community engagement, rather than conventional communications, was key to sharing information and engaging with Aboriginal and Torres Strait Islander communities. Building relationships with communities through yarning, utilising Aboriginal and Torres Strait Islander staff, engaging local leaders to be community champions, employing local and trusted faces as spokespeople in marketing and videos, and the community engagement shown by the [Johnathan Thurston \(JT\) Academy](#), and supported clinically by Queensland Health, showed increased community engagement and uptake with vaccination, testing and integration with health services. The use of famous identities as a drawcard, supported by trusted health professionals providing advice and personal stories, increased community engagement and uptake of the COVID-19 vaccination.

Biosecurity Arrangements and Public Health Directions

- xxi. That the local leadership (Mayors) of the remote Aboriginal and Torres Strait Islander communities (Aboriginal Shire Council areas) were involved in the discussions and decisions to enact the Federal Government-designated biosecurity area restrictions was appreciated by the mayors and their communities. The local government elections that occurred mid-way through the restrictions had impacts on the subsequent level of support as there were a number of new mayors elected who had not been involved in the decision-making process.
- xxii. The true impacts of the Federal Government-designated biosecurity area restrictions, and later Queensland Government Public Health Directions, had not been fully considered prior to their implementation. They were enacted quickly, with little warning, and many people from the impacted communities were stuck outside of their area, requiring accommodation and quarantine support, that had not been pre-planned or well understood. There was little understanding initially of how to operationalise the legislation and the restrictions impacted supply chain, services, staff movements and community support by organisations that relied on 'fly-in, fly-out' workforces. The restrictions were experienced differently by various communities, but it was frequently expressed that in relation to exemptions, there was 'one rule for white workers, and another rule for members of the community'. Where communities were generally self-sufficient (e.g., Northern Peninsula Area and Torres Strait) the restrictions were well accepted and tolerated by communities. These communities generally appreciated the restrictions as they felt more protected and wanted to reimplement a level of restriction in the face of the Omicron strain outbreak. Where communities did not have their own stores/supply chains/medical services etc. and relied on neighbouring towns that weren't included in the biosecurity area (e.g., Cherbourg, Woorabinda and Yarrabah), there were significant difficulties experienced. These communities held concerns that restrictions would be reimposed in the face of subsequent outbreaks and were generally not supportive of this.

Agency-Specific Arrangements

- xxiii. The establishment of the daily/regular meetings of the Mayors of the remote Aboriginal and Torres Strait Islander communities, led by the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP), and supported by Queensland Department of Health was well received by the communities as it enabled regular information sharing, discussion and decision-making to occur. There were concerns raised that the meeting was led by DSDSATSIP rather than Queensland Health, as the lead agency, and that the Hospital and Health Services (HHS) who are the representatives at Local and District Disaster Management Groups were not included. The HHSs regularly felt that they were missing what information was being shared and therefore weren't 'on the same page' as the Department of Health which impacted local relationships and the trust between councils and the HHSs.
- xxiv. The Hospital and Health Services (HHSs) were often not provided with early (or any) notification of what might be announced at the daily Press Briefing by the Chief Health Officer, with announcements coming as a surprise and the HHSs then having to respond to what had been announced to the public at the same time. This included announcements such as the implementation of the Federal Government biosecurity area restrictions, changes to policy and Health Directions, borders etc. It subsequently eroded some of the trust the HHSs had built with agencies of the Local and District Disaster Management Groups and had them 'on the back foot' regarding planning and response operations having to occur with little to no notice.
- xxv. Like the Hospital and Health Services (HHSs), each Public Health Unit (PHU) operated differently within the pandemic response. There was not always strong integration with the PHU and the HHS COVID-19 response capability and where this didn't exist there appeared to be some erosion of trust between the areas, duplication of work, and different approaches to the same communities. Where a Hospital and Health Service did not have their own Public Health Unit, there were resourcing difficulties as they relied on other, already busy, PHUs to assist with their workload (e.g., North West HHS relied on Townsville PHU, and Torres and Cape relied on Cairns PHU, but eventually established their own).

Vaccination Rollout

- xxvi. The vaccination rollout to Aboriginal and Torres Strait Islander people was significantly impacted by the change in policy and messaging around the AstraZeneca (Oxford) COVID-19 vaccine. The rollout of AstraZeneca commenced in March 2021 but was halted in April 2021 due to the reported risks of incidence of blood clots and deaths from the vaccine and the change in policy for it only to be used for people over the age of 60 years. Delays to the vaccine rollout to Aboriginal and Torres Strait Islander communities was a result of the change in processes that had to be undertaken to provide supply chain of the Pfizer (Comirnaty) COVID-19 vaccine to Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) and First Nations people in regional and remote areas. Increased media coverage also increased the vaccine hesitancy in communities and there was a noticeable distrust in other vaccines after the messaging surrounding AstraZeneca. Rollout of the Pfizer vaccine to regional and remote areas didn't gain

momentum until the last quarter of 2021, and it wasn't until Public Health Direction and policy changes were introduced (e.g., 'no jab no play') that the vaccination rates in Aboriginal and Torres Strait Islander people increased significantly. The outbreaks in early 2022, the concerted effort to increase vaccination rates through contextualised community rollout, and provision of incentives (such as the Make the Choice campaign collateral) also saw an increase in vaccination rates.

- xxvii. Data accuracy of the vaccine rate and rollout was a consistent problem. Issues were raised with the accuracy of the baseline population data used, capturing of vaccinations recorded in the Australian Immunisation Register (AIR), versus the Queensland COVID-19 Vaccine Management System (QCVMS), what had been administered through Queensland Health clinics versus private providers (e.g., pharmacies, General Practitioner clinics, Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) etc.). It was noted that the demand for data, and workload associated, often impacted the operationalisation of the vaccine rollout. In Aboriginal and Torres Strait Islander communities, the baseline data often did not reflect the current population and therefore reporting was inaccurate.

Patient Care and Safety

- xxviii. The increase in availability of virtual care models and telehealth was well received, particularly by rural and remote communities who would otherwise have to leave community and travel large distances to access specialised health care. Localised Virtual Care models for COVID-19 positive patients, such as introduced by Torres and Cape and Central Queensland Hospital and Health Services (HHSS), to service their communities, provided culturally appropriate healthcare and education delivery. Using local and First Nations staff, having an opt-out model where every Aboriginal and Torres Strait Islander person who tested positive was contacted, being able to provide care on country, and being able to assess everyone to determine if they met the criteria for anti-viral treatment, allowed for comprehensive and safe care. The state-led opt-in model was generally believed to be unsuitable for Aboriginal and Torres Strait Islander people as initially it did not capture Aboriginal and Torres Strait Islander identification, was opt-in rather than opt-out, and the thresholds did not accurately meet the risk profiles and requirements of Aboriginal and Torres Strait Islander needs.
- xxix. With the efforts of the health system being largely focused on the response to the COVID-19 pandemic since early 2020, the care of other diseases has reduced significantly in many areas. As resources were diverted to the pandemic response, many business-as-usual functions were reduced across both Hospital and Health Services (HHS) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs). These changes have seen a reduction in childhood immunisation rates, increases in chronic disease progression, and increases in otherwise preventable diseases such as sexually transmitted infections (STIs) due to reduced testing and education.

Lessons Identified

First Nations Leadership

- A. Aboriginal and Torres Strait Islander integration at the Hospital and Health Service and Department of Health executive leadership levels is essential to ensure representation and advocacy for the Aboriginal and Torres Strait Islander workforce and the communities they serve. Where this already occurs it should be maintained, and where it does not it should be implemented and strengthened.

Consideration and Integration of First Nations Perspective

- B. Health delivery, across all facets of disease and health care, to Aboriginal and Torres Strait Islander communities should be co-designed to ensure it meets the needs of the people it is serving. Co-design should occur across the Hospital and Health Service (HHS), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), other relevant services within the community (such as Aboriginal and Torres Shire Councils), and with key community members.

Role of First Nations Staff

- C. The Aboriginal and Torres Strait Islander Health Worker and Health Practitioner workforce requires a review to align and standardise across the Hospital and Health Services (HHSs) their scope of practice (including maintaining the capability to undertake vaccinations, in extension to the Pandemic Emergency Order), clinical governance, remuneration, and engagement with and integration into the rest of the health system workforce.

Health Service Integration with other Agencies

- D. The Queensland Department of Health and Hospital and Health Services (HHSs) should continue to engage with the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) in their areas to further build relationships and understand the capacity and capability of the different organisations. Through this collaboration, service delivery to community should be co-designed, as outlined in Lesson Identified B.

Alignment with the Queensland Disaster Management Arrangements

- E. That Hospital and Health Services (HHSs) should continue to build and maintain relationships with their Local and District Disaster Management Groups (LDMGs/DDMGs). Discussions should be had with these groups to consider and advocate for how other representatives from the health system (e.g., Primary Health Networks (PHNs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), Aged Care etc.) can be represented on the relevant groups.

Community Engagement and Communications

- F. Community engagement and communications should be enabled to be developed locally so they can be contextualised to suit the needs of the community. Where state-wide messaging is required, guidelines should be developed for messaging and communications, and support provided to local Hospital and Health Services (HHSs) and other organisations to develop localised messaging that is in line with the guidelines but still suit the needs of the community, particularly for Aboriginal and Torres Strait Islander people. Further work should be undertaken to understand and integrate the power of community engagement, rather than just conventional communication methods.

Biosecurity Arrangements and Public Health Directions

- G. Further review of the implementation and operationalisation of the Federal Government-designated biosecurity area restrictions and Queensland Government Health Directions to remote Aboriginal and Torres Strait Islander communities should be undertaken to inform planning for future occurrences where restrictions such as these may be required. Consideration of supply chain, access to health care, education and other services (in and out of community) and the process of exemptions (including for community members), quarantine and cultural safety should be included.

Agency-Specific Arrangements

- H. Where meetings are held by Queensland Department of Health to share information with local government or agencies that may interact with the health system, consideration should be made to extend the invitation to the relevant Hospital and Health Services (HHSs) to ensure that there is consistent messaging across the levels of the health system. Consideration should also be given to providing HHSs with advanced notification of significant changes to policy or events that will impact their planning and response requirements before it is provided to the public.

Vaccination Rollout

See Lesson Identified B. in [Consideration and Integration of First Nations Perspective](#) and Lesson Identified F. in [Community Engagement and Communications](#)

Patient Care and Safety

- I. The continued availability of telehealth and Virtual Care models for other diseases and medical requirements should be explored to enable Hospital and Health Services (HHSs) to continue to provide culturally appropriate and safe, specialised, care to Aboriginal and Torres Strait Islander people in their communities, reducing the requirement for them to travel off country, reducing the burden on the HHS and travel system, and increasing the accessibility of specialised health care to Aboriginal and Torres Strait Islander people.



*A Torres Strait Islander man gets his COVID-19 Vaccination.
(Source: QH Asset Library)*

Analysis Methodology

The approach to debriefing was conducted utilising "Story Telling or Facilitated Learning" as an effective way to share the learning regarding the response. Stories are effective educational tools because listeners become engaged and therefore remember. Listening to a storyteller can create lasting personal connections, promote innovative problem solving, and foster a shared understanding regarding experiences. A survey was also provided to participants who were unable to participate in a face-to-face session, and to others to broaden the scope.

The total outreach of the process captured more than 80 personnel, across six Hospital and Health Services, and more than 24 Aboriginal Community Controlled Health Organisations, other agencies and Government Departments. 1,309 observations were collected.

The analysis of the data collected was in line with in the [Queensland Health Lessons Management Guide](#)³, [Queensland Disaster Management Lessons Management Framework](#)⁴ and National Handbook of [Lessons Management](#)⁵, taking the approach of:

³ Queensland Health (2019). Lessons Management Guide

⁴ Inspector General Emergency Management (IGEM) Queensland (2020). Queensland Disaster Management Lessons Framework

⁵ Australian Institute of Disaster Resilience (AIDR) (2019). Lessons Management

Collecting Observations

In the context of an evaluation, it is the evidence or data collected by an evaluator, that is, what is seen or discovered (observed) during the evaluation. Observations can be of good practices to be sustained, or opportunities for improvement. An observation conveys the basic details of the observed issue and contains information sufficient for further analysis. It is constructed as the result of interviewing or examining a source (for example a survey, questionnaire or post operations report), and takes the form of a paragraph that contains an informative comment that can be coded and categorised with other like observations. During this process observations have been collected through a combination of individual and group interviews, survey responses and written submissions. The focus of the debrief process included what worked well, what needed improvement, and enabling factors and barriers, from the perspective of the participants.

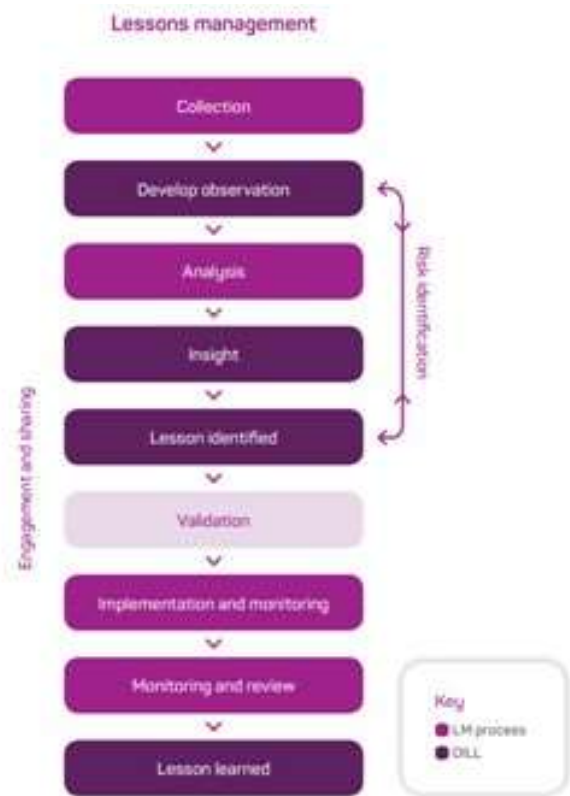


Figure 1: Elements of a Lessons Management Process

Developing Insights

An Insight is a deduction drawn from the observations collected, which needs to be further considered. Insights provide guidance for future analysis and potential action. Insights can be positive or negative and can contribute to reinforcing positive behaviour or changing practices. Insights occur when there are multiple observations (pieces of evidence), which are similarly themed. As a general rule, a minimum of three observations (from multiple sources) should be used as the basis for an insight, although an insight may be developed when a single observation poses a high risk to the organisation. Insights may also identify an opportunity for further analysis. Insights can be positive or negative and can contribute to reinforcing positive behaviour or changing practices. An insight defines the issue, not the solution. It is apparent from the mapping of the outcomes of the report, that a group of insights leads to a lesson identified.

Developing Lessons Identified

A Lesson Identified is a mature deduction based on the analysis of one or more insights/observations that can either sustain a positive action or address an area for improvement.

A ‘lesson identified’ is distinguishable from a ‘lesson learned’ in that it only has the potential to add value and needs to be communicated and implemented for any benefit to be derived from it.

Lessons Learned: A lesson is only learned once the approved change is implemented and embedded in the organisation. Depending on the changes required, it may take several years for the change to be institutionalised across the organisation. A full iteration of a lessons learned cycle would involve the identification of a lesson; an action proposed and agreed, the solution implemented and then tested/validated to ensure the change is an improvement and the desired behaviour is sustained across the organisation. This review does not include Lessons Learned as the Lessons Identified have not yet been through the full lessons cycle.

Scope of the Review

The debrief process was assigned a broad scope looking at the First Nations COVID-19 response by Queensland Health and a selected sample of the Hospital and Health Services (HHSs). The review also looked at the health service integration with Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP), specifically Aboriginal and Torres Strait Islander Partnerships; Local Disaster Management Groups (LDMGs) and District Disaster Management Groups (DDMGs) through the Queensland Disaster Management Arrangements (QDMA); and with the Queensland Aboriginal and Islander Health Council (QAIHC) COVID-19 response and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs).

The Aim, Terms of Reference and Scope of the review can be found at [Annexure 1](#).



Nurse in community doing vaccinations. (Source: QH Asset Library)

Data Mapping

Data mapping is provided throughout this report to ensure that the review considered all the data collected throughout the process to provide the best evidenced-based outcomes. These maps show the density of sources of data collected (de-identified) for the Focus Areas, along with how this data was categorised as per the National Handbook standard.

When reading the mapping throughout the report, the data is categorised in two broad themes, these are:

- **Sustain** – Observations that led to positive outcomes and should be continued in the future. This includes factors that enabled success.
- **Improve** – Observations which suggest things that did not go so well and could be improved in the future. This includes barriers to success.

Each observation has been themed into the 10 Focus Areas identified in this report, and coded against the P²OST²E Elements of Capability, and National Themes 1 and 2⁶. Further information about these elements can be found at [Annexure 2](#).

The figures below show the data maps for the review.

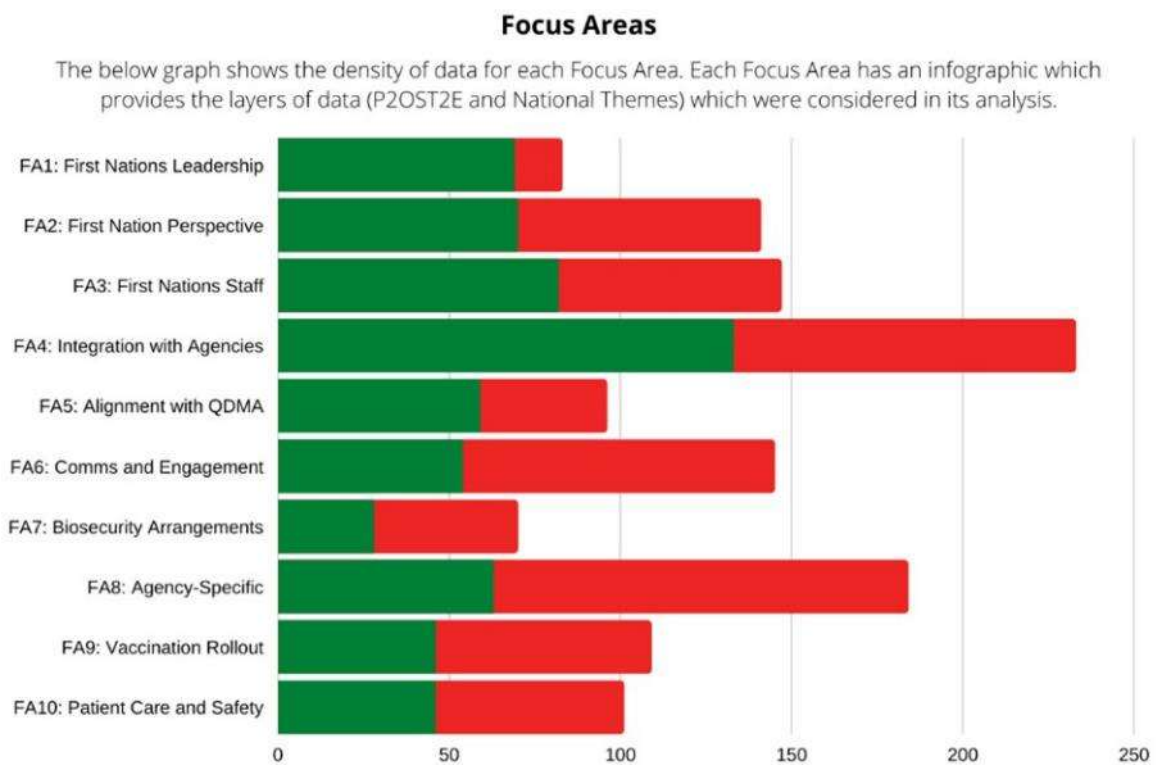


Figure 2: Breakdown of all data by Focus Area

⁶ AIDR (2019). Lessons Management p. 27

P2OST2E

The P2OST2E graph shows the data analysed against the fundamental inputs to capability.

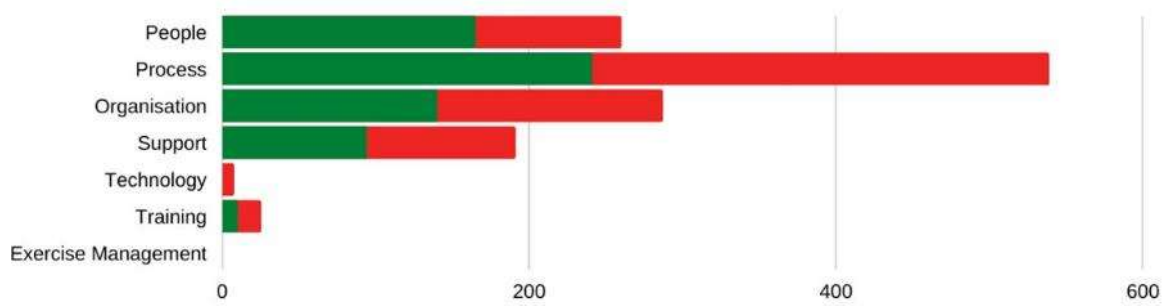


Figure 3: Breakdown of all data by P2OST2E Elements of Capability

National Level 1 Themes

The National Level 1 graph shows the data analysed against the National Level 1 Themes.

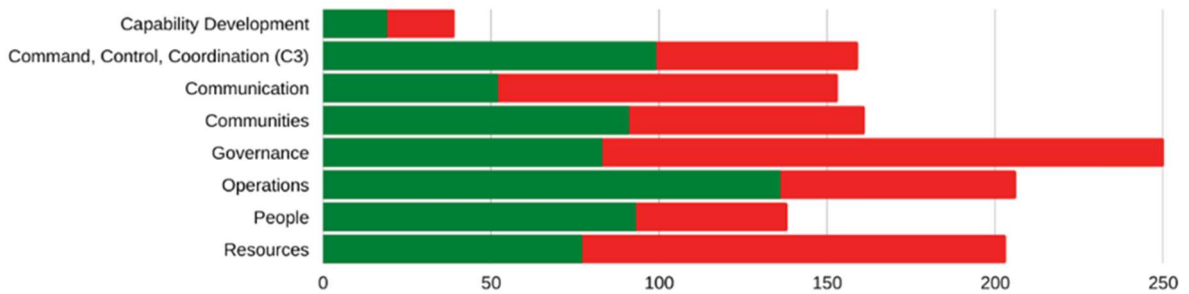


Figure 4: Breakdown of all data by National Level 1 Themes

National Level 2

The National Level 2 graph shows the data analysed against the National Level 2 Themes.

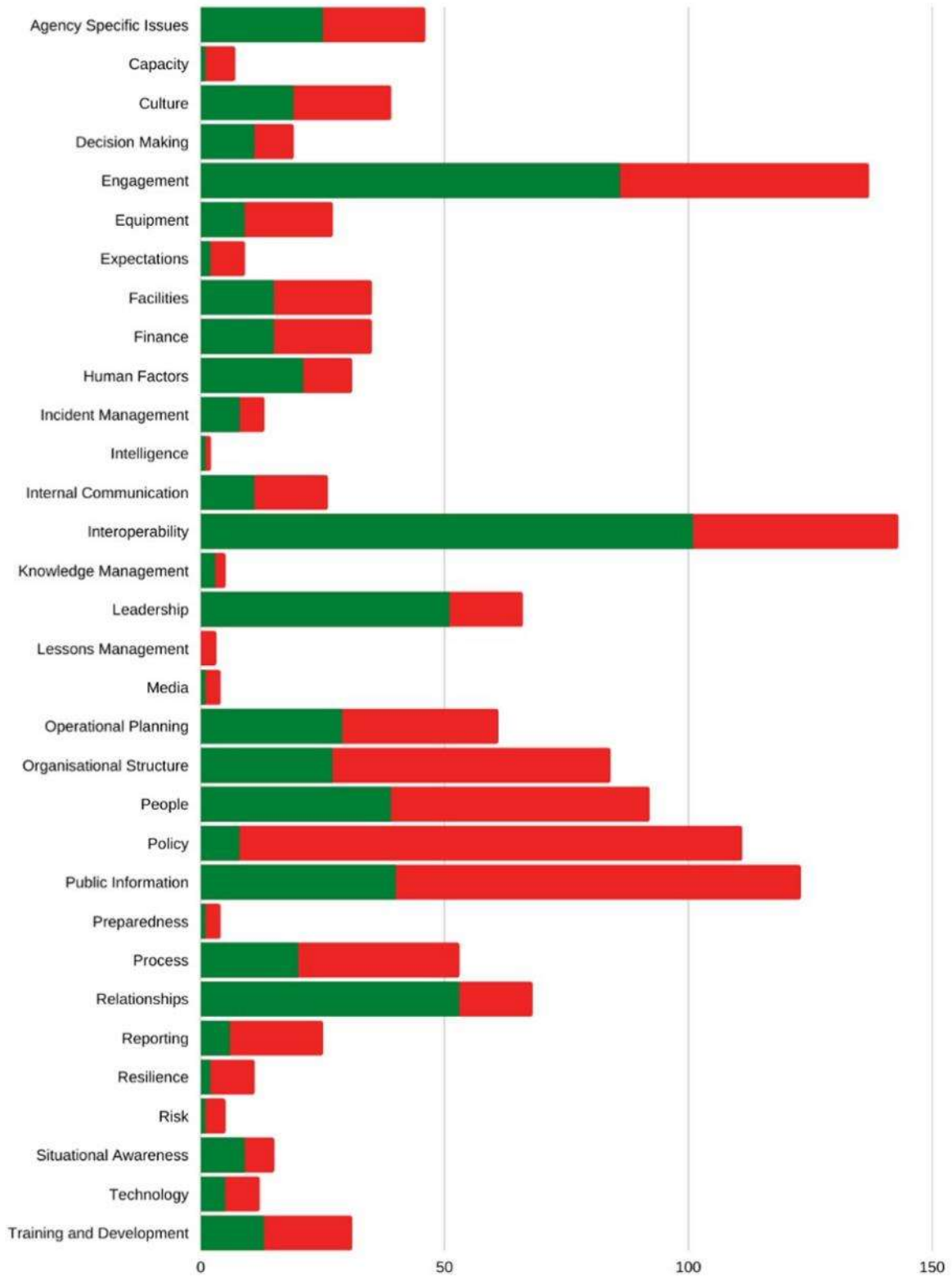


Figure 5: Breakdown of all data by National Level 2 Themes

Chronology of COVID-19 – A Story Through the First Nations Perspective

2019

In December 2019, the first human case of COVID-19 was identified in Wuhan, China.

2020

Within a few weeks, on 25 January 2020, the first cases were recorded in Australia (one in Victoria and three in New South Wales). The virus spread to Queensland where a Public Health emergency was declared on 29 January, the same date as the state's first confirmed case. The World Health Organization (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern the following day (30 January).

On 1 February, limits on international travel began with restrictions placed on people travelling to Australia from China. On 6 February, Queensland legislation was strengthened by the *Public Health (Declared Public Health Emergencies) Amendment Bill 2020*, and later that month Australia activated its emergency plan (29 February). During February, in the Northern Territory, Land Councils began producing health messages in Aboriginal Languages to ensure communities received clear, accurate health messaging regarding COVID-19.

In early March, the National Aboriginal Community Controlled Health Organisation (NACCHO) convened the COVID-19 Aboriginal and Torres Strait Islander Advisory Group, to develop and deliver a National Management Plan to protect communities. Around the same time, First Nations communities across Australia began self-initiated border closures, first the Anangu Pitjanjatjara Yankunytjartjara (South Australia), then Cape York (Queensland) and then Aboriginal communities in Western Australia. These closures were community-led decisions which were aimed at protecting the community, and more specifically the Elders in the community who are a natural resource and keepers of the culture, lore, and wisdom for their Nation.

On 1 March, approximately 2.5 months after COVID-19 was first identified in China, the first Australian death due to COVID-19 within our country occurred in Perth, Western Australia. Ten days later (11 March) the World Health Organisation declared the COVID-19 outbreak a pandemic. On 13 March, a Torres Strait Islander was the first Australian First Nations person to be diagnosed with COVID-19. Queensland recorded the state's first death from COVID-19 on 25 March. Five months later, in August 2020, an Aboriginal person in New South Wales became the first Aboriginal or Torres Strait Islander person in Australia to die from the COVID-19 virus.

The Queensland Department of Health's, Aboriginal and Torres Strait Islander Health Division developed and activated the First Nations COVID-19 Response Team in March 2020 when the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General identified that the pandemic would present unique challenges for First Nations people and require a specialised approach.

During March 2020, travel restrictions increased to prevent further cases of COVID-19 being brought into the country. From 16 March 2020, people arriving in Australia were required to self-isolate and Australians were banned from international travel. Shortly afterwards on 20 March 2020, Australian borders were closed to all non-citizens and non-residents. In Queensland, power was given directly to the Chief Health Officer (rather than the Minister for Health and Minister for Ambulance Services on behalf of the Cabinet) to make 'Directions', amongst other things, allowing them to declare restrictions on movement, gatherings, and business activities, to set social distancing or masking requirements, and to close borders.

From 22 March 2020 the Queensland Government stopped all non-essential travel to remote communities on Cape York and in the Torres Strait and introduced 14-day quarantine periods prior to travel into these locations when required. Six days later (28th March) these restrictions were extended to First Nations communities across the state following the new requirements issued by the Australian Government under the *Biosecurity Act 2015* (Commonwealth). On 23 March 2020, Queensland introduced Stage 1 of Restricted Entry into Queensland, with only Queensland residents and those considered an 'exempt person' being allowed to enter Queensland, at the same time lockdowns commenced across Australia and included business closures, density limits and restrictions on gatherings. State schools became student-free with students working from home under parent supervision. Whilst effective in protecting the physical health of First Nations peoples and communities, these restrictions impacted on engagement in cultural activities such as sorry business and connecting to family who moved off country for study or work in the usual way. March ended with the publication of the Management Plan for Aboriginal and Torres Strait Islander Health by the Commonwealth Department of Health (31 March 2020).

In April 2020, Queensland Government strengthened the state border restrictions with every person crossing the border, including Queensland residents, requiring a permit. In addition, people who had been in a declared COVID-19 hotspot in the previous 14 days had to self-quarantine for 14 days. Online education within the home for school age students was extended until mid-term (22 May 2020) with schools and day care providers only open for children of essential workers.

Restrictions began to gradually ease in May 2020 allowing travel for recreation purposes. These restrictions eased further in June 2020. From 1 June 2020 Queenslanders were able to enjoy unrestricted travel throughout the state, and people could dine-in at restaurants and cafes, attend a gym, cinema, library, museum, art gallery, or place of worship. On 12 June 2020, remote communities were removed from the Biosecurity Determination and state-based arrangements commenced. This was followed by increasing allowance to 100 attendees at funerals and increasing visitor allowance at nursing homes to two visitors, including children. These changes increased opportunities for communities to resume and engage in face-to-face cultural practices and reconnect with kin who do not reside the same geographical location. State border closures still impacted on kinship and community connections for those living off country in another state.

On 10 July 2020, the Queensland border opened but closed again on 1 August 2020, this time to people in designated hotspots, which was later extended to all New South Wales and Australian Capital Territory on 8 August 2020. On 22 August 2020 restrictions came into place again for Queensland, the toughest restrictions in Greater Brisbane Region, to combat an outbreak of the COVID-19 virus. The increased restrictions were reduced gradually between 25 September and 17 November 2020. Meanwhile, elsewhere in the world the Delta variant of COVID-19 was emerging in India. It was identified as being more transmissible than the original COVID-19 strain and within six months would become the dominant version of the virus worldwide.

Between 1 December and 12 December 2020, Queensland border restrictions eased allowing travel between Victoria, Greater Sydney, New Zealand, and South Australia. On 20 December, the Queensland border was re-closed to New South Wales hotspots. By the end of the year 1,253 people in Queensland had been diagnosed with COVID-19; of these 10 were identified as Aboriginal or Torres Strait Islander people. Across the state six people had died due to COVID-19, none of whom were identified as Australian First Nations peoples.

2021

Intermittent periods of increased restrictions and localised lockdowns occurred throughout 2021 in response to increases in case numbers. This began in January with a three-day lockdown of greater Brisbane from 8 January 2021 and a resumption of increased restrictions across the state including mask-wearing and gathering limits to manage localised outbreaks of the COVID-19 virus. By the end of January 2021, the Therapeutic Goods Administration (TGA) had provisionally approved the Pfizer (Comirnaty) COVID-19 vaccine for use in Australia for people aged 18 years and over.

On 1 February 2021, Queensland reopened its borders to New South Wales. In February 2021, the first batch of Pfizer arrived in Australia and the Therapeutic Goods Administration provisionally approved the AstraZeneca (Oxford) vaccine. On 22 February the first dose of Pfizer vaccine was given in Queensland (Gold Coast).

Phase 1A of the vaccination rollout began on 8 March 2021. Phase 1B commenced on 22 March 2021 and included Aboriginal and Torres Strait Islander people over the age of 55 years as a vaccination priority group. The broader Indigenous population became eligible on 8 June 2021.

As Australia started vaccinations for COVID-19, our neighbouring country New Zealand began experiencing an increase in COVID-19 cases and was removed as a 'safe travel country' for Queenslanders, this international border closed for a month and reopened on 20 March 2021. Increased case numbers were experienced in Brisbane which resulted in a three-day lockdown of the greater Brisbane area from 29 March.

On 9 April 2021 changes to vaccine recommendations occurred, with AstraZeneca no longer recommended for people aged 50 years or younger. From 23 April 2021, Queensland closed its border to Western Australia hotspots. A month later the border was closed to Victoria on 28 May. On 29 June South East Queensland, Townsville (including Magnetic Island and Palm Island) entered a three-day lockdown.

By the end of June 2021, the number of Aboriginal or Torres Strait Islander people in Queensland diagnosed with COVID-19 reached 14. An increase of four cases since 31 December 2020. Fortunately, there had been no First Nations deaths due to COVID-19. Across Queensland the total number of people diagnosed with COVID-19 reached 1,696. An increase of 443 cases since 31 December 2020. Seven people had died from COVID-19 an increase of one death since 31 December 2020.

In July 2020 Queenslanders again become more isolated from other states as the borders were closed again: to Victoria from 16 July, South Australia from 21 July and New South Wales from 23 July. The month ended with South East Queensland entering a seven-day lockdown on 31 July.



Three First Nations people showing off their vaccinations (Source: QH Asset Library)

On 8 August 2021, the towns of Cairns and Yarrabah began three-day lockdowns as a case was identified in Cairns. As this localised lockdown period ended, the state border reopened to South Australia. Restrictions increased again in South East Queensland on 30 September in response to increased localised case numbers. These localised restrictions eased again on 8 October. Tragically, during this period, on 25 August 2021 an Aboriginal person in New South Wales became the first Aboriginal or Torres Strait Islander person in Australia to die from COVID-19.

In November 2021, the TGA approved COVID-19 self-tests (home use, Rapid Antigen Tests (RAT)) for supply in Australia. In Queensland 70% of people aged 16+ had been fully vaccinated (two vaccine doses). In South Africa, the Omicron Variant of COVID-19 was identified. This variant was thought to be more infectious, and the severity of symptoms associated with Omicron at this time was still unknown, but early reports indicated a mild disease, at least in the younger population. Also, in November, El Salvador became the first country to remove testing requirements for entry to the country.

Queensland identified two Omicron cases on 8 December 2021. On 13 December, Queensland borders opened to New South Wales and Victoria (with some restrictions in place e.g., vaccination requirements). Masks become mandatory across the entire state in many public and outdoor places. On 17 December mandatory vaccine requirements came into effect for some venues (e.g., hospitality). By the end of 2021, 552 Aboriginal and Torres Strait Islander people in Queensland had been diagnosed with COVID-19, an increase of 548 cases in 6 months, many of which occurred in December. The total number of people in Queensland diagnosed with COVID-19 reached 13,863 cases. An increase of 12,167 cases since 30 June 2021, many of which occurred in December upon opening of the borders. There had been no additional deaths from COVID-19 in Queensland in the past 6 months. 86.37% of people in Queensland aged 16+ were fully vaccinated (two vaccine doses).

2022

2022 began similarly to 2021 with an increase in restrictions across the state of Queensland from 2 January. However, these restrictions were quickly eased beginning with removal of all domestic border requirements (e.g., vaccination requirement) on 15 January. On 22 January, the Queensland Government updated vaccination advice recommending a booster (3rd dose) for Queenslanders aged 16 years and older who had their second vaccination dose 3+ months ago. A second booster (4th dose) was also recommended for people aged 65 years or older, residents of aged care or disability care facilities and Aboriginal or Torres Strait Islander people aged 50 years or older and have received their first booster 17+ weeks ago.

As local restrictions eased, so too did those for international travellers, and from 22 January 2022 the 14-day hotel-based quarantine requirements were ceased for vaccinated international travellers. Sadly, during this month, on 7 January 2022 an Aboriginal person became the first Aboriginal or Torres Strait Islander person in Queensland whose death was due to COVID-19.

By the end of March 2022, 91.7% of Queensland people aged 16+ had been fully vaccinated. The number of Aboriginal or Torres Strait Islander people in Queensland diagnosed with COVID-19 reached 25,700 cases, an increase of 25,138 cases in 3 months. Tragically, 30 Aboriginal or Torres Strait Islander people had died from COVID-19 in the first three months of 2022. The number of Queensland people diagnosed with COVID-19 reached 758,000 cases, an increase of 744,173 cases in three months. Of these, 727 people in Queensland have died with COVID-19 an increase of 720 deaths in three months.

From 14 April 2022, vaccination requirements to enter venues such as restaurants, pubs, and cinemas were ceased, enabling people who were unvaccinated for any reason to be able to socialise and interact with families and friends in public settings. Between April and May 2022, the world began to open again, with countries reducing travel restrictions on travel, Brazil removed the requirement of having a negative COVID-19 test to enter the country. While Iceland, Ireland and Norway ceased vaccination requirements to enter the countries.

On 9 May 2022, people in Queensland who are a close contact are no longer required to quarantine when non-symptomatic, however they are required to always wear a mask when outside the home and some restrictions apply. The requirements for unvaccinated travellers to home-quarantine for seven days was removed. From 26 May all Queenslanders over six months of age were being offered free flu vaccination due to the increased incidence of influenza in the community.

As of the end of June 2022, the health system is transitioning into a 'new normal', recovering from the impacts that the COVID-19 pandemic has had on the system, whilst planning how COVID-19 will be managed moving forwards.

A further timeline can be found at [Annexure 3](#).

Focus Area 1: First Nations Leadership

Leadership for Aboriginal and Torres Strait Islander people, by Aboriginal and Torres Strait Islander people, was a strong theme identified throughout the review process. This leadership was present in community, through formal positions such as Aboriginal and Torres Strait Shire Councils and Mayors, Elders and Leadership Forums, to informal leadership from members of the community and people stepping up to support mob. In the health system, leadership was shown by many Aboriginal and Torres Strait Islander staff, from formal positions as members of executive teams, to Health Workers on the ground in community. Aboriginal and Torres Strait Islander leadership was respected and valued by community, and where the Aboriginal and Torres Strait Islander voice was integrated into the response to the COVID-19 pandemic, outcomes such as better relationships, increased community engagement and compliance, and increased interaction with the health system was seen.

Where the Aboriginal and Torres Strait Islander leadership voice was not as strong, there appeared to be more of a disconnect between community and the health system.



*An Elder receiving his COVID-19 vaccine
(Source: QH Asset Library)*

Observations and Analysis

There were 83 observations related directly to the focus area of First Nations Leadership. Of these observations, there were 69 **Sustain**, and 14 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

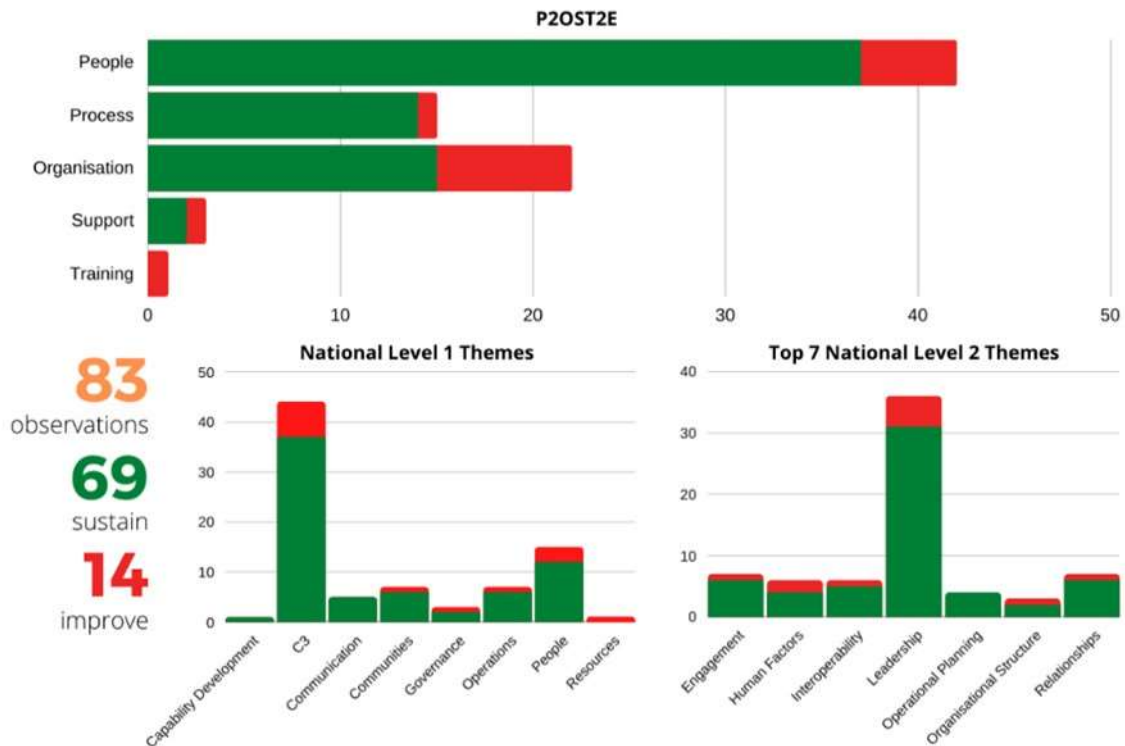


Figure 6: Breakdown of data for Focus Area 1

What worked well

- Having the Mayors and other First Nations leaders on board with vaccination gave the community a greater confidence and saw an increase in vaccination rates in those communities.
- There was good overall leadership by Councils and their Mayors.
- There was generally strong leadership shown by Mayors, particularly in deciding to close communities through the Biosecurity arrangements and managing the consequences of the same.
- Mayors of the discrete communities had a big influence over their communities, and this was leveraged and well used.
- The Yarrabah Leadership Forum worked very much as a team and with a culture of respect and teamwork and provided leadership to the Local Disaster Management Group (LDMG), Council and community.
- The response to COVID-19 has significantly built and improved the relationships between some Hospital and Health Services and the Mayors of the First Nations communities. Robust and open conversations can be had and there is mostly respect and trust from both sides.
- Early networks and relationships were established between Queensland Department of Health and the Mayors of the discrete communities through regular meetings. This provided opportunity for the Mayors to engage with Queensland Health, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP) and State Ministers on a regular basis.
- The standing up of the Queensland Department of Health, Aboriginal and Torres Strait Islander Health Division First Nations COVID-19 Response in March 2020 when the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General

identified that the pandemic would present unique challenges for First Nations people and require a specialised approach was a good decision.

- The inclusion of the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General in the Queensland Health executive team ensured that First Nations health was integrated into the pandemic response from the highest levels.
- There was strong First Nations leadership shown at Darling Downs Hospital and Health Service, and this leadership was supported and enabled by the HHS.
- Children's Health Queensland had First Nations leadership present in the Executive Leadership Team, who met daily during the response as the Incident Management Team (IMT), so there was a First Nations voice at the executive table and issues were raised and integrated as equally as other portfolios.
- The leadership of the local Aboriginal Health Worker was vital in the success of the outbreak management and vaccination rollout in Cherbourg.
- There was increased leadership and coordination shown by many in the First Nations workforce. This was contributed to by the responsibility they felt for their communities.
- It was noted that one of the most valuable experiences from the pandemic response was that people were enabled to do what they needed to do with the resources they needed (whether they were enabled to do so, or self-initiated).

Challenges

- Some HHSs did not have First Nations representation in the Emergency Operations Centres or Incident Management Teams, so they were not present during the operational decision-making and execution.
- It was noted that some communities feel like they are being told 'you don't know what you're doing'. It has to be the other way: Councils and community lead themselves and have to be seen as equals in the response.
- It wasn't always remembered by the health system that Council is the head of community and that there needs to be more meaningful and timely engagement. "You [Health] are an equal member – your expertise is welcome, but you are part of the team/family."
- Some HHSs did not integrate their First Nations leads in the executive team, so they were unable to advocate as strongly for their communities.
- There was a noticeable gap when the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General was absent from executive meetings and when their proxies weren't as strong with pushing First Nations priorities.
- There was, and remains, a lack of a defined regional structure to First Nations leadership, particularly in the HHSs. Each HHS operates differently, and each First Nations Lead has a different level of involvement.
- There was increased leadership and coordination shown by many in the First Nations workforce however across some HHSs they weren't given the opportunity and encouragement to do this and often felt like they had to "jump up and down" to be heard.

Insights

- i. The Mayors and Councillors of Aboriginal and Torres Shire Councils know their communities and showed strong leadership and advocacy throughout the pandemic response. As leaders, they have the rapport and respect of community, and this was evidenced throughout the response. Elders and other local leaders (such as the Yarrabah Leadership Forum, and similar) were integral to community engagement, advocating for community, modelling behaviours, supporting the vaccination rollout and leading the local response for their communities under the Queensland Disaster Management Arrangements (QDMA). Integration of this leadership into the health response enabled the recognition and leveraging of existing Social Capital, Human Capital and Cultural Capital within local communities which lead to more effective pandemic responses within these communities.
- ii. Where there was strong integration of the Aboriginal and Torres Strait Islander executive lead into the Hospital and Health Service (HHS) executive team and COVID-19 response teams, there was evidence of stronger integration and consideration of First Nations health and representation in the pandemic response operations. In some areas, the converse was identified, with Aboriginal and Torres Strait Islander executive leads not being well integrated and so there was less focus and consideration for the health and needs of Aboriginal and Torres Strait Islander people.
- iii. The Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General was a strong First Nations voice in the Queensland Department of Health, advocating for First Nations Health Equity in the response to the COVID-19 pandemic. Their phrase “First Nations First” is now known and used across the department.
- iv. Where there was a strong Aboriginal and Torres Strait Islander Health Worker workforce, or staff from other disciplines (e.g., nursing), presence and integration in the front-line response, stronger connection and integration with community was seen. First Nations workforces are known and trusted by the communities they work with and where there was First Nations leadership and presence in vaccination teams, outbreak management teams etc. there was increased vaccination rates, increased compliance, increased testing, increased connection with health services, and increased First Nations staff satisfaction.

Lesson Identified

- A. Aboriginal and Torres Strait Islander integration at the Hospital and Health Service and Department of Health executive leadership levels is essential to ensure representation and advocacy for the Aboriginal and Torres Strait Islander workforce and the communities they serve. Where this already occurs it should be maintained, and where it does not it should be implemented and strengthened.

Focus Area 2: Consideration and Integration of the First Nations Perspective

There were strong examples of co-design and integration of the Aboriginal and Torres Strait Islander perspective into health care delivery throughout the COVID-19 pandemic response. The strongest example of this occurred in Cherbourg, where the health system worked closely with Council and community to deliver services that suited the needs and desires of community. Examples included: empowering an Aboriginal Health Worker to lead the response; enabling Council to be the trusted face of community messaging and communications; working closely with the local Aboriginal Medical Service (AMS) and other health providers; sharing information; and utilising the skill sets and connections of Aboriginal and Torres Strait Islander Health Workers and other staff.

Another strong example of integration of the Aboriginal and Torres Strait Islander perspective into the response was in Cairns and Hinterland Hospital and Health Service (CHHS), with strong community connection occurring with the Aboriginal and Torres Strait Islander workforce employed as part of the Public Health Unit (PHU) to provide education, engagement, testing and vaccination to community.

Where co-design, or integration of Aboriginal and Torres Strait Islander perspectives into health care delivery was not strongly utilised, there was a disconnect between the satisfaction experienced by community and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSCCHOs) and what the health services thought they were delivering to community.



*Clayton Abreu, Cairns First Nations COVID-19 Response Team.
(Source: Video snapshot, QH Asset Library)*

Observations and Analysis

There were 141 observations related directly to the focus area of Consideration and Integration of First Nations Perspectives. Of these observations, there were 70 **Sustain**, and 71 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

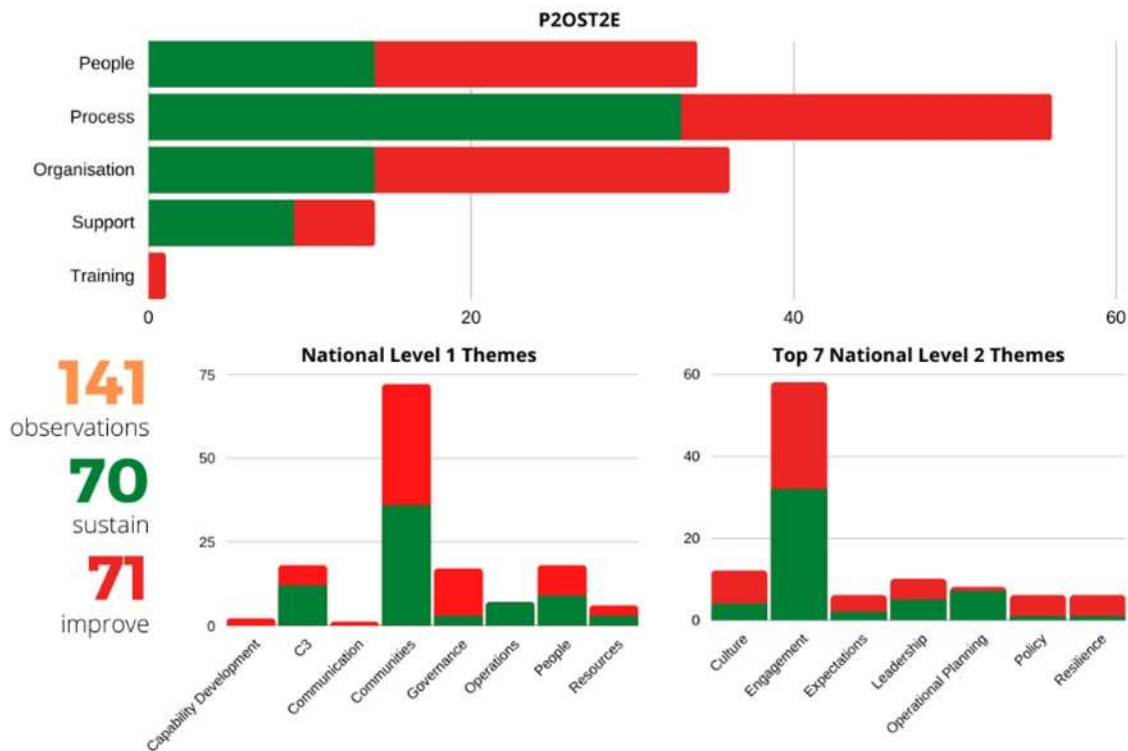


Figure 7: Breakdown of data for Focus Area 2

What worked well

- The ability to deliver a flexible and blended strategy, such as door to door vaccination, attending communities and 'going to where people are', engaging with elders and community leaders, and providing culturally safe care, to increase vaccination rates among First Nations people was effective.
- It was identified that there was no 'one way' to roll out the vaccination and that Queensland Health and others needed to take all opportunities that were presented to them and run with it.
- The ability to ensure culturally appropriate language and accurate resources tailored to First Nations peoples were utilised was effective.
- The support from Apunipima Cape York Health Council, Gurriny Yealamucka Health Service, Wuchopperen and Mamu Health Service, as well as the Cairns First Nations PHU Team allowed First Nations people to feel comfortable with vaccination teams entering their communities. These local A&TSICCHOS were the front of all vaccination approaches within the CHHS discrete communities, with HHS teams assisting and delivering the vaccinations and this was effective.

- The service of the First Nations PHU Team provided a culturally safe service and way of working and this was appreciated by the community.
- Taking the vaccination to the people, e.g., into the community, door to door, where people work and play etc. was beneficial to increasing uptake.
- The HHS tried to implement some ways of doing things e.g., drive through testing clinics, vaccination clinics at certain locations but it soon became evident that these weren't meeting the needs of the communities. With support from First Nations workforce these were adjusted to better meet the needs of community.
- In having discussions with Mayors, it was identified that the Mayors were right and knew their communities. Door to door vaccination was one of the most effective ways to rollout the vaccination, and it reinforced the need to work with communities and listen to their needs.
- Incentivising vaccination was mostly effective for First Nations communities. Especially the T-Shirts and use of Jonathon Thurston to deliver a First Nations perspective. This needed to occur sooner and in further consultation with the communities.
- It was identified that if you engaged well with one person, they could bring in 10 or more for vaccination. It was the local engagement that mattered.
- Community Champions played a significant role in increasing the vaccination rate in the Northern Peninsula Area (NPA) and Torres Strait Islands regions. They were able to talk to community and were trusted advisors who were well respected, and their opinions listened to.
- Darling Downs Hospital and Health Service and the First Nations Team are looking in the places where traditional health care doesn't look. They are guided by Council and the community needs. "They tell us what they need, and we work out how to do it" "the services we currently deliver don't meet the needs and expectations of the community." This has been flipped to talk to the community rather than provide services that are just data lead. The HHS is giving the community ownership and seeing good outcomes from this. Council is spreading the message and community is following them.
- It was noted that there will always be challenges in working across regions that are geographically, socially and culturally diverse, but the power is in understanding Health Equity and working with each community and each person in how they need health care delivered.
- Working with the local health providers (A&T&SICCHO, GPs etc.) enabled better outcomes because the local providers already had a relationship with the community and understood their needs.
- Health Equity was the key to increasing the vaccination rate in Cherbourg, by understanding what the community needed and delivering it their way, rather than a 'one size fits all' approach.
- The First Nations Health Worker team in the PHU was initially set up as response team and an investigations team – then had to turn it around and do engagement. They had to listen to community, respect the knowledge shared (system pushes you into a way of doing things but important to step out and be led by community). Get out and try to understand what the issues are and how they can be best addressed on the ground without overstepping/stepping on etc. Having First Nations people in the team who had the local connection, local knowledge and local understanding was key to being able to design a program that was effective and inclusive.

- There was a lot of reluctance by the Public Health Physicians with the easing of restrictions in the First Nations communities This came from their concern for the health and health outcomes of the population.
- It was raised that the Mayors of the discrete communities are there to serve their communities and it is important for Queensland Health to maintain that trust and those relationships that have been built.
- There is an importance in shared decision-making and so clinical and public health response to COVID-19 in communities needs to be collaborative. But the responses must ensure local community leaders and communities are central to that response.
- Initially 'super clinics' were established but it was found that community weren't attending them. Care had to be adjusted and provided in a way that the community would access, and so they realised that the care needed to go to the people e.g., home visits. Once this commenced the vaccination rate increased significantly.
- Having local people caring about local communities and working with those communities was essential.
- Having a health service in the community is integral to being connected and integrated with community and providing a location for people to attend.
- Having long term and trusted relationships in communities are essential.

Challenges

- The majority of the Aboriginal and Torres Strait Islander population live in the urban areas, with a small percentage in the discrete communities – but there was always a bigger focus on the discrete communities.
- Where there is a smaller First Nations population percentage in a local government area (e.g., not in a discrete community), there is less focus on this cohort of the population from the local councils (and more of a negative perception, e.g., a perceived increase in youth crime in these areas).
- Services were provided in discrete communities that weren't often available to First Nations people in other areas, for example, home visits.
- In some cases, First Nations teams had to argue against the institutional racism in the health service to be able to deliver what community needed.
- Some political parties and politicians tried to cause unrest and spread misinformation about COVID-19 and vaccination. This impacted the messaging and engagement with these communities.
- Some communities wanted to lock down, but wanted to do it under their own control, not always with the state/commonwealth control.
- The Queensland Department of Health COVID-19 System Response Lead Division noted that wider and deeper engagement with consumers and consumer groups could have been done better.
- Queensland Health had to learn that what works for one community doesn't necessarily work for another. They need to listen to the community.
- There was disconnect by some HHSs in engaging the communities and their leaders to effectively support the management of the response and get the best outcomes for each, different, community.
- In some HHSs, First Nations staff weren't asked for their input/involvement in the response planning so when initiatives for testing/vaccination etc were rolled out, they didn't meet the needs of the First Nations people.

- In some HHSs, it is not just in the COVID-19 response where First Nations staff aren't actively involved in planning health service delivery to ensure it is fit for community.
- Many HHSs have a diverse community with different factors e.g., cross-border, discrete communities (though some not isolated), and dispersed First Nations populations across the rest of the population. It is difficult to focus on all the different types of engagement and there were often only resources to focus on one or two at a time.
- The use of COVID-19 hospitals, and not being able to care for COVID-19 patients on country did not respect the First Nations perspectives of care on country. After the first case (in a border town) was removed to Brisbane, people in the towns were reluctant to test, and effectively 'went to ground' because they didn't want the same thing happening to them.
- A concern was raised that the policy reach needs to be stronger within Queensland Health. There is not enough First Nations representation on Boards or in the HHSs. Where there is representation, it is often perceived as tokenistic, and they have not necessarily been provided with any authority.
- Community satisfaction is the key driver and outcome of public health care; however, this is often not considered.
- In some cases, First Nations Leads and other staff had to “jump up and down” – to get what they needed (e.g., the establishment of an urban First Nations vaccination clinic, dedicated First Nations mobile teams etc.). It was felt that some HHSs did not understand, or try and understand, the needs. In some places, staff had to argue in the health service against the institutional racism to be able to deliver what the community needed.
- The Indigenous public health lens looks like more than immunisation – it's holistic and about going back to trauma-informed, holistic care, education, social, wellbeing. This is not well-acknowledged or met in health systems.
- All clinical networks are responsible for Aboriginal and Torres Strait Islander Health. It's not just about Aboriginal and Torres Strait Islander people taking responsibility for everything, it's about educating and supporting the whole system. “Mob caring for mob – we know how to care for our people” is a concept that needs wider acceptance from the greater 'white privilege' health system. It's not about mob doing everything, but about mob having leadership and designing what works for them.
- Health Equity has been the backbone of some area responses, and how it is different to equality. There are many people who don't understand this, and questions have been raised around, “haven't they been offered enough?” when in fact it is about meeting the different needs and motivations of communities and individuals.
- In some areas, Aboriginal and Torres Strait Islander staff and consumers felt like they were being treated as 'second class citizens' again. The relationships between the COVID-19 lead and the First Nations lead were disjointed in some cases and in some areas, it was felt that the cultural voice was almost silenced by the clinical voice, when these needed to work together to provide holistic care to community.
- External providers (such as 'fly in, fly out' providers) often didn't have existing relationships with communities so there was no trust. Because of this, they often couldn't be utilised for frontline response in some areas.

Insights

- v. When the response actions acknowledged and honoured the diversity of health response needs of Aboriginal and Torres Strait Islander peoples and communities, and incorporated First Nations ways of knowing, being and doing into co-designed health care which met community needs, better outcomes were seen. This was evidenced in increased vaccination rates, increased testing, increased compliance, and increased engagement with health services. Examples of meeting communities needs included door to door testing and vaccinations, bringing vaccinations out of clinics and delivering them at common meeting places, and having First Nations staff deliver care to First Nations people.
- vi. Remote Aboriginal and Torres Strait Islander communities were provided specific focus by health services due to their remoteness and vulnerability of their populations. Urban areas, where the majority of Aboriginal and Torres Strait Islander people reside, however with not as high a percentage of the population, were not provided with the same concentrated focus, despite the population having a similar vulnerability profile as the remote communities.

Lesson Identified

- B. Health delivery, across all facets of disease and health care, to Aboriginal and Torres Strait Islander communities should be co-designed to ensure it meets the needs of the people it is serving. Co-design should occur across the Hospital and Health Service (HHS), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), other relevant services within the community (such as Aboriginal and Torres Strait Islander Shire Councils), and with key community members.

Focus Area 3: Role of First Nations Staff

Aboriginal and Torres Strait Islander representation and utilisation in the workforce varies across the Hospital and Health Services (HHSs) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHO). Aboriginal and Torres Strait Islander Health Workers and Health Practitioners make a vital contribution to health care in Australia in both specialised service delivery and in a wide range of mainstream health care roles⁷. Their roles may include enhancing the amount and quality of clinical services provided to Aboriginal and Torres Strait Islander clients, facilitating communication with Aboriginal and Torres Strait Islander people and communities, and practice administration and management⁸. Wide variations occur across the HHSs and A&TSICCHOs in how Aboriginal

⁷ The Lowitja Institute (2014). Shifting gears in career: identifying drivers of career development for Aboriginal and Torres Strait Islander workers in the health sector: Policy brief. Melbourne: The Lowitja Institute.

⁸ Bird, M., Henderson, C. (2005). Recognising and enhancing the role of Aboriginal and Torres Strait Islander health workers in general practice. *Aboriginal and Islander Health Worker Journal*, 29(3), 32-34

and Torres Strait Islander Health Workers and Health Practitioners are utilised, with A&TSICCHOs generally utilising their clinical capabilities more than HHSs. Across the HHSs, many of the Aboriginal and Torres Strait Islander Health Workers and Health Practitioners are used more for cultural capabilities, and many are employed within the Administration Officers stream, therefore not utilising their clinical capability.

The introduction of the *Emergency Order Pandemic Response to Coronavirus Disease (COVID-19)* and inclusion of the Aboriginal and Torres Strait Islander Health Workers to be able to provide the COVID-19 vaccine provided some shift to how Aboriginal and Torres Strait Islander Health Workers were utilised across the HHSs, however many were still not empowered or



Saibai Island Indigenous Health Worker receiving her COVID-19 vaccination
(Source: QH Asset Library)

able to use their clinical skills. COVID-19 Vaccination Training for Health Workers was developed and delivered by Queensland Health and of the 320 people who were trained, the vast majority who went on to undertake vaccine delivery were from the A&TSICCHOs.

Where Aboriginal and Torres Strait Islander Health Workers were empowered and enabled to support their communities, better outcomes such as staff satisfaction, community connection and engagement with the health system, increased vaccination rates, increased compliance and increased testing.

Observations and Analysis

There were 147 observations related directly to the focus area of Role of First Nations Staff. Of these observations, there were 82 **Sustain**, and 65 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

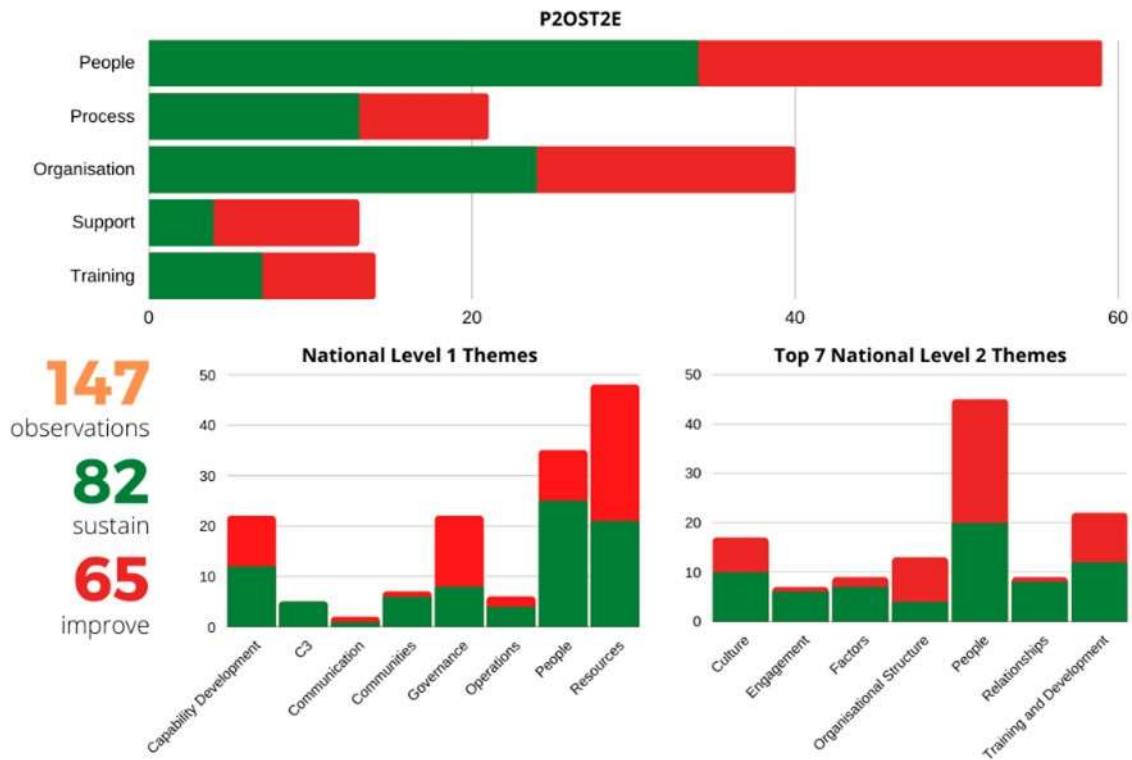


Figure 8: Breakdown of data for Focus Area 3

What worked well

- A&TSICCHO staff are often from Community, so when they were trained to support the pandemic response, and were able to use their training, they knew what to do, knew the community, knew the houses, families etc.
- Having First Nations staff in teams brought cultural awareness to the teams and the subsequent planning and response, enabled better connections with the community and community organisations, and enabled a balance of ideas and experiences to be had within the teams. They used relationships and rapport to produce improved health outcomes and better outcomes were able to be achieved because of the existing relationships and trust that existed.
- Upskilling of Aboriginal and Torres Strait Islander Health Workers and Practitioners increased vaccination capacity and provided culturally appropriate care.
- Having the Aboriginal and Torres Strait Islander Health Workers on the ground improved the community buy-in and enabled local leadership and cultural safety.
- Aboriginal and Torres Strait Islander Health Workers who underwent the vaccination training and worked in clinics are now empowered and enabled to work more to their scope and this is having positive outcomes for them professionally and for the communities they serve.
- The nursing and other clinical streams have ‘had their eyes opened’ about what Aboriginal and Torres Strait Islander Health Workers and other streams of health professionals (including graduates) can do. This has been a huge disruptor and produced good changes.
- The First Nations Team is now more linked in with Hospital in the Home (HITH) at Darling Downs Hospital and Health Service (DDHHS) than they ever have been, as a result of the relationships and trust that was developed during the response. The First Nations team

were able to show their value and move towards a proactive response rather than reactive. Now that the COVID-19 response is slowing and there is transition back to business-as-usual there is some resistance by HITH and other providers to continue the same level of involvement with First Nations team; however, the First Nations team is actively working to continue to embed the new processes that have been formed that provide better outcomes for their communities.

- DDHHS noted that the current Executive Director Nursing and Midwifery is very supportive of increasing the scope and empowerment of the Aboriginal and Torres Strait Islander workforce.
- We've really proven that our First Nations people will turn up to be vaccinated by their own people, and that the Indigenous Health Worker has been a safe and efficient and effective model for the delivery of vaccines. We need to look at how we can embed this into a sustainable model of practice.
- The pandemic response has enabled the focus to shift to improving the role of the Aboriginal and Torres Strait Islander Health Worker role and function.
- Implementing an Aboriginal and Torres Strait Islander Health Worker Lead who was from community was really important as they already had existing relationships and knew how best to contact and connect with people. This Aboriginal and Torres Strait Islander Health Worker Lead and the rest of the Aboriginal and Torres Strait Islander Health Worker team stepped up to provide personalised and wholistic care to the community.
- Without the Aboriginal and Torres Strait Islander Health Worker Lead at Cherbourg, the health services wouldn't know who was who, where they were etc. Having the local knowledge, community links, relationships, rapport and a dedicated person on the ground was essential.
- As the Health Workers increased their confidence (with mentoring, support and practise) their outcomes with vaccinating were better. "we're not used to doing that stuff. It made us feel a bit like nurses. It was a big move being able to do that stuff and build the rapport. Being able to work with Aunty and Uncle and be able to give them the jab rather than having to go to the nurse". Many now have the confidence of community and so their role needs to continue.
- When doing case interviews, having connections to community in the contact tracing team improved the contact tracing outcomes because there was better trust and relationships.

Challenges

- In some HHSs, not many of the Aboriginal and Torres Strait Islander Health Workers who completed the COVID-19 vaccination training went on to deliver vaccinations. One reason was because they weren't comfortable performing the skill, despite the training. Some Aboriginal and Torres Strait Islander Health Workers needed more mentoring and support to be able to work well clinically.
- There were some Aboriginal and Torres Strait Islander Health Workers who were very interested in performing vaccinations, who could have deployed to other health services that needed them, but there was no opportunity provided to do this. It would have been beneficial if there was an Aboriginal and Torres Strait Island surge workforce available, as there was for nurses and other positions.

- The vaccination training was important. However, completing the online modules on their own was a challenge. The A&TSICCHO converted to learning in a community of practice where the Health Workers were able to talk together about challenges and barriers and work through the modules together. It was really important for them to work and learn together.
- The First Nations workforce identified levels of cultural burnout from the increased cultural mentoring that was required.
- There is a lot of trauma in the Aboriginal and Torres Strait Islander Health Worker profession that hasn't been managed or dealt with. This is a combination of cultural and historical trauma (racism) and Health Worker specific trauma (health system).
- There is currently no 'long-term' career pathway for Aboriginal and Torres Strait Islander Health Workers, especially within HHSs.
- The pandemic response has exposed how many First Nations people are working in Queensland Health who have Health Worker/Practitioner qualifications but aren't working to their full scope, or clinically at all. Often these people are only being used as Liaison Officers and not harnessing their skills and qualifications. There is often resistance from nursing and other clinical staff who work alongside them, and by the HHS in general, to allow them to work to their potential scope of practice. The roles are not well defined, and they are often siloed across the HHS.
- Health Care workers often don't know where they fit in the system. There is no clear role definition and scope, especially across the different sectors of health (e.g., HHS, PHN, A&TSICCHO etc.)
- The Yarrabah vaccination rollout was a good example of the collaborative work between Aboriginal and Torres Strait Islander Health Workers and the Commonwealth nursing workforce resource. The Health Workers led the community engagement and vaccination, with the support of the nursing staff.
- Aboriginal and Torres Strait Islander Health Workers are our untapped and unappreciated workforce. They live and work in community, hold the trust and respect in communities. They are already skilled, but the system needs to empower them to work to their potential, at the moment they are underutilised, under respected, underpaid.
- There are concerns that the scope of practise and utilisation of the Aboriginal and Torres Strait Islander Health Workers will be lost once the threat of COVID-19 passes.
- We are not training our younger generation to fill the Aboriginal and Torres Strait Islander Health Worker roles. The workforce is aging and there is no local training.
- There is a significant pay discrepancy between Aboriginal and Torres Strait Islander Health Workers and other health professions. This is leading to retention and attraction issues.
- In some HHSs, First Nations staff weren't asked for their input/involvement in the response planning. Some really struggled to get the HHS buy-in and support and there was a case where one group had to go to the Union to push for support.
- In some areas, there was disrespect, racism and bias against Aboriginal and Torres Strait Islander staff and community members by non-indigenous HHS staff.

Insights

- vii. The Hospital and Health Services (HHSs) generally had low employment rates of Aboriginal and Torres Strait Islander Health Workers, and where these positions did exist, their clinical capability was generally underutilised, with their focus being more about cultural capability support. Where Aboriginal and Torres Strait Islander Health Workers were empowered and utilised to their potential, good outcomes were seen, including increased vaccination rates, increased connection to community, increased integration with health services, and increased First Nations staff satisfaction. It was generally accepted that this underutilisation was because of a general lack of understanding of the clinical governance of Health Workers, and Health Workers often opted to work in the Administration Officer stream as Indigenous Health Liaison Officers (IHLOs) due to pay disparities and a lack of clear pathway for career progression. Aboriginal and Torres Strait Islander Health Workers in Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) are utilised more in their clinical capacity. There are disparities between the roles and responsibilities between Health Worker positions in A&TSICCHOs and HHS.
- viii. The implementation of the Emergency Order Pandemic Response to Coronavirus Disease (COVID-19) and inclusion of the Aboriginal and Torres Strait Islander Health Workers to be able to provide the COVID-19 vaccine was a welcomed step in increasing the scope for Aboriginal and Torres Strait Islander Health Workers. This increased scope reduced strain on the greater workforce, to enable business as usual services to continue, and reduced the need for 'fly in, fly out' workforces in some areas. The training that was developed and delivered for Health Workers by Queensland Health was comprehensive and provided the required baseline knowledge. What was initially missing was additional mentoring and support to increase Health Worker confidence and the uptake of Health Workers delivering the vaccine after completing training. The Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) workforce were the primary Health Worker workforce that attended and implemented the use of the training, where Hospital and Health Service (HHS) Health Workers were more likely to be engaged in a cultural liaison role, even after completing training.
- ix. When Aboriginal and Torres Strait Islander staff (across all disciplines) were integrated into teams and included in decision-making there was a strong First Nations focus, culturally responsive health care was provided, and better outcomes seen for communities. Where the Aboriginal and Torres Strait Islander workforce was not engaged, they felt like they had to "jump up and down" to be included and be able to co-design and deliver culturally appropriate and safe health care for their communities. Once engaged, outcomes such as increased vaccination rates, increased testing, and increased engagement with health services were seen.

Lesson Identified

- C. The Aboriginal and Torres Strait Islander Health Worker and Health Practitioner workforce requires a review to align and standardise across the Hospital and Health Services (HHSs) their scope of practice (including maintaining the capability to undertake vaccinations, in extension to the Pandemic Emergency Order), clinical

governance, remuneration, and engagement with and integration into the rest of the health system workforce.

A First Nations Perspective

“My name is Lynette Brown; I identify as a Gooreng and Barada Barna woman with strong connections to the communities of Woorabinda and Cherbourg. I have lived in Cherbourg for over 20 years with my partner and two children. I have mostly worked around human services as I have a passion for improving the quality of life of the people in my community.

My journey in health started as a Medicare Officer for an Aboriginal Medical Service (AMS). With my experience with Medicare Australia and the experience of our Nurse, we were able to establish a model of care that both maximised Medicare billing but more importantly, provided comprehensive care for our clients. After a few other roles in between, I then became the Practice Manager and decided I needed formal health qualifications to keep our Aboriginal Health Workers safe and working within their scopes of practice.

I started with Queensland Health as a casual administration officer and took opportunities as they arose, which led me to working in the Cherbourg COVID-19 Vaccination Super Clinics. The clinics gave me the opportunity to watch how the clinics operated, to yarn with clinicians and to become familiar with the systems and processes. I found that just working in the environment helped to increase my knowledge of COVID-19, COVID-19 vaccines and inspired me to further develop my skills. I completed face to face vaccination training, online modules, and on-the-job mentoring. I have been the only Aboriginal Health Worker that has been working in the COVID/Flu vaccination space in Cherbourg. I can perform all duties of the clinic; administration, drawing-up and vaccinating.



There have been many challenges, some that come with working in health and others that don't belong in any workplace, but with the support of my Clinic Lead and the Darling Downs Indigenous Health team, I have been able to navigate my way through. I believe it helps to be passionate, confident, to have a great rapport with your community and to work alongside a great team, this is what makes my work managing the Cherbourg COVID-19 response so successful. My role in Cherbourg has led me to some great opportunities to share our work in Cherbourg with the State, Australia, and the rest of the world.

Aboriginal Health Workers are very important to Queensland Health, we are the link between our services and the communities.”

Story of Lynette Brown, proud Gooreng Gooreng and Barada Barna woman – Darling Downs HHS



*Dr Noel Hayman, Metro South Hospital and Health Service
(Source: Video snapshot, QH Asset Library)*

Focus Area 4: Health Service Integration with other Agencies

The COVID-19 pandemic response was a multi-agency response and could not be managed by one organisation or agency alone. The health system includes the Commonwealth and State Departments of Health, Hospital and Health Services (HHSs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), Primary Health Networks (PHNs) and General Practitioners, Pharmacy and Allied Health providers, Aged Care, Disability Support services, and Not-for-Profit organisations. These services operate under different funding and governance streams, at State and Commonwealth levels. Interoperability between these different services was key to providing a health system response and it was highlighted by many involved in the review that the relationships that existed before, or were built during, the pandemic response were integral to how these services worked together to support their communities.

Where integration of service delivery, data sharing, and trust and transparency between organisations occurred, stronger and more timely community support outcomes were seen.

Observations and Analysis

There were 233 observations related directly to the focus area of Health Service Integration with other Agencies. Of these observations, there were 133 **Sustain**, and 100 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

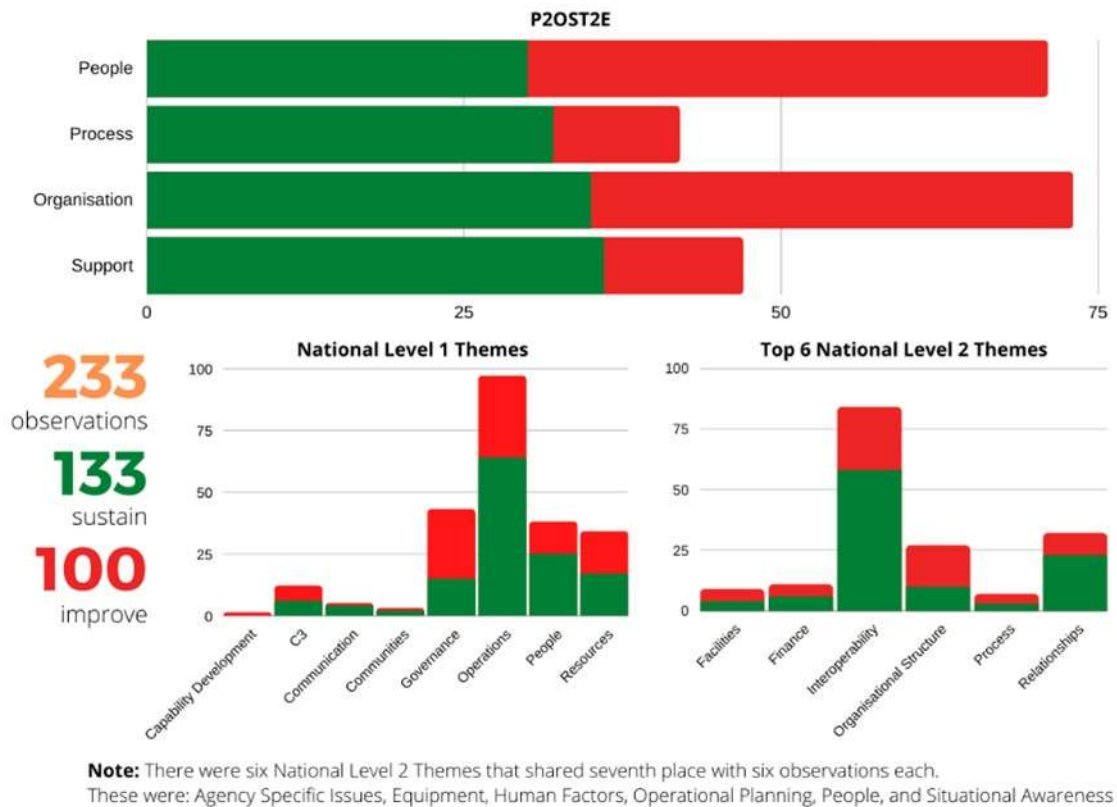


Figure 9: Breakdown of data for Focus Area 4

What worked well

- In Yarrabah, and across Cairns and Hinterland Hospital and Health Service (CHHHS), the Department Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP) complemented the Yarrabah Leadership Forum to provide support to the community and they already had good rapport and respect in the community and were able to leverage off this.
- Collaboration with the Aboriginal Medical Services (AMS) and A&TSICCHOs was vital.
- The Queensland Aboriginal and Islander Health Council (QAIHC) weekly meetings were beneficial to discuss and raise issues such as funding, testing, PPE etc.
- Generally, there was a solidification of the working relationships across the entire health system (including A&TSICCHOs, HHSs and other primary providers).
- Collaboration between the levels of the health system have improved over time.
- The regional First Nations vaccination discussions, established by Queensland Health, were an excellent example of collaborative meetings. They included Queensland Health chairs, PHN, HHS representatives, Public Health Units (PHUs), National Taskforce representatives and A&TSICCHOs.
- Some of the silos that existed internally to Queensland Health and the HHSs, and between agencies and organisations were broken down during the response to COVID-19 response.
- Working with Councils and other organisations to provide Social Support (e.g., delivery of Food and Hygiene Hampers) to positive households to minimise movement around the community was beneficial.

- Whilst there were pre-existing relationships between HHSs, PHUs and other agencies, these were further established over the course of the response and have improved the response capability for the community.
- The working relationship between the executives of the Queensland Department of Health Aboriginal and Torres Strait Islander Health Division and DSDSATSIP was extremely beneficial to share messaging, understand support requirements and work together for the communities.
- Queensland Health's Aboriginal and Torres Strait Islander Health Division worked hand in hand with the newly established Office of Rural and Remote Health because they covered a similar demographic (particularly around the discrete communities). This enabled them to share resources and combine efforts.
- When A&TSICCHOs were brought to the table to be involved in the response there were many that got heavily involved and saw greater outcomes for their communities
- There were very good relationships at the officer level between QAIHC and Queensland Department of Health which enabled collaborative work to occur.
- Queensland Health was generally responsive to what the Community Controlled Sector was experiencing, to the extent it was able to change.
- The relationships between Queensland Health and QAIHC, and the HHSs and A&TSICCHOs have improved, and it is expected that this will now continue into the 'Living with COVID-19' phase.
- The COVID-19 response has forced a change in the way care is delivered in community, in a good way. A&TSICCHOs have been enabled to provide care that Queensland Health ordinarily 'held on to'. For example, the Deadly Ears program – Queensland Health would attend community once per quarter, however when they were unable to attend due to lockdowns, they worked so the A&TSICCHOs could deliver the care and then be funded for it. This has enabled more frequent and community-based care to occur.
- In general, Hospital and Health Services have a better understanding of what A&TSICCHOs can do now and are working closer with them to enable more community-based care.
- The COVID-19 response has demonstrated that it is possible to 'just do' things, without the barriers that used to exist.
- There was often a difference in what was presented as a formal response and what actually occurred. For example, the formal response was that Queensland Health would not supply Rapid Antigen Tests (RATs) to A&TSICCHOs and similar organisations as it was not necessarily their requirement to do so, however there were cases where these were supplied by HHSs locally to fill a need and ensure community health and safety.
- There was generally a good relationship between Queensland Health, the A&TSICCHOs and PHN in terms of sharing vaccination resources, vaccines, staff, consumables etc. to deliver a system-wide response and rollout for each community.
- HHS First Nations vaccination teams supported the A&TSICCHOs with their vaccination rollout. This particularly occurred where the A&TSICCHOs didn't have appropriate staffing or where there was no local clinic in a town (e.g., Goondiwindi).
- The 'town hall' approaches, at the Queensland Department of Health level, to sharing information to all external stakeholders worked well for the most part. Sometimes they were too broad, but they served their purpose of sharing information.

- The A&TSICCHO sector was not prepared for pandemic, but they acted, responded, spent money to respond, and protected their staff and community (before funding was confirmed).
- There was a lot of 'pointing fingers' for responsibility between the Commonwealth and State Departments of Health, when in reality the HHSs were providing support to A&TSICCHOs 'behind their backs' because it was just something that needed to be done (e.g., providing RATs and PPE etc.).
- The Queensland Department of Health First Nations COVID-19 Team provided support to the A&TSICCHOs that wasn't there prior to the establishment of the team.
- The pandemic did bring down some barriers between organisations and people, 'to get the job done'.
- In some areas, A&TSICCHOs had strong relationships with the PHUs and First Nation Leads before the COVID-19 pandemic. This was generally due to other disease outbreak management, such as syphilis, and meant that everyone knew the players and structures and were able to morph into the COVID-19 response.
- The previous relationships that had been built across PHUs, community and the First Nations lead assisted in the COVID-19 pandemic response.
- PHUs often have a trusted relationship with the Mayors of remote Aboriginal and Torres Strait Islander communities. These relationships were built before the COVID-19 pandemic and was pivotal to the response in many areas.
- Sharing of data with the Mayor/Councils, A&TSICCHOs and other support organisations, to be able to provide a coordinated response to the community, helped everyone provide support and understand the state of play with positive cases and close contacts.
- Relationship with local GPs, A&TSICCHOs and support organisations, and sharing information between them and the HHS meant that they were better able to table to track people down, support cares, share contacting – maintain the relationships with key clinicians in community etc.
- The Make the Choice campaign was developed in partnership with QAIHC. The development workshop that was held with QAIHC, Institute of Urban Indigenous Health (IUIH) and Queensland Health to develop the campaign was very collaborative and values based.

Challenges

- The pandemic has highlighted the lack of services available in some areas.
- A&TSICCHOs that 'fly in, fly out' do not have the same relationships with community, and these arrangements were interrupted during lockdowns and implementation of restrictions, impacting the response.
- In some cases, Queensland Health wouldn't share the details of COVID-19 positive cases, case numbers or other data with support organisations and this impacted their ability to provide support to these members of the community.
- Early in the response there was a fracture between the commonwealth response, State, HHS response and sector response.
- Initially the health system response was not coordinated (e.g., the PHN, A&TSICCHOs, HHS etc. were working in silos and providing ad-hoc services rather than collaboratively). there were no predefined roles and responsibilities across the different organisations and these had to be developed on the go.

- Early in the response, the A&TSICCHOs were left as an afterthought and not brought into the planning early enough. It was poorly understood by Queensland Health and the HHSs what resources A&TSICCHOs had available and what they could do.
- It was initially difficult for the PHN to get involved with the response as the response was predominantly dominated by the HHS.
- Whilst there were good relationships at the officer level between Queensland Health and the QAIHC, the executive relationships did not always mirror this and was a barrier to collaboration and engagement.
- Queensland Health would frequently be resourced but not share these resources with A&TSICCHOs to support the community response. An example of this was with Rapid Antigen Tests (RATs). Queensland Health had a stockpile but was holding them to use at their own testing sites, rather than distributing to A&TSICCHO sites as well to share the workload and disperse the impacts of long queues and under-testing due to lack of availability. This had a subsequent flow on to First Nations people being tested (or not), receiving care (or not), and increased the burden at Queensland Health sites.
- Queensland Health was generally risk adverse and not overly innovative or make early decisions to solve problems. Problems seemed to escalate, and until Queensland Health felt 'comfortable', or the situation became untenable (e.g., RAT distribution) then a decision would be made.
- A&TSICCHOs have multiple streams of funding (federal, state, HHS and QAIHC) but they are not always held to account for the services they are supposed to deliver. Where the HHS wants to hold them to account, they feel they are unable to because of the 'politics' in play. Some A&TSICCHOs do not have the capacity and capability to deliver the services they are funded/contracted to deliver but they are not always owning up to this, so service delivery is slipping. For example, child immunisation rates in some communities.
- As the Make the Choice campaign was nearing release, and at release, QAIHC and IUIH stepped back and were less engaged with its release and continuation.
- Much of the early engagement with the A&TSICCHOs and Queensland Health was led by the Department of Health Aboriginal and Torres Strait Islander Division and not the HHS. The Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General brought the A&TSICCHOs together with Queensland Health, but the HHSs weren't always included.
- In some areas there was a high reliance on the A&TSICCHO by the HHS to deliver services and support to the communities, but the A&TSICCHOs didn't necessarily have the resources to undertake this.
- In some areas there is poor interoperability between the A&TSICCHO and the HHS. This was present before the pandemic and remains.
- Some areas of the regions seemed to get more support and focus than the non-discrete First Nations communities.
- The pandemic emergency order allowed for patient information sharing across the A&TSICCHO and the HHS which contributed to patient care. This does not exist in business-as-usual times and will require a Memorandum of Understanding (MoU) to be in place to continue the models of care that have been implemented. Where some HHSs are trying to put these MoUs in place there have been barriers.
- There are some differing opinions between some A&TSICCHOs and HHSs and a disconnect in what was perceived to have gone well/not well/level of support provided etc.

- In some areas, the HHSs could have communicated better with Councils and community organisations.

Insights

- x. Some Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) felt that they didn't have a "seat at the table" within the health system, and that it is not an integrated health system but rather a group of different systems. It was generally felt that Hospital and Health Services (HHSs) didn't understand or trust the capability that exists in A&TSICCHOs and so didn't always utilise this. Where relationships between organisations already existed, there was a higher level of collaboration and integration of services. As relationships grew and solidified, so did the ability for a coordinated response for communities with less duplication, more streamlined approach to service delivery, and increased outcomes to communities.
- xi. Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) are generally well known and respected within the communities they serve, particularly in the remote Aboriginal and Torres Strait Islander communities. A&TSICCHOs generally just 'got in and delivered' for the communities, stepping up for the safety of their staff and clients, even when funding arrangements were not clear, and this was noticed in the continued and/or increased delivery of services provided by the A&TSICCHOs. The pandemic response highlighted the lack of services and resources in some areas, particularly where an A&TSICCHO works with a 'fly in, fly out' workforce.
- xii. There was often confusion around what and how much data (such as name and addresses of positive cases) could be shared by Queensland Health and the Hospital and Health Services (HHSs) with other organisations involved in the pandemic response, such as Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), Queensland Police Service (QPS), Aboriginal and Torres Strait Islander Shire Councils etc.) to support the provision of care to the community. Where data sharing arrangements were established between the HHS and other organisations (as evidenced in Yarrabah, Woorabinda, and Cherbourg), a more streamlined and coordinated approach to patient care and safety was evidenced. This included A&TSICCHOs and councils being able to access information to be able to deliver welfare packs and undertake welfare checks with people who were isolating.
- xiii. There was a general lack of coordination and understanding of resource sharing between agencies, such as Queensland Health, Hospital and Health Services (HHS) with other government departments or Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs). Queensland Health policy generally outlined that certain resources would not be distributed (e.g., Rapid Antigen Tests (RAT) and Personal Protective Equipment (PPE) to organisations outside of Queensland Health or the HHS, however HHSs often made local arrangements with their A&TSICCHOs and provided some resources. Where this occurred it was appreciated, however the different approaches across HHSs caused some confusion. Different Local and District Disaster Management Group areas and different agencies also had different arrangements for the access of state agency housing and other resources and these different processes often caused confusion and delays in access.

- xiv. The Queensland Department of Health First Nations COVID-19 Response Team initiated and coordinated meetings between Hospital and Health Services (HHSs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), and other relevant agencies, some of which had never collectively been in discussion together, and provided a level of Departmental policy and clinical support to First Nations HHS leads, A&TSICCHOs and HHS COVID-19 response teams that hadn't been experienced before. This additional coordination and support was generally well received, particularly in regard to outbreak management, vaccination support and resourcing, however not all stakeholders understood the role of the Team, how they fit in the disaster management or business as usual structures, what they required from the HHSs or A&TSICCHOs, or what support they could provide. The Team was not always well linked into the Queensland Health disaster management arrangements (i.e., with the State Health Emergency Coordination Centre (SHECC)).
- xv. Queensland Department of Health and Queensland Aboriginal and Islander Health Council (QAIHC) initially worked closely for the development of the Make the Choice vaccination campaign. Queensland Health provided funding and support to develop the concept, marketing materials, distribution and advertising, however as the campaign was nearing release, there appeared to be differing opinions and goals on the campaign and QAIHC were less engaged with its release and ongoing engagement. Whilst the campaign was identified as a success and Queensland Health continued the rollout, this breakdown had an impact on the ongoing rollout and potentially the overall success that could have been seen with this branding.

Lesson Identified

- D. The Queensland Department of Health and Hospital and Health Services should continue to engage with the Aboriginal and Torres Strait Islander Community Controlled Health Organisations in their areas to further build relationships and understand the capacity and capability of the different organisations. Through this collaboration, service delivery to community should be co-designed, as outlined in Lesson Identified B.

Focus Area 5: Alignment with the Queensland Disaster Management Arrangements

The existing Queensland Disaster Management Arrangements (QDMA) provided a trusted and known framework for agencies to operate under in response to the COVID-19 pandemic, even with the top-down approach that was seen in this response.

Queensland Health (both in the Hospital and Health Services and Department of Health) generally struggled to understand their Lead Agency role in the QDMA which had downstream impacts on their engagement and collaboration with the Local and District Disaster Management Groups (LDMGs/DDMGs), however the already-established relationships across LDMGs and DDMGs were the bedrock to the coordinated multi-agency response.

The Chairs of the Local Disaster Management Groups (local Mayors) were connected to their communities and able to lead the on-ground response with the support of the agencies of the LDMG.

Where Primary Health Networks and Aboriginal and Torres Strait Islander Community Controlled Health Organisations were integrated into the LDMGs there was better connectedness across the health system and better community outcomes seen.

Observations and Analysis

There were 96 observations related directly to the focus area of Alignment with the Queensland Disaster Management Arrangements. Of these observations, there were 59 **Sustain**, and 37 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

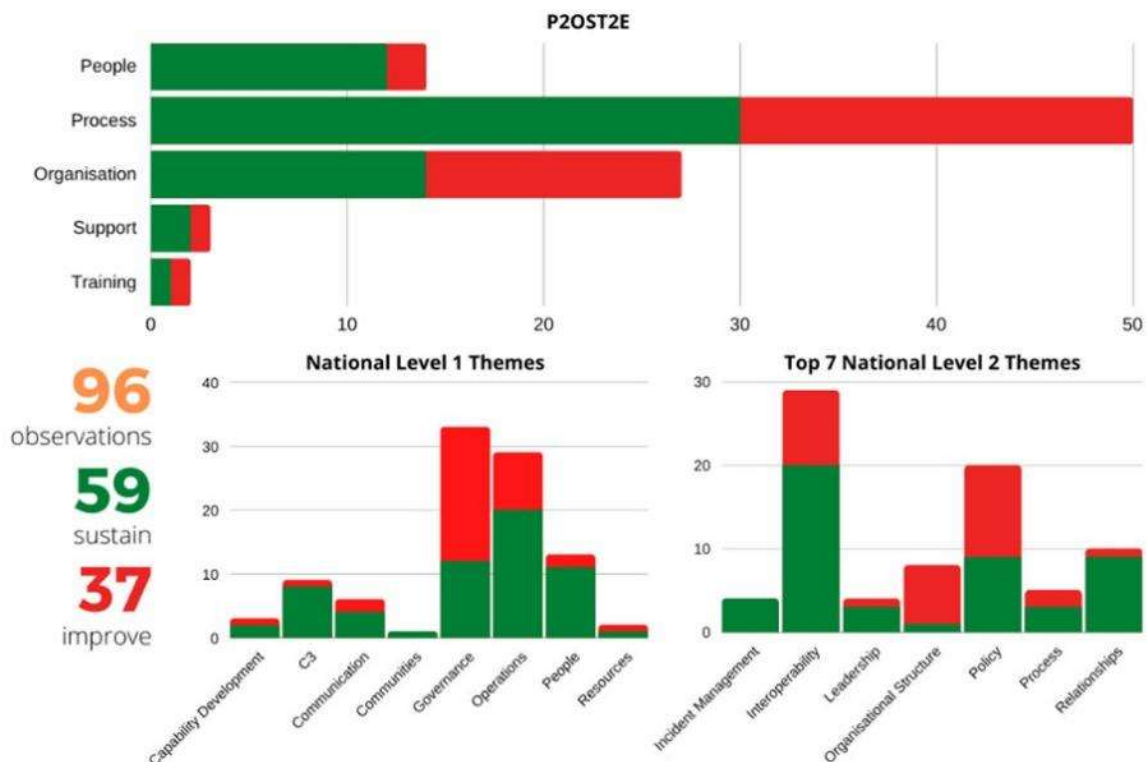


Figure 10: Breakdown of data for Focus Area 5

What worked well

- There was high trust in the QDMA and how they operated during a disaster. They had been 'tried and tested' in other events.
- There is an existing, trusted relationship within the QDMA.
- The QDMA have served the response well, enabling a framework for a multi-agency response.
- Where regular meetings with the LDMG/DDMGs occurred, there was increased information sharing and support across the agencies.
- Where the PHN and A&TSICCHOs were able to be engaged with the LDMG, this assisted with closing the barriers.
- The 'disaster' concept enabled people to 'just do' without the barriers that would normally exist.
- The QDMA supported local decision-making within the framework.
- The agencies of the LDMGs and DDMGs have become more transparent in their capabilities and limitations.
- Having the right person in a position or on a group is far more important than just having a 'bum on a seat'. The HHSs appear to be getting better at doing this.
- There is a strong desire to maintain and continue to strengthen the LDMG/DDMG relationships across the HHSs.
- Over time, as Health and the other agencies worked with the local Council, relationships and outcomes improved.
- Whilst Queensland Health was the lead agency, many of the things that were required in the response were out of scope for Queensland Health, and so relied on other agencies for support. This generally occurred, leveraging off the other agencies within the QDMA e.g., Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP), Queensland Fire and Emergency Services (QFES), Queensland Police Service (QPS) etc.
- QPS approached the response from a public safety perspective, unlike other states that were there as crime and enforcement. This supported the response and built more trusted community relationships between the community, health and QPS.
- LDMGs and DDMGs provided big support with finding locations, transporting vaccine, safety etc. Many HHSs identified that they couldn't have done it without them.

Challenges

- After the Local Government elections in 2020, there were many new Mayors and Councillors and they had to learn the QDMA and how they apply to the COVID-19 pandemic response.
- The COVID-19 response operated from a top-down approach rather than the ground-up approach (like normal) and this was a new adjustment to get used to.
- There is concern that without the QDMA continuing in the future management of COVID-19 there will be structural and relationship breakdowns, with barriers returning because they don't have the framework to operate under.
- The *Disaster Management Act 2003* implies that Queensland Health, as the representatives on the LDMG/DDMG, have responsibility for all health care, when this is not the case. This is a frustration felt across the HHSs, PHNs and A&TSICCHOs.

- The LDMGs operate differently across different areas and there are different levels of engagement (e.g., some have good PHN/A&TSICCHO engagement whereas others initially did not, or still do not).
- A&TSICCHOS, PHNs and other health entities aren't generally represented on LDMGs or DDMGs. This led to communication breakdowns, not harnessing the full capacity of the health system, and not understanding the nuances in complexities across the different levels of the health system.
- Initially the response was difficult to run because it wasn't a 'health' response in that people were unwell, but that it was a 'social' response in terms of the impacts lockdowns etc. were having on communities. This meant that Queensland Health leadership wasn't as strong as it should have been at times.
- A&TSICCHOs generally don't have a seat at the LDMG and so were unsure how to link into the response. Health representatives on the LDMG were generally unsure how to include A&TSICCHOs and other private health providers, or if they should/could, considering the different arrangements.
- Often there were multiple requests for information through multiple channels, rather than using the QDMA, causing duplications, delays and different messaging.
- There is no 'united voice' of Queensland Health and there is not a lot of coordination between the Department of Health and the HHSs, and other health services.
- There were structural issues with the QDMA, particularly around the perception of the Lead Agency. Queensland Health were not seen as strong leaders in the space, and QPS were not the right fit to lead a health/social response.
- Agencies of the QDMA were used to QPS leading disaster responses, as they do for primary hazards (storm/cyclone/flood), that it was difficult to define what other agencies should do as 'Lead Agency' in the other hazards.

Insights

- xvi. The Queensland Disaster Management Arrangements (QDMA) was a well trusted and established framework for the multi-agency coordinated response required for the COVID-19 pandemic response. The QDMA places local government as the lead for their communities, enabling a community-led and informed response, supported by the other agencies of the QDMA. Local Disaster Management Plans, whilst not pandemic-specific, provided well-tested plans to enact a coordinated response. What impacted this response was that it was more a top-down approach, rather than the traditional bottom up, meaning Local Disaster Management Groups (LDMGs) were enacting policy provided from above, rather than being able to inform requirements from community. Where there were strong relationships across LDMGs and District Disaster Management Groups (DDMGs) a more coordinated and community-focused response was evidenced.
- xvii. Queensland Health (both in the Hospital and Health Services (HHSs) and Department of Health) generally struggled to understand their Lead Agency role in the Queensland Disaster Management Arrangements (QDMA). This then had downstream impacts on their engagement and collaboration with Local and District Disaster Management Groups (LDMGs/DDMGs), and trust-building and relationships with the other agencies.
- xviii. Not all representatives of the health system (e.g., Primary Health Networks (PHNs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations

(A&TSICCHOs), Aged Care etc.) are represented on all Local or District Disaster Management Groups (LDMGs/DDMGs). This has led to a poor understanding of this greater health system and the role that Queensland Health and the Hospital and Health Services (HHSs) play as the only health system representative, their requirement and/or ability to coordinate the whole of health system representation, and that they cannot represent on behalf of the other organisations without authority being provided to them. Where representation of the greater health system (e.g., PHNs and A&TSICCHOs) existed on LDMGs and DDMGs there was greater sharing of information and coordination of response.

Lesson Identified

- E. That Hospital and Health Services (HHSs) should continue to build and maintain relationships with their Local and District Disaster Management Groups (LDMGs/DDMGs). Discussions should be had with these groups to consider and advocate for how other representatives from the health system (e.g., Primary Health Networks (PHNs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), Aged Care etc.) can be represented on the relevant groups.

Focus Area 6: Community Engagement and Communications

Many participants of the review identified that communications from Queensland Health, both publicly to communities and internally to Hospital and Health Services (HHSs) had some issues.

Public communications were generally controlled and developed by the Queensland Department of Health, and it was identified that many of the conventional methods of communication used (media, website etc.) did not always meet the needs of Aboriginal and Torres Strait Islander communities. It was identified that tailored communications for Aboriginal and Torres Strait Islander people came too late in the response and weren't contextualised enough for each community. It was generally felt that locally developed and contextualised communications, and stronger community engagement practices, would have had better outcomes for connecting and providing information for communities.

Building relationships with communities through yarning, using Aboriginal and Torres Strait Islander staff, engaging local leaders, utilising local and trusted faces as spokespeople in marketing and videos, and the community engagement shown by the Johnathan Thurston Academy, and supported clinically by Queensland Health, showed increased community engagement and uptake with vaccination, testing and integration with health services.



Healthcare staff showing off their Make the Choice mask (Source: QH Asset Library)

Observations and Analysis

There were 145 observations related directly to the focus area of Community Engagement and Communications. Of these observations, there were 54 **Sustain**, and 91 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

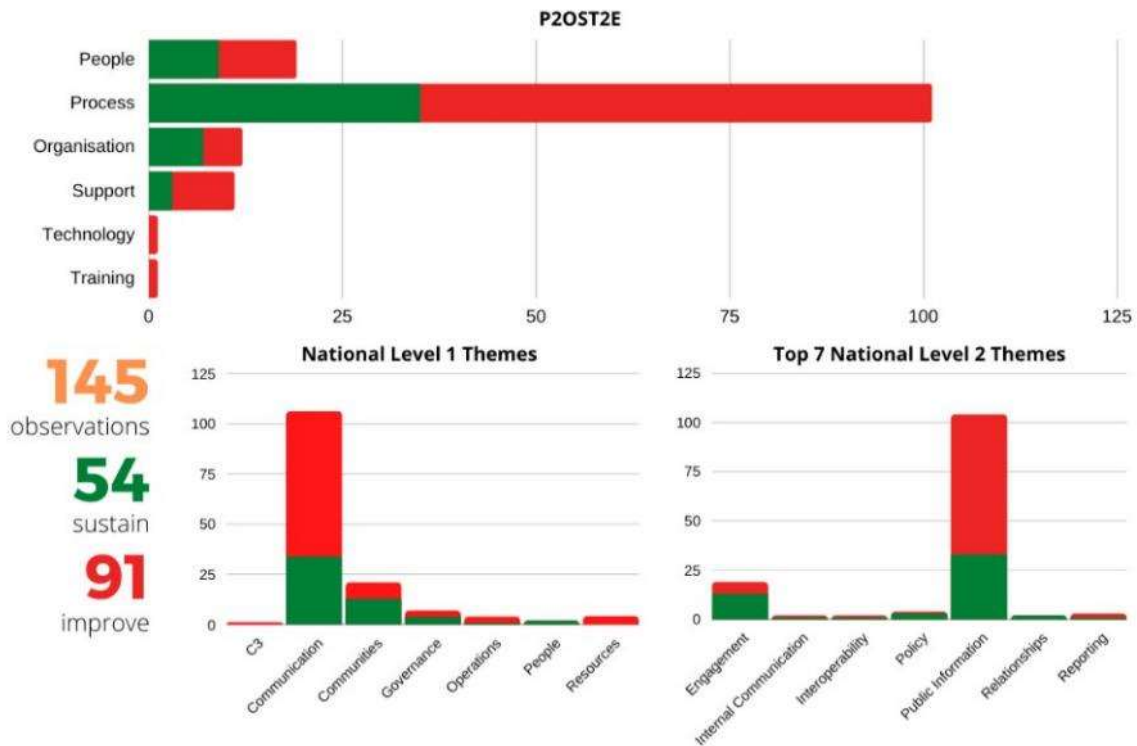


Figure 11: Breakdown of data for Focus Area 6

What worked well

- Changes in social policy (vaccine requirements to enter pubs etc.) encouraged members of the community to get vaccinated.
- Outbreaks validated the seriousness of the disease and reduced some of the 'naysayers' that were spreading discord in the community.
- The use of video for messaging to community received a larger number of hits and shares than written message.
- Having Aboriginal and Torres Strait Islander branding, particularly localised branding, helped to improve uptake of vaccinations and community interest.
- The decision to run the Make the Choice campaign through Queensland Aboriginal and Islander Health Council (QAIHC) was made because many First Nations people have distrust in Queensland Health and are more likely to respond to their A&T SICCHOs messaging. The focus of much of the campaign development was centred around 'what do we want people to feel' e.g., feel good, not ostracised etc.
- The Make the Choice campaign shirts were well received by the community, and the other Make the Choice resources helped with promotion of COVID-19 awareness and vaccinations. The Make the Choice campaign is well recognised across the First Nations communities.
- The Chief Health Officer (CHO) Public Health Directions were a good tool to clearly define requirements and expectations.
- Queensland Health developed resources were able to fill a gap for those HHSs who didn't have the resources to deliver their own.
- Communications and media can only solve part of the problem. Engagement is the key to influence real change. This was evident in the engagement completed by Johnathan Thurston (through the JT Academy) with the community visits, yarning and First Nations

people (such as Aboriginal and Torres Strait Islander Health Workers and other staff engaging with First Nations communities).

- The visits from Jonathon Thurston were beneficial and well received by the community. It significantly increased uptake of the vaccination in the visited regions. An indigenous man talking to indigenous people about COVID-19 and the vaccination was powerful and significantly increased the vaccination rollout. The community felt like they knew him, and it wasn't a stranger telling them about something strange.
- The unique rollouts of the vaccine and response required unique and contextualised communications. This wasn't always provided by Queensland Health, but HHSs tried to influence this as they knew their communities.
- Local champions and local discussions yielded better results.
- Having First Nations people talking to First Nations people was the most effective way of communicating and engaging.
- When the A&TSICCHOs were able to undertake their own messaging, they were able to contextualise the messaging to suit their community needs and this saw better outcomes and understanding by the community.
- When community sees local faces saying the same message (know, trust, like) then they believe it and take it on.

Challenges

- The communications received for dissemination to community were generally Metro-based, and not contextualised for regional/remote areas.
- Conventional communication strategies to the general community did not work well with First Nations People.
- More use of local, trusted, spokespersons for messages and videos etc. would have been more beneficial and better received by the community.
- Local persons weren't always utilised to spread local messaging. There was too much reliance on state communications, but these weren't contextualised.
- Aboriginal and Torres Strait Islander branding occurred 'almost too late', and it should have been implemented sooner. The First Nations perspective by the Department was 'late to the party'. For example, initial messaging and communications did not consider the First Nations perspective and appropriate communication development was frequently delayed.
- Communications have been a bit 'black and white' and need to talk in the 'grey' and be more truthful e.g., "wear a mask to minimise sickness" rather than the current "wear a mask to avoid".
- It wasn't well communicated that areas of the state were in different 'phases' e.g., discrete communities were in "protection" when the rest of the state were in "suppression" this meant that there were some misaligned expectations. It was often out of sync for timing, and their Aboriginal and Torres Strait Islander community didn't want to read about it, they wanted to talk about it.
- The Commonwealth, Queensland Department of Health, HHSs and other government agencies had different messaging, and this impacted communications.
- HHSs identified that they were not always allowed/enabled to produce their own external communications and there were often delays in receiving appropriate community-focused communications, delaying what they could then provide to the community.

- The Make the Choice campaign was launched on 19 August 2021. Many of the HHSs felt that this was too delayed in the COVID-19 response (as vaccinations had been available since March 2021).
- The unique rollouts of the vaccine and response across HHSs required unique and contextualised communications. This wasn't always provided by Queensland Health.
- Centrally controlled messages didn't work. They lost efficacy by the time it got to the rural/remote areas. The communications that were distributed by Queensland Health were not always culturally appropriate, and "were not in our language". HHSs believed they were not allowed to translate them into languages of the community.
- Due to the lack of communications coming from Queensland Health, the A&TSICCHOs developed their own resources and then shared these across their networks (including interstate).
- Much of the messaging that was coming out of the State/Federal health departments was not relevant for First Nations communities. For example, 'isolate in a spare room' when many communities are suffering from overcrowding in houses, and the definition of 'family' being 3-4 people, when in First Nations communities it could be 20+. These messages had to be contextualised for the local communities because of this disconnect.
- There were delays in distribution of communications from Queensland Health because communications had to be centrally approved from the Department of Health. This made contextualised messaging difficult and delayed.
- Lived experience was not shared as much as it could be. By telling our community about our experiences they listen and take action.
- Only using South East Queensland, or one particular area's people, in state-wide education and communications is not effective. Local mob needs to see local mob providing information and education for good effect.
- Much of the information provided was reliant on being connected to the internet/having a computer but this is not always available and accessible to people.
- Local social media is more powerful than any Queensland Health media – need to know and use this better and find the moderators/admins and work with them/use these channels better.

Insights

- xix. Much of the communications and related messaging developed centrally by Queensland Health was generally focused on metro areas (and in particular the context of South East Queensland) but expected to be used for all of Queensland. This centralised messaging was often out of sync with other areas of Queensland and therefore not relevant at the time of distribution, and the conventional communication strategies and the content was not (and was not always allowed to be) contextualised for regional or remote areas or take into consideration the context of Aboriginal and Torres Strait Islander culture, family dynamics, local resources and infrastructure, and consumption of information. There were significant delays in providing Aboriginal and Torres Strait Islander targeted messaging (e.g., the Make the Choice vaccination campaign was not released until August 2021, when the vaccine had been available since March 2021). When Hospital and Health Services (HHSs) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) were able to develop and deliver community-informed messaging, taking into account the needs of individual communities and locations, the messaging was better understood and applied.

- xx. Community engagement, rather than conventional communications, was key to sharing information and engaging with Aboriginal and Torres Strait Islander communities. Building relationships with communities through yarning, utilising Aboriginal and Torres Strait Islander staff, engaging local leaders to be community champions, employing local and trusted faces as spokespeople in marketing and videos, and the community engagement shown by the Johnathan Thurston (JT) Academy, and supported clinically by Queensland Health, showed increased community engagement and uptake with vaccination, testing and integration with health services. The use of famous identities as a drawcard, supported by trusted health professionals providing advice and personal stories, increased community engagement and uptake of the COVID-19 vaccination.

See also Insight xv. in [Focus Area 4: Health Service Integration with Other Agencies](#)

Lesson Identified

- F. Community engagement and communications should be enabled to be developed locally so they can be contextualised to suit the needs of the community. Where state-wide messaging is required, guidelines should be developed for messaging and communications, and support provided to local Hospital and Health Services (HHSs) and other organisations to develop localised messaging that is in line with the guidelines but still suit the needs of the community, particularly for Aboriginal and Torres Strait Islander people. Further work should be undertaken to understand and integrate the power of community engagement, rather than just conventional communication methods.



Make the Choice campaign web banner (Source: QH Asset Library)

Our New World Together

Known as the sunshine state, what makes this place unique is its vibrant locations, the rich Aboriginal and Torres Strait Islander culture it reflects and its embodiment of our strong connection to the land and sea.

A cornerstone of the Aboriginal and Torres Strait Islander culture is the ability to connect with one another; locally, nationally and internationally.

Protecting our Aboriginal and Torres Strait Islander people and communities is our number one priority. This artwork is broken up into different sections which shows the complexities and challenges COVID-19 brings into our daily lives.

It shows the travelling lines as good information is shared as we make our way to different communities, rural and remote. These conversational yarns along the way, allow our mob to ask questions, stay informed and to understand and respect concerns they have.

The COVID-19 molecule front and center shows the focal point and the particles around it. It also reminds us of the milky way, something we all share together when we look up to the sky and navigate through life today.

Circles throughout the artwork are the meaning of life that are continually constant. They will change in shape and grow as our thoughts evolve with new information we receive along the way.

These yarning circles also provide a place of communication and hope. This is also evident in our relationships, our compassion and it reflects the importance of family, strength, protection and power. Lines crossing over shows the two cultures' and their traditional art practices of weaving with coconut and black palm leaves. Weaving also signifies people, song and place and coming together as one.

Symbols of feathers show reference to our totems, their energy and spirit. And the male dhari headdress. And also Pearl shells are still today an important cultural practice.

The trees and their roots show both cultures strong and proud. As its roots draw deep from freshwater and saltwater which are the sources of life and replenishes and renourishes our healing places.

The dots throughout show our communities coming together that make up our diverse and respected community members such as: elders past, present and emerging.

This artwork shows the journey we face and the long road we have together.

Make the choice that's right for you, your family and your mob.

Nyall youndoo Jinna la galing
(Happy journeys and safe travels)

Jedess Hudson

Figure 12: The artwork and story of the Make the Choice campaign

Focus Area 7: Biosecurity Arrangements and Public Health Directions

The Federal Government-designated biosecurity area restrictions (under the Commonwealth *Biosecurity Act 2015*) essentially locked down the remote Aboriginal and Torres Strait Islander communities across Queensland for a period of three months. These restrictions were enacted quickly, and whilst the Mayors of these communities were consulted on and involved in the decision-making to enact these restrictions, the consequences of the restrictions had not been well considered or planned for. The operationalisation of the restrictions was not well understood and there were initial issues with the provision of exemptions for members of the community and service providers to leave or return.

Some communities, such as Yarrabah and Cherbourg, were isolated from their nearest towns where all supplies are sourced from, and consideration had not been given to replace this supply chain. In later stages more local resolutions were enacted to support workable local solutions which considered local risk and social factors. Other locations such as the Northern Peninsula Area (the Cape) and the Torres Strait were part of a broader area where travel within the area, and between townships could occur, alleviating some of these issues. The different areas had different experiences with the restrictions and in turn some valued the restriction and felt safer for them, whilst other communities felt that they were unnecessary and unfairly handled.

Observations and Analysis

There were 70 observations related directly to the focus area of Biosecurity Arrangements and Health Directions. Of these observations, there were 28 **Sustain**, and 42 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

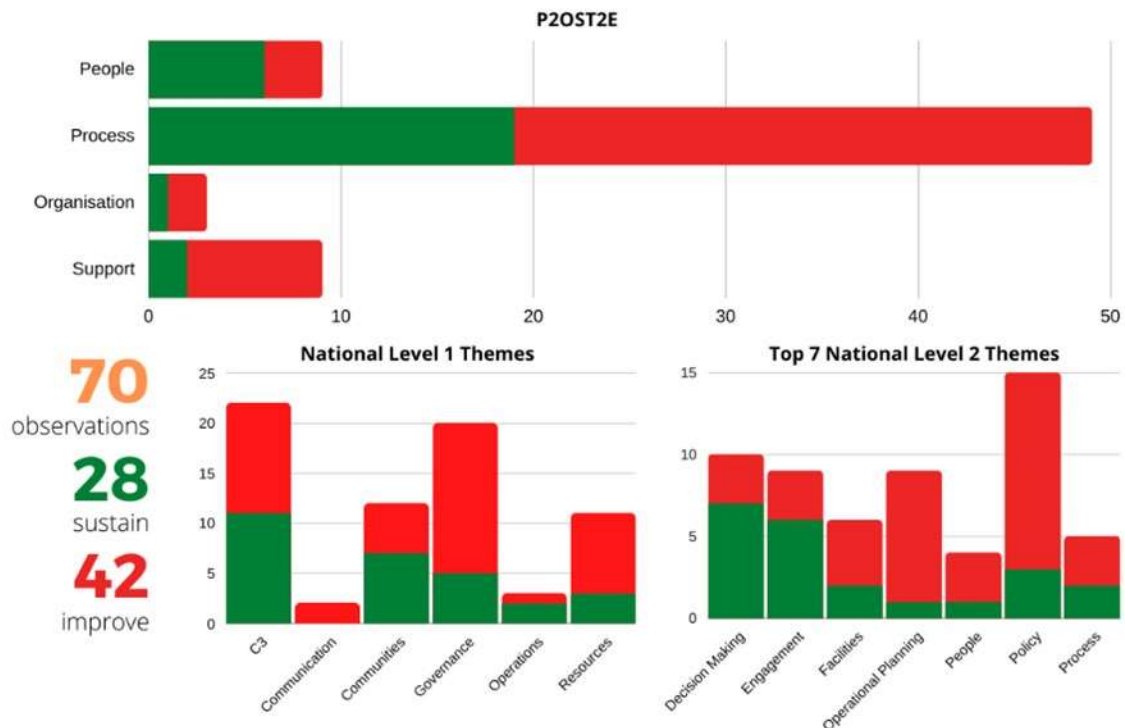


Figure 13: Breakdown of data for Focus Area 7

What worked well

- There was a lot of consultation with the Mayors about the introduction of the biosecurity arrangements, the mayors of the discrete communities were involved in the decision to enact the *Biosecurity Act 2015* and the arrangements regarding lockdowns of the communities and unanimously chose to allow this for the safety of their communities.
- The communities having choice in the lockdowns likely assisted with their compliance and acceptance of the arrangements.
- The *Biosecurity Act 2015* lockdowns of discrete communities did assist in preventing the transmission of the COVID-19 virus into these communities.
- After the Local Government elections in 2020 there were many new Mayors who weren't involved in the decision-making about the *Biosecurity Act 2015* lockdowns, but they stuck with the decisions and enacted them to the best of their ability.
- The decision to remove the *Biosecurity Act 2015* arrangements occurred at a good time, once more was known about the virus and how local arrangements could be managed.
- The workloads of the Human Biosecurity Officers in the enactment of the lockdowns were very large, when these officers were already busy managing the pandemic response. Some areas, such as North Queensland, only had one person who could undertake this role. Eventually North Queensland had more than one Human Biosecurity Officer and this aided in the exemption process.
- The Biosecurity lockdowns were successful because the Local Disaster Management Group (LDMG) listened to community, and the State listened to the LDMGs about what they wanted.
- With the restrictiveness of the biosecurity arrangements a lot of innovation and problem-solving occurred that resolved many long-standing issues (e.g., dialysis chairs being installed at Yarrabah).

- There was a generally positive feeling in the communities of the Northern Peninsula Area and Torres Strait surrounding the Biosecurity lockdowns as they were able to manage the flow of people into community and added to feelings of safety.
- In the Northern Peninsula Area and Torres Strait, it was well-received that locals could make local decisions about who could come into community and for what purpose during the biosecurity lockdowns. This enabled management of the flow of people and gave the LDMG oversight on management plans.

Challenges

- There was a local government election shortly after the decision to enact the biosecurity lockdowns and that there were many new Mayors who weren't involved in the decision-making who now had to manage the legacy arrangements. The Biosecurity Lockdowns made it a challenge to control entry to communities and still provide support to them (e.g., supply of goods and services). This was particularly evident in Cherbourg, where all shopping is done in Murgon, but Murgon wasn't included in the area, and Yarrabah with neighbouring Cairns.
- If they had their time again, some Mayors would resist the 'Lockdowns' and not implement the checkpoints etc. The checkpoint was difficult to manage.
- The *Biosecurity Act 2015* lockdowns added unnecessary anxiety to the daily routines of community.
- There were resource complications during the lockdowns, particularly in regard to security, workforce and food supply, especially when the isolated communities didn't have local access to supplies etc.
- The Biosecurity lockdowns were introduced with no prior warning to the HHSs and without consideration of the unintended consequences of the short-notice lockdowns. There were hundreds of patients and other members of the population who were suddenly locked out of their communities and required quarantine and social supports, which had not been pre-planned or the requirements understood. This meant that arrangements were rushed and made up on the spot. The lockdown of communities didn't take into account people who were out of their communities at the time, or the services that needed to come into community, and this was managed as an afterthought.
- The implementation of the Biosecurity lockdowns were 'chaos.' They were implemented with little understanding of what they actually meant, what would be involved and how inflexible they were. The Human Biosecurity Officers (of which there were limited numbers) were crushed with the workload, on top of what they were already managing for the COVID-19 response.
- Services (social and healthcare) were, at short notice, unable to access the communities included in the Biosecurity lockdowns and alternate arrangements had to be made. Prior planning would have enabled prepositioning of services and staff to enable continuity of services and care.
- The Biosecurity arrangements did negatively impact on staffing for the discrete communities as many staff are sourced from agencies and live outside of community, and often outside of Queensland.
- The lockdown arrangements appeared to be very 'government focused' only and did not take into account community perspectives.

- If they had their time again, and knew what they did now, they probably would have not used the *Biosecurity Act 2015* arrangements and instead look to the use of Public Health Directions, as was brought in later in the response.
- Cooktown and Weipa were not initially included in the Biosecurity arrangements for the Cape Area which had significant impacts on the other communities due to the population and services provided to/from these communities to the discrete communities.
- Each discrete community included in the Biosecurity arrangements had different arrangements for accessing, approvals etc. so it was difficult to have streamlined approach to support communities and return patients/populations.
- There was often a double standard for exemptions to go in/out of locked down communities. For example: nurses and other services could come into community to deliver care (without quarantine requirements), but residents couldn't leave community to attend health care without having to quarantine on return. The community was often angry that they were locked in/out and felt like there were different rules for them compared to white people coming into community.

Insights

- xxi. That the local leadership (Mayors) of the remote Aboriginal and Torres Strait Islander communities (Aboriginal Shire Council areas) were involved in the discussions and decisions to enact the Federal Government-designated biosecurity area restrictions was appreciated by the Mayors and their communities. The local government elections that occurred mid-way through the restrictions had impacts on the subsequent level of support as there were a number of new Mayors elected who had not been involved in the decision-making process.
- xxii. The true impacts of the Federal Government-designated biosecurity area restrictions, and later Queensland Government Public Health Directions, hadn't been fully considered prior to their implementation. They were enacted quickly, with little warning, and many people from the impacted communities were stuck outside of their area, requiring accommodation and quarantine support, that had not been pre-planned or well understood. There was little understanding initially of how to operationalise the legislation and the restrictions impacted supply chain, services, staff movements and community support by organisations that relied on 'fly in, fly out' workforces. The restrictions were experienced differently by different communities, but it was frequently expressed that in relation to exemptions, there was 'one rule for white workers, and another rule for members of the community'. Where communities were generally self-sufficient (e.g., Northern Peninsula Area and Torres Strait) the restrictions were well accepted and tolerated by communities. These communities generally appreciated the restrictions as they felt more protected and wanted to reimplement a level of restriction in the face of the Omicron strain outbreak. Where communities did not have their own stores/supply chains/medical services etc. and relied on neighbouring towns that weren't included in the biosecurity area (e.g., Cherbourg, Woorabinda and Yarrabah), there were significant difficulties experienced. These communities held concerns that restrictions would be reimposed in the face of subsequent outbreaks and were generally not supportive of this.

Lesson Identified

- G. Further review of the implementation and operationalisation of the Federal Government-designated biosecurity area restrictions and Queensland Government Public Health Directions to remote Aboriginal and Torres Strait Islander communities should be undertaken to inform planning for future occurrences where restrictions such as these may be required. Consideration of supply chain, access to health care, education and other services (in and out of community) and the process of exemptions (including for community members), quarantine and cultural safety should be included.

Focus Area 8: Agency-Specific Arrangements

The review noted some specific discussions regarding Queensland Health and Hospital and Health Service (HHS) arrangements, including the dissemination of information from the Department of Health through to the HHSs and the integration of Public Health Units (PHUs) and HHSs.

There were many observations captured that related to other agency-specific arrangements. As these are out of scope for the review, they have not been included in this report.

Observations and Analysis

There were 184 observations related directly to the focus area of Agency-Specific Arrangements. Of these observations, there were 63 **Sustain**, and 121 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

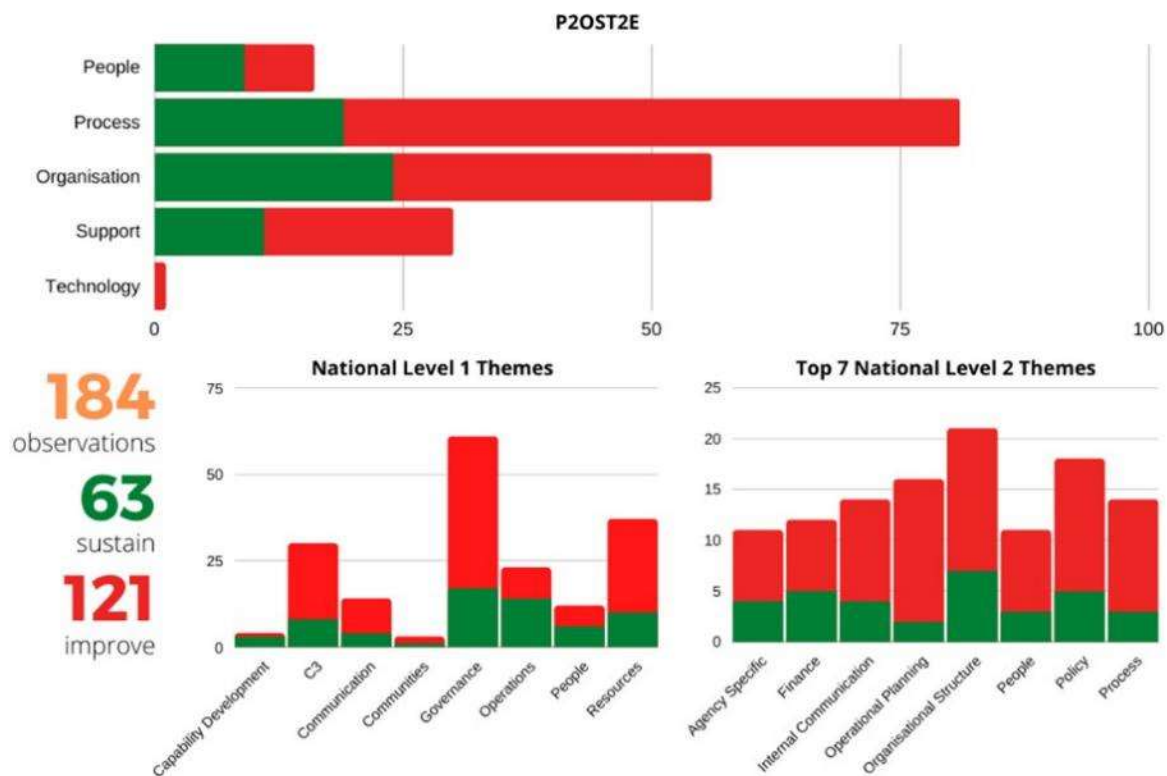


Figure 14: Breakdown of data for Focus Area 8

What worked well

- Many of the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) appreciated the support provided by the Queensland Health Aboriginal and Torres Strait Islander Health Division.
- The Chief Health Officer always worked with the safety of the community first in mind and was very 'humane' in her approach.
- The biosecurity lockdowns and ongoing response almost 'forced' relationships to improve between Torres and Cape Hospital and Health Service (TCHHS) and Cairns and Hinterland Hospital and Health Service (CHHHS) due to the number of patients who were undertaking treatment in Cairns but belonged to TCHHS. These relationships have now improved the way the HHS' work together for business-as-usual (BAU) operations.
- The COVID-19 response has accelerated the provision of health care and health equity to First Nations and that this work and trajectory needs to continue. BAU arrangements will not achieve Health Equity or Close the Gap.
- The response encouraged problem-solving and being solution focused. There is fear that this will be lost as we return to BAU.
- The accessibility of the Aboriginal & Torres Strait Islander Health Division for consultation and involvement was a positive. Having the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General at the executive level and part of the decision-making team was crucial in ensuring the response considered the needs of First Nations people.
- When the Director of Nursing position started in the Department of Health First Nations COVID-19 team the contact and usefulness of the team was improved. The HHSs felt like they knew who to reach out to and what the team could offer. It was great to have the nursing/clinical support from the First Nations COVID-19 Team.

- As the vaccination rollout increased, the First Nation's team at the HHS had more to do with the Department of Health Aboriginal and Torres Strait Islander Health Division COVID-19 Response Team and appreciated the support provided. The team, and especially the Public Health Physician, supported outbreak management, response, vaccine rollout and were very supportive and useful.
- The COVID-19 response enabled everyone to 'just get stuff done', often without the bureaucracy. Whilst there is some risk in doing this, there is a greater risk in not doing anything or delaying it.
- Queensland Health funding was provided quickly and with flexibility, which enabled the A&TSICCHOs to stand up a lot of their responses.

Challenges

- Frequently, the transmission of information from the Department came through the BAU channels, and not through the Disaster Management structure that had been stood up, meaning that the HHS Emergency Operations Centres (EOCs) (COVID-19 response teams) often weren't aware of changes or information because it had gone through to the Chief Executives etc. and had not come to the EOCs.
- Queensland Health struggled to work within the Disaster Management Arrangements, switching between the Disaster Management and BAU structures but not using one or both consistently. This often caused confusion in reporting lines, responsibilities, communication, and the overall response.
- The daily/weekly meetings that were occurring with the Mayors, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP) and Queensland Health did not include a representative of the HHS so they were unaware that these were occurring or what was being discussed. At times, this directly impacted communications and trust between the Mayors and the HHSs.
- The HHSs were often not provided with early (or any) notification of what might be announced at the daily Press Briefing by the Chief Health Officer (CHO), with announcements coming as a surprise and the HHSs then having to respond to what had been announced to the public at the same time. This included announcements such as the biosecurity lockdowns, changes to policy/health directions, borders etc. It was frustrating that the HHS would find out what was occurring/new policy changes at the CHO media briefing at the same time as the community and other agencies. This meant that the HHS was ill-informed and lost trust with their stakeholders for not sharing information they didn't have.
- There were a lot of short notice, public announcements from the Queensland Department of Health that the HHSs then had to enact. For example, pop up clinics at Bunnings. These announcements had very little lead time and most of the time with no consultation with the HHSs.
- The silos that existed in Queensland Health made the response difficult (e.g., State Health Emergency Coordination Centre (SHECC) vs Aboriginal and Torres Strait Islander Health Division vs COVID-19 System Response Group (CSRG)). It was challenging to know who was doing what and when, as there was limited coordination and communication about this. The First Nations COVID-19 team was not well integrated into the system response or with SHECC and there was a lack of unified governance over who was doing what in the department.

- Initially, there was a lack of testing capability in the remote communities in the early phase of the pandemic. When the Kirby Institute offered Point of Care (PoC) testing to additional locations, the initial response from Queensland Health was 'no'. After some negotiations, this was able to be changed and the PoC testing was provided in some remote locations.
- Queensland Health wasn't able to support flexible funding arrangements to the A&TSICCHOs. In the end, the Queensland Aboriginal and Islander Health Council (QAIHC) received pockets of money and purchased/resourced what the A&TSICCHOs needed and then 'gifted' them to them as they weren't able to provide the money directly. This made for double handling and dilution of the end result.
- Initially some HHSs struggled to get appropriate supplies of PPE due to the way it was allocated by Queensland Health. It took a quite a while to sort this out and left gaps in PPE supply initially.
- There was no clarity about what the function of the Department of Health's First Nations COVID-19 team was and how they could be used, what they needed from the HHS etc. having one person as a conduit into the First Nations COVID-19 team works better than having multiple contacts reaching into the HHS.
- Queensland Department of Health First Nations COVID-19 Team meetings were ok, but not all the right players were invited. They only went to the First Nations Lead and not to COVID-19 lead, so messages didn't always get shared.
- There needed to be more clarity about why particular meetings were occurring and what their function was.
- Many of the HHSs had pre-existing staffing issues and the pandemic compounded these.
- Whilst there was some alignment in planning between CSRG and the Aboriginal and Torres Strait Islander Health Division, initially this could have been done better.
- It was noted that the centrally-based HHS staff often did not understand the local context of some of the health locations and communities across the HHS, the challenges they faced, or the way that support needed to be provided to them.
- Outbreak management planning was often done from a Health perspective and not from a whole-of-community, holistic response.
- There can't always just be a centralised approach out of Brisbane, there needs to be regional, place-based, leadership and community.
- The public health system is very rule based/strict, the pandemic response showed us that we can behave differently, and we can have different outcomes, if we're willing to be innovative and take risks.
- TCHHS had to establish a temporary Public Health Unit (PHU) to support their area as the Cairns/Tropical PHU were unable to support them as they usually would.
- There were often silos between the HHSs and the PHUs. In these cases, had the HHS used the PHU network better the response potentially could have been more streamlined and effective. PHUs often already know the players and have done this before in other outbreaks but this knowledge was not always used.
- The PHUs operated differently across the different HHSs.

Insights

- xxiii. The establishment of the daily/regular meetings of the Mayors of the remote Aboriginal and Torres Strait Islander communities, led by the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP), and

supported by Queensland Department of Health, was well received by the communities as it enabled regular information sharing, discussion, and decision-making to occur. There were concerns raised that the meeting was led by DSDSATSIP rather than Queensland Health, as the lead agency, and that the Hospital and Health Services (HHSs) who are the representatives at Local and District Disaster Management Groups were not included. The HHSs regularly felt that they were missing what information was being shared and therefore weren't 'on the same page' as the Department of Health which impacted local relationships and the trust between councils and the HHSs.

- xxiv. The Hospital and Health Services (HHSs) were often not provided with early (or any) notification of what might be announced at the daily Press Briefing by the Chief Health Officer, with announcements coming as a surprise and the HHSs then having to respond to what had been announced to the public at the same time. This included announcements such as the implementation of the Federal Government biosecurity area restrictions, changes to policy and Public Health Directions, borders etc. It subsequently eroded some of the trust the HHSs had built with agencies of the Local and District Disaster Management Groups and had them 'on the back foot' regarding planning and response operations having to occur with little to no notice.
- xxv. Like the Hospital and Health Services (HHSs), each Public Health Unit (PHU) operated differently within the pandemic response. There was not always strong integration with the PHU and the HHS COVID-19 response capability and where this didn't exist there appeared to be some erosion of trust between the areas, duplication of work, and different approaches to the same communities. Where an HHS did not have their own PHU there were resourcing difficulties as they relied on other, already busy, PHUs to assist with their workload (e.g., North West HHS relied on Townsville PHU, and Torres and Cape relied on Cairns PHU, but eventually established their own).

Lesson Identified

- H. Where meetings are held by Queensland Department of Health to share information with local government or agencies that may interact with the health system, consideration should be made to extend the invitation to the relevant Hospital and Health Services (HHSs) to ensure that there is consistent messaging across the levels of the health system. Consideration should also be given to providing HHSs with advanced notification of significant changes to policy or events that will impact their planning and response requirements before it is provided to the public.

Focus Area 9: Vaccination Rollout

The COVID-19 vaccination rollout commenced in March 2021 with the first doses of the AstraZeneca (Oxford) vaccine. Initially this vaccine was deemed suitable for all Aboriginal and Torres Strait Islander populations, with these communities being included in phase 1b of the vaccination rollout and doses being administered across many of the communities. In April 2021, the rollout was halted with changes in policy due to the reported risks of incidence of blood clots and deaths from the AstraZeneca vaccine. There was increased media and reporting during this time, and this significantly impacted the trust in the vaccination program and increased vaccine hesitancy in Aboriginal and Torres Strait Islander communities.

With this policy change came delays to the vaccine rollout to Aboriginal and Torres Strait Islander communities as a result of the change in processes that had to be undertaken to provide supply chain of the Pfizer (Comirnaty) COVID-19 vaccine to Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) and Queensland Health facilities in regional and remote areas.

Rollout of the Pfizer vaccine to regional and remote areas didn't gain momentum until the last quarter of 2021, and it wasn't until Health Direction and policy changes were introduced (e.g., 'no jab no play') that the vaccination rates in Aboriginal and Torres Strait Islander people increased significantly. The outbreaks in early 2022, the concerted effort to increase vaccination rates through contextualised community rollout, and provision of incentives (such as the Make the Choice campaign collateral) also saw an increase in vaccination rates.

Data and reporting were also issues raised by review participants, with there being significant interest in vaccination rates, but also ongoing issues with data integrity.



Cairns First Nations COVID-19 Response Team (Source: QH Asset Library)

Observations and Analysis

There were 109 observations related directly to the focus area of Vaccination Rollout. Of these observations, there were 46 **Sustain**, and 63 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

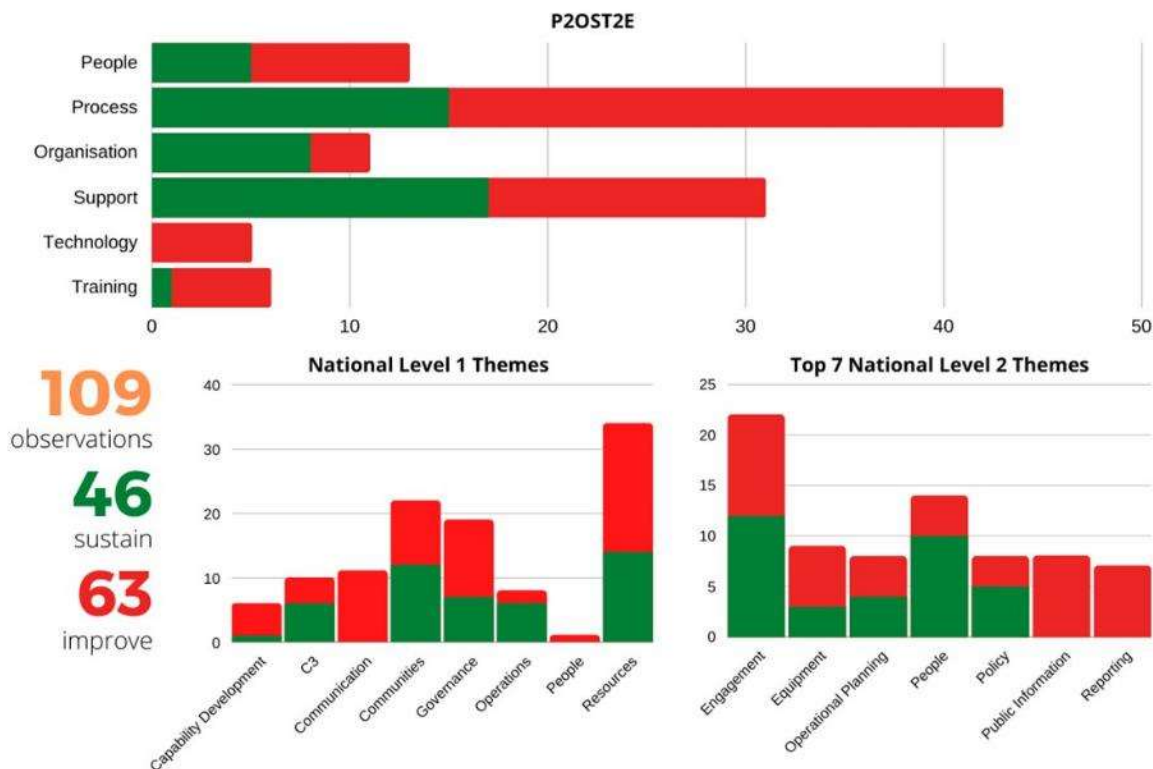


Figure 15: Breakdown of data for Focus Area 9

What worked well

- There was a noticeable increase in vaccination rates when the policy changed that required vaccination to attend hospitality and other venues.
- The Mater Health and other vaccination providers were essential and invaluable to the vaccination rollout. They enabled the 'known' staff to target their outreach to the community whilst they worked 'behind the scenes' in preparing and administering vaccinations. There was a great working relationship between the Mater teams and local community.
- The Vaccine Taskforce was a multi-agency/state-wide program involving the Primary Health Network (PHN), A&TSICCHOs, General Practitioners (GPs), Queensland Health, Aboriginal Medical Services (AMS) etc., and that it had such a broad reach was one of its strengths.
- The Vaccine Taskforce was able to deploy appropriate fridges/freezers to every Hospital and Health Service (HHS) (including rural/remote) to enable storage of all of the vaccines. This aided in the rollout of the COVID-19 vaccine but will also prepare the HHSs for future mRNA vaccine programs.

- The vaccine rollout has helped deliver a sustainable long-term model for future vaccination rollouts, especially in rural/remote/discrete communities.
- Having GPs and pharmacists on board to roll out the vaccination enabled another way of connecting with the community. We need to not underestimate the value of pharmacies and A&T/SICCHOs in vaccination rollout. They are familiar to communities, well-frequented and trusted.
- There was a lot of vaccine hesitancy in the First Nations population, however with the increased communications, engagement and leadership through local leaders the vaccination rate significantly improved.
- Many HHSs altered their way of doing business by undertaking vaccinations 'where people where' If this meant going down to the beach, going to where people were fishing etc. and just having a yarn and offering the vaccine, this is what they did and it worked.
- Initially vaccination rates in discrete communities were lagging, there was an innovative response by HHSs to do vaccinations in the community (e.g., going door to door, attending community events, locating vaccination teams in locations that people frequented etc.)
- The HHS and its clinical staff had to adjust to working outside of a clinical setting. For the most part, staff reacted well to this and the staff who did were engaged more to support delivery.

Challenges

- At the commencement of the vaccination rollout in 2021 there wasn't enough vaccine available to meet demand.
- The rollout of the Queensland COVID-19 Vaccination Management System (QCVMS) was not entirely appropriate for the remote areas, their technology, connectivity, logistics and arrangements. The early rollout of vaccination that occurred in the Torres Strait outer islands and other remote communities, and required use of QCVMS, was difficult due to lack of network and ICT infrastructure to enable effective use of the system and the 'pressure' that was being applied by the Department for 'up-to-date' information.
- The vaccination rollout in First Nations communities (particularly in the islands of the Torres Strait and other remote areas) was going really well, until the first death from the AstraZeneca vaccine occurred, and the changes in position on the vaccine were present in the media and general communications. This led to misinformation and fear and halted the successful vaccination rollout for a period of months.
- With the stalling of the vaccination (AstraZeneca) program in April 2021 it was difficult to replace the AstraZeneca with an alternate vaccine such as Pfizer because of the initial supply constraints, difficult cold-chain storage and more difficult constitution. there was a significant delay between the AstraZeneca policy change and the supply of Pfizer. This meant that vaccinations were delayed.
- The media management around the AstraZeneca rollout greatly impacted the uptake of what was essentially a safe and effective vaccine. This greatly delayed to vaccine rollout across vulnerable communities.
- The vaccination rate gap between First Nations and the general population increased substantially after the 'scare' from AstraZeneca.

- It was 'tough going at the start' with the vaccine rollout, especially in the young people. There was a lot of misinformation on social media, and this led to increased hesitancy and distrust of the vaccine and the government. It got to the point where enforcing social policy became a driver.
- The 'data was always wrong' and there were discrepancies. Generally, at the state system level they were correct, but the further localised the reporting the more discrepancies there were.
- The baseline Australian Immunisation Register (AIR) data was generally incorrect (based on Medicare data) and so that in turn meant that reporting and other data was incorrect. Especially in communities with small numbers where the baseline population data wasn't accurately represented.
- There was so much thirst for data and debate around data that it distracted from the actual vaccination rollout.
- There was initially a lot of on-ground confusion between the State and Commonwealth and the initial rollout wasn't as coordinated as it could have been.
- The strategy for the vaccination rollout was developed in the 'big city' with no consultation with community to meet their needs (e.g., locations, timings etc.) It felt like a constant battle with the HHS to advocate for what the community needed. We were told what would occur, rather than being able to develop a strategy that would meet each of our communities.
- There was a lot of 'politics and hype' about how frontline staff and Aboriginal and Torres Strait Islander people would be the first to be vaccinated (under phase 1b), however vaccinations didn't start in remote communities until well after the other phases had commenced in the metro areas. It felt like a farce and caused a lot of distrust by the community and local staff because of the delays.
- There was an interesting dichotomy of messaging and delivery, particularly around vaccination. For example, Elders were getting vaccinated, but the younger generation didn't want to. They were getting their information from different sources.

A First Nations Perspective

My Name is Roxy, and I am proud Aboriginal woman living on Kalkadoon Country, Mount Isa Queensland.

My role over the past 12 months has been the COVID-19 Senior Communications & Engagement Officer within the Strategic Communications Branch. My role focused on First Nations COVID-19 vaccinations communications. Starting with the branch in May 2021, I quickly learned the challenges were around the ever-changing information and ensuring changes were communicated effectively and appropriately across the state.

Despite these challenges I really enjoyed getting out, engaging with community around vaccination hesitancy, and creating meaningful communications resources. Working on the Make the Choice campaign was a highlight and a great success, it's a pretty proud moment when I can point out an Orange Make the Choice shirt and say, "that's the campaign I worked on."



Story of Roxanne Chapman, proud Aboriginal woman – Strategic Communications Branch

Insights

- xxvi. The vaccination rollout to Aboriginal and Torres Strait Islander people was significantly impacted by the change in policy and messaging around the AstraZeneca (Oxford) COVID-19 vaccine. The rollout of AstraZeneca commenced in March 2021 but was halted in April 2021 due to the reported risks of incidence of blood clots and deaths from the vaccine and the change in policy for it only to be used for people over the age of 60 years. Delays to the vaccine rollout to Aboriginal and Torres Strait Islander communities was a result of the change in processes that had to be undertaken to provide supply chain of the Pfizer (Comirnaty) COVID-19 vaccine to Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) and First Nations people in regional and remote areas. Increased media coverage also increased the vaccine hesitancy in communities and there was a noticeable distrust in other vaccines after the messaging surrounding AstraZeneca. Rollout of the Pfizer vaccine to regional and remote areas didn't gain momentum until the last quarter of 2021, and it wasn't until Public Health Direction and policy changes were introduced (e.g., 'no jab no play') that the vaccination rates in Aboriginal and Torres Strait Islander people increased significantly. The outbreaks in early 2022, the concerted effort to increase vaccination rates through contextualised community rollout, and provision of incentives (such as the Make the Choice campaign collateral) also saw an increase in vaccination rates.
- xxvii. Data accuracy of the vaccine rate and rollout was a consistent problem. Issues were raised with the accuracy of the baseline population data used, capturing of vaccinations recorded in the Australian Immunisation Register (AIR), versus the Queensland COVID-19 Vaccine Management System (QCVMS), what had been administered through Queensland Health clinics versus private providers (e.g., pharmacies, General Practitioner (GP) clinics, Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) etc.). It was noted that the demand for data, and workload associated, often impacted the operationalisation of the vaccine rollout. In Aboriginal and Torres Strait Islander communities, the baseline data often did not reflect their current location and therefore reporting was inaccurate.

Lessons Identified

Refer to Lesson Identified B in [Focus Area 2: Consideration and Integration of First Nations Perspective](#)

Refer to Lesson Identified F in [Focus Area 6: Community Engagement and Communications](#)

Focus Area 10: Patient Care and Safety

Many Aboriginal and Torres Strait Islander peoples experience substantial health disparities compared to other Queenslanders and the response to the COVID-19 pandemic has, in many cases, distracted the health system from the diagnosis, treatment and health education of other diseases and illnesses. Two main themes were identified during the review process were of the care of Aboriginal and Torres Strait Islander people with COVID-19, and the reduction in business-as-usual services to Aboriginal and Torres Strait Islander people, such as childhood immunisation and Sexually Transmitted Infection (STI) testing and treatment.

Observations and Analysis

There were 101 observations related directly to the focus area of Patient Care and Safety. Of these observations, there were 46 **Sustain**, and 55 **Improve**. Other observations captured under other focus areas may also have indirectly related to this focus area and are captured elsewhere. The observations outlined in this section are excerpts of the observations recorded through the review process and are direct quotes or paraphrases taken from the participants.

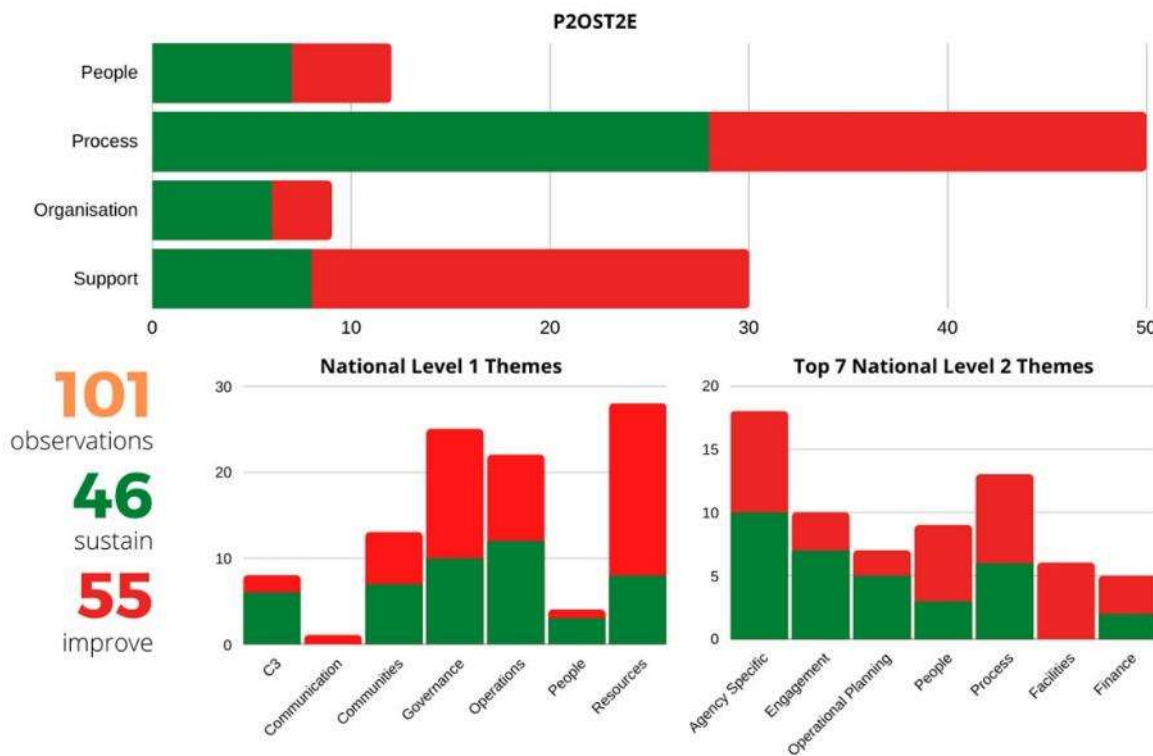


Figure 16: Breakdown of Data for Focus Area 10

What worked well

- Having mobile testing services in hotspots was beneficial.
- The increased availability and use of Telehealth was very successful for continuing to connect with clients. It has been a gamechanger and the permanent addition of this to Medicare will enable more care to be provided on Country.
- The changes to models of care with additional Hospital in the Home (HITH) and Virtual Wards will enable increased health care to be provided on Country and this should maintain and improve the health status.
- Some HHSs opted to not join the opt-in 'Covid Care at Home' model that the State released as they felt it would not adequately serve their populations. Instead, they continue to follow up all of their positive results and then people can choose to opt out of care. Initially 100% of people were opting in to virtual care, this has now reduced to about 30% as people feel more comfortable about living with COVID-19.
- Where anti-viral infusions needed to occur, doctors flew out to the remote islands so that patients could remain in community. Whilst the logistics of the vaccination and anti-viral was expensive and resource-heavy, there were good outcomes.

Challenges

- Since Rapid Antigen Tests (RATs) have been made available there has likely been under-reporting of positive cases in the community.
- There were frequently concerns about overcrowding in houses and the lack of services and ability to get services in for repairs.
- The availability of housing for quarantine/isolation became political. And whilst there were often spare agency housing, they weren't always being utilised to support the community.
- Other chronic diseases have been 'forgotten' during the COVID-19 pandemic, but they have not gone away. COVID-19 has distracted the health system from other diseases such as cancers and STIs etc.
- Business as usual health management didn't exist during the COVID-19 pandemic response (e.g., Mental Health) and so now they are playing catch up.
- The provision of the vaccination service added a burden to the normal service delivery. There were no additional staff/resources so 'normal' business suffered. Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) had to 'overwrite' normal service delivery to deliver COVID-19 services, and this has had an impact on the business.
- The Health Gap exists not just because of health inequities but also housing, education and other social determinants and this needs to be remembered as we transition away from just COVID-19.
- Care pathways between hospital care and primary care of COVID-19 patients are still not established in all Hospital and Health Services (HHSs). Whilst models have been announced by Queensland Health recently, they are not integrated so often community is seeking support from A&TSICCHOs, placing further pressure on the already stretched workforce and resources.
- The Virtual Care models implemented by the State were too prescriptive and their thresholds and models of care were not going to work for some areas.
- The opt-in model of care was implemented rapidly with little consultation initially. The system was aware of the gaps for vulnerable communities, including First Nations, when implementing the opt-in model of care. This was done because of time constraints to meet the needs of the 'majority' of the population, and they are now actively working to fill those gaps.
- there was a lack of infrastructure available in rural and remote communities, particularly in regard to testing, and a reliance on flights to get tests in and out of community. This saw delays in results and people having to unnecessarily quarantine, in difficult situations, for extended periods.

Insights

- xxviii. The increase in availability of virtual care models and telehealth was well received, particularly by rural and remote communities who would otherwise have to leave community and travel large distances to access specialised health care. Localised Virtual Care models for COVID-19 positive patients, such as introduced by Torres and Cape and Central Queensland Hospital and Health Services (HHSs), to service their communities, provided culturally appropriate healthcare and education delivery. Using local and First Nations staff, having an opt-out model where every Aboriginal and Torres Strait Islander person who tested positive was contacted, being able to provide care on country, and

being able to assess everyone to determine if they met the criteria for anti-viral treatment, allowed for comprehensive and safe care. The state-led opt-in model was generally believed to be unsuitable for Aboriginal and Torres Strait Islander people as initially it did not capture Aboriginal and Torres Strait Islander identification, was opt-in rather than opt-out, and the thresholds did not accurately meet the risk profiles and requirements of Aboriginal and Torres Strait Islander needs.

- xxix. With the efforts of the health system being largely focused on the response to the COVID-19 pandemic since early 2020, the care of other diseases has reduced significantly in many areas. As resources were diverted to the pandemic response, many business-as-usual functions were reduced across both Hospital and Health Services (HHS) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs). These changes have seen a reduction in childhood immunisation rates, increases in chronic disease progression, and increases in otherwise preventable diseases such as sexually transmitted infections (STIs) due to reduced testing and education.

Lesson Identified

- I. The continued availability of telehealth and Virtual Care models for other diseases and medical requirements should be explored to enable Hospital and Health Services (HHSs) to continue to provide culturally appropriate and safe, specialised care to Aboriginal and Torres Strait Islander people in their communities, reducing the requirement for them to travel off country, reducing the burden on the HHS and travel system, and increasing the accessibility of specialised health care to Aboriginal and Torres Strait Islander people.



Kelly Trudgen, First Nations COVID-19 Response Team and Samantha Johnson, JT Academy in Bamaga (Source: QH Asset Library)

Conclusion

The response to the COVID-19 pandemic has tested the health system in Queensland, across Australia, and around the world.

Queensland's Aboriginal and Torres Strait Islander people were, and continue to be, disproportionately at risk of the effects of COVID-19 due to the substantial health disparities present compared to other Queenslanders.

Since early 2020 the Queensland Department of Health, Hospital and Health Services (HHSs), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs) and other agencies in the Queensland Disaster Management Arrangements (QDMA) have worked together to support the COVID-19 response to the Aboriginal and Torres Strait Islander communities of Queensland. This review has captured data from a sample of the organisations involved to understand the enabling factors and barriers that contributed to the successes and shortcomings of the health system response.

This report has provided the outcome from the analysis of the 1,311 observations collected, taken from face-to-face interviews, surveys, written statements, and document analysis. Using the data methodology described, ten primary themes emerged, and from these themes, 29 Insights and eight Lessons Identified have been identified.

Many opportunities exist for the Queensland Department of Health to capture and embed the Lessons Identified from the COVID-19 pandemic response to continue to inform other areas of First Nations health, with a focus on Health Equity and Closing the Gap.

The review thanks the participants of the process for their time, honest discussions, and sharing of their expertise gained over the course of the pandemic response.

Annexure 1

Aim of the Evaluation

The aim of the evaluation is to undertake a review of the health system response to COVID-19, with the focus being on First Nations people and communities, to identify lessons which can be translated to inform other areas of First Nations health, with a focus on Health Equity and Closing the Gap.

Terms of Reference

1. To facilitate a lessons management process reviewing aspects of the COVID-19 response for First Nations people across Queensland.
2. To facilitate, attend and gather observations from formal debriefs inclusive of: HHS representatives, Public Health Unit (PHU) representatives, ACCHOS and members of Disaster Management Groups.
3. To interview key stakeholders to gather their observations and input into the debrief process.
4. To review and consider supporting documentation e.g., COVID-19 response plans, Situation Reports etc.), debriefs conducted by other agencies and groups, internal reports and external reviews, to gather their observations and input.
5. Based on all collated observations, prepare a report for the Chief Aboriginal and Torres Strait Islander Health Officer, I, Aboriginal and Torres Strait Islander Health Division, setting out the successes, Lessons Identified and Treatment Options (i.e., Recommendations) for improvement.
6. Virtual debriefs and opportunities for written submissions, in support of the face-to-face or facilitated debrief processes, are supported.

In Scope

Within the context of the terms of reference, the following matters are **IN** scope:

- First Nations COVID-19 response
- Queensland Department of Health First Nations COVID-19 response
 - Aboriginal and Torres Strait Islander Health Division
 - COVID-19 First Nations Response Team
 - State Health Emergency Coordination Centre (SHECC)
 - COVID-19 System Response Group (CSRG)
- HHS First Nations COVID-19 response (Cairns, Central Queensland, Darling Downs, Gold Coast, Metro South, North West, South West, Torres and Cape, Townsville)
 - First Nations Leads
 - Public Health Units (PHUs)
 - Health Emergency Operations Centres (HEOCs)
 - Disaster Management Units
 - Integration with Queensland Aboriginal and Islander Health Council (QAIHC) COVID-19 response and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs)
- Health service integration with the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP), specifically Aboriginal and Torres Strait Islander Partnerships

- Health service integrations with Local Disaster Management Groups (LDMGs) and District Disaster Management Groups (DDMGs) through the Queensland Disaster Management Arrangements (QDMA)
- Health service integrations with the Commonwealth Department of Health.
- COVID-19 Response Plans
- Implementation of legislation and Public Health Directions relating to the COVID-19 response for First Nations people and communities.

Out of Scope

Within the context of the terms of reference, the following matters are OUT of scope:

- Declaration of the COVID-19 pandemic
- The response by other agencies e.g., Queensland Police Service, Aboriginal and Torres Strait Islander Community Controlled Health Organisations, etc.
- Department of Health, Hospital and Health Service or other agency whole-of-COVID-19 response (where not relevant to non-First Nation's focus)

Management of the Evaluation

Responsible Person: Haylene Grogan – Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Aboriginal and Torres Strait Islander Division

Coordinator: Greg Richards – A/Senior Director, First Nations COVID-19 Response Team

Evaluator Lead: Carla Bailey – Assistant Director of Nursing, First Nations COVID-19 Response Team

Evaluators: Kelly Trudgen, Vanessa Clements, Dr Katie Panaretto, Dr Sean Cowley, Annie Parks, Karina Baigrie, Lisa Nissen, Melissa Bergin, Rebekah Woulff (First Nations COVID-19 Response Team)

Annexure 2

P²OST²E and National Themes

P²OST²E Elements of Capability

P²OST²E	Elements of capability
People	Roles, responsibilities, accountabilities, skills
Process	Plans, policies, procedures, processes
Organisation	Structure, jurisdiction
Support	Infrastructure, facilities, maintenance, resources
Technology	Equipment, systems, standards, security, intra-operability
Training	Capability, qualification, skill levels, identification of required courses
Exercise Management	Exercise development, structure, management, conduct

National Themes

National themes



Annexure 3

COVID-19 Pandemic – A Timeline

December 2019

12 – First human cases of COVID-19 identified in Wuhan, China.

January 2020

- 7 – Chinese authorities identify and named the novel virus, 2019-nCoV.
- 20 – Confirmation that the virus can spread from person to person.
- 25 – Australia records its first four cases (one in Victoria, three in New South Wales (NSW)).
- 29 – Queensland Records its first case of novel corona virus (Gold Coast).
- 29 – Queensland declares a Public Health Emergency.
- 30 – The World Health Organisation (WHO) declares the COVID-19 outbreak a Public Health Emergency of International Concern.

February 2020

- 1 – Australia commences restrictions on people travelling from China.
- 6 – Queensland legislation strengthened by the *Public Health (Declared Public Health Emergencies) Amendment Bill 2020*.
- 11 – The WHO names the disease COVID-19, virus itself is named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
- 29 – Australia activates its emergency plan.

March 2020

- 1 – Australia records its first death from COVID-19 in Perth, Western Australia.
- TBC – In Queensland, power is given directly to the Chief Health Officer (rather than the Health Minister on behalf of the Cabinet) to make 'Directions', amongst other things allowing them to declare restrictions on movement, gatherings and business activities, to set social distancing or masking requirements, and to close borders.
- 11 – The WHO declares the COVID-19 outbreak a pandemic.
- 13 – **First Aboriginal or Torres Strait Islander person in Queensland to be diagnosed with COVID-19 (Torres Strait Islander).**
- 16 – International arrivals must now self-isolate on arrival and a ban is placed on Australians travelling abroad.
- 20 – Australia closes its borders to all non-citizens and non-residents.
- 22 – **Queensland Government stops all non-essential travel to remote communities on Cape York and in the Torres Strait. Anyone wishing to travel to these areas must go into quarantine (in managed accommodation) for 14 days on the mainland prior to travel.**
- 23 – Lockdowns commence across Australia and includes some business closures, density limits and restrictions on gathering.
- 25 – Queensland records its first death from COVID-19.
- 26 – Queensland introduces Stage 1 of Restricted Entry into Queensland, with only Queensland residents and those considered an 'exempt person' being allowed to enter Queensland by air, sea, rail or road from another state or territory.
- 27 - **Strict travel restrictions applying to Queensland Aboriginal and Torres Strait Islander communities come into effect under the Biosecurity Act 2015 (Commonwealth).**
- 28 – Hotel quarantine program commences.

April 2020

3 – Queensland strengthens their border restrictions with every person crossing the border, including Queensland residents, requiring a permit. In addition, a person who had been in a declared COVID-19 hotspot in the previous 14 days has to self-quarantine for 14 days.

May 2020

1 – Queensland eases stay at home restrictions, with people able to leave their homes for recreation and the distance they can travel extended.

15 – Queensland further eases restrictions.

June 2020

1 – Queenslanders able to enjoy unrestricted travel throughout the state. People able to dine-in at restaurants and cafes, to attend a gym, cinema, library, museum, art gallery, or place of worship.

12 – Queensland's remote communities are removed from the Biosecurity Determination and state-based arrangements commence.

July 2020

10 – Queensland borders reopen.

August 2020

1 – Queensland Borders close to designated hotspots.

8 – Queensland closes borders to NSW and ACT.

22 – Increased restrictions come into place for Queensland, with toughest restrictions in Greater Brisbane.

September 2020

25 – Queensland restrictions ease.

October 2020

2 – Stage 4 of Queensland Roadmap with restrictions easing further.

16 – Further reduction of restrictions.

November 2020

3 – Queensland opens border to NSW (except Greater Sydney/declared hotspots).

16 – Queensland closes border to South Australian hotspots.

17 – Restrictions ease further.

December 2020

TBC – The Delta variant of concern is identified in India.

1 – Queensland opens its border to Victoria and Greater Sydney.

12 – Queensland opens its borders to New Zealand and South Australia.

20 – Queensland Closes its border to NSW Hotspots.

31 – Total number of Aboriginal or Torres Strait Islander people in Queensland diagnosed with COVID-19 reaches 10. There have been zero deaths to date.

31 – Total number of people in Queensland diagnosed with COVID-19 reaches 1,253.

31 – Total number of people in Queensland who have died with COVID-19 reaches 6.

January 2021

8 – Three-day lockdown of greater Brisbane, increased restrictions across the state including mask-wearing, gathering limits etc.

25 – The TGA provisionally approves the Pfizer COVID-19 vaccine for use in Australia for people aged 18 years and over.

February 2021

1 – Queensland opens its borders to NSW.

15 – First batch of Pfizer arrives in Australia.

16 – The TGA provisionally approves the AstraZeneca vaccine.

22 – First dose of Pfizer vaccine is given in Queensland (Gold Coast).

24 – New Zealand removed as a 'safe travel country'.

March 2021

8 – Vaccination rollout to Phase 1A (including Aboriginal and Torres Strait Islander people over the age of 50 years) commences.

20 – Queensland opens its borders to New Zealand again.

29 – Three-day lockdown of greater Brisbane.

April 2021

9 – Changes to vaccine recommendations (AstraZeneca for over 50's only).

23 – Queensland Closes its border to Western Australia hotspots.

May 2021

28 – Queensland closes its border to Victoria.

June 2021

29 – South East Queensland, Townsville (including Magnetic Island and Palm Island) enters a three-day lockdown.

30 – Total number of Aboriginal or Torres Strait Islander people in Queensland diagnosed with COVID-19 reaches 14. An increase of 4 cases since 31st December 2020. There have been zero deaths to date.

30 – Total number of people in Queensland diagnosed with COVID-19 reaches 1,696. An increase of 443 cases since 31st December 2020.

30 – Total number of people in Queensland who have died with COVID-19 reaches 7. An increase of 1 death since 31st December 2020.

July 2021

16 – Queensland closes the border to Victoria.

21 – Queensland closes the border to South Australia.

23 – Queensland closes the border with NSW.

31 – South East Queensland enters seven-day lockdown.

August 2021

8 – Cairns and Yarrabah goes into three-day lockdown.

12 – Border opens to South Australia.

29 – First Aboriginal or Torres Strait Islander person in Australia dies from COVID-19 in NSW (Aboriginal).

September 2021

30 – Restrictions increase in South East Queensland.

October 2021

8 – Restrictions ease in South East Queensland.

November 2021

15 – Queensland reaches 70% of people aged 16+ who are fully vaccinated.

24 – Omicron Variant identified in South Africa. This variant is thought to be more infectious. The severity associated with Omicron is still unknown, but early reports indicate mild disease, at least in the younger population.

December 2021

8 - Queensland identifies two Omicron cases among previously reported COVID-19 infections.

13 – Borders open to NSW and Victoria (with some restrictions in place e.g., vaccination). Masks become mandatory across the entire state in many public and outdoor places.

17 – Mandatory vaccine requirements come into effect for some venues (e.g., hospitality).

23 – COVID-19 cases begin to surge across Queensland.

TBC – Rapid Antigen Testing becomes an acceptable method of testing.

31 – Total number of Aboriginal or Torres Strait Islander people in Queensland diagnosed with COVID-19 reaches 562 cases, an increase of 548 cases since 30th June 2021. There have been zero deaths to date.

31 – Total number of people in Queensland diagnosed with COVID-19 reaches 13,863 cases. An increase of 12,167 cases since 30th June 2021.

31 – Total number of people in Queensland who have died with COVID-19 reaches 7. This has not increased since 30th June 2021.

31 – Queensland reaches 86.37% of people aged 16+ who are fully vaccinated.

January 2022

2 – Restrictions increase across Queensland.

7 – First Aboriginal or Torres Strait Islander person in Queensland dies from COVID-19 (Aboriginal).

15 – Queensland removes all border requirements (e.g., vaccination requirement).

15 – Queensland number of cases identified in one day peaks at 37,148 notifications.

22 – Queensland borders open to vaccinated international travellers (no longer required to quarantine).

March 2022

30 – Queensland reaches 91.7% of people aged 16+ who are fully vaccinated.

31 – Total number of Aboriginal or Torres Strait Islander people in Queensland diagnosed with COVID-19 reaches 25,656 cases, an increase of 25,094 cases since 31st December 2021.

31 - Total number of Aboriginal or Torres Strait Islander people who have died with COVID-19 reaches 30, an increase of 30 deaths since 31st December 2021. This represents approximately 4.07% of total COVID-19 deaths and shows an approximate death rate of 0.12% (to date).

31 – Total number of people in Queensland diagnosed with COVID-19 reaches 447,221 cases, an increase of 433,358 cases since 31st December 2021.

31 – Total number of people in Queensland who have died with COVID-19 reaches 737, an increase of 730 deaths since 31st December 2021. Approximate total death rate of 0.16% (to date).

