State Emergency Management Plan

Viral (Respiratory) Pandemic Sub-Plan

Victoria State Government | Department of Health

Contents

Abbreviations

Abbreviation	Description
ACCHO	Aboriginal Community Controlled Health Organisations
AHPPC	Australian Health Protection Principal Committee
AUSMAT	Australian Medical Assistance Team
CHO	Chief Health Officer
COVID-19	coronavirus disease 2019
DH	Victorian Government Department of Health
EM Act	*Emergency Management Act (1986 and 2013)* (Vic.)
EMC	Emergency Management Commissioner
EMJPIC	Emergency Management Joint Public Information Committee
GP	General Practitioners
HESP	State Emergency Management Plan: *Health Emergencies Sub-Plan*
LPHU	local public health unit
MEMP	Municipal Emergency Management Plan
MEMPC	Municipal Emergency Management Planning Committee

Abbreviation	Description
NGO	non-government organisation
PHW Act	*Public Health and Wellbeing Act 2008* (Vic.)
PPE	personal protective equipment
REMP	Regional Emergency Management Plan
REMPC	Regional Emergency Management Planning Committee
SCRC	State Crisis and Resilience Council
SEMP	State Emergency Management Plan
SHEMC	State Health Emergency Management Coordinator
SHEMT	State Health Emergency Management Team
TGA	Therapeutic Goods Administration
TTIQ	test, trace, isolate and quarantine
VPF	Victorian Preparedness Framework
WHO	World Health Organization

1 Introduction

1.1 Purpose

The State Emergency Management Plan (SEMP) *Viral (Respiratory) Pandemic Sub-Plan* (the plan) outlines the arrangements for managing the consequences of pandemics caused by respiratory viruses in Victoria. This plan is activated in conjunction with the arrangements set out in the SEMP *Health Emergencies Sub-Plan* (HESP).

The response arrangements in this plan are activated upon advice from the Chief Health Officer (CHO) or the appointment of the State Controller – Health by the Control Agency Officer in Charge (Secretary, Department of Health).

A pandemic is the worldwide spread of a new disease.[1] For this plan, the new disease comes from a novel respiratory virus. The type of virus may be new to science or previously unidentified in humans. A novel virus transmits via the respiratory system and typically results in respiratory illness.

Every Victorian Government department and agency may have a plan in place to address the consequences of a pandemic on their organisation and service delivery obligations, and their responsibilities.

As the control agency for human disease, the Victorian Department of Health (DH) is responsible for the maintenance and communication of this plan which incorporates feedback from external consultation required under the *Emergency Management Act 2013*. This includes a broad range of Victorian emergency services and related agencies.

Further information regarding emergency management arrangements for other emergencies with potential health risks can be found in the corresponding SEMP sub-plans <https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans>.

This plan supersedes the *Victorian action plan for pandemic influenza* (2015).

1.2 Scope

This plan provides strategic information about Victoria's mitigation, preparedness, response, and recovery arrangements for viral respiratory pandemics. It:

- outlines the legal framework for managing a pandemic at a national and state level
- describes the pandemic response, including roles and responsibilities
- highlights effective measures for managing a pandemic to build and support community resilience
- addresses resourcing, staff safety and wellbeing in managing the pandemic
- highlights potential consequences to various sectors from the pandemic
- outlines the return to business as usual, or an evolved business as usual, as the pandemic transitions into seasonal activity
- strengthens accountability for managing and mitigating risks associated with health emergencies
- outlines how community will be provided with information, guidance, and advice of viral respiratory pandemics.

This plan does not address epidemics, which are a widespread occurrence of an infectious disease in a community at a particular time. It also does not include details about the operational plans of individual agencies.

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1 Source: https://www.healthdirect.gov.au/what-is-a-pandemic

1.3 Authorising environment

The *Emergency Management Act (1986 and 2013)* (EM Act 2013) provides the legislative basis to manage emergencies in Victoria.

The SEMP <https://www.emv.vic.gov.au/responsibilities/semp> outlines provisions for the mitigation, preparedness, response, relief, and recovery from emergencies and specifies the roles and responsibilities of agencies in relation to emergency management. The SEMP identifies DH as the control agency for human disease, which includes pandemics.

The HESP provides the foundation for the coordinated and integrated response to health emergencies, including pandemics. The HESP also provides an overview of the response structure for health emergencies.

Additionally, the SEMP *Animal Plant Environmental Marine Biosecurity Sub-Plan* provides information relating to pandemics where non-human hosts act as disease reservoirs, or for the transmission of a novel virus.

Other Victorian legislation and plans relevant to the management of pandemic risks and potential consequences include:

- *Charter of Human Rights and Responsibilities Act 2006* (Vic)
- *Health Services Act 1988* (Vic)
- *Occupational Health and Safety Act 2004* (Vic)
- *Public Health and Wellbeing Act 2008* (Vic)
- *Victorian guidelines for planning safe public events*
- *Victorian health management plan for pandemic influenza*.

This plan is a subordinate plan of the SEMP and has been approved by the State Crisis and Resilience Council (SCRC).

At the state, national, and international level, there are governance structures, legislation, plans and guidelines that link to this plan. Refer to Appendix A: Key supporting information.

1.4 Implementation

The response arrangements in this plan will be activated if a novel (respiratory) virus emerges.

The plan supports existing operational plans.

1.5 Audience

The audience for this plan comprises Victorian Government and agencies, bodies, departments, and other organisations within the Victorian health sector that have roles and responsibilities in the management of a viral (respiratory) pandemic.

Given the dynamic and interdependent nature of the Victorian health system, it is vital that all relevant entities follow this plan to ensure the coordinated and effective management of a viral (respiratory) pandemic health emergency.

Community sectors, community service organisations, and individuals may also find the contents of this plan informative.

1.6 Assumptions

This plan is based on the following assumptions:

- The reader is familiar with the SEMP <https://www.emv.vic.gov.au/responsibilities/semp>, as it outlines the holistic details of the arrangements for an integrated, coordinated and comprehensive approach to emergency management in Victoria.
- The reader is familiar with the SEMP HESP <https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans>, as it outlines the coordinated arrangements for managing the risks and consequences of health emergencies in Victoria, including pandemics.
- Details regarding relevant activities of individual agencies are covered in agency plans and supporting doctrine.

1.7 Exercising and evaluation

DH will conduct an exercise of this plan with key stakeholders across state and local government and the health system within 12 months from when the plan is endorsed by the SCRC, and then once every two years.

The exercises will test a potential real-life situation. Planning for these exercises should address:

- who should participate, ensuring participants reflect all levels of decision-making, including SCRC, the State Control Team, industry and local government
- how feedback of key stakeholders, such as relevant representative bodies, businesses, industry and non-government organisations (NGOs), will be considered and incorporated
- the exercise objectives, desired outcomes, level of detail required and clarity of roles, structures and accountabilities.

The exercises will be evaluated and, where improvements to the emergency management arrangements are required, the plan will be amended, and a revised version issued.

Exercises will be conducted in accordance with the *Australian Institute for Disaster Resilience (AIDR) Managing exercises handbook* <https://knowledge.aidr.org.au/resources/handbook-managing-exercises/> and will consider varying scenarios with different hazards, scales, duration and severity.

In the event of an emergency response using the arrangements under this plan, DH will organise an operational debrief with the health sector and participating agencies as soon as practicable after the cessation of any response activities. The debrief will be undertaken as part of broader operational learning and lessons management activities. All participating agencies, including recovery agencies, will be represented. The purpose of the debrief is to evaluate the adequacy of preparedness and response arrangements and recommend any improvement opportunities for future events. Debriefing should allow adequate time for consultation with stakeholders to ensure robust evaluation of activities. The debrief may be conducted in lieu of an exercise.

A pandemic may be complex and of long duration, such as the COVID-19 pandemic. Real-time evaluation or multiple debriefs should be considered to ensure ongoing capture of improvement opportunities and learnings.

1.8 Review

This plan was current at the time of publication and remains in effect until modified, superseded or withdrawn.

DH, as the control agency for human disease, will review and update this plan every three years in accordance with the SEMP, or more frequently, as required. At the time of publishing, several emergency management reviews were under way, and early findings have been considered in the drafting of the plan where possible. Further review of this plan may need to be undertaken once reports and recommendations for these are finalised.

1.9 Linkages and hyperlinks

As this plan does not seek to duplicate information, linkages and hyperlinks to resources and websites have been incorporated.

Resources identified frequently within the plan (such as SEMP and HESP) may not be hyperlinked in each instance.

At the time of publication linkages and hyperlinks were accurate.

2 The pandemic threat

A pandemic caused by a novel respiratory virus is a significant risk to everyone in Victoria, given people will have little or no pre-existing immunity to the virus. It has the potential to cause high levels of morbidity and mortality, challenge the ability of the state health system to cope, and disrupt the community socially and economically. At risk communities are disproportionately impacted by the health impacts of pandemics and activities should be prioritised towards these groups. A pandemic will be prolonged, lasting several months or years.

Respiratory viruses have the greatest potential to cause pandemics, due to the strong link between the emergence of a novel pandemic strain of virus, the human–animal transmission interface and transmission properties of respiratory viruses. Influenza and coronaviruses have high genetic mutation rates, which creates a significant potential for the emergence of new (novel) viral strains infectious to humans.

Pandemic mitigation, preparedness, response, and recovery should involve a continuous process of planning and implementation that reflects the learnings from training, exercises, and experiences. In recent history, Victoria has experienced pandemics such as the coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2 which emerged in 2019 and Swine Flu, an influenza pandemic caused by influenza virus H1N1, which Australia experienced in 2009. The experience and learnings from these pandemics inform how the Victorian Government prepares for and responds to pandemics.

Figure 1: Key milestones of a pandemic

| Identification of a new virus that has sustained human-to-human community transmission | Virus enters Australia and Victoria (if it is not first identified here) | Determination of the severity of the virus | Customised pandemic vaccine developed and made widely available (if necessary) | Disease activity returns to seasonal levels, marking the end of the pandemic |

2.1 Key milestones of a pandemic

Figure 1 shows the key milestones in an emerging pandemic.

Pandemics will vary in transmissibility, severity, duration, and impact therefore preparedness, response, relief, and recovery phase will need to remain scalable and flexible.

This plan provides information to inform the most appropriate actions to achieve the following key outcomes:

- the novel virus is rapidly identified within the Victorian community
- the spread of the novel virus is reduced to ensure the health system is not overwhelmed
- access to the health system is maintained through a collaborative approach across public and private health services
- the risk of exposure is minimised through appropriate and proportionate public health measures
- the morbidity and mortality of those infected is minimised where possible
- the impact and consequences for Victorians both in daily life and in the longer term is minimised
- the immediate welfare needs for confirmed or suspected cases, close contacts, or people unable to work due to restrictions are met, especially in priority communities including food, material, and socioeconomic needs

- the community has adequate and equitable access to testing and vaccinations
- timely and proactive communications are delivered in most languages spoken by the Victorian community and accessible formats to ensure affected businesses, industries, communities, and at-risk populations are provided for
- representatives of at-risk community groups are embedded in planning, response, relief, and recovery.

2.2 Modelling

Infectious disease models will outline scenarios of how the novel virus might spread through the community, depending on parameters such as population movement, physical distancing and vaccination. Key messaging from modelling should be shared as early as possible among those with a responsibility under this plan and key stakeholders, to ensure a common and consistent operating process. Modelling will likely be necessary during the pandemic as more information is known, or as the virus mutates. This will also inform the scalable response described in Chapter 6 – Response.

Modelling may consider the following assumptions:

- transmissibility
- clinical severity
- the vulnerability of the population and the influence this will have on the spread and clinical severity of the disease
- the lack of immunity, and whether people with underlying illness or immunocompromised conditions are likely to experience more severe outcomes
- the effectiveness of interventions, such as public health safety measures, to minimise transmission within the community
- the preparedness and capacity of the health system, which affects the way public health and healthcare is provided, including specialist expertise, acute care and intensive care, testing, transport, the pathology system, and ambulance services
- workforce availability and infrastructure requirements, including equipment and supplies.

DH, in collaboration with external partners, uses models to better understand pandemics and to inform responses. Modelling may need to be adjusted as more information is known or as the virus mutates.

2.3 Transmissibility

The novel virus may spread via direct or indirect contact, as described in Table 1. How the virus spreads is a critical factor in modelling, as well as for preparedness and response activities.

Transmissibility affects the breadth and speed of spread across the world, as well as within the Australian and Victorian communities. It is possible transmissibility may change during the pandemic, especially as the virus mutates.

Table 1: Methods of transmission via direct or indirect contact

Direct

Mode of transmission	Description
Person-to-person contact	Infectious diseases are commonly transmitted through direct person-to-person contact. Transmission occurs when an infected person touches or exchanges body fluids with an uninfected person.
Droplet spray transmission	Transmission occurs when the virus spreads through the air by droplet sprays such as by: • coughing • sneezing • speaking to an individual within close proximity.

Indirect

Mode of transmission	Description
Airborne transmission	Droplet nuclei of < 5 μm in diameter stay suspended in the air and are disseminated by air currents. These particles can infect a susceptible person through inhalation.
Contaminated object transmission	Virus is transferred by contact with a contaminated object.
Animal-to-person transmission	A zoonotic disease or infection that is naturally transmissible from vertebrate animals to humans, requiring animal control.

2.4 Clinical severity

The clinical severity will affect the number of people who present to primary care services or require hospitalisation, as well as the number of deaths. Furthermore, severity can affect demand for Emergency Services Telecommunications Authority's (ESTA) Triple Zero (000) call-taking, or patient transport and ambulance services. This can be an early indicator of community impacts, including community response to the pandemic, and subsequently the demands on the health system.

Clinical severity is likely to change during different phases of a pandemic and depends on viral mutations and the availability and efficacy of pharmaceutical interventions.

2.5 Genomics and adapting measures to new strains

Whole genome sequencing allows comparison of viral genome sequences and may identify similarities or variations between them to better understand potential chains of transmission and identification of groups of similar sequences that form genomic clusters. Genomic sequencing and clustering information can be used to identify or confirm potential links between cases and potential sources of infection, and to identify outbreaks.

Mutations are a normal part of viral evolution and many variant strains do not cause any notable impact. However, when a particular mutation, or combination of mutations, offer a virus relative advantage, this may enable a strain to become dominant within a population. Advantageous mutations may allow a virus to have increased transmissibility, cause milder or more severe disease or impact the effectiveness of pharmaceutical interventions, such as medicines and vaccines or the ability of the immune system to neutralise the virus and allow reinfection shortly after infection with a previous strain of the virus.

3 Roles and responsibilities

When a novel virus poses a serious public health risk to the Victorian community, the Premier of Victoria, after consultation with the CHO and Minister for Health, can make a pandemic declaration. *Victoria's pandemic management framework*, developed under Part 8A of the *Public Health and Wellbeing Act 2008* (Vic.) (PHW Act), provides a specific framework to manage pandemics effectively and outlines the process and arrangements for declaring a pandemic. See Figure 2 for high-level overview of Victoria's pandemic declaration roles and responsibilities.

Under the *PHW Act,* a State of Emergency can still be declared, this will depend on the threat and potential longevity of a pandemic.

For further information, see Victoria's pandemic management framework <https://www.health.vic.gov.au/covid-19/victorias-pandemic-management-framework>.

Clearly articulated roles ensures accountability, and supports shared responsibility for mitigating, preparing for, responding to, and recovering from health emergencies.

Agencies and those with roles and responsibilities under this plan should know their role statements in the SEMP, which provides the roles and responsibilities by agency and emergency management phase. These are matched against the Victorian Preparedness Framework's (VPF) core capabilities and critical tasks that Victoria requires to effectively manage before, during and after major emergencies. Detailed information about agency roles and responsibilities and how they map to the VPF capabilities and tasks <https://www.emv.vic.gov.au/responsibilities/semp/roles-and-responsibilities/vpf-alignment>.

The roles and responsibilities identified in this plan are not exhaustive and should be read in conjunction with relevant legislation, plans, frameworks, and guidelines.

Table 2 outlines the authority and role for key decision-making functions (functional leads) in a health emergency response where DH is the control agency. It is important to note any role in the table can have a deputy appointed, when required. Also, an individual can only have one functional role at a time.

Figure 2: High-level overview of Victoria's pandemic declaration roles and responsibilities
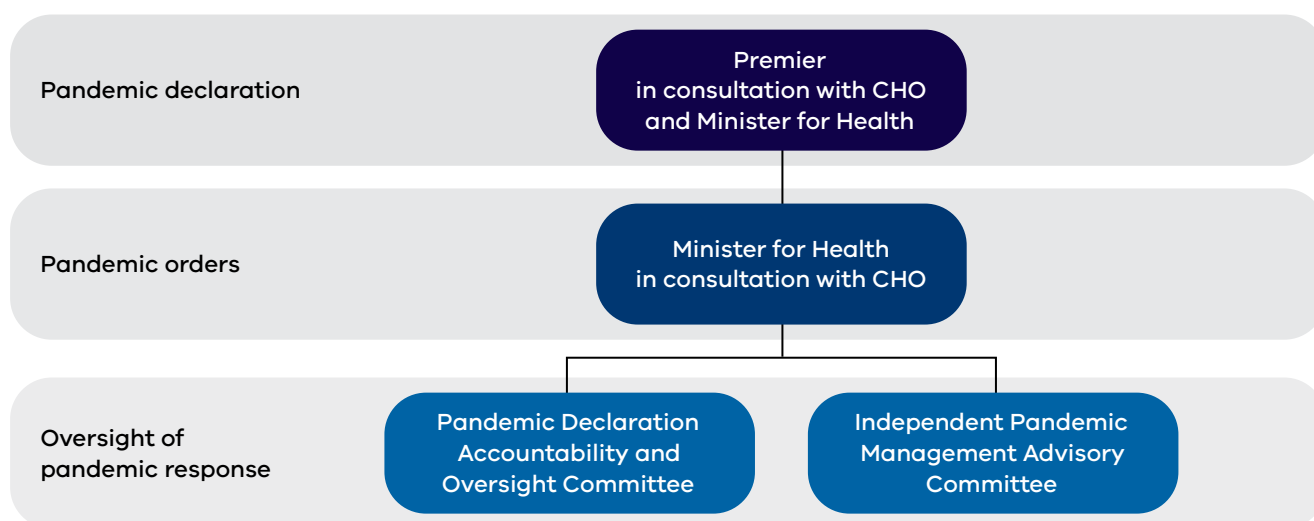
Table 2: Key roles and responsibilities in a health emergency response – Department of Health as control agency

Role	Responsibility
Emergency Management Commissioner (EMC)	The role of the EMC is outlined in the SEMP.
Control Agency Officer in Charge (CAOiC) Secretary, Department of Health	Overall control of response activities for health emergencies (class 2 emergency).
State Controller – Health As appointed by the CAOiC	The role of the State Controller is outlined in the SEMP. Additionally, the State Controller – Health: • may appoint a Deputy Controller/s • will consider authorisation required under relevant Acts when appointing roles • will appoint a State Health Emergency Management Coordinator or Public Health Commander to lead a State Health Emergency Management Team (SHEMT) • may delegate responsibilities or actions to other agencies.
State Health Emergency Management Coordinator (SHEMC) Deputy Secretary Public Health (or delegate) Appointed by Secretary, Department of Health	Ensure appropriate appointments are made to state tier functions, including State Health Commander, State Health Coordinator, Public Health Commander. Provide executive administrative support to ensure these functions operate effectively. Advise the State Controller – Health on the appointment of a Deputy State Controller – Health, if required. Seek advice from the SHEMT lead, the DH Commander and CHO as required.
State Health Emergency Management Team (SHEMT)	Manage the whole-of-health response to an emergency. The lead of the SHEMT is either: • the **Public Health Commander**, where the response requires public health expertise • the **State Health Coordinator**, where coordination of emergency response activities across the health system is required (including hospitals, primary health, and other acute services).
Public Health Commander (Public Health Command functional lead) Chief Health Officer (or delegate)	Report to the State Controller – Health. Command the public health functions of a health emergency response (including investigating, eliminating, or reducing a serious risk to public health). Appointed as SHEMT Lead where the control agency requires public health expertise. Exercise management, control, and emergency powers of the CHO under relevant public health legislation.

Table 2: Key roles and responsibilities in a health emergency response – Department of Health as control agency (continued)

Role	Responsibility
Chief Health Officer (CHO)	Authority under the PHW Act for decisions on matters of public health. Under section 22 (1)(a) of the PHW Act, the CHO by instrument may delegate powers to a registered medical practitioner. May authorise exercise of certain powers under a declared state of emergency. This includes public health risk powers and emergency powers for Authorised Officers. Exercise powers, either specified or delegated, under other relevant public health legislation.
State Health Coordinator (Health Coordination functional lead) Senior Department of Health officer appointed by the SHEMC	Report to the State Controller – Health. Coordinate DH emergency response activities across the health system (including hospitals, primary health, and other acute services).
State Health Commander (Health Command functional lead) AV Emergency Management Director (or delegate, unless otherwise appointed by the SHEMC) To command the pre-hospital response	Report to the State Controller – Health. Command pre-hospital care resources across agencies and service providers at the state tier (including field response, ambulance services, non-emergency patient transport, licensed first aid service providers, first responder assistance, spontaneous volunteers). Provide situational awareness to DH Commander on incidents that may have broader impacts on the health system.
DH Commander Rostered Department of Health Senior Executive	Monitor the impact of a health emergency to DH staff, key stakeholders and funded health services and coordinate the departmental activities to manage these consequences. Deploy DH personnel where required to assist in responding to a health emergency. Authorise public communications regarding the impacts upon departmental services. Represent DH on emergency management committees in Victoria's governance structure, highlighted in Appendix A: Key supporting information.
Incident Controller (IC)	Lead and manage incident tier response control. A deputy IC can be appointed if required. For IC appointment see HESP Table 2: Incident response levels for health emergencies (Department of Health as control agency).
Regional Health Coordinator	Report to the State Health Coordinator. Coordinate at the regional level DH emergency response activities across the health system (including hospitals, primary health, and other acute services).
Hospital Commander Health service executive Appointed from within the health service	Manage the emergency and lead the response for their health service. Engage with the key stakeholders (state and regional, local) to provide a cohesive response to the emergency. Assist with identifying emerging risks in collaboration with the state tier response.

3.1 Department of Health control agency functions

Once a pandemic has been declared, DH, as the control agency, is responsible for leading and establishing integrated arrangements to respond to the pandemic. DH will coordinate government departments, their sectors, and agencies to support the pandemic response.

Government departments and agencies are required to have preparedness arrangements (including a business continuity plan) and a pandemic response plan (including operational arrangements DH will consider undertaking to respond to a pandemic).

Support agencies should ensure they have the capability and flexibility to respond to a pandemic, with consistent assessment throughout the response. Support agencies should consider what may be required of them, how long their support may be needed and their function in stand down operations. Further information for support agencies is outlined in the SEMP.
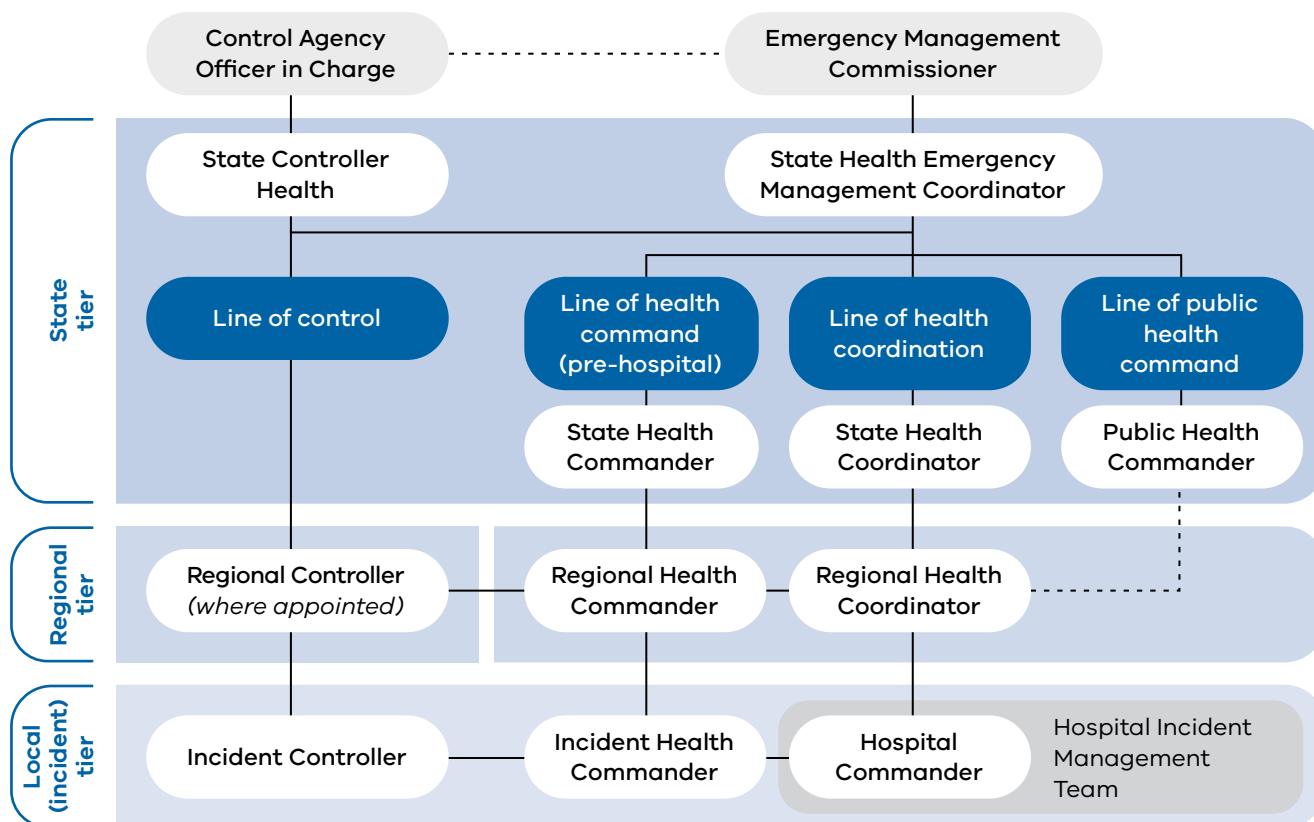
The HESP outlines roles and responsibilities to ensure a coordinated and integrated response to pandemics.

The State Controller – Health will continually assess roles and adapt where required to effectively scale up or down the pandemic response.

As the control agency for specified health emergencies, DH is responsible for:

- providing whole-of-health leadership and direction, to mitigate, plan and prepare for health emergencies as set out in Chapter 4 – Mitigation and preparedness
- working with community, state and local government, and key partners in the health sector to prepare for public health emergencies

- mitigating health risks by enforcing public health legislation in collaboration with local government
- developing and implementing public health plans, guidelines, advice that raise awareness about health risks and how to mitigate the risk
- reducing transmission of potential health threats through case and contact management
- monitoring, detecting, and investigating health emergencies or potential threats as soon as practicable
- providing a coordinated response during a health emergency as set out in Chapter 6 – Response
- scaling up and down response arrangements, as appropriate as set out in Chapter 6 – Response
- issuing and approving public information and warnings as set out in Chapter 5 – Public information and community engagement
- establishing strong relationships and lines of communication with government departments and agencies that may be required to perform roles and responsibilities including compliance and enforcement functions
- the timely provision of information, intelligence, and data from the control agency to all government department to enable discharge of roles and responsibilities including compliance and enforcement
- managing consequences of the health emergency to support an effective response and recovery as set out in Chapter 3 – Roles and responsibilities – Consequence management
- ensuring the health system can effectively respond and mitigate the adverse consequences for communities
- facilitating the transition to recovery as set out in Chapter 7 – Recovery.

Figure 3: Reporting relationship for health emergencies (Department of Health as control agency)

State tier

Control Agency Officer in Charge — — — Emergency Management Commissioner

State Controller Health

State Health Emergency Management Coordinator

Line of control

Line of health command (pre-hospital)

Line of health coordination

Line of public health command

State Health Commander

State Health Coordinator

Public Health Commander

Regional tier

Regional Controller *(where appointed)*

Regional Health Commander

Regional Health Coordinator

Local (incident) tier

Incident Controller

Incident Health Commander

Hospital Commander

Hospital Incident Management Team

3.2 Key support activities

3.2.1 Support agencies

Key support agencies and organisations have the skills, expertise, and resources to provide response, relief and recovery activities. Many of these agencies coordinate their activities with other providers within their functional sector. The State Controller – Health leads the coordination of these activities through the State Emergency Management Team.

All agencies must have internal plans for managing their responsibilities as outlined in the relevant SEMP. Any government or non-government agency may be requested to assist in a health emergency response, relief, or recovery if it can contribute to the management of the emergency.

3.2.2 Social, economic and wellbeing support

A pandemic response requires actions to be implemented across government, business, and community to achieve the best outcome for Victorians. State Controller – Health can distribute roles and responsibilities across government to undertake specific actions.

Engagement with business will include ongoing information to allow them to implement actions that support ongoing economic activity, reduce staff furlough, and maintain supply chains.

Ongoing engagement with the broader community about the actions they can take to keep them safe from the virus and how to access clinical, social, or economic support to maintain their wellbeing during a pandemic.

3.3 Concurrent emergencies

In the event a pandemic occurs concurrently with one or more emergencies, the State Controller – Health must consult with the EMC and other relevant control agencies, to determine (and document) appropriate control arrangements.

3.4 Consequence management

Under the EM Act 2013, the EMC is responsible for consequence management for a major emergency, which includes health emergencies and fulfils this role through the State Consequence Manager.

4 Mitigation and preparedness

Mitigation and preparedness are interrelated, as they both seek to reduce the severity of an emergency. Any new pandemic presents a significant risk and threat to Victoria and, more broadly, Australia, given there will be little or no pre-existing immunity in the community to the virus.

Federal and state government departments and agencies, local government, NGOs, industry, the health sector, communities, and individuals have a shared responsibility to take steps to prepare for and mitigate the impact of a pandemic.

The mitigation and preparedness activities for a novel virus are initially, based on approaches and knowledge from previous outbreaks, epidemics, and pandemics. Planning and preparedness must be agile and scalable and apply an adaptive management approach that responds as new information emerges.

Effectiveness of planning will require national consistency, particularly the movement of people in and across border regions.

4.1 Victorian Government

The governance structure for decision making and information sharing for the Victorian Government is outlined in Appendix A: Key supporting information.

The Victorian Government works to mitigate risks to public health and the health system and prepares for pandemics based on experience from previous pandemics or exercises.

4.1.1 State tier

As the control agency, DH is responsible for:

- monitoring, surveillance and investigation of infectious diseases and other notifiable conditions to identify a novel virus with pandemic potential or new cases associated with a novel virus in Victoria. This is supported by similar efforts by the Australian Government and the World Health Organization (WHO)
- establishing sharing arrangements with the Australian Government
- collection and analysis of data to identify population risks and at-risk groups for targeted interventions, adjusting responses according to infection risk and geographic considerations
- providing outreach and extensive consultation to communities to deliver information, identify infection risks and support interventions to manage infection spread
- providing leadership and authoritative advice to inform relevant planning for pandemics
- developing, monitoring, and supporting the capability and capacity of the health system to respond to pandemics
- creating partnerships with health service providers to build capability and capacity
- providing advice, warnings, and education, including recommended actions to prepare or mitigate impacts of pandemics to key stakeholders and the public. Public information and community engagement is further explored in Chapter 5
- providing timely, tailored, and relevant information to the community to allow individuals to make informed decisions about their health and safety. This is particularly vital for those most at risk

- establishing strong relationships and networks, as well as identified communication channels, that can quickly and effectively disseminate trusted information and provide feedback loops on what other supports/actions are required.

Victorian Government departments and agencies are collectively responsible for:

- developing, reviewing, and exercising relevant planning for pandemic preparedness and response, such as emergency management plans and protocols, business continuity plans and occupational health and safety plan. Planning should address how human behaviours and responses to the pandemic can support or undermine an effective response
- ensuring the necessary equipment, protocols and communication is in place to support employees working remotely or flexibly
- supporting regional and local emergency management and business continuity planning and exercising that includes stakeholders who have a role in preparedness or response or may be affected by a pandemic
- considering the upstream and downstream interdependencies of supply chain management issues
- promoting pandemic preparedness to key sectors and stakeholders based on advice from DH
- having assurance of critical resources or assets necessary in the pandemic response
- supporting individuals, particularly those most at risk, and communities to prepare, respond and recover from pandemics.

Agencies' roles and responsibilities for mitigation and preparedness are set out in the SEMP.

4.1.2 Regional tier

At the regional tier, Regional Emergency Management Planning Committees (REMPCs) are responsible for preparing regional emergency management planning, including the development of Regional Emergency Management Plans (REMPs). The REMPs should identify how the region will prepare, respond, and recover from pandemics in alignment with state planning to provide a coordinated and integrated approach. This should include ensuring the necessary equipment, protocols and communication is in place to support employees working remotely or flexibly.

Every Victorian Government department, including DH, has legislated membership on all eight REMPCs.

A collaborative approach led by the regional tier to leverage local resources and community networks should incorporate local community health, general practice, health services, Primary Health Networks, and other community organisations. The approach should have a particular focus on those most at risk.

4.2 Australian Government

The authorising environment set out in Appendix A: Key supporting information explains the decision making and information exchange between the Australian, states and territories governments.

4.2.1 Department of Health and Aged Care

The emergence of a novel virus overseas with the potential to cause a pandemic is monitored and investigated by the Australian Government Department of Health and Aged Care in conjunction with the WHO and DH.

The Department of Aged Care and DH develops and maintains national health emergency response plans which should inform the state, regional and local emergency management plans.

DH also coordinates the provision of essential medicines and equipment from the National Medical Stockpile. The National Medical Stockpile is intended as a strategic reserve that stores and purchases medicine and equipment to meet high levels of demand during a national health emergency, such as a pandemic. Provisions for a pandemic could include essential pharmaceuticals, vaccines, antidotes, and personal protective equipment (PPE).

Through the National Critical Care and Trauma Response Centre, the Australian Government trains and coordinates Australian Medical Assistance Team (AUSMAT) teams of health professionals for international and domestic deployment. AUSMAT teams can be deployed, along with the Australian Defence Force, to assist with pandemics.

4.3 Local government

Under the EM Act 2013, local governments chair the multiagency municipal emergency management planning committees (MEMPCs), which assess municipal-level risks and plan accordingly. MEMPCs are responsible for preparing Municipal Emergency Management Plans (MEMPs). MEMPs outline the agreed municipal-level emergency management arrangements by all participating emergency service, government and NGOs in the municipal footprint, not just local government.

The roles of local government and other local agencies documented in MEMPs or MEMP sub-plans must be consistent with state plans, including the SEMP and this plan.

Local governments should also develop, maintain, and exercise business continuity and occupational health and safety plans to ensure the continuity of services during a pandemic. Plans should ensure the necessary equipment, protocols and communication is in place to support employees working remotely or flexibly.

4.4 Health sector

The health sector comprises a number of subsectors, including community health, public health, health education, allied health services, primary care and health and medical research. The sector also includes organisations and businesses that provide medical services, manufacture medical equipment or drugs, provide medical insurance, or otherwise facilitate the provision of care to patients.

The health sector is responsible for preparedness and mitigating pandemic risks to the Victorian community and the sector itself.

The health sector should develop, maintain, and exercise pandemic, business continuity and occupational health and safety plans and arrangements. Planning should incorporate

the key services and functions of the health sector and other aspects of support the health sector will provide to help the Victorian Government's pandemic response.

4.4.1 Aboriginal Health

The needs and concerns of Aboriginal and Torres Strait Islander peoples should be recognised in the plans of every primary health practice or service. At a population level, there is a significant gap between the health status of Victoria's Aboriginal population and the non-Aboriginal population.

Acute respiratory infections such as colds, influenza and pneumonia can worsen symptoms and lead to serious consequences for people with chronic respiratory conditions. Aboriginal

people are more likely to have chronic respiratory diseases such as asthma and chronic obstructive pulmonary disorders (Australian Health Ministers' Advisory Council 2012).

Primary health services that focus on Aboriginal people will need to consult widely with the communities that they service to help respect cultural sensitivities, as much as is practicable, while maintaining infection prevention and control standards.

The whole-of-Victorian-Government pandemic communication strategy, co-created with Aboriginal Organisations and Aboriginal communities, should address the specific needs of Aboriginal and Torres Strait Islanders people as discussed in public information and engagement (as outlined in Chapter 5).

4.5 Critical infrastructure and essential services

Disruption to critical infrastructure and services, such as public transport, water, gas, electricity, fuel and government services, and the transportation of food and goods are further potential consequences of pandemics. Disruptions to these lifeline services may also cause significant long-term economic impacts.

Victorian Government departments, agencies and the owners and operators of critical infrastructure should undertake a structured risk assessment process. This process should identify the risks and interdependencies facing their organisations. They should also have robust business continuity plans to ensure they can respond to and recover from any disruption.

The ability to work remotely for many sectors has been demonstrated through the COVID-19 pandemic. This flexibility could be included in organisational preparedness.

Planning should enable continued operation of critical infrastructure and delivery of essential services during a pandemic. Scarce resources should be managed according to:

- a priority basis
- how the pandemic may affect occupational health and safety obligations
- requirements for sustaining an essential workforce against risks such as transmission and absenteeism.

Planning should also consider obligations, such as for testing, vaccination or wearing masks, and resourcing and other requirements across different operating environments or workplace settings.

The wider pandemic management effort should consider other sectors such as education, which includes both transmission risk and the economic impact of school closures (such as, driving broader workforce absenteeism). Mitigation and preparedness requirements for settings such as schools, early childhood and tertiary education could include considerations for online learning, and localised approach to outbreaks such as closing schools or mandating face coverings for specific year levels.

Sectors may need to consider requirements for maintaining waste services, such as clinical waste, or for animals (companion, domesticated, wild and feral) in relation to potential involvement in local transmission of a novel zoonotic respiratory virus.

Owners and operators of critical infrastructure will need to stay up to date with the latest health information as it evolves and provide this information to employees as part of the response to the pandemic (as outlined in Chapter 6).

Education and support to comply with public health order is important both in infection prevention and control strategies before any restrictions are in place, as well as when they come into place, to help organisations understand requirements of any restrictions. Clear and consistent messaging is important to aid compliance and therefore to reduce the risk of transmission.

4.6 Industry and business

All Victorian businesses, industries and organisations are encouraged to ensure their planning incorporates disruptions that may occur during a pandemic.

The ability to work remotely has been demonstrated by many organisations through the COVID-19 pandemic. This flexibility could also be included in organisational planning and preparedness.

Planning should enable continued delivery of goods and services, and consideration should be given to how a pandemic may impact occupational health and safety obligations.

Education and support to comply with public health measures is important both in infection prevention and control strategies before any restrictions are in place, as well as when they come into place to help organisations understand requirements of any restrictions. Clear and consistent messaging is important to aid compliance and therefore to reduce the risk of transmission.

All workplaces, employers and venue operators will need to stay up to date with the latest health information as it evolves, and provide this information to employees as part of the response to the pandemic (as outlined in Chapter 6).

4.7 Community service organisations

Peak bodies of community service organisations (CSOs) are key avenues for timely, trusted communications. They can play a role to support and build capacity and capability among members to plan, prepare for and mitigate against viral pandemics.

The ability to work remotely has been demonstrated by many organisations through the COVID-19 pandemic. This flexibility could be included in organisational planning and preparedness.

Planning should enable continued delivery of community support services, particularly those where greater needs or risks may be present. Plans may encompass a broad range of needs fundamental to minimising the impacts of a pandemic, including public information, food and other essentials such as medication, income support, debt management, counselling and personal support needs.

CSOs that work with at-risk groups should include specific strategies and considerations in their pandemic planning. Considerations may include:

- limiting visitors to care facilities
- meeting basic needs of individuals to improve compliance with public health advice or requirements
- promoting food and other relief services to individuals
- ensuring tailored programs and supports which are culturally safe and addressing diversity and inclusion barriers to getting tested and complying with isolation requirements
- ensuring there are accessible communications available for at-risk groups (such as clear CALD communications, easy to read/understand English resources, Auslan resources)

- public health materials in community languages as well as easy English versions, consultation with (and messaging with) priority community leaders
- addressing barriers through co-design to getting tested, accessing medical care, and complying with isolation or quarantine requirements
- promoting vaccinations.

Disability service providers and other types of care facilities will require particular mitigation and preparedness plans in place. This is because they are more likely to accommodate, provide services for, or work with people at higher risk of significant adverse outcomes from viral diseases. Planning for rapid scale up of prevention and outbreak management responses in these settings is needed, so that residents or clients who are potentially more vulnerable are protected.

Demand for CSOs' services will escalate during pandemic periods, as experienced during COVID-19. Many CSOs will require targeted support to respond. This includes managing the impact on their own business continuity as well as increasing service provision to meet demands. This will be particularly relevant for services that are legislated, are necessary for preventing immediate risks of harm, and those that support daily care needs.

4.8 Individuals

Individuals have a responsibility to stay up to date with the latest health information to best protect themselves, their family, and their community.

At-risk, marginalised groups and those with special needs are especially vulnerable during a pandemic. This may include older Victorians and people with chronic diseases, pregnant women, those who are immunosuppressed, people with disabilities, culturally diverse community members, those with low socioeconomic status, people experiencing homelessness and Aboriginal and Torres Strait Islander communities.

People living in close communities, such as prisons, residential aged care settings, disability accommodation, boarding/rooming houses and high-density public housing may also be more vulnerable. This may also apply to people living in remote communities and people from culturally and linguistically diverse backgrounds.

The Australian Government and Victorian Government will provide authoritative public health advice and guidance to keep people informed about how to stay safe. However, people may rely on peak bodies, key stakeholders, community leaders and faith leaders who are the trusted voices to reinforce the messages in a relatable way.

Preparedness and mitigation activities on an individual level will depend on virus transmissibility and clinical severity. Assessing at-risk groups is an ongoing process that needs to consider:

- using a population health approach can identify the most at-risk groups
- susceptibility to acquiring the virus
- gender and age factors
- the nature of the pandemic/virus (for example airborne versus contact versus blood contact only).

5 Public information and community engagement

Providing clear, timely, tailored, and accurate public information to the Victorian community about how to stay safe and access support services is critical during a pandemic. It will also be essential to engage directly with the community, particularly those most at risk.

Victorian Government departments and agencies must provide a seamless and coordinated public information and community engagement response at every stage of the pandemic.

Sector specific communications and engagement planning should be undertaken by relevant departments and agencies. Plans should consider the potential and likely impact of the pandemic on the community, their clients, services, workforce, as well as impacted industries and other stakeholders.

Comprehensive and far-reaching communications and engagement approaches, methods, and channels, will be required to reach all Victorians along with targeted communications and engagement with hard to reach or high-priority communities

It is essential that planning takes into consideration appropriate communications and engagement channels for Aboriginal and Torres Strait Islanders, those from culturally and linguistically diverse backgrounds and Victorians with a need for accessible communications.

Appendix C: Public information and community engagement arrangements provides more information.
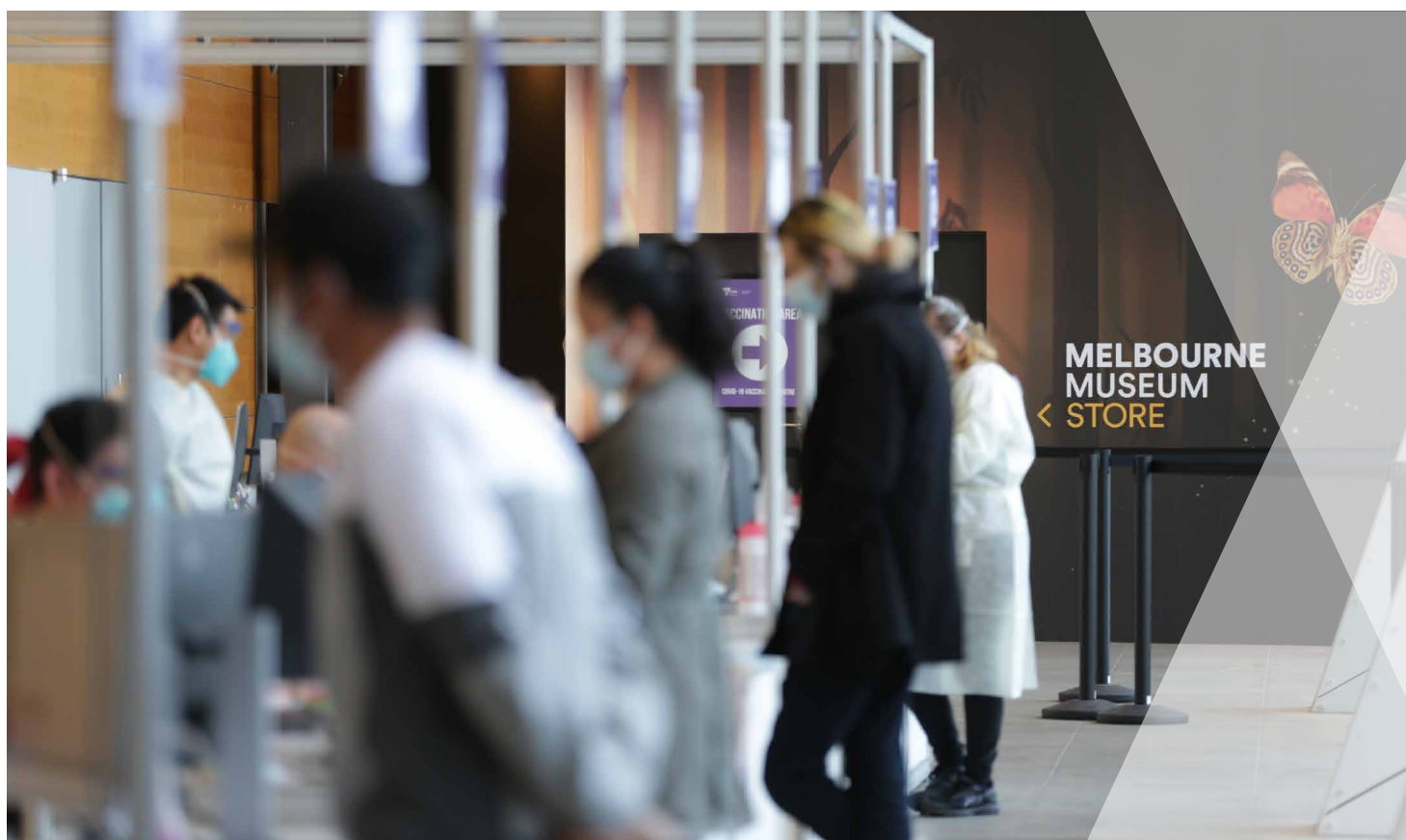
6 Response

When a pandemic is declared, there are flexible and scalable response activities that may be implemented to protect Victorians.

The State Controller – Health will work closely with key support agencies and departments to assess the dynamic changes required to response activities. These dynamic changes can be determined by:

- transmissibility, new emerging evidence, mutations or subvariants of the virus
- socioeconomic and cultural contexts
- public attitudes (such as pandemic fatigue, misinformation)
- health system capacities (such as workforce shortages)
- surge workforces.

The pandemic response will likely entail:

- a collaborative cross-government response engaging with various sectors
- if applicable, and certain thresholds are met, containing the virus through pandemic orders and the enforcement of these orders, subject to decision by the Minister for Health
- communicating and engaging with the community at risk of the virus and the important behavioural changes required. Chapter 5 outlines communications arrangements in further detail
- if applicable, for example during a global pandemic, the insights, evidence, learnings and approaches from other countries will assist in informing the Victorian government's planning and response mechanisms
- where appropriate scaling up or down departmental and agency response plans
- recovery and relief activities to be implemented in response phase.

The HESP's 'Appendix B: Health response assessment' provides detail on key considerations in each step of the health emergency assessment process. Further pandemic assessment considerations that will influence the response arrangements and strategies include:

- **stand-by response stage** – sustained community person-to-person transmission detected overseas
- **initial action response stage** – cases detected in Australia, but information about the disease is scarce
- **targeted action response stage** – cases detected in Australia, and enough is known about the disease to tailor measures to specific needs.

This plan is highly integrated with the responsibilities and dependencies of the Australian Government through national forums and nationally consistent decision making. While some Australian Government responsibilities are outlined in Chapter 4 (e.g. monitoring for novel virus, national emergency plans, national medical stockpile), specific roles in international border settings, monitoring and securing supply chains, management of private aged care facilities and National Disability Insurance Scheme participants/residential disability accommodation and constitutional responsibility for quarantine. The Australian Health Protection Principal Committee (AHPPC) facilitates national deliberations informing state level implementation of actions to outline the complexity and dynamics in the planning and decision-making process.

6.1 Response strategies

The clinical severity and transmissibility of a virus will determine the response strategies implemented to manage the outbreak.

6.1.1 Pandemic orders

The Minister of Health, as advised under Victoria's pandemic management framework, can make pandemic orders to protect public health if the Premier declares a pandemic. The CHO and other relevant parties will be consulted before pandemic orders are put in place to ensure the following has been considered:

- impacts to human rights under the *Charter of Human Rights and Responsibilities*
- all relevant factors (such as socioeconomic factors)
- the proportionate nature of the public health restrictions to the public health risk at the time
- epidemiological evidence, public health advice and legal advice at the relevant time
- the extent to which the orders can be reasonably and practicably enforced.

For more information about this framework, see Victoria's pandemic management framework <https://www.health.vic.gov.au/covid-19/victorias-pandemic-management-framework>.

Public health and social measures that may be implemented in pandemic orders may include:

- confirmed case and close contact restrictions (such as isolation, quarantine, requirement for individuals experiencing symptoms to isolate and get tested)
- social restrictions (such as limiting reasons individuals are permitted to leave home, applying density quotients at public and private settings, face masks or coverings to be worn either outdoors, indoors or within specific settings)

- workplace restrictions, exemptions and permits, such as prohibiting the operation of businesses, working from home orders, proof of vaccination to attend the workplace, issuing essential worker permits, border restrictions (e.g., requirements upon arrival to Victoria such as testing, isolation or quarantine)
- facility restrictions particularly in high-risk settings (such as limiting access in hospitals, aged care facilities and other health services et cetera, proof of full vaccination status before entry, requiring visitors to wear personal protective equipment when entering facilities).

The Victorian community has a shared responsibility to abide by orders and restrictions imposed to limit or reduce the spread of the virus, and, where required, adhere to Commonwealth restrictions.

Pandemic orders may provide a legal basis to enforce public compliance with requirements, which aim to reduce the spread of a virus. Additionally, public health interventions including health promotion campaigns, can encourage effective public health interventions (such as hygiene and physical distancing).

6.1.2 Enforcement

Authorised Officers are delegates under certain acts who have the authority to carry out compliance and/or enforcement functions. Under the PHW Act, DH can appoint Authorised Officers from government departments, agencies such as Victoria Police, WorkSafe and local councils. Victoria Police would perform an enforcement function.

During the COVID-19 pandemic, the Victorian Government provided the Secretary, Department of Health with the power to appoint Authorised Officers under section 30 of the PHW Act to carry out COVID-19 compliance and enforcement obligations and powers set out in Part 9 of the PHW Act.

In addition, when a pandemic declaration is in force, the CHO can authorise Authorised Officers to use public health risk powers and pandemic management powers. These sets of powers provide a broad range of measures to protect public health including the ability to:

- detain a person if reasonably necessary to protect public health
- close premises for a period of time reasonably necessary to investigate or eliminate or reduce a risk to public health
- impose restrictions of movement
- require the use of personal protective equipment
- direct persons to undertake COVID-19 tests.

Authorised Officers can be delegated the authority to issue infringement notices and official warnings to assist in monitoring compliance. They may conduct patrols, inspections and intelligence operations to monitor and enforce compliance with pandemic orders (and previously public health directions). Authorised Officers are required to identify the relevant provisions which an individual or group has allegedly breached.
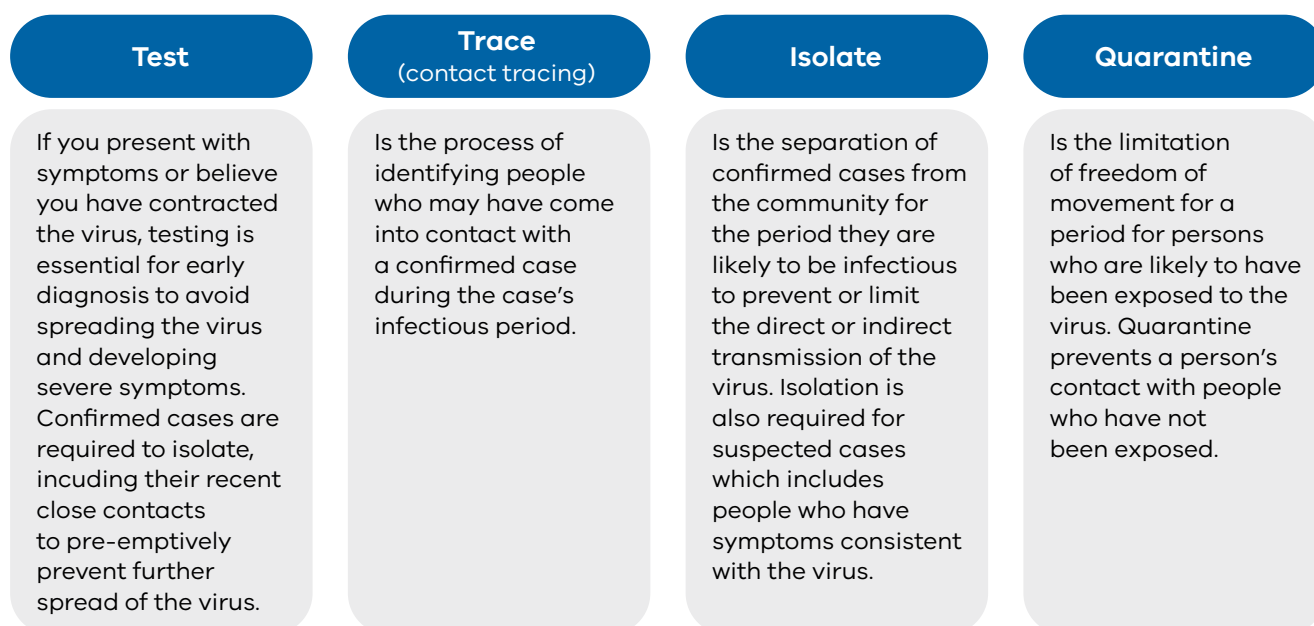
Consideration will be given to resourcing Authorised Officers and providing appropriate training requirements. Government departments, such as Victoria Police, may be required to assist where appropriate.

All reasonable effort will be taken to consult with agencies and departments performing compliance and enforcement functions prior to issuing pandemic orders to ensure orders are practicable from a compliance and enforcement perspective.

6.1.3 Test-trace-isolate-quarantine

A test, trace, isolate and quarantine (TTIQ) system can help control the spread of an infectious disease by identifying confirmed cases and close contacts to ensure isolation and quarantine measures occur as soon as possible. Monitoring the public health risks and adapting the TTIQ system (if in use) during a pandemic is required to ensure the response remains effective.

Figure 4: Breakdown of TTIQ system

Test	Trace (contact tracing)	Isolate	Quarantine
If you present with symptoms or believe you have contracted the virus, testing is essential for early diagnosis to avoid spreading the virus and developing severe symptoms. Confirmed cases are required to isolate, incuding their recent close contacts to pre-emptively prevent further spread of the virus.	Is the process of identifying people who may have come into contact with a confirmed case during the case's infectious period.	Is the separation of confirmed cases from the community for the period they are likely to be infectious to prevent or limit the direct or indirect transmission of the virus. Isolation is also required for suspected cases which includes people who have symptoms consistent with the virus.	Is the limitation of freedom of movement for a period for persons who are likely to have been exposed to the virus. Quarantine prevents a person's contact with people who have not been exposed.

The effectiveness of these measures in containing new outbreaks depends on the transmission dynamics of the virus, other mitigation strategies and the proportion of transmission that occurs from infections without symptoms.

The objectives of a TTIQ system include:

- high testing rates and the efficient and effective communication of test results to individuals
- timely contact tracing using various resources such as apps and software
- high isolation and quarantine compliance for close contacts and travellers into Victoria
- timely self-isolation of symptomatic individuals and their close contacts
- surveillance programs to understand prevalence in a setting of high incidence.

Ensuring a timely testing and contact tracing process is in place leads to early detection or early quarantine measures for potential infectious or infected individuals. If a confirmed case is already in quarantine during their infectious period, the public health risk is significantly reduced.

As suspected or confirmed cases, close contacts, people potentially exposed to the virus and the symptomatic are required to isolate or quarantine, people may be eligible for support provisions including, income support, psychosocial support, and health care as needed.

In instances of non-compliance either by choice or due to extenuating circumstances, a collaborative approach between Victorian government departments and agencies may be required to respond to and manage individuals. This may include enforcement measures where breaches have occurred.

6.1.4 Vaccinations and antiviral medicines

Vaccines

In some instances, vaccines, once available, may be effective in managing the spread of the virus.

Vaccines:

- reduce or minimise mortality and morbidity
- reduce transmission of the virus minimise the impact on healthcare services.

The time needed to develop and produce a customised vaccine in sufficient quantities may take months, even years in a pandemic situation.

Antivirals

Antiviral medicines are used to treat viruses for people in hospital or in the community who may be at risk of progressing more severe symptoms. Antivirals are not a substitute for vaccinations and do not replace the need for vaccinations.[2] However, antiviral treatments may reduce the risk of hospitalisation or death in infected individuals.

2 https://www.nps.org.au/coronavirus/antiviral-treatments-for-covid-19

Table 3: Vaccine and antiviral program responsibilities

Entity	Responsibility
Commonwealth government	Predominantly leads vaccination programs with advice from the Australian Technical Advisory Group on Immunisation (ATAGI) <https://www.health.gov.au/committees-and-groups/australian-technical-advisory-group-on-immunisation-atagi> and the regulatory authority Therapeutic Goods Administration (TGA).
	The TGA approves vaccinations which the Commonwealth Government procures and allocates stock to jurisdictions.
	Monitors the safety of vaccines by:
	• passive surveillance – where individuals report side effects and adverse events directly to TGA
	• active surveillance – where participating clinics use AusVaxSafety <https://ausvaxsafety.org.au/our-work/national-vaccine-safety-surveillance> to send messages to individuals who received vaccines and ask if they had any reactions.
	• Responsible for logistics and equitable distribution of vaccines and eligibility parameters for Pharmaceutical Benefits Scheme subsidy for antivirals.
	The TGA will grant provisional approval for antiviral treatments to be administered to the community and are available in Victoria through the National Medical Stockpile (NMS).
State government	Has a role in monitoring potential risks with antiviral medicines, vaccine rollouts and assists in guiding vaccination planning and delivery in Victoria.
	Considerations include:
	• vaccine and antiviral supply and distribution (for example, priority workforces, at-risk cohorts, including those high at risk of disease progression)
	• communication and engagement campaigns
	• prevention or mitigating of misinformation
	• incentives or restrictions for vaccinations (such as vaccine mandates).
	The Victorian Government may also invest in the development and manufacturing of vaccines such as mRNA Victoria.
Health Services, including LPHUs	Has a role in the provision of vaccine roll out and distribution of antivirals medicines.
	LPHUs ensure local community and organisations actively participate in development and implementation of response arrangements or services.
ACCHOs	Ensures culturally appropriate provision of vaccines and antiviral medicines to Aboriginal and Torres Strait Islander people.
Primary Health Networks	Provide vaccine programs and antiviral medicines through health providers such as general practitioners and pharmacists and, if established, through public vaccination clinics.

6.2 Workforce

6.2.1 Resourcing

Resource planning and arrangements for surge staffing, resource sharing, rostering, job-sharing, and fatigue management are essential. The minimum staffing levels sufficient to safely maintain critical services should be determined early and reviewed often.

The pandemic response may require staff to increase their committed work hours, although requests for flexibility on their part will be appropriate to their skills and Enterprise Bargaining Agreement or contract. Consideration should be given to:

- part-time or casual staff who can work additional hours
- staff able to defer annual or long service leave
- people recalled to work from leave
- sharing/redeploying staff across VPS departments
- those with non-clinical skills to fill certain roles
- health professional volunteers and retired staff who can assist
- agency staff
- impacts of casualisation for some workers, who may not have access to paid sick leave
- fatigue levels, burnout, and high turnover due to surge activities and demands.

6.2.2 Workforce infection prevention and control

WorkSafe Victoria advises where a risk to health is identified at a workplace, employers must, so far as is reasonably practicable, eliminate the risks, or minimise the risks. The *Occupational Health and Safety Act 2004* sets out clear responsibilities for employers and employees.

Employers should consider a pragmatic and precautionary approach to managing work absences, with a view to promoting health and safety for individuals, others in the workplace and the public generally.

Infection prevention and control measures are among the most effective tools available to contain the spread of viruses in all work environments and in the community. The type of control measures required depends on the level of risk as well as the availability and suitability of controls for each workplace, and may include:

- promoting awareness of the risks of the pandemic
- providing adequate facilities or products (such as PPE and hand sanitiser) to allow employees to maintain good hygiene practices
- optimising air ventilation in the workplace
- directing workers to stay home and get tested if unwell
- where indicated, advising employees to self-isolate as per the latest advice
- developing an infection prevention and control policy
- implementing flexible work arrangements for staff who do not need to be on site and others who may be more at risk of severe illness
- supporting all employees who are not fit for work due to contracting the virus to follow the public health advice and isolation requirements.

Occupational health and safety risks must be assessed and documented. Infection prevention and control guidelines should be circulated and well understood by all staff.

6.2.3 Scalable workforce arrangements to deliver essential services

The Victorian Government must ensure the continuity in the delivery of essential services throughout the course of the pandemic. Critical infrastructure sectors are highly interconnected, have strong interdependencies and are reliant on other sectors and supply chains, both domestically and internationally.

Arrangements to support essential workers and understanding of dependency on supply chains are two areas that should be included in all organisational planning considerations (for example prioritising vaccinations and testing and issuing essential worker permits).

A critical dependency for all government departments, businesses and NGOs is an available workforce. It is important for all these bodies to consider the health, safety, and welfare of employees before, during and after an emergency. They should also ensure strong, timely communications to staff and clients, customers, and stakeholders.

6.3 Health system

The entire health system will work to contain the spread of the virus and reduce morbidity and mortality.

A pandemic response will likely see increased demand for the health system. Where possible, efforts should be made to ease the strain on the system.

6.3.1 Public hospitals

Hospitals play a critical role in the pandemic response.

Modelling (as described in Chapter 2.2) can be used to predict the demand for services and potential stress on the system. The Victorian Government may assist hospitals to identify and source critical medical supplies and consumables that may be in high demand or not readily available due to manufacturing pressures.

Preparedness and response activities include undertaking assessments of air handling and ventilation, implementing infection prevention and control measures and streamlining and optimising clinical configurations to reduce the spread of patient and health worker infections.

Depending on the clinical severity of illness associated with the virus, additional actions may be required to ease stress on the system, including pausing non-essential surgical procedures. The Victorian Government may enter into funding agreements with private hospitals to support a whole-of-health system response.

Centralised statewide control and coordination of health system activity may be required in order to maintain access for the community to critical and necessary services, and to preserve capacity within the system for pandemic-related responses.

6.3.2 Private hospitals

Depending on the complexity and scale of a pandemic, the Victorian government may enter into agreements with private hospitals to deliver additional services and support to alleviate public hospital pressures.

Future pandemic planning should include collaboration with Victoria's public and private hospitals. This will relieve pressure on public hospitals and ensure the entire health system operates at full capacity in a pandemic.

6.3.3 Aboriginal Community Controlled Health Organisations

Aboriginal Community Controlled Health Organisations (ACCHOs) are primary healthcare service providers that deliver holistic, culturally safe and trauma-informed health services to Aboriginal Victorians and their communities.

As part of Victoria's broader primary healthcare system, ACCHOs offer access to health services aimed at improving health and wellbeing outcomes for individuals, their families, and their communities. While this helps to prevent hospital admissions, Aboriginal Victorians continue to experience poorer health and wellbeing outcomes than non-Aboriginal Victorians.

ACCHOs are experts in delivering culturally safe services with unique insights into the local needs and aspirations of their local communities. In emergency management situation, such as a pandemic, ACCHO's are leaders in responding to local community needs. They do this by:

- using existing relationships to provide culturally informed and safe health services
- distributing public health messaging to communities based on Aboriginal ways of knowing, being and doing
- developing culturally appropriate resources and strategies that reflect public health advice
- promoting prevention measures that focus on the strengths of Aboriginal culture.

All primary healthcare organisations can benefit from ACCHO expertise and leadership by working closely with their local ACCHOs to capture the needs of Aboriginal people in their service plans and emergency procedures. In doing so, the public health sector can close the gap in Aboriginal health and wellbeing outcomes so that all Victorians can benefit from a high-quality, world-class health system.

6.3.4 Local public health units

There are nine local public health units (LPHUs) established in July 2020 to help improve responsiveness to outbreak management by providing a surge-ready workforce. They are the frontline of Victoria's place-based public health operations, with support and oversight from DH.

LPHUs strengthen Victoria's public health response to a pandemic and support engagement with their respective local communities. They work in collaboration with community partners, general practitioners and hospital-based services to enable better identification, prevention, and minimisation of public health risks to the Victorian community.

Planning should ensure the necessary equipment, protocols and communication are in place to support employees working remotely or flexibly.

6.3.5 NURSE-ON-CALL

NURSE-ON-CALL is a Victoria-wide telephone helpline that provides immediate expert health advice from a registered nurse, 24 hours a day, 7 days a week.

The agreement between DH and Healthdirect Australia, which manages the service, allows for a range of additional NURSE-ON-CALL services to be activated in the event of a health emergency.

Additional telephone services and digital services can be tailored to meet the needs of the particular requirements of the emergency.

6.3.6 General practice respiratory clinics

General practice respiratory clinics (GPRCs) provide patients access to, face-to-face assessment for respiratory symptoms, testing and treatment.

As part of a partnerships between PHNs, the Victorian Government and the Australian Government, GPRCs operate in many locations around the state and country.

Respiratory clinics reduce the risk of further respiratory virus transmission, help to optimise the use of available stocks of PPE, and help reduce the pressure on hospital emergency departments in a pandemic.

The Australian Government Department of Health and Aged Care website <https://www.health.gov.au/resources/publications/covid-19-national-health-plan-primary-health-respiratory-clinics> provides further information.

6.3.7 High-risk Accommodation Model

An appropriate high-risk accommodation model may be required to ensure appropriate public health measures are in place to protect the health and wellbeing of residents living in high-risk accommodation settings during a pandemic.

A high-risk accommodation model of service can enable the rapid delivery of:

1. Catchment planning
2. Prevention and preparedness, and
3. Outbreak responses
4. Community engagement
5. Active linkage to social support

Such models can aid in the prevention of further outbreaks and if or when prevention fails, response to early and effective reduction of transmission is necessary to promote community recovery.

6.3.8 Ambulance services

Demand for ambulance services to provide emergency prehospital care and support the health system's response may increase significantly during a pandemic.

Communication and engagement, community health and primary health response can assist in mitigating demand for emergency care (provided by ambulance services and emergency departments) by providing safe and effective care in the community.

6.3.9 Community health

Diverting care away from health services to be managed in community health settings, can reduce demand on critical care services and hospital workforce, while minimising patient exposure to hospital acquired infections. The community health sector is an agile, responsive and vital partner to deliver care including to at-risk Victorians.

Community health services:

- focus on the provision of locally responsive care
- are locally based with extensive knowledge and existing service provision networks
- provide health information about pandemics in culturally and linguistically appropriate formats to highly at-risk and culturally diverse communities
- provide important out-reach and in-reach support including through telehealth to at-risk clients who are particularly at-risk during periods of social isolation and physical distancing
- undertake prevention and preparedness activities and provide support for outbreak response
- implement necessary programs or services to respond directly to a pandemic.

6.3.10 Primary Health Networks

Primary Health Networks:

- coordinate access to primary care resources including general practice, pharmacy, community mental health and alcohol and drug services for emergency response (for example, in response to Local Health Network code brown, support for field primary care clinics)
- facilitate the delivery of warnings and public health messages to primary care sector (as above)
- commission health services to support community recovery.

For example, DH coordinated the implementation of the COVID Positive Pathways program during the COVID-19 response to provide clinical care and support at home for Victorians diagnosed with COVID-19. The program was delivered by Victorian hospitals, community health services (including collaboration with Aboriginal health services), GPs and other providers.

COVID Positive Pathways included functions such as Hospital in the Home (HITH) to avoid admission to a hospital for clinical treatment.

6.3.11 Commonwealth managed health settings

DH will undertake coordination and planning between the health sector and the interfaces with Commonwealth managed health settings including disability and aged care settings with regard to workforce implications, resourcing and capacity to implement response across at-risk groups.

6.4 Relief (as part of response)

Relief is the provision of assistance to meet the essential needs of individuals, families and communities during and in the immediate aftermath of an emergency.

Relief activities should begin as soon as necessary, which is often during the response phase. They continue into the immediate aftermath of a health emergency.

Depending on the level of impact and consequences associated with the pandemic, relief considerations should include ensuring affected communities receive:

- essential support to meet their basic and immediate needs
- food and hygiene items particularly for those required to isolate or quarantine and those unable to access shops
- psychosocial and mental health support
- financial assistance, to businesses and all employees particularly for those whose workplace may be closed and those who need to isolate or quarantine but do not have sick leave entitlements
- temporary accommodation for those who may need to isolate or quarantine away from their normal residence such as healthcare workers.

The delivery of relief services is coordinated by Relief Lead Agencies (RelLAs) and Relief Support Agencies (RelSAs) as identified in the SEMP.

6.5 Transition to recovery

Specific roles and responsibilities for delivery of recovery coordination and recovery activities are set out in SEMP.

The Controller at the relevant tier should take a lead role in facilitating transition to recovery and is responsible for notifying the health system of the de-escalation of response activities and return to 'business as usual' or the 'new normal'.

When it has been determined to transition to recovery, the Controller will:

- notify relevant public health services, private hospitals, the primary health sector and other health sector stakeholders of incident stand down
- ensure an operational debrief of all participants to learn from the emergency management experience is conducted
- consider peer support advice and information for personnel involved in a response, such as access to employee assistance programs.

The type, scale and complexity of a health emergency will determine transition structures and requirements to support the coordination of recovery arrangements. Decisions made during the response phase will affect recovery arrangements for health emergencies. Collaboration between response and recovery agencies is imperative for a seamless and coordinated transition to recovery. All agencies involved should cooperatively share information, planning and decision making to execute plans.

Considerations must also be taken where concurrent emergencies are occurring and how this could impact transition to recovery arrangements.

Once the emergency response activities have concluded and where relief and recovery activities need to continue, the arrangements for managing the emergency will formally transition to recovery. Recovery is further discussed in Chapter 7 – Recovery.

7 Recovery

Recovery is 'the assisting of persons and communities affected by emergencies to achieve a proper and effective level of functioning'.

Victoria's recovery arrangements align with the National Principles for Disaster Recovery <https://knowledge.aidr.org.au/resources/national-principles-for-disaster-recovery/>, SEMP and HESP.

Appendix A:
Key supporting information

The tables below provide relevant state, national and international governance structures, legislation and plans related to this plan; this list is not exhaustive.

Legislation

International

Legislation	URL
International Health Regulations 2005 (IHR)	https://www.who.int/health-topics/international-health-regulations

National

Legislation	URL
Therapeutic Goods Act 1989	https://www.legislation.gov.au/Details/C2017C00226
National Health Security Act 2007	https://www.legislation.gov.au/Details/C2016C00847
Biosecurity Act 2015	https://www.legislation.gov.au/Details/C2017C00303

State

Legislation	URL
Emergency Management Act 2013	https://www.legislation.vic.gov.au/in-force/acts/emergency-management-act-2013/015
Emergency Management Act 1986	https://www.legislation.vic.gov.au/in-force/acts/emergency-management-act-1986/051
Public Health and Wellbeing Act 2008	https://www.legislation.vic.gov.au/in-force/acts/public-health-and-wellbeing-act-2008/040
Victoria's Pandemic Management Framework	https://www.health.vic.gov.au/covid-19/victorias-pandemic-management-framework
Health Services Act 1988	https://www.legislation.vic.gov.au/in-force/acts/health-services-act-1988/167
Charter of Human Rights and Responsibilities Act 2006	https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015
Occupational Health and Safety Act 2004 (Vic)	https://www.legislation.vic.gov.au/in-force/acts/radiation-act-2005/033

Plans, arrangements and guidelines

International

Resource	URL
WHO Influenza Risk Management Guide	https://www.who.int/publications/i/item/WHO-WHE-IHM-GIP-017-1

National

Resource	URL
Australian Government Department of Health and Aged Care	https://www.health.gov.au/
Australian health management plan for pandemic influenza (AHMPPI)	https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-ahmppi.htm
Australian health sector emergency response plan for novel coronavirus (COVID-19)	https://www.health.gov.au/resources/publications/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19
Emergency response plan for communicable disease incidents of national significance (National CD Plan)	https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-CD-plan.htm
National strategy for disaster resilience (NSDR)	https://recovery.gov.au/about-us/governance-and-reporting/strategies-and-frameworks
National Medical Stockpile (NMS)	https://www.health.gov.au/initiatives-and-programs/national-medical-stockpile
National guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia	https://www.health.gov.au/sites/default/files/documents/2022/02/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-residential-care-facilities-in-australia.pdf

State

Resource	URL
State emergency management plan (SEMP)	https://www.emv.vic.gov.au/responsibilities/semp
SEMP Health Emergencies Sub-Plan	https://www.emv.vic.gov.au/responsibilities/state-emergency-management-plan-sub-plans
Victorian health management plan for pandemic influenza (VHMPPI)	https://www.health.vic.gov.au/publications/victorian-health-management-plan-for-pandemic-influenza-october-2014
Emergency risks in Victoria	https://www.emv.vic.gov.au/state-emergency-risk-assessment-reports

Committees and forums

National

Committee/forum	URL
National Federation Reform Council (NFRC)	https://federation.gov.au/nfrc
National Cabinet	https://federation.gov.au/national-cabinet
Health National Cabinet Reform Committee (HNCRC)	https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm#related-committees-or-groups
The Health Ministers Meeting (HMM)	https://federation.gov.au/other-meetings/ministers-meetings
Australian Technical Advisory Group on Immunisation (ATAGI)	https://www.health.gov.au/committees-and-groups/australian-technical-advisory-group-on-immunisation-atagi
The Health Chief Executives Forum (HCEF)	https://www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef
Australian Health Protection Principal Committee (AHPPC)	https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc
Communicable Diseases Network Australia (CDNA)	https://www1.health.gov.au/internet/main/publishing.nsf/Content/cda-cdna-index.htm
National Health Emergency Management Subcommittee (NHEMS)	https://www.health.gov.au/committees-and-groups/australian-healthprotection-principal-committee-ahppc

State

Committee/forum	Description
State Crisis and Resilience Council (SCRC)	Peak crisis and emergency management advisory body to the Victorian Government and provides advice to Ministers and relevant Cabinet subcommittees. It is responsible for the development and implementation of whole-of-Victorian-Government EM policy and strategy. It does not make operational or tactical decisions.
Emergency Management Joint Public Information Committee (EMJPIC)	Has representatives from all government departments and agencies Ensures a coordinated and cohesive communications approach, and response arrangements in place
Municipal Emergency Management Planning Committee (MEMPC)	Responsible for the preparation and review of their Municipal Emergency Management Plan (MEMP) Ensure the MEMP is consistent with the SEMP and with the relevant REMP Provide reports and recommendations to the region's REMPC in relation to any matter that affects or may affect EM planning in their municipal district
Regional Emergency Management Planning Committee (REMPC)	Responsible for the preparation and review of their Regional Emergency Management Plan (REMP) Ensure the REMP is consistent with the SEMP Identify how the region will prepare, respond and recover from pandemics in alignment with state planning

Appendix B: Glossary

This is not an exhaustive list of definitions relevant to this plan. More definitions can be found in the SEMP and SEMP HESP.

Term	Definition
Biosecurity	All the measures taken to minimise the risk of infectious diseases caused by viruses, bacteria or other microorganisms entering, emerging, establishing or spreading in Australia, potentially harming the Australian population, our food security and economy.
Business continuity	The uninterrupted availability of all key resources supporting essential business function. Business continuity management provides for the availability of processes and resources to ensure the continued achievement of critical services objectives.
Clinical severity	How sick the virus makes people
Epidemic	Spread of a disease above what is normally expected in a certain area but is contained to a region or community
Endemic	Regularly found among particular people or in a certain area
Isolation	Segregation and separation of persons who are infected or suspected of being infected from other persons under the PHW Act
Mitigation	Activities needed to eliminate or reduce the incidence or severity of emergencies, and the minimisation of their effects
Novel	New
Pandemic	An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people
Pandemic order	Includes restrictions that are necessary to protect the community during a pandemic as cited in Victoria's pandemic management framework
People most at risk	Individuals and communities who have the potential to be adversely affected by a disaster or emergency and who, because of the circumstances in their everyday lives, require significant and coordinated priority intervention, response and support from a variety of government and non-government organisations and the broader community for their safety.
Quarantine	Limitation of freedom of movement for a period of time for well persons who are likely to have been exposed to the virus (contact) to prevent their contact with people who have not been exposed. This may be voluntary or mandatory.
Respiratory virus	A virus affecting the respiratory tract
Transmissibility	The ability of the virus to spread between people

Appendix C: Public information and community engagement arrangements

This guidance provides information and advice on planning for pandemic communications and engagement. It covers national and state governance arrangements, workforce planning, messaging and communications and engagement channels.

Governance

The Australian Government Department of Health and Aged Care coordinates and leads national pandemic response and health messaging via the National Health Emergency Media Response Network.

Departments and agencies should review the public information and engagement chapters in the current national communicable disease and pandemic plans <https://www.aph.gov.au/ About_Parliament/Parliamentary_Departments/ Parliamentary_Library/pubs/rp/rp1920/Quick_ Guides/AustralianPandemicResponsePlanning> to ensure alignment and consistency.

In Victoria, the Department of Premier and Cabinet (DPC) has a role in coordinating pandemic public information response; this role may vary in intensity and actions undertaken and may be delegated to another agency depending on public information needs.

This is supported by the Emergency Management Joint Public Information Committee (EMJPIC). Facilitated by Emergency Management Victoria (EMV), EMJPIC has representatives from all government departments and agencies, and ensures the Victorian Government has a coordinated and cohesive communications approach, and response arrangements in place.

Regional and Border Public Information Committees may also be convened to help coordinate communications for localised outbreaks and border issues. Local public health units and local government will be essential members of any local or regional public information committees established.

Victorian Government departments and agencies' communications and engagement plans should outline their internal governance and authorisation arrangements for a pandemic. It is recommended departments and agencies streamline their approval processes to minimise the delay of essential information and engagement.

Planning

Scenario planning

Sector specific communications and engagement planning should consider a range of possible scenarios and their associated risks and mitigations.

For example, a highly infectious airborne virus associated with severe disease is likely to disrupt health and essential services; essential workforces; supply chains; interstate and international travel; and require financial and other support services for people, families, and businesses.

A less infectious and less severe virus may only require restrictions in certain settings, such as schools, hospitals, aged and disability care facilities.

Scenario planning should consider immediate to longer term consequences and how to communicate and engage throughout the different phases of a pandemic.

Workforce planning

A significant increase in resourcing and capacity will likely be required during a pandemic, including maintaining 24-hour, seven day a week coverage during peak times.

Departments and agencies who oversee critical and essential services should plan for how they will resource an immediate response and how they will increase their capacity.

Workforce planning can include identifying and training surge staff, establishing cross-government resource sharing, job-sharing, and seven days a week rostering.

Planning should also identify critical communication functions, such as media and social media and ensure scalable resourcing arrangements are in place.

For more information on workforce planning see Chapter 6.2 – Workforce.

Insights and community engagement

Community, stakeholder, and other insights should be used to inform all communications and engagement planning.

It is essential that departments and agencies have well established and trusted relationships with their communities, industries, and stakeholders. This is particularly important for Aboriginal and Torres Strait Islanders and culturally and linguistically diverse communities to help build community resilience.

Insights from community, stakeholders and other sources should also inform how to communicate and identify effective broad-based and targeted communications channels.

Effective media and social media monitoring tools should also be established.

Communications and engagement channels

A range of comprehensive and far-reaching communications and engagement channels and approaches will be required to reach all Victorians.

A dedicated web presence, media, advertising campaigns, digital and social media, telephone hotlines, stakeholder and community networks will all be leveraged throughout the pandemic.

It is essential that targeted communications and engagement channels are used to reach Aboriginal and Torres Strait Islanders, those from culturally and linguistically diverse communities, and vision and hearing-impaired Victorians.

Planning should also ensure there are arrangements in place for the rapid translation of critical or localised outbreak information across different channels.

Messaging

Messaging needs to be accurate, consistent, encourage behaviour change, and be easy to comprehend and translate.

Using scenario planning and insights, departments and agencies can develop messaging that pre-empts the impacts and consequences on community, their clients, services, industries, and stakeholders may experience during a pandemic.

Implementation

This section provides advice on implementing communications and engagement plans once a pandemic is, or is likely, to be declared.

Public Information Unit

Establish a public information unit dedicated to the pandemic response. Ensure key functions, such as media, digital and social media, communications, and community and stakeholder engagement are stood up.

Rostering key roles 24 hours, seven days a week may be required at peak times throughout the pandemic.

Daily scheduled meetings are recommended with all functions represented to provide updates. Use current insights from stakeholders, community and media/social media monitoring to inform your communications for the day.

Action planning

Begin by reviewing your scenario planning, risks and mitigations.

The review should consider what is known about the virus and its likely impacts to inform detailed action planning. Scenario plans should be revisited as more is understood about the virus, its severity, transmissibility, and as a vaccine or other treatments are developed.

Workforce and recruitment

It is likely departments and agencies will need to rapidly scale up their workforce and use surge staff from within their organisation or from across government.

Develop clear and streamlined processes for onboarding staff including guides, process manuals and 'just in time' training.

Fatigue management and managing staff wellbeing will be crucial. Establish rosters or job share arrangements for key roles and functions. Ensure staff are provided with rest days and promote employee assistance programs and other support services.

Insights and community engagement

It will be important to draw on established community and industry networks to inform our communications and engagement response. Departments and agencies can use established networks to test messaging and campaign materials to ensure it is effective and culturally and linguistically appropriate.

Daily media and social media monitoring should be undertaken with insights and data reported to executives and key decision-makers to inform the broader pandemic response.

Communications and engagement channels

Departments and agencies should activate their identified communication and engagement channels including but not limited to media, paid advertising campaigns, digital and social media, as well as stakeholder and community engagement channels.

Content for digital, social and hotlines will need to be regularly reviewed and updated as the situation, directions, or restrictions are changed.

Regular press conferences should be held to provide the community with real-time information and updates. Auslan interpreters should be used at all press conference and closed captioning used on all video content.

Media spokespeople and those delivering messaging should be trusted, confident and experienced subject matter experts authorised to speak on behalf of the Victorian Government.

Using community and faith leaders to develop and share messaging is also an effective strategy for reaching communities and consumers through trusted sources. Established local networks should also be leveraged to disseminate important or urgent messages to communities.

Messaging

Departments and agencies are responsible for developing their own messaging about impacts to their services during the pandemic, and any support services offered.

Messaging should be reviewed and updated regularly. It should be aligned to current public health advice and may be informed by community and stakeholder insights.

It should also:

- reflect current public awareness and attitudes
- be responsive and empathetic
- encourage social cohesion
- help reduce stigma
- correct misinformation.

Messaging should also factor in disparities in access to medical care, socioeconomic status, employment conditions or other factors, such as low literacy, gender, or ethnicity.

Information that helps the community understand the situation and how to stay safe, should be translated (including easy English) as a priority. Messaging must be appropriately authorised before use.