COVID-19

Pandemic plan for the Victorian Health Sector

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VICTORIA State Government | Health and Human Services

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Executive Summary

Introduction

Coronavirus (COVID-19) is a respiratory illness caused by a new virus. Symptoms range from a mild cough to pneumonia. Some people recover easily, others may get very sick very quickly. There is evidence that it spreads rapidly from person to person.

Travel restrictions and rapid public health responses have contained the spread of the virus in Australia so far. However, its rapid spread in other countries outside of China means COVID-19 is now an emerging pandemic.

The World Health Organisation (WHO) has declared a Public Health Emergency of International Concern due to an emerging pandemic of coronavirus disease 2019 caused by a newly identified virus, SARS-CoV-2.

Information about clinical assessment and public health characteristics of COVID-19 is at:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Implications for Victoria

The growing risk of an outbreak in Australia requires an acceleration in planning our health response.

Victoria is well prepared for dealing with COVID-19. Victorian health services, hospitals, primary care and emergency services have existing pandemic influenza preparedness arrangements.

The health system undertakes pandemic response exercises and is prepared for the COVID-19 public health emergency. However, all health systems will be challenged in the event of a pandemic, so it is important we plan for all possible scenarios.

This is a guide for preparing and responding to the virus for Victoria's health sector and will be regularly updated as we learn more about the transmission of the virus, control measures and treatments.

The Victorian Government Department of Health and Human Services (DHHS) is the control agency for this Class 2 public health emergency[1] and will take urgent action under legislation including the *Public Health and Wellbeing Act 2008*, *Emergency Management Act 2013* and Commonwealth *Biosecurity Act 2015* to safeguard the health and wellbeing of all Victorians[1].

A staged response

Victoria's response to COVID-19 is a four-stage process, working together with all states, territories and the Commonwealth. The four stages may overlap through the course of pandemic response.

Responses within each stage of this plan should be considered a menu of initiatives to be deployed as appropriate at any time, informed by growing knowledge of the virus and local experience of its spread and impact. Victoria is passing through Stage 1 at this time but is preparing for, and may soon be at, Stage 2.[1]

The table overleaf outlines each of the four stage and these will be expanded on in the remainder of this document.

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[1]A Class 2 emergency is a major emergency that is not a Class 1 emergency or a warlike act or act of terrorism. (Class 1 emergencies are either major fires or emergencies with MFB, CFA or SES as control agency). The response in a Class 2 emergency is a collaboration across the health sector, government agencies and the community.

Stages of response:	
Stage 1	Initial containment stage
Stage 2	Targeted action stage
Stage 3	Peak action stage
Stage 4	Stand-down and recovery stage

Overall objectives

The overall objectives of this plan are to:

1. Reduce the morbidity and mortality associated with COVID-19.

2. Slow the spread of COVID-19 in Victoria through rapid identification, isolation and cohorting of risk groups.

3. Empower the Victorian community, health professionals and the community to ensure a proportionate and equitable response.

4. Support containment strategies through accurate, timely and coordinated communication and community support.

5. Mitigate and minimise impacts of the pandemic on the health system and broader community.

Important principles

Our response is guided by the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* and the pandemic response plans of other jurisdictions.

These principles guide us to ensure our response is:

- Flexible and proportionate, and can be scaled up or down as required
- Reliant on existing health systems and health system governance where possible
- Inclusive of all Victorians and acts to reduce any form of xenophobia in the response
- Focused on protecting vulnerable Victorians, including with underlying health conditions, compromised immune systems, the elderly, Aboriginal and Torres Strait Islanders, and those from culturally and linguistically diverse communities
- Integrated with the efforts of the Commonwealth, other states and territories and relevant public agencies and sectors to make best use of common systems, plans and processes.

Outlook

An emerging global pandemic

The evidence is incomplete, but strongly suggests that SARS-CoV-2, the virus that causes COVID-19, meets the criteria for being capable of causing a pandemic, which are:

1. Humans have little or no pre-existing immunity

2. The virus causes disease in humans, and

3. The virus has the capacity to spread readily or efficiently from person to person.

Likely impact on Victoria's population

The population health impact of COVID-19 will be determined by:

1. How readily it can be transmitted (transmissibility)

2. The seriousness of the illness it causes (clinical severity).

Response measures for a pandemic of a respiratory virus depend on factors such as:

1. How spread occurs

2. Whether a person is infectious prior to onset of symptoms, and

3. Severity of illness in those infected.

Modelling pandemic impact

An initial model has been developed by DHHS to estimate the impact of COVID-19 on the Victorian population to help Victorian health services plan and prepare.

The model estimates infections, healthcare-seeking episodes, hospitalisations, critical care admissions and potential for deaths at three different levels of clinical severity: mild, moderate and severe. The model relies on data about transmissibility, severity and how the outbreak of COVID-19 spreads, using the best current evidence for COVID-19.

There is a wide span of possibilities for the impact of a Victorian outbreak of COVID-19, but there is a high probability that any emerging pandemic and its impacts will be prolonged. Our aim is to ensure public health interventions are effective and well targeted, and can minimise the pandemic period and the consequent impacts on the health system and broader society.

The modelling makes an emphatic case for doing detailed planning now, regardless of the severity of any emerging pandemic: planning for the worst case should be a part of that work.

Healthcare services and health professionals must prepare for the possibility of a significant and prolonged increase in demand for healthcare services, and work to ensure the effectiveness and integrity of the health system through the period ahead.

Modelling will continue as further data is available to help the health sector estimate the potential impact on health services, general practice and the health sector. This will include estimates for consumption of personal protective equipment (PPE) based on different levels of usage and models of care.

Implications of the model

The trajectory of the COVID-19 pandemic is highly uncertain, but it is likely to coincide with the Australian influenza season, so the effects of both diseases may be felt simultaneously.

Although measures to reduce exposure such as social distancing, infection control and hygiene practices may be more effective for COVID-19 than influenza, we can expect human-to-human transmission via droplets, direct contact with nasal secretions or contact with objects or materials that carry the virus.

There will be increased, and potentially high, levels of workforce absenteeism. Older Victorians and people with chronic diseases are known to be at greater risk of COVID-19 infection. Early information suggests milder illness in children, particularly those nine years and under. Pregnant women are also reported to have no higher risk of severe disease than the general population.

However, the global situation is still evolving. As more data comes to hand, it is reasonable to expect that other groups (such Aboriginal and Torres Strait Islander communities or those with immunosuppression) may be reported as having a higher relative risk.

How is Victoria responding?

COVID-19 is assessed as being of moderate clinical severity, however, we are preparing so that we are ready to respond if a larger, or more severe outbreak occurs. This plan outlines these preparations, and critical actions our health system would take. These stages apply regardless of clinical severity, and primarily relate to the nature of transmission within Victoria. The stages are:

Stage 1 **Initial containment**	• Monitor and investigate outbreaks as they occur, identify and share accurate information about the virus on a timely basis • Contribute to local and international research efforts • Communicate with the community about the nature of COVID-19, risk reduction measures and ensure community cohesion • Communicate with at-risk groups about preventive actions • Prepare hospital surge management activities to be ready for potential increased demand • Engage closely with the primary care sector to ensure appropriate clinical knowledge, response and capacity
Stage 2 **Targeted action**	**In addition to the measures above**: • Slow the disease transmission with social distancing, and coordination with the plans of other government agencies, including police, ambulance, fire services, SES, transport and education agencies • Ramp up risk reduction communication activity across the community and especially at-risk groups • Begin to implement hospital resource and demand management strategies to maximise resources available for containment • Prioritise diagnostic testing to critical risk groups
Stage 3 **Peak action stage**	**In addition to the measures above:** • Coordinate and prioritise hospital activities to maintain essential services and support quality care • Divert resources from less urgent care, implement alternate models of care, staff surge strategies and appropriate management of supplies • Focus laboratory testing on areas of critical need

Scope and purpose of this plan

This plan is intended as an overarching guidance document to inform more detailed planning at individual practice and institutional level.

All healthcare providers should use this plan, and further materials provided by DHHS to determine how a pandemic may impact their service, their patients or clients and themselves as individual practitioners, and use those insights to determine further planning and preparedness activities required.

Detailed operational plans will be required across all healthcare services in order to be fully prepared for the potential impact of COVID-19 on our healthcare services and community more broadly.

This plan has a greater level of detail for General Practice and inpatient hospital services, because the bulk of acutely unwell patients will present there, however there are elements which are relevant across all healthcare providers.

This plan is not intended as education for the general public. Information for the general public can be found at the DHHS COVID-19 website:

https://www.dhhs.vic.gov.au/coronavirus

This plan is not intended as a guide for the broader, non-health sector. The Victorian Action Plan for COVID-19 Pandemic is under development and will be available from the Emergency Management Victoria website once complete.

Stage 1: Initial containment

The most effective way to reduce the impact of COVID-19 is to reduce exposure.

There is no antiviral therapy for COVID-19, nor is there a vaccine available. Our understanding of COVID-19 evolves every day. Its rapid global spread shows that COVID-19 is highly contagious.

Key priorities in the initial containment stage

Action by the Victorian health system in this stage focuses on:
- **Preparation and planning**
- **Maximising case detection**
- **Minimising transmission**
- **Engaging the community**
- **Characterising the virus, the disease and the epidemic.**

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Preparation and planning

It is important the whole Victorian health system takes the opportunity to prepare for COVID-19 in the event the pandemic increases in scale or severity.

All health services should now develop or review local plans for pandemic preparedness, response and recovery. DHHS will develop checklists and templates for these relevant to specific sectors, however every organisation will have specific needs and differences. The below are a minimum set of considerations for all healthcare providers

For the **initial containment** stage these plans should include:
- Clear incident management governance protocols for your organisation
- Protocols to identify and test suspected cases in your organisation – including triage in emergency departments and general practice
- Protocols for case management specific to your organisation and setting
- Protocols for contact management specific to your organisation and setting, including contact tracing mechanisms
- Protocols for outbreak management in your setting, (if appropriate).
- Protocols for infection prevention and control procedures in your organisation, including updates and staff education and audits
- Staff absenteeism protocols
- Regular communications to staff, patients and/or clients.

For the **targeted action** stage plans should include (in addition to the above):
- Consideration of streamed or cohorted care in acute care settings
- Consideration of cancellation, or delay of non-urgent care or procedures
- Consideration of how your service might implement or articulate with alternate models of care relative to the service including (but not limited to)
  - Acute Respiratory Centres

- – Telehealth or Remote healthcare. This would apply for both local and remote consultations in order to minimise contact and exposure of suspected cases to the community.
  - – Increased Hospital in the Home services
- Consideration of requirements to scale key clinical services, including critical care and palliative care
- Capacity and capability to manage outbreaks in all health settings, including residential and aged care, disability services and rehabilitation/step-down settings.
- Careful management of workforce capacity and wellbeing
- Supporting and maintaining quality care for those most in need
- Consideration of management through Residential In Reach (RIR) programs now in place statewide, providing multidisciplinary health services directly into public and private aged care facilities.

For the **peak action** stage these plans should include (in addition to the above):

- Implementing plans developed in the first two stages in a proportionate manner
- Significant triaging and prioritising of care needs
- Consideration of designated hospitals for COVID-19 patients, in addition to Acute Respiratory Centres
- Planning for the full range of scenarios relating to the size and duration of an outbreak.

Links to specific preparedness tools for different healthcare agencies to assist with preparedness and planning activities will be added to the DHHS COVID-19 website in coming days, at:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19

Annual influenza planning should be integrated with your planning for dealing with COVID-19, to ensure a simultaneous surge in demand can be managed. Staff influenza immunisations, the promotion of influenza immunisation to all at-risk patients, and other annual measures will be even more important than usual.

Maximising case detection

The primary objective of the containment stage is to actively identify all cases of infection and contain them to prevent broader outbreaks.

Testing during this stage is focused on individuals with compatible illness from the highest risk countries and regions globally, with consideration given to all international travellers presenting with illness within 14 days of travel.

Work is currently underway to increase capacity in Victoria's reference laboratory, followed by quality assurance of commercial assays for use in metropolitan hospitals, before expansion to all primary laboratories, contingent on TGA approval (or exemption) and NATA accreditation of testing at national level.

All healthcare providers should regularly check the DHHS website at:

https://www.dhhs.vic.gov.au/coronavirus

This provides case definitions and geographic areas of risk, both internationally and within Australia.

All healthcare providers should have clear protocols and mechanisms in place for early identification potential cases of COVID-19 in patients, clients and staff. Rapid testing is critical to early identification and isolation of cases and their close and casual contacts.

Acute health care providers should also have procedures in place for:

- Early triage of presenting patients across the service

- Identifying patients who are presenting for unrelated clinical problems who may be from high risk regions or close contacts of confirmed cases

- Isolation and assessment of potential cases

- Identified testing pathways

- Clear follow up and procedures for test results

- Notification requirements to DHHS.

Other healthcare organisations should develop clear procedures for:

- Isolation of potential cases from other clients once identified

- Referral procedures and pathways for possible cases to the most appropriate clinical setting in order to facilitate testing.

Minimising transmission

There is growing evidence COVID-19 is transmitted directly through infectious droplets or indirectly through contact with surfaces contaminated by respiratory droplets.

Quarantine

Quarantine refers to home isolation of well people who are deemed at risk of COVID-19 due to travel location or contact with a case. As the COVID-19 emergency response has progressed there has been varying requirements for returned travellers to quarantine after being in a high-risk location.

Current quarantine requirements are available at:

https://www.dhhs.vic.gov.au/victorian-public-coronavirus-disease-covid-19

All healthcare services should remain abreast of the current quarantine requirements for staff in general, and staff working in higher risk occupations, such as acute health care and aged care. All healthcare services should have procedures in place for managing staff who are quarantined and facilitating return to work.

All healthcare services should ensure their staff are familiar with the most up to date quarantine advice for returned travellers in order to advise patients and clients appropriately.

Case management

Case management guidance can be found at:
https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19.
This advice will change as more information becomes known about COVID-19 and the causative agent, SARS CoV-2. As case numbers increase, requirements may change for practical reasons.

All healthcare services must ensure the relevant staff are familiar with, and have ready access to, the most up to date case management guidelines.

All healthcare services with inpatients or residents should have procedures in place to manage small and large numbers of cases in their facilities in accordance with the guidelines at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19. These procedures should consider location of patient/s or clients, staffing, infection prevention and control requirements, visitor policies and other care needs of the patient or client.

As a rule, cases should be managed in home or hospital isolation until they are no longer infectious. It is preferable for cases to be managed in the setting most appropriate to their clinical condition, however in the early stages of the response, many cases will be managed in hospitals to minimise any unnecessary exposure to other household members. As the pandemic progresses, appropriate triage arrangements must be targeted to support those requiring inpatient care.

All healthcare services should ensure staff are aware of clearance criteria for confirmed cases, in order to determine when patients can leave isolation, clients can return into regular healthcare access and staff with confirmed COVID-19 can return to work.

Contact identification and management

All healthcare providers should have procedures for identifying and managing contacts of confirmed cases in their organisations. Definitions for contacts and guidance on management of contacts can be found at: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 .

All healthcare providers should consider how patients, clients, staff and visitors to their organisation could be identified and contacted rapidly if there are exposures in their organisation. Healthcare providers should also consider the impacts of exposures to vulnerable patients or clients, and on business continuity in the event of increased staff absences due to illness, quarantine or the need to care for family.

Infection control precautions

All healthcare providers should actively promote hand hygiene, respiratory hygiene and cough etiquette to staff, patients and visitors. Health services should review signage, update staff briefings and make hand sanitising stations, tissues and safe disposal facilities widely available.

Acute healthcare providers should have up to date guidance for their setting, in line with the Australian standards at:

https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/national-infection-control-guidelines

and the Victorian guide:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 .

Staff must be regularly trained and assessed in the use of appropriate PPE. Hand hygiene PPE usage, and cleaning and disinfection procedures should be audited for compliance and quality improvement during the initial action and containment stage of the COVID-19 response.

Other healthcare providers should ensure infection control practices in their facility or workplace are appropriate to their setting and in line with national guidance where available.

Engaging the community

It is critical to communicate to the public what is known about COVID-19, what is unknown, and what is being done. Communication of actions critical to mitigate impact and protect the population must be continually reinforced.

All healthcare providers should familiarise themselves with key messages on risks and characteristics of COVID-19, the focus of testing and approaches to contact tracing and case management. Community confidence in the health response will be affected by the accuracy, consistency and currency of information they receive from their health professionals.

Key messaging, social media tiles, posters, translated material and other communications materials can be found at:

https://www.dhhs.vic.gov.au/coronavirus.

DHHS has developed a communications plan to help encourage Victorians to take proactive measures to minimise disease transmission. It will:

- Provide timely, accurate and accessible information about risks at each disease stage and about changes in preparedness and response activities

- Provide transparent, consistent, responsive, and empathetic messaging in local languages through trusted channels of communication

- Provide information on the most appropriate channel for obtaining further information to minimise needless workload on high cost frontline services

- Inform the community about services available to support those diagnosed with COVID-19

- Ensure community cohesion and overcome any potential for racist responses that victimise identifiable groups in the community.

A regular review of messaging and communications approaches will ensure:

- messages are up-to-date, accurate and responsive to current public awareness and attitudes

- messages are consistent across Victoria and the rest of Australia

- messages are consistent across the health sector

- the frequency and content of communication is appropriate for the audience and response stage

- key spokespeople deliver clear, actionable, confident and authoritative messages

- communications are delivered to relevant audiences via the optimal channels and are culturally appropriate

- community networks are engaged to help disseminate important or urgent messages

- there is a balance between providing general information about the disease trajectory while ensuring accuracy, privacy to individual patients and the minimisation of public alarm.

Within DHHS, a dedicated media team is currently responding to media enquiries and helps to coordinate information relating to COVID-19 across government and the health sector. Healthcare services can contact the media team, 24 hours per day via +61 3 9096 8840.

Additional DHHS staff will be available for on-call help and support with localised or targeted communication activities.

Characterising the virus, the disease and the epidemic

Additional data will be required to improve understanding of COVID-19 to inform Victoria's response

strategies and minimise the spread and overall impact of the pandemic, especially in relation to:

- Infectious periods (pre and post symptom onset)
- Transmissibility parameters, including R0 (R nought)
- Mortality and morbidity
- Higher risk patients

DHHS is working with health services, laboratories and research organisations to collect, analyse and rapidly disseminate accurate epidemiological data regarding COVID-19.

All health services should ensure they are able to provide basic and enhanced data regarding cases and contacts upon request to ensure the broader response to COVID-19 is effective.

Victoria is well placed to support the global research effort into COVID-19 and SARS-CoV-2. Victoria has one of the world's best regarded medical research networks, and deep experience in tackling infectious disease.

Research work is being undertaken in five key areas:

- Diagnostics
- Epidemiological modelling and support
- Clinical research
- Treatment – assessment of antivirals
- Vaccine development,

Stage 2: Targeted action

If the pandemic escalates

The scale and severity of COVID-19 may worsen, and while it isn't inevitable, it's a possibility we must prepare for. If COVID-19 escalates in scale and severity, the priorities of DHHS and the Victorian health system must move to a different stage of response where the imperatives are:

- **Slowing the spread of the disease**

- **Adopting sustainable strategies and models of care**

- **Appropriate management of workforce and essential supplies**

- **Supporting and maintaining quality care for those most in need**

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Slowing the spread of COVID-19

Minimising transmission of COVID-19 must continue to be a priority as the number of cases grows. This can be tackled both at the community level as well as across the health care system.

Community based actions

Social distancing measures

Slowing the peak of the outbreak with further social distancing measures may also help avoid a surge in demand for health services. These measures will be considered by government as new information comes to hand, and may include:

- Proactive and reactive school, vocational education and university closures

- Workplace measures, such as workplace closures and increased working from home

- Cancellation of mass gatherings, sporting and cultural events

- Voluntary isolation of people who may have been exposed to COVID-19

More direct community education

A community information campaign may be necessary to target key risk groups and the general community with information about infection prevention and control strategies, including hand and surface hygiene, cough and sneeze etiquette, staying home from work or school if sick, when to seek medical attention and how to find out more.

Key messages will continue to be developed with public health advice and in conjunction with Australia's key health officials. These messages will aim to protect, empower and build confidence amongst the general community about how to safeguard their health given their personal circumstances.

Healthcare system actions

Expanded testing

Testing during this stage is initially focused on individuals with compatible illness who are in a geographic cluster, population group or network known to have cases of illness or transmission, but extending to all individuals with compatible illness.

A Victorian Laboratory Plan for COVID-19 is in development, and COVID-19 testing capability will be extended from Public Health Laboratories into hospital and primary laboratories. DHHS is working with Commonwealth agencies to assist with this expansion.

Acute healthcare providers should plan for mechanisms to implement increased testing capacity in their laboratory services and to ensure results are rapidly transmitted to improve patient flow and ensure patients being managed in the community continue to home isolate.

The rapid testing and notification of results will also enable more timely identification and notification of close contacts, which will decrease further spread of illness.

Strict case and contact management

All healthcare providers should support workers to comply with public health recommendations for isolation if they become a case or close contact of a case. These requirements may change as the outbreak continues. Healthcare services must remain informed of the most current requirements for case and contact management which can be found here https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19.

Rapid identification and management of outbreaks in healthcare and other residential facilities

Respiratory illnesses spread rapidly in closed settings, particularly those with vulnerable patient or client groups. This has already been demonstrated to be the case with COVID-19 in international outbreaks.

All healthcare services who have patients, clients, or residents who reside permanently or temporarily in their facility should start preparing now for how to identify and manage an outbreak in their facility. DHHS and the Commonwealth will provide guidance with relevant protocols. Existing influenza outbreak guidelines provide appropriate principles and actions and should be used until specific protocols and guidance in developed.

Adopting sustainable strategies and models of care

Growing home-based care across all health services, including hospital in the home

DHHS will work with the Commonwealth on models of telephone triage and support to suspected and confirmed cases of COVID-19. These services will help determine the clinical severity of illness prior to presentation for diagnosis and care. Individuals with mild illness can then be appropriately triaged to home care and away from Primary or Emergency Care settings. Advice will be widely distributed for individuals and carers on how to manage and sustain home isolation and the supports available.

All healthcare services should direct concerted focus towards supporting people at home using telehealth and phone consultations to avoid unnecessary presentations by patients with mild illness, or unnecessary attendance for consultations.

Hospital in the home (HITH) services allow a range of clinical conditions to be safely managed without the need for a stay in hospital. HITH services are already provided by many Victorian public health services and hospitals should consider expanding the nursing and other resources available to HITH.

Acute healthcare services should commence or continue planning on how these services can be expanded to ensure satisfactory standards of care during a COVID-19 pandemic response.

Non-acute/non-inpatient healthcare services should commence planning on how they might expand home based, telehealth or other remotely accessed services to maintain continuity of care for their clients whilst avoiding high risk settings.

Managing acute presentations to General Practice and emergency departments

Presentations to emergency departments and General Practice will increase as the response moves into the targeted action stage and case numbers increase.

All health services should have comprehensive triage and risk assessment protocols in place as per the initial containment stage (planning and preparation section).

Acute care providers should plan for mechanisms to segregate patients presenting with acute respiratory tract infections from the remainder of the patient population in both settings. Many services have already done this during previous outbreaks and pandemics and are already in planning to reinstate these processes.

Cohorting of these patients in a separate waiting room may become necessary as numbers of presenting patients increase, in both emergency departments and General Practice**.**

General practices may also consider having dedicated clinic times each day for patients with acute respiratory infections. These arrangements will depend on the establishment of other stand-alone clinics or other models for testing suspected patients.

Managing patient flows through acute respiratory clinics

Streamed and cohorted care should be implemented as cases increase.

DHHS is working with health services to identify appropriate locations and develop service models for acute respiratory clinics (ARCs).

ARCs provide one option for healthcare facilities to respond to increased patient demand during a pandemic. ARCs may be activated by health services at any time to meet local demand. DHHS, in consultation with health services, may also direct the opening of ARCs.

The purpose of ARCs is to ensure:

- Emergency departments and General Practices are not overwhelmed with suspected COVID-19 cases
- Hospital-associated transmission of COVID-19 is minimised by keeping potentially infectious patients separate from other patients
- A standardised method for assessing and managing patients is adopted.

Proximity to existing EDs or GPs will be considered in selecting sites for these clinics. This will reduce inconvenience for patients and staff moving to and from the clinics.

Potential ARC sites should offer layout enabling dedicated entrances and exits, separate waiting areas, receptions, triage and clinical areas.

Acute healthcare services should be prepared to set up their own acute respiratory clinic in the event of a surge in patients with respiratory illness. Services should draft rosters for multidisciplinary teams,

including administrative staff to schedule visits, answer calls and follow up results. As far as possible, staff for ARCs should not be drawn from existing EDs, intensive care or specialist units.

Some health services have large campuses without an ED. Each of these have a range of non-urgent services that could be deferred or relocated to create capacity for an ARC or cohorting of inpatients undergoing treatment.

DHHS will identify other potential community sites for ARCs. Some community health services have multiple sites with a significant footprint. Many or most of their services are non-urgent and some could be transferred to alternative locations to free up space for an ARC.

Victoria will work with the Commonwealth to plan enabling support for clinics. This may include changes to GP and acute care reimbursement models including, for example, phone triage and longer consultations as required. Commitment to existing patients may be a barrier to GP participation. The Commonwealth and Primary Health Networks will be asked to help support rescheduling and referring of existing patients.

DHHS will develop a standardised approach to rapid collection of patient data from these clinics, to inform the response at the health service and state level.

Health services should consider how to inform local healthcare providers of clinic locations and operating hours should the need arise. Private hospitals with EDs may also consider having plans for establishing clinics.

Managing demand on acute wards

All healthcare services who manage acute admissions for respiratory illnesses should commence internal planning to determine how to manage increasing numbers of patients who require inpatient support. Health services should plan for rapid test turnarounds to enable cohorting of confirmed cases.

Acute healthcare services should plan for alternative pathways to admission for patients being referred from ARCs in order to prevent bed block at emergency departments.

All healthcare services should plan for the possibility of a COVID-19 outbreak on a ward where non-COVID-19 patients are being cared for. Outbreak management plans should be in place and well understood by all staff.

Managing demand in critical care services

Critical care services could experience a significant increase in demand for personnel, specialised equipment and beds in the event of a significant increase in presentations. **All providers of critical care** should review existing stock and equipment to be able to cope with a potential increase in demand.

DHHS will continue to work with EDs of public and private health services on critical care service continuity planning to manage demand in intensive care units (ICUs), high-dependency units, paediatric intensive care units (PICUs), neonatal intensive care units (NICUs) and medical retrieval services, as these services operate at or near full capacity on a regular basis.

This planning will address critical care capacity and capability for severe COVID-19 infection against modelled scenarios and provide an ethical prioritisation framework for provision of critical care. All options to increase critical care capacity will be explored including equipment and staffing uplifts, reduction in non-emergency critical care admissions, prioritisation and triage of admission.

Managing palliative care services

COVID-19 impacts older people and those with pre-existing comorbid conditions more than younger and otherwise healthy people. Just as we see in influenza season, an escalation in coronavirus cases will result in **palliative care services** experiencing demand. Many of these services will need to be delivered

in the home. Likewise, **acute healthcare services and general practitioners** should ensure the advanced care plans of very elderly and unwell patients are up to date and well understood by the patient's regular care team, family or next of kin.

Appropriate management of workforce and essential supplies

A people challenge for health service leaders

An escalation in COVID-19 cases may have some management challenges for Victoria's health services leadership. There may be a simultaneous increase in demand for clinical staff, public health staff, aged care outreach staff, administrative, support and human resources staff, while at the same time, we see an decrease in staff availability due to illness, quarantine or carer duties.

DHHS will work with health services and industrial partners/unions to develop workforce surge guidelines to manage the identification, recruitment and use of surge staff across Victoria's health networks. Further work will be undertaken with industrial partners on employment conditions that would apply during a pandemic, including attendance, salary payments and the ability to require staff to provide additional support outside their usual job description.

Health services should refresh pandemic human resource plans developed during the initial containment stage as required to:

- Ensure staff are aware that requests for flexibility on their part will be appropriate to their skills and Enterprise Bargaining Agreement.

- Determine minimum staffing levels sufficient to safely maintain services

- Identify part time staff who can work additional hours

- Identify staff who are prepared to defer annual or long service leave

- Identify casual staff who can work additional hours

- Confirm timely approval for overtime and appropriate rest to minimise the risk of fatigue

- Identify employees whose 'return to work' plans may allow them to be deployed

- Identify staff who have recently left the organisation and who might be temporarily re-engaged

- Identify staff who can provide non-clinical support and could be redeployed

- Identify available agency resources

- Identify staff who can perform planning, communication and resource management, as well as the training and orientation of surge staff

- Ensure occupational health and safety risks are assessed and documented and infection control guidelines are well understood

- Ensure a list of health professional volunteers is developed and able to be drawn from, consistent with previous practice in other public emergencies.

Managing people at a challenging time

Staff must be rostered appropriately, with manageable shift lengths, down-time between shifts, regular breaks and access to refreshments.

Support with preparing for and recovering from management of an outbreak escalation should include:

- Appropriate and open communication about the status of the pandemic and plans in place

- Education and training tailored to every role, whether front-line, public health, laboratory, primary healthcare, emergency services or other clinical work. This may be in the form of webinars to ensure timely and maximal access for participation

- A properly briefed Employee Assistance Program to support staff mental health needs.

Staff exposure to COVID-19

Healthcare workers can be exposed to infections including COVID-19 as part of their duties, placing themselves and other staff and patients at risk. As well as undertaking full infection prevention and control measures, health care facilities should specify a framework for the assessment, screening and vaccination of healthcare workers, including the influenza vaccine.

If a healthcare worker is exposed to COVID-19 or becomes a case, **all healthcare services** should ensure the recommended procedures for healthcare worker management are well known and in place as per the guidelines for health services and general practice found here:

https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19 .

Broader workforce support

Managing staff fatigue will be essential for a surge period of potentially many weeks. Staffing in the middle of a COVID-19 related surge would need to consider team-based assessment approaches to determining appropriate admissions and discharges from the ICU, including prompt resumption of care on a non-critical care ward by a usual care team and step-down care. This may require increasing the staffing and clinical oversight of step-down wards, and potentially increasing the acuity of patients leaving ICU.

Where staff are identified as potential surge staff they should be familiarised with the current ICU environment prior to any COVID-19 related surge and undergo appropriate training in the use of PPE.

DHHS will continue to work with the Commonwealth to support all health practitioners to have the appropriate capability and capacity to respond to an escalation of COVID-19. Key partners will be the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Nursing and Midwifery Federation (Victorian Branch) (ANMF) and the Australian Medical Association, who all provide important channels for assisting and educating GPs and infection control nurses.

DHHS will also work with the Commonwealth and Aged Care sector to build capacity for:

- Outbreak detection and management

- Infection prevention and control

- End of life planning and care.

- Personal protective equipment and consumables.

DHHS has existing comprehensive guidance for the management of outbreaks in Residential and Aged Care settings available here:

https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/respiratory-illness-management-in-aged-care-facilities.

These guidelines will be republished for COVID-19 outbreak management. There are also existing national guidelines for influenza management in aged care. The Commonwealth is leading in the development of a national COVID-19 plan for residential and aged care. The national guidelines for influenza management are available here:

https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-flu-guidelines.htm.

Personal Protective Equipment (PPE) and consumables

Adequate access to supplies of PPE will be critical to protect health professionals as they manage the spread of COVID-19. DHHS has worked with primary health networks to support general practitioners through the distribution and monitoring of P2 respirators.

An initial round of distribution of P2 respirators (N95 masks) has been undertaken by Primary Health Networks. At the request of DHHS, PHNs provided limited P2 respirators to each general practice in their distribution where there was knowledge that the general practice was low on P2 respirators, and at the time when P2 respirators were required for testing of all samples due to limited information about mode of transmission.

DHHS is assessing stocks of critical devices such as oxygen machines, ventilators and ECMO machines.

Health services should review their own fleets of critical equipment and work with Health Purchasing Victoria and DHHS to ensure that enough treatment capacity exists to meet a possible surge in demand.

The Australian Government is responsible for maintaining the National Medical Stockpile (NMS), which provides strategic reserves of medicine and equipment to enable rapid access to standardised items that may not be available in a timely routine supply channels during periods of increased national or international demand. The Chief Health Officer can request deployments from the NMS.

DHHS will work continue to with the Australian Government to coordinate provision of PPE to healthcare settings. DHHS will work with health services, Primary Health Networks, Health Purchasing Victoria and clinical networks to:

- Develop a **COVID-19 Personal Protection Equipment and Consumables Plan** to centralise procurement and distribution to primary care, acute respiratory illness clinics and hospitals. The plan will consider strategies to promote prudent use of PPE consumables and ensure PPE is prioritised for acute healthcare settings. A PPE supply team will be identified in DHHS and HPV to manage all logistics of PPE management and supply.

- Identify any potential pharmaceutical or equipment shortages that could arise from increased local and overseas demand or supply chain issues. Work is underway to identify critical consumables, especially by a critical care working group, in relation to intensive care provision.

- Model by scenario possible PPE consumption in different models of care will be undertaken, and over different scenarios. This modelling will show assumptions including use rates for different types of healthcare workers, and

- Review supply chains for critical PPE and consumables to understanding options and probability of acquisition of critical consumables and options for local manufacturing and supply.

Supporting and maintaining quality care for those most in need

It is reasonable to expect that population groups already known to be at increased risk of severe influenza infections will also be at increased risk during COVID-19, including elderly Victorians, Aboriginal and Torres Strait Islanders or those from culturally and linguistically diverse (CALD) communities.

Information materials have been developed in a range of languages for the COVID-19 response, including Chinese.

Primary healthcare and public health services may wish to adapt information or develop their own material based on their known specific client needs. It is important, however, to be consistent with infection prevention and control and other public health principles set out in this plan.

Victoria's public health services include significant aged care services and will include responses for

those services in their local pandemic response plans.

Aboriginal communities are a focus for pandemic planning as they are characterised by having higher numbers of at-risk individuals (i.e. people at higher risk of severe complications from respiratory infections) than the general community. DHHS also recognises the importance of self-determination in development of health initiatives for Aboriginal communities.

Planning activities are being undertaken at Commonwealth level to develop appropriate guidance and materials to support Aboriginal people, communities and health services throughout the stages of the COVID-19 response.

There are a number of barriers for Aboriginal people to access mainstream health services, such as availability, location, cost and continuity of care. For a range of reasons there may be potential for wide-spread reluctance of Aboriginal people to present to EDs, dedicated clinics and other mainstream health services during a pandemic.

Health services must ensure that appropriate services are available to mitigate the impact of COVID-19 in Aboriginal communities. Aboriginal Community Controlled Health Organisations (ACCHO) should be engaged through established partnerships at a health service level. DHHS will work with VACCHO at a statewide level to seek advice on pandemic planning and its cultural appropriateness for Aboriginal people and communities.

Other closed settings

Risks of outbreak are greater in residential and secure services. DHHS will work with the non-government sector to provide guidance to disability and private aged care services, and with government agencies to support the readiness of secure services. This will include work with Justice Health to develop a specific **COVID-19 Response Plan for Custodial Health.**

Stage 3: Peak action

In the event of a severe and sustained outbreak

Action by the Victorian health system in this stage focuses on:

• **Managing impacts and protecting capacity**

• **Managing triage and models of care to minimise morbidity and mortality;**

• **Managing business and community continuity**

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Managing impacts, protecting capacity

A severe and sustained outbreak of COVID-19 would have significant impacts on Victoria's health system, resulting in:

• significantly increased numbers of presentations to general practitioners, emergency departments, hospital admissions, intensive care unit admissions and excessive levels of healthcare use

• potential exposure to health workers, police, in-home community services and others encountering potentially affected people

• increased numbers of patient transfers for Ambulance Victoria, combined with the challenge of ensuring rapid turnaround of ambulance disinfection protocols.

Testing during this stage is for all individuals with compatible illness but may be limited by capacity; management of cases may therefore also occur based on clinically compatible illness alone.

If the clinical severity is high, widespread severe illness will cause high levels of morbidity and mortality and challenge the capacity of the health sector. The community focus of governments, agencies and sectors will be on maintaining essential services.

Regular communication with Victoria's health sector and the community will be focused on providing accurate information about the status of the outbreak and implications for access to health services.

Managing triage and models of care to minimise morbidity and mortality

Triaging COVID-19 presentation

The general principles on presentation of cases to EDs are likely to include:

• providing appropriate signage in multiple languages on entry doors and in waiting area and triage assessment points

• ensuring appropriate infection prevention and control measures are taken by all staff and by parents of presenting children and any others who are likely to be in the same room as a suspected case

• if required, immediately isolating the patient in a NPIR (or single room if NPIR not available) and minimise unnecessary staff and family contact

• reconfiguring waiting areas in EDs to increase social distancing to minimise the potential for transmission of COVID-19

• discouraging the patient from leaving prior to further assessment

- obtaining clinical and exposure information to allow for an initial risk assessment to be made

- screening and triage according to case definitions provided by DHHS, ensuring suspected patients wear a mask while being moved to a ward, and keeping the patient separated as much as possible from other patients and staff.

Emergency departments may also be required to compile lists of patients and staff who were in contact with the patient, including their mobile phone numbers and other contact information, for contact follow up if required.

Further useful information is available from the Australasian College of Emergency Medicine (ACEM) who have developed guidelines on the management of severe influenza, pandemic influenza and emerging respiratory illnesses in Australasian emergency departments.

Safe and effective medical, nursing and midwifery care for all patients

It will be vital to ensure the right care is delivered to the right patient in the right location.

People presenting with symptoms of COVID-19 together with other health issues such as trauma, or cardiovascular acute presentations must be managed appropriately in the most appropriate location, using appropriate infection control.

Not all patients with COVID-19 symptoms should be diverted to a separate clinic if they require specialist emergency department care for another reason. Emergency departments and health facilities will need to have plans to manage such patients.

Patients presenting with other symptoms may also have COVID-19. Hence it is important to have an enhanced focus on infection prevention and control in the ED.

Assessment of patients being triaged for intensive care should ideally be undertaken prior to the patient being transported to the ICU. Triage should occur in the ED or referring unit, or other hospital where clinicians need to have effective collaboration between ED, specialty and ICU clinicians to achieve the best outcome for the patient. This may be face-to-face or via telephone or telehealth to connect clinicians to discuss appropriateness for intensive care admission.

Triage will be enacted at the same level across the state, to promote equity of access of patients to intensive care. It is important that these tools are used for all potential admissions, not just infection-related admissions. Tools are being refined to promote national consistency.

Other strategies for preserving clinical resources

During the peak action stage of the pandemic, health services should implement plans already developed during earlier stages. This may include the activation or expansion of additional clinics to manage increasing volumes of patients.

Health services should adopt a systematic and transparent prioritisation of services as demand for treatment grows. DHHS will work with health services through the governance mechanisms outlined in this plan to develop consistent thresholds and responses.

These may include:

- Deferring non urgent elective surgeries

- Transfer of elective surgery to other public or private hospitals

- Early discharge or transfer of patients when safe to do so

- dealing with emergencies only.

As demand for critical care grows, health services will need to strengthen team-based decisions about appropriate admissions and discharges from the ICU (including prompt resumption of care on a non-

critical care ward by a usual care team) and ensure that adequate step-down care is available. This may require increasing the staffing and clinical oversight of step-down wards, in light of potentially increased acuity of patients leaving ICU.

Health services may need to open additional beds in existing non-commissioned physical intensive care bed spaces and consider progressively converting appropriately monitored beds to intensive care. These may include Coronary Care Units (CCU), High Dependency Units (HDU) and any other available space.

Health services will be expected to work with private hospitals to utilise private ICU capacity, especially for patients requiring more routine post-operative care.

As demand for critical care capacity increases DHHS and Safer Care Victoria will facilitate guidance from clinical experts on how to manage priorities appropriately.

Managing business and community continuity

A pandemic is likely to cause significant disruptions to society and challenge social cohesion. Social distancing measures may have wide-ranging effects on business, the economy and public sentiment. The main economic and social impacts are likely to be on events, travel, tourism, the logistics and supply chain industry, higher education, tertiary and vocational education institutions.

With the potential for large numbers of people in self-isolation at home, digital connectivity will be an essential tool to ensure community cohesion and disseminate accurate and timely COVID-19 updates.

The Victorian Action Plan is a plan for all sectors and outlines key roles and responsibilities for managing business continuity and effects across the Victorian heath and wider community. It is currently in development and applies similar principles to the existing Victorian Action Plan for Pandemic Influenza:

https://files-em.em.vic.gov.au/public/EMV-web/Victorian-action-plan-for-pandemic-influenza.pdf.

Victorian Government responsibilities

All Victorian government departments, their sectors and agencies are responsible for preparing for and supporting the response to a COVID-19 pandemic.

Each Victorian government department is required to have preparedness arrangements in place, including business continuity plans, and must develop a COVID-19 incident response plan that outlines the operational actions DHHS will consider undertaking in response to a COVID-19 pandemic.

Preparedness activities for a COVID-19 pandemic should also include:

- ensuring business continuity plans are current and well understood

- identifying incident management plans and systems

- communicating COVID-19 plans and arrangements with staff

- promoting good hygiene, which includes hand hygiene and respiratory/cough etiquette.

Local councils

Local councils and should now implement existing pandemic plans including adapting plans for COVID-19, including business continuity plans. Councils should use information about the timing and magnitude of likely illness as a guide to the general magnitude and timing of potential illness peaks.

DHHS will also provide advice about the potential benefits of social distancing interventions, such as school or university closures, mass gathering cancellations or quarantine and isolation measures.

Businesses and non-government organisations

Government cannot manage the impact of pandemic or maintain essential services on its own.

Businesses and non-government organisations will also play a vital role to help contain the disease and assist communities to continue functioning.

The Victorian Government encourages all organisations to be prepared. Organisations that provide key services or operate critical infrastructure must be able to continue operations.

Business continuity planning that includes pandemic-specific considerations will help minimise the impact of a pandemic on the organisation, protect staff and contribute to community functioning.

Stand-down and recovery

A careful transition back to normal

Action by the Victorian health system in this stage will focus on:

- **Ceasing activities that are no longer needed;**
- **Undertaking monitoring and surveillance for a possible further outbreak;**
- **Transitioning the Victorian health system to normal business;**
- **Working with the Victorian community on the ongoing work of recovery;**
- **Undertaking an evaluation and revision of plans for the pandemic.**

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A co-ordinated response to minimise risks

Depending on the scale of the outbreak, recovery following a pandemic could be significant and require a whole of government and community response.

Stand down and recovery activities will start with the onset of a decline in presentations and recorded cases and may take many weeks to decline significantly. The scale and duration of recovery is dependent upon the scale and duration of the outbreak.

Ceasing activities no longer required

Commercial arrangements for supply or expanded services put in place during the pandemic will be terminated in accordance with contract provisions.

Whole of government and sector specific channels will be used to advise workplaces, schools and other sections of the community about how a safe and healthy return to normal business can occur.

Monitoring for further outbreak

Ongoing laboratory testing will be required to identify any emerging resistance to antiviral medication which would pose risks of further outbreaks.

Transition to normal business

In the health sector, elective and other non-urgent services will resume. Careful review and prioritisation of patients whose care was delayed, and whose condition may have deteriorated, will need to occur to ensure that adverse outcomes are minimised.

Stockpiles of critical consumables and equipment will need to be reviewed and replenished as required, including to prepare for any further outbreaks.

Just as clear communication and community engagement is required for pandemic responses, the community will need to understand and support a lowering of safeguards and scaling back of response efforts.

The community will need reassurance that ongoing vigilance will be maintained. Specific information for groups at risk or with special will be provided about the transition of services. This includes Aboriginal and Torres Strait Islanders, elderly Victorians and people from culturally and linguistically diverse backgrounds.

Ongoing recovery

Some sections of the health system, economy and community may be more adversely affected than others.

Relief and recovery will need to be well-informed by local community and targeted for best effect.

Pandemics, like other emergency events can cause or exacerbate a range of psychological reactions and symptoms. Most people recover from such traumatic events, but for some the effects are long lasting.

Bereaved people and workforces on the frontline are at higher risk.

Racist responses to an outbreak threaten the wellbeing and mental health of groups targeted.

Mental health impacts can be reduced by recognising and supporting community resilience through all stages of emergencies from prevention, preparedness, response and recovery. Targeted support to groups more at-risk will be critical to promote a sense of safety, collective community support and recovery.

Psychological first aid, community engagement and psycho-social support, along with formal mental health interventions will form part of the health response to COVID-19.

Resources for coping with the impact of natural disasters are available on the Australian Centre for Post-traumatic Mental Health at www.acpmh.unimelb.edu.au

Evaluation and revision of plans

It will be critical to evaluate and review planning and implementation of the COVID-19 response across the health and other sectors, and at a whole of government level. The Victorian government will ensure that learnings from the COVID-19 experience inform future planning for pandemics and other large scale health system activations.

Governance

National plans and responsibilities

This plan is informed by the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* (COVID-19).

The Australian Health Protection Principal Committee (AHPPC), comprising Chief Health Officers from states and territories and chaired by the Australian Government Chief Medical Officer, is the main coordinating body for public health policy matters for the COVID-19 response.

The Chief Human Biosecurity Officers group, which includes Victoria's Chief Health Officer, reports to the Australian Government Chief Medical Officer in their capacity as Director, Human Biosecurity under the *Commonwealth Biosecurity Act 2015*.

Chief Human Biosecurity Officers and Human Biosecurity Officers have powers in relation to listed human diseases. This includes powers to quarantine and manage risk related to suspected or confirmed COVID-19 cases.

The Communicable Diseases Network Australia (CDNA), reporting to the AHPPC, provides public health guidance and coordinates specialist assessment and management of cases, contacts and surveillance.

Victorian Legislative powers and authorising environment

Chief Health Officer and public health legislation

The *Public Health and Wellbeing Act 2008* aims to protect the health and wellbeing of the population and establishes provisions for managing infectious disease. The Act gives the Victorian Chief Health Officer powers and responsibilities for managing risks to public health arising from outbreaks of infectious disease.

The Act empowers the Victorian Minister for Health, on the advice of the Chief Health Officer - and after consultation with the Minister for Police and Emergency Services and the Emergency Management Commissioner - to activate emergency powers when there is a serious risk to public health.

Public health emergency powers

The Chief Health Officer and authorised delegates may exercise certain powers under a state of emergency in order to investigate, eliminate or reduce a serious risk to public health. The emergency powers include the power to:

- Detain persons or groups within the emergency area for a period reasonably necessary to eliminate or reduce a serious risk to public health
- Restrict movement of a person or group within the emergency area
- Prevent any person or group from entering the emergency area
- Give any other direction that is considered reasonably necessary to protect public health.

The Secretary of DHHS may order a municipal council, officer or authorised officer to perform any functions or duties or exercise any powers that the Secretary directs.

The Secretary may also perform any functions or duties, or exercise any powers, of a municipal council.

A Class 2 emergency

A Class 2 emergency exists when there is a statewide emergency of likely major impact. A Class 2 public emergency has been declared in the case of COVID-19 and a Class 2 controller has been appointed to coordinate inter-agency responses at the state level. DHHS is the lead agency.

Public and denominational hospitals

The *Health Services Act 1988* empowers the Secretary to DHHS to give written directions to public hospitals (metropolitan and rural) and denominational hospitals in relation to matters including:

- actions that the hospital should take to ensure the health services provided by the hospital are safe, patient-centred and appropriate
- the purposes which the hospital should serve and those to which the hospitals should give priority
- the number and types of patients that should be treated
- the manner and extent of co-ordination of admission, care and treatment of patients with hospitals and health care agencies.

The Minister for Health may also give directions to public hospitals (metropolitan and rural) on any matter the Minister thinks is in the public interest provided it relates to the operation of hospitals and other health care agencies.

Private Hospitals, Day procedures centres and other health service establishments

Private hospitals, day procedure centres and other health service establishments are registered by the Secretary of DHHS under the *Health Services Act 1988*. The Secretary has limited powers to give directions to private hospitals, day procedure centres and other health service establishments. These are:

- to require the proprietor to comply with standards in regulations relating to the health care provided by that agency.
- to provide specified information to the Secretary by a specified date in a specified manner.
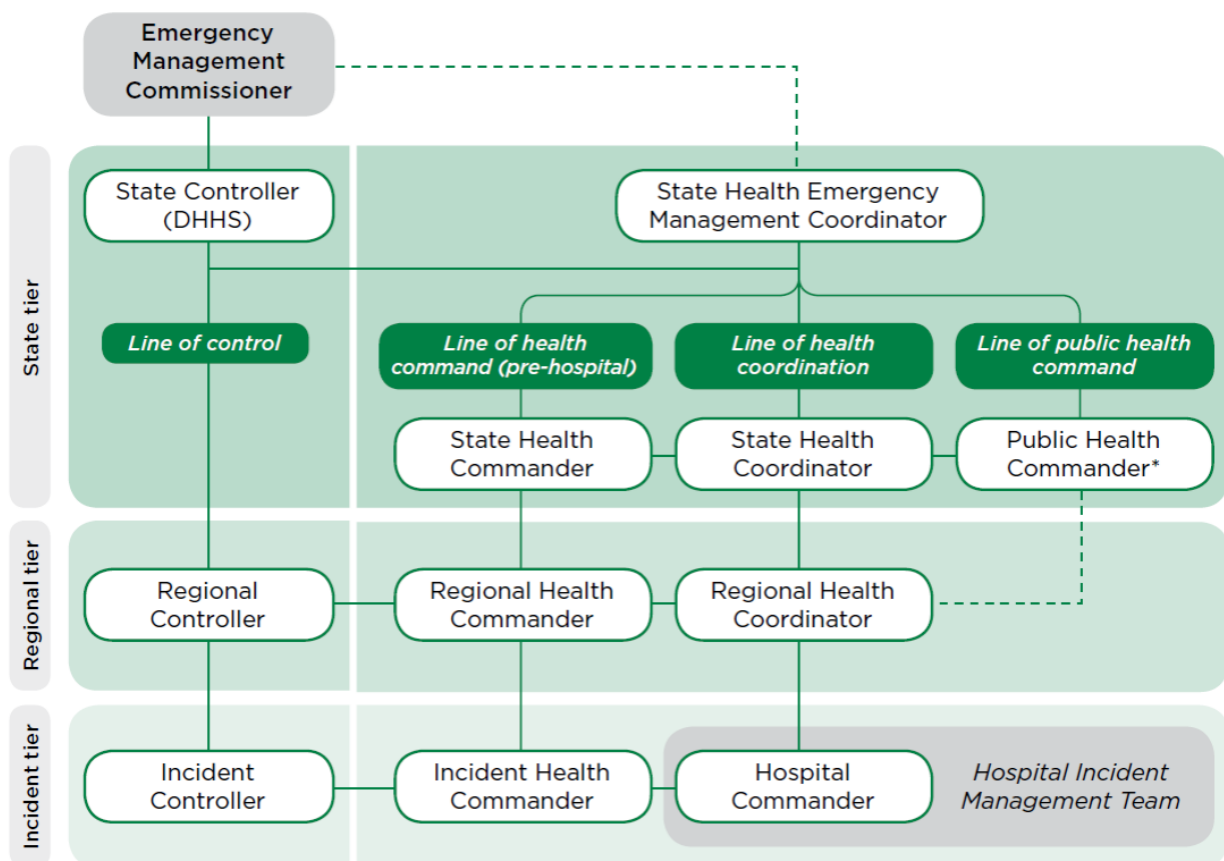
Victorian plans and governance

This plan is based on principles and proposed actions outlined in the Victorian Health Management Plan for Pandemic Influenza (VHMPPI).

Department Incident Management Team

The Secretary of DHHS chairs a Health Services Pandemic Leadership Team to mobilise advice and leadership across the Victorian health system.

The DHHS response is coordinated through a single Departmental Incident Management Team (DIMT) chaired by the Public Health Commander for this public health emergency.

The DIMT reports to the Chief Health Officer and Class 2 Controller and is operating under the principles of the State Health Emergency Response Plan, State Health Emergency Response Arrangements and Concept of Operations for Health Emergencies.

Advisory groups and bodies

The clinical networks of Safer Care Victoria provide expert advice to the DIMT and DHHS' response. DHHS will engage with chief executive officers and chief medical officers of Victorian public health services and Victorian private hospitals, the Royal Australian College of General Practitioners and other peak bodies and stakeholders to maximise clinical engagement in determining the best measures to combat this rapidly emerging pandemic.

Short-life working groups may be convened, and lead officers on the DIMT working to the principles of the Australasian Inter-Service Incident Management System (AIIMS) will lead work to coordinate DHHS' response.