

~~PROTECTED CABINET~~

# Prime Minister’s National Cabinet Brief

**Title**                   Item 2.a: Standing COVID-19 update from the Chief Medical Officer

**Meeting**             Friday 1 May 2020

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**Summary**

s 22(1)(a)(ii)

**Background**

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Australia has conducted over 536,000 tests, about 2,105 per 100,000 population. Test positivity in the past 7 days has been 0.1%, much lower than the cumulative positivity rate of 1.3%. All states have now expanded testing protocols to all people with mild symptoms of COVID-19 to quickly identify cases.

s 22(1)(a)(ii)

**PROTECTED CABINET**

PM&C  
Secretary  
Ms Patterson  
Mr Duggan  
Ms Barry  
Ms Quilty  
Mr Roper  
Ms Wilson  
Mr  
Goldsworthy  
Mr Colquhoun  
Mr McDonald  
Ms McGregor  
Ms Oliver  
Ms Winslow  
Mr Neil  
Ms Fell  
Mr Reed  
Mr Goldie  
Ms Wong  
Ms Craig  
Mr Hupalo  
Mr Poels

**DEPARTMENT OF THE PRIME MINISTER AND CABINET**

**To:** Prime Minister

**THROUGH:** Cabinet Secretary

**UPDATE ON DEVELOPMENT OF COVID-19 VACCINES AND TREATMENTS**

s 22(1)(a)(ii)

PMO  
Dr Kunkel  
Ms Adams  
Mr Caroly  
Mr Black

CABINET  
SECRETARY

**Key Points:**

1. An effective, accessible vaccine is the only way to control COVID-19 permanently and return to pre-COVID-19 life without significant mortality. The demand for treatment options for those suffering the disease is also immense. This is driving unprecedented global and Australian research effort to discover and deliver vaccines and treatment.
  - a. Australian researchers have proven themselves early. Doherty Institute scientists were the first to grow the novel coronavirus in the laboratory outside of China and shared it with public health laboratories nationally and the World Health Organization. This is allowing researchers to not only validate test results, but commence work on better diagnostic tests, treatments and a vaccine.
2. A summary of Australian and international COVID-19 research, including Australian Government funding, prepared by the Department of Health is at Attachment B.

s 22(1)(a)(ii)

**ATTACHMENTS**

s 22(1)(a)(ii)

**ATTACHMENT B AUSTRALIAN AND INTERNATIONAL COVID-19 RESEARCH**

s 22(1)(a)(ii)

s 22(1)(a)(ii)

### Australian Government funding for COVID-19 research

Research area <sup>2</sup>	Funded from the Medical Research Future Fund (MRFF)		
	Responsible Organisation	Quantum	Status and notes
Diagnostics	Peter Doherty Institute for Infection and Immunity (University of Melbourne) [Emerging Priorities and Consumer Driven Research Initiative]	\$2.6M	Four projects funded: 1. development of new simpler pathology test 2. development of new testing protocols to increase testing throughput 3. development of new deployment framework for new coronavirus serology test (for retrospective diagnosis) 4. post-market assessment of new rapid screening tests approved by the TGA to inform their best use.
	s 22(1)(a)(ii)		

s 22(1)(a)(ii)

**LitCovid<sup>7</sup>**

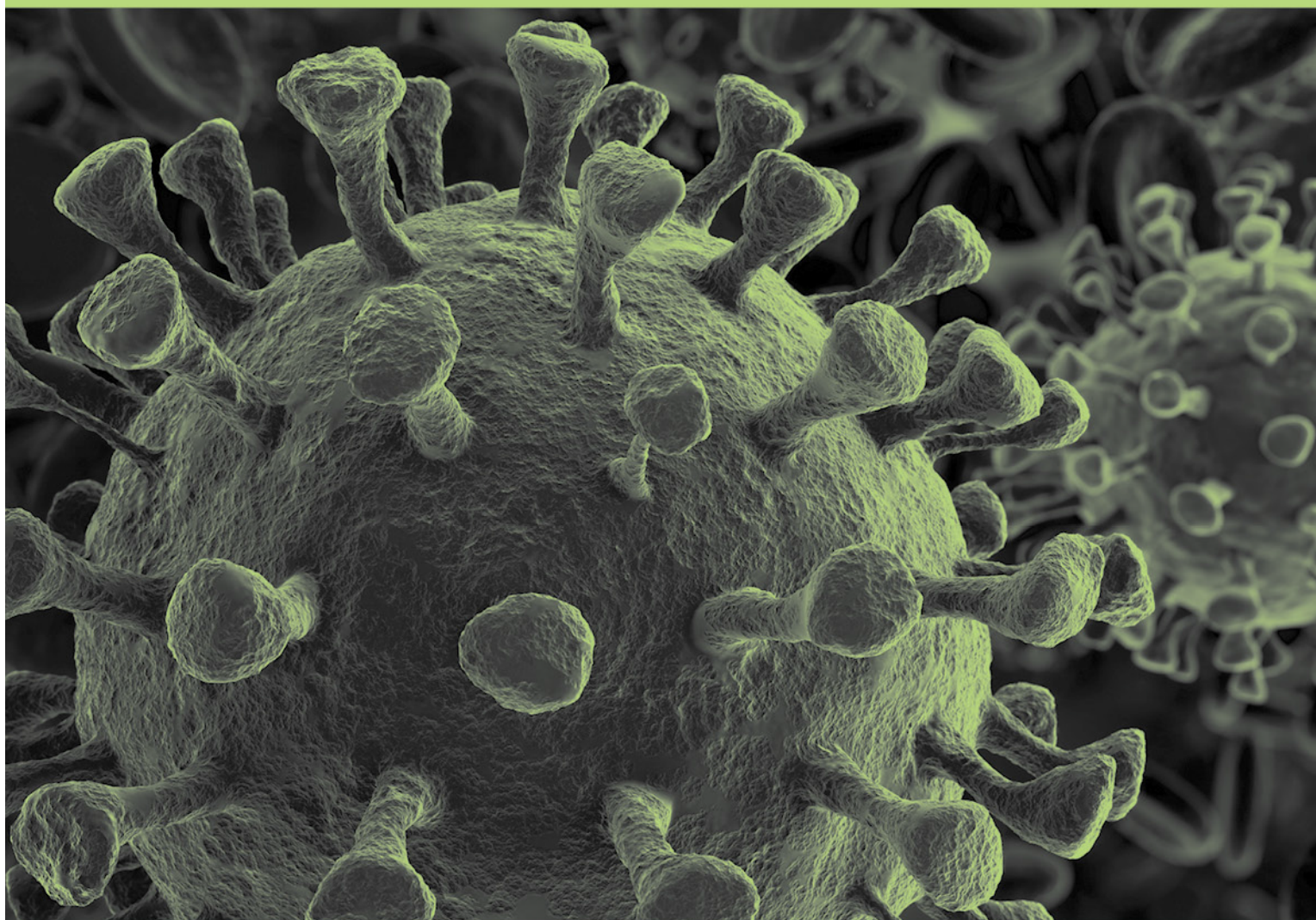
- LitCovid is a curated literature hub for tracking up-to-date scientific information about the 2019 novel Coronavirus.
- As at 14 April 2020, there had been:
  - 423 publications with general information (general information and news)
  - 427 publications on the mechanisms of disease (symptoms, clinical characteristics, and findings from sequence and image analysis)
  - 390 publications on transmission (characteristics and modes of COVID-19 transmissions, such as human-to-human)
  - 808 publications on diagnosis (disease assessment through symptoms, test results, and radiological features)
  - 864 publications on treatment (treatment strategies, therapeutic procedures, and vaccine development)
  - 1409 publications on prevention (prevention, control and management strategies)
  - 239 case reports (descriptions of specific patient cases)
  - 103 publications on epidemic forecasting (modelling and estimating the trend of COVID-19 spread).

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<sup>7</sup> <https://www.ncbi.nlm.nih.gov/research/coronavirus/>



**Australian Government**  
**Department of Health**



# **AUSTRALIAN HEALTH SECTOR EMERGENCY RESPONSE PLAN FOR NOVEL CORONAVIRUS (COVID-19)**

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## **Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)**

Publications Number: 12723

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# PART 1

## Overview of the National Approach

### 1. Executive Summary

#### **Context**

Viral respiratory diseases have the greatest potential to cause pandemics and the key threat of emergence of a pandemic strain of virus lies at the human-animal interface. Every so often there has been emergence of novel influenza strains in animals such as birds and pigs, such as H5N1, H1N1 and H7N9, and these viruses have caused significant morbidity and mortality in humans. To date none of these viruses have caused sustained human to human transmission.

Pandemic influenza remains a key global health threat and the Australian Government and the broader Australian health sector is well prepared to respond to an influenza pandemic. The Australian Health Management Plan for Pandemic Influenza (the AHMPPI) is the key nationally agreed document to guide Australia's response.

In December 2019, China reported cases of a viral pneumonia caused by a previously unknown pathogen that emerged in Wuhan, a city of 11 million people in central China. The initial cases were linked to exposures in a seafood market in Wuhan where a large range of live animal and animal products were sold. The pathogen was identified as a novel (new) coronavirus (recently named Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)), which is closely related genetically to the virus that caused the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). SARS-CoV-2 causes the illness now known as Coronavirus disease 2019 (COVID-19). Currently, there is no specific treatment (no vaccine and no antiviral) against the new virus.

Given what we know about pandemic preparedness, response and the significant global impacts of the SARS outbreak in 2003, the influenza pandemic in 2009 and the Middle East respiratory Syndrome (MERS) in 2013 and again in 2015, we cannot afford to be complacent.

Due to heightened global concerns around the pandemic potential of COVID-19, following a meeting of the World Health Organization (WHO) International Health Regulations Emergency Committee, the Director-General declared the outbreak of COVID-19 a Public Health Emergency of International Concern on 30 January 2020.

Australia is well prepared and has excellent health systems to deal with this virus. All areas of the health sector are well informed and actively engaged in the national response.

While there is still much we don't know about the characteristics of SARS-CoV-2, Australia has taken a precautionary approach in line with preparedness and response guidance for a pandemic, working collaboratively with state and territory and whole of government partners to implement strategies to minimise disease transmission through strong border measures and widespread communication activities.

## The plan

This, the first Australian Health Sector Emergency Response Plan for Novel Coronavirus (the COVID-19 Plan) is designed to guide the Australian health sector response. It should be considered a living document that will be periodically updated. As we learn more about the virus and its key at risk groups, and as potential treatments become available such as antiviral drugs and vaccine, we can target resources and public health interventions to most effectively protect the health of all Australians.

The novel coronavirus outbreak represents a significant risk to Australia. It has the potential to cause high levels of morbidity and mortality and to disrupt our community socially and economically. The national approach to this plan has been based on the AHMPPI, noting that the response to the novel coronavirus outbreak is now in the Initial Action stage. Accordingly, the preparedness and standby stages have not been included.

Australia will approach this novel coronavirus outbreak by undertaking activities to:

- monitor and investigate outbreaks as they occur;
- identify and characterise the nature of the virus and the clinical severity of the disease;
- research respiratory disease-specific management strategies;
- respond promptly and effectively to minimise the novel coronavirus outbreak impact;
- undertake strategies to minimise the risk of further disease transmission; and
- contribute to the rapid and confident recovery of individuals, communities and services.

The activities required to support our community during this novel coronavirus outbreak will involve state and territory governments, the Australian Government and many other health sector parties. Coordination and communication at the national level will be particularly important during our current active response.

## Response stages

To clearly show how the approach will change over the course of responding to a novel coronavirus outbreak, the COVID-19 Plan is divided into several stages.

The following table outlines the key activities in each of the COVID-19 Plan stages.

**Table 1: Key activities in each of the COVID-19 Plan stages**

COVID-19 Plan STAGES	ACTIVITIES
Action	<p>Action is divided into two groups of activities:</p> <p><i>Initial (when information about the disease is scarce)</i></p> <ul style="list-style-type: none"><li>• Minimise transmission;</li><li>• Prepare and support health system needs;</li><li>• Manage initial cases and contacts;</li><li>• Identify and characterise the nature of the disease within the Australian context;</li><li>• Provide information to support best practice health care and to empower the community and responders to manage their own risk of exposure; and</li><li>• Confirm and support effective governance arrangements.</li></ul> <p><i>Targeted (when enough is known about the disease to tailor measures to specific needs)</i></p> <ul style="list-style-type: none"><li>• Ensure a proportionate response;</li><li>• Support and maintain quality care;</li><li>• Communicate to engage, empower and build confidence in the</li></ul>

COVID-19 Plan STAGES	ACTIVITIES
	community; and <ul style="list-style-type: none"> <li>• Provide a coordinated and consistent approach.</li> </ul>
Standdown	<ul style="list-style-type: none"> <li>• Support and maintain quality care;</li> <li>• Cease activities that are no longer needed, and transition activities to normal business or interim arrangements;</li> <li>• Monitor for a second wave of the outbreak;</li> <li>• Monitor for the development of resistance to any pharmaceutical measures (if being used);</li> <li>• Communicate to support the return from emergency response to normal business services; and</li> <li>• Evaluate systems and revise plans and procedures.</li> </ul>

Once response activities are completed arrangements will return to the Preparedness stage, to monitor for any future novel coronavirus outbreaks; maintain plans and response agreements; research novel coronavirus-specific management strategies; and ensure resources are available and ready for a rapid response.

### ***Objectives and activities***

The **strategic objectives** across all stages and activities proposed in this plan will be to:

- Identifying and characterising the nature of the virus and the clinical severity of the disease in the Australian context;
- Minimise transmissibility, morbidity and mortality;
- Minimise the burden on/ support health systems; and
- Inform, engage and empower the public.

The activities which should be implemented will be selected by the Australian Health Protection Principal Committee (AHPPC), in consultation with relevant parties and on advice from expert bodies.

Reflecting a flexible approach, choices on implementation of public health measures may vary across states and territories to reflect the jurisdictional context, particularly in relation to timing of implementation and stand down, however negotiation within AHPPC will ensure a coordinated and consistent approach.

### ***Proportionate response***

A key goal of the decision making process is to achieve a response that is proportionate to the level of risk, acknowledging that the risk is not the same across population groups. A response that is appropriate to the level of impact the novel coronavirus outbreak is likely to have on the community, and on vulnerable populations within the community, will make the best use of the resources available and minimise social disruption.

Although it will only be possible to quantify the overall impact of the outbreak once it has run its course, to assist planners, an estimate of the anticipated level of impact will be developed early in the response, and updated as new data becomes available. This estimate will be used to:

- guide the allocation of resources, to ensure resources are not wasted and are conserved for use as long as possible (including anticipation of when they are needed, as this will change over time);
- put in place strategies to supplement likely shortfalls (e.g. innovative options);
- reduce the risk to vulnerable people.

The level of impact that the novel coronavirus has on the Australian community will depend on a number of factors. The most influential will be the clinical severity and transmissibility of the disease, and the capacity of the health system to cope with the demand and the need for specialist services.

### ***Communication and consultation***

The management of a novel coronavirus outbreak will require governments, health sector industry and the community to work together. Communication will be a priority under this plan, to ensure responders are provided with timely, accurate and comprehensive clinical information and advice in order to effectively manage patients; implement novel coronavirus control measures and minimise their own risk of exposure. Consultation with responders and with the public will be essential to inform decision-making.

Public communication will be used to provide an opportunity both to address any public concern caused by the novel coronavirus outbreak and to engage the public in strategies to manage the impact of the disease. By giving the public up to date, consistent and accurate information about the status of the disease overseas and in Australia they can participate in managing the outbreak by taking steps to reduce the risk to themselves and their families. They can also make more informed decisions about work and travel, taking up health recommendations and planning for people in at-risk groups. Information about the implementation of activities and arrangements will be used to build public confidence in the capacity of health services to manage the response.

## 2. Introduction

This section outlines the aims of this plan, key factors in the approach taken, the context within which it has been developed and methods of achieving a response proportionate to the risk posed by the current novel coronavirus outbreak.

This plan has been developed specifically to manage the national response to the outbreak of novel coronavirus which commenced in China in 2019. It is heavily based on the AHMPPI, as discussion of key committees and expert groups have agreed the approach and activities of the AHMPPI are relevant and broadly applicable to the novel coronavirus outbreak.

Much is still unknown about the novel coronavirus, however our understanding is growing daily. This plan is a living document which will be updated as needed and as new information becomes available.

### 2.1 Aims of the national response to the novel coronavirus outbreak 2019/20

Australia's whole-of-government communicable disease frameworks, at Australian, state and territory government levels, aim to protect Australia's social function and economy.

During the novel coronavirus outbreak, the health sector will aim to minimise the outbreak's impact on the health of Australians and our health systems. This, the COVID-19 Plan, is the Australian national health sector plan for the outbreak of novel coronavirus 2019/20, and contributes to these aims by:

- clarifying the roles and responsibilities within the health sector of the Australian Government and state and territory governments;
- identifying areas where national guidance and coordination will be provided, and how this will be achieved; and
- supporting decision makers to respond in a manner that is flexible, informed and proportionate to the circumstances at the time.

### 2.2 Key aspects of this plan

The key factors in this plan's approach include:

- the use of **existing systems** and governance mechanisms, particularly those for other respiratory diseases (such as influenza) and human biosecurity;
- a **flexible** approach that can be scaled and varied to meet the needs experienced at the time;
- **evidence-based decision making**;
- strong linkages with **emergency response** arrangements;
- clear strategic approaches to the collection of national **surveillance** data; and
- an emphasis on **communication** activities as a key tool in management of the response.

### 2.3 Comprehensive approach

This plan takes an emergency response approach as its framework. This approach will allow it to be readily integrated into broader emergency arrangements. It will also assist those who are implementing activities during a health emergency to communicate more easily with others outside the health sector.

Consistent with Australia's strategic approach to emergency management, the COVID-19 Plan acknowledges the importance of seeing the management of all hazards within an ongoing cycle of activities in the four areas of:

- **P**revention;
- **P**reparedness;
- **R**esponse; and
- **R**ecovery.

(Use of these terms with the initial letter in bold will indicate these areas of the emergency management cycle in this plan.)

This plan will focus primarily on the area of **R**esponse, to meet the greater need for coordination and guidance at a national level for COVID-19. To reflect the changes in priorities as the outbreak response progresses and facilitate the more detailed planning required, Response activities will be further divided into two stages:

- Initial Action and Targeted Action; and
- Standdown.

Table 2 indicates the general focus of activities in each stage of the COVID-19 Plan. The current status of the virus in each stage is noted in italics. To ensure that flexibility is maintained, these stages are deliberately broad. To make it easier to relate activities to these stages, colours have been allocated to each and used as markers in this plan.

**Table 2: Key activities in each stage of the COVID-19 Plan, commencing in Action, as Australia already has cases.**

COVID-19 Plan STAGES	ACTIVITIES
Action  <i>Cases detected in Australia</i>	<p>Action is divided into two groups of activities:</p> <p><i>Initial (when information about the disease is scarce)</i></p> <ul style="list-style-type: none"> <li>• minimise transmission;</li> <li>• prepare and support health system needs;</li> <li>• manage initial cases and contacts;</li> <li>• identify and characterise the nature of the disease within the Australian context;</li> <li>• provide information to support best practice health care and to empower the community and responders to manage their own risk of exposure; and</li> <li>• confirm and support effective governance.</li> </ul> <p><i>Targeted (when enough is known about the disease to tailor measures to specific needs)</i></p> <ul style="list-style-type: none"> <li>• ensure a proportionate response;</li> <li>• support and maintain quality care;</li> <li>• continue to communicate to engage, empower and build confidence in the community; and</li> <li>• provide a coordinated and consistent approach.</li> </ul>



COVID-19 Plan STAGES	ACTIVITIES
Standdown  <i>The public health threat can be managed within normal arrangements and monitoring for change is in place.</i>	<ul style="list-style-type: none"> <li>• Support and maintain quality care;</li> <li>• cease activities that are no longer needed, and transitioning activities to seasonal or interim arrangements;</li> <li>• monitor for a second wave of the outbreak;</li> <li>• monitor for the development of resistance to any pharmaceutical measures being used;</li> <li>• communicate to support the return from pandemic to normal business services; and</li> <li>• evaluate systems and revise plans and procedures.</li> </ul>

## 2.4 Whole of government planning to support the novel coronavirus response

This plan outlines the health sector approach to responding to the novel coronavirus outbreak. It is supported by the Emergency Response Plan for Communicable Diseases Incidents of National Significance: National Arrangements (National CD Plan) (<https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-CD-plan.htm>).

The National CD Plan outlines how non-health sector agencies will support the health sector response and how agencies across Australian, state, territory and local governments will work together to protect Australia from the threat of a major communicable disease outbreak.

Guidance on the public health management of novel coronavirus is available in the Communicable Diseases Network Australia (CDNA) National Guidelines for Public Health Units in the Series of National Guidelines (SoNGs) (<https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>).

The COVID-19 Plan acknowledges that the primary responsibility for managing the impact of the novel coronavirus lies with the state and territory governments and that each jurisdiction will have its own plans and protocols. Therefore the majority of operational detail will be found in these plans.

## 2.5 Legal framework

Although Commonwealth biosecurity legislation and state and territory public health and emergency response laws provide a legislative framework to underpin actions that may be required, measures will rely on voluntary compliance rather than legal enforcement wherever possible. The principal areas of legislation available to support response actions are described in the following subsections.

### ***The Biosecurity Act 2015***

The *Biosecurity Act 2015* authorises activities used to prevent the introduction and spread of target diseases into Australia. People reasonably suspected to have a listed human disease (LHD) specified under the Act are required to comply with a range of biosecurity measures and requests for information as directed by the Director of Human Biosecurity (DHB), Australia's Chief Medical Officer (CMO); Minister for Health; or a biosecurity official or human biosecurity officer as stipulated in the Act. The Governor-General also has the power to declare a human biosecurity emergency, which authorises the Health Minister to implement a broad range of actions in response. These could be applied to respond to a serious infectious disease outbreak or a pandemic. 'Human coronavirus with pandemic potential' is an LHD. Diseases can be added to the list of LHDs (as declared in the *Biosecurity (Listed Human Diseases) Determination 2016*) at any time by the DHB at short notice.

### ***The National Health Security Act 2007***

The *National Health Security Act 2007* (NHS Act) authorises the exchange of public health surveillance information (including personal information) between the Australian Government, states and territories and the WHO. The National Health Security Agreement supporting the NHS Act formalises decision-making and coordinated response arrangements that have been refined in recent years to prepare for health emergencies.

### ***State and territory government legislative powers***

States and territories have legislative powers that enable them to implement biosecurity arrangements within their borders and that complement Australian Government biosecurity arrangements. They also have a broad range of public health and emergency response powers available under public and emergency legislation for responding to public health emergencies.

### ***International legislative obligations***

The *International Health Regulations 2005* (IHR) is an international public health treaty that commits signatory countries to take action to prevent, protect against, control and provide a public health response to the international spread of disease. As a signatory, Australia has a range of obligations, including reporting and maintaining certain core capacities at designated points of entry and informing the WHO if any measures implemented interfere with international trade or travel.

### ***Therapeutic Goods Act 1989***

The *Therapeutic Goods Act 1989* establishes a framework for ensuring the timely availability of therapeutic goods (i.e. medicines, medical devices and biological products) that are of acceptable quality, safety and efficacy/performance. There are provisions within the legislation that operate at an individual patient level and at a program level (such as the maintenance of a National Medical Stockpile (NMS)) to allow for the importation and supply of products and the use of new, disease-specific in vitro medical diagnostic tests that have not been approved for use in Australia. These products may be required to deal with an actual threat to individual and public health caused by an

emergency that has occurred or to create a preparedness to deal with a potential threat to health that may be caused by a possible future emergency.

## 2.6 Ethical framework

In 2008, AHPPC agreed on an ethical framework to guide health sector responses. These values will be taken into account when planning and implementing actions under this plan, and can be outlined as:

**Equity** - Providing care in an equitable manner, recognising special needs, cultural values and religious beliefs of different members of the community. This is especially important when providing health services to vulnerable individuals, such as Aboriginal and Torres Strait Islander peoples and people who are culturally and linguistically diverse.

**Individual liberty** - Ensuring that the rights of the individual are upheld as much as possible

**Privacy and confidentiality of individuals** - Is important and should be protected. Under extraordinary conditions during a pandemic, it may be necessary for some elements to be overridden to protect others.

**Proportionality** - Ensuring that measures taken are proportional to the threat.

**Protection of the public** - Ensuring that the protection of the entire population remains a primary focus.

**Provision of care** - Ensuring that health care workers (HCWs) are able to deliver care appropriate to the situation, commensurate with good practice, and their profession's code of ethics.

**Reciprocity** - Ensuring that when individuals are asked to take measures or perform duties for the benefit of society as a whole, their acts are appropriately recognised and legitimate need associated with these acts are met where possible.

**Stewardship** - That leaders strive to make good decisions based on best available evidence.

**Trust** - That health decision makers strive to communicate in a timely and transparent manner to the public and those within the health system.

## 2.7 Proportionate response

Prior to 2009, planning for pandemics and major communicable disease outbreaks was aimed at responding to a worst case scenario. The 2009 influenza A(H1N1) pandemic showed clearly the need for the flexibility to scale the response to be proportionate to the risk associated with the current disease.

### 2.7.1 Outbreak Impact

The level of impact that the outbreak has on the Australian community will depend on a number of factors.

The **clinical severity** of the disease will affect the number of people that present to primary care, and who need to be hospitalised (and consequently the burden on the health system). The clinical severity also affects the number of deaths and the level of concern within the community. As clinical severity increases, the visibility of the disease (i.e. how easy it is to be aware of cases) is likely to increase. Greater visibility of cases to medical services makes them more amenable to measures to manage the disease's impact.

The **transmissibility** of the virus between humans will affect the breadth and speed of spread across the globe and the Australian community. The transmissibility of the novel coronavirus is as yet unknown. As at 6 February 2020, the World Health Organization has estimated the virus to have a preliminary reproduction number ( $R_0$ ) of 1.4 to 2.5.

The **capacity of the health system** will influence the way that healthcare is provided. Australia has an excellent health system. However, there is a limit to the services that are able to be provided, which may well be tested during an outbreak of a novel coronavirus with pandemic potential. In some areas, the health system already reaches capacity at peak times, such as during severe influenza seasons. A major outbreak will increase the demand on specialist expertise, particularly in acute care, such as intensive care nursing, emergency medicine and ambulance services. It may also increase the demand on specialist equipment, some of which requires specialist training to implement and is of limited availability, such as extracorporeal membrane oxygenation (ECMO). Demand on primary health care will also increase, exacerbated by the need to attend to patients affected by the changes in availability of services at hospitals.

The **effectiveness of interventions** will affect individual health and the levels of morbidity and mortality that need to be managed by the health system. Currently there are no effective antivirals available and there is no vaccine. Availability of a customised novel coronavirus vaccine would be the greatest tool in reducing the impact. It is not known if or when this might be available. There is still no vaccine available for the other major coronaviruses SARS and MERS. Interventions that change behaviours, such as hand hygiene, isolation and social distancing will also influence the impact of the disease. Early clinical trials of candidate antiviral drugs in severe cases will be of great importance to determine if any of them have clinical efficacy.

The **vulnerability** of our population will influence the spread and clinical severity of the disease. Vulnerability is unique and will make comparisons with the experience of the outbreak overseas indicative only. As the outbreak is caused by a novel virus, the lack of immunity in the population will make it more vulnerable than would be the case with diseases such as seasonal influenza (where there is usually some cross-immunity from previous seasonal strains). Case information to date has indicated that people with underlying illness or immunocompromised conditions are likely to experience more severe outcomes.

### **2.7.2 Application of outbreak impact levels to decision making**

Although it will only be possible to quantify the overall impact of the outbreak once it has run its course, informed by surveillance activities, an estimate of the anticipated level of impact will be made early in the response, and continually updated as data availability allows, and used to help planners:

- allocate resources where they are needed (including anticipation of when they are needed, as this will change over time);
- put in place strategies to supplement likely shortfalls (e.g. innovative options);
- reduce the risk to vulnerable people;
- minimise the disruption to the community; and
- provide a response that is proportionate to the level of impact.

Characterisation of the virus will be undertaken as early as possible in the outbreak, including ongoing analysis of sequencing information that could indicate viral mutation, and revised regularly as more information becomes available. While all the factors mentioned above will be considered as part of the decision making process, they will have different degrees of influence.

#### *Clinical severity:*

Clinical severity is likely to be critically important in making an estimate of impact. It will strongly impact on the morbidity and mortality at an individual and population level, the burden on the health system and the concern within the community. Explanations of impact in terms of clinical severity are also easily understood at a personal and public health level. As clinical severity increases, the following will also increase:

- the demand for high end services, such as Intensive Care Unit (ICU), paediatric and respiratory care (associated with this will be increased demand for specialized equipment

and health care professionals, such as ECMO and ICU nurses). High end services are areas likely to increase the demand on support services, such as laboratories, much more than increased demand in general wards;

- the demand for services associated with management of the deceased;
- the importance of informing and supporting at-risk groups;
- the importance of measures to promote prompt presentation and diagnosis, while minimising opportunities for transmission;
- the importance of building confidence within the community;
- the proportion of infected individuals seeking treatment, which means the public health interventions to reduce ongoing transmission that rely on identification of cases will likely be more effective.

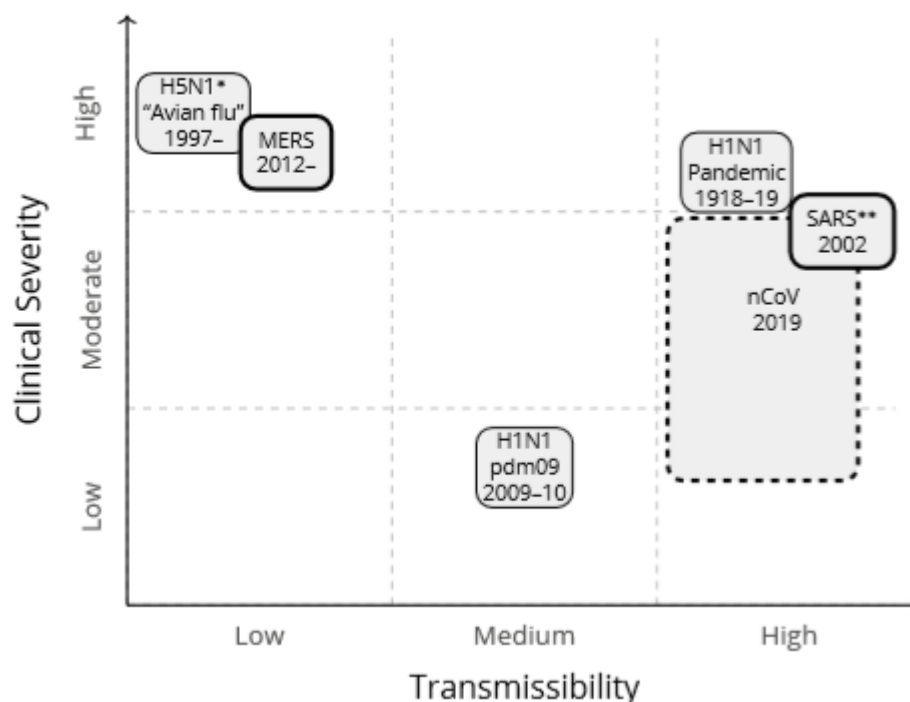
#### Transmissibility:

Following clinical severity, transmissibility will be considered, to help determine the likely speed of spread and the timing of the demand on health services, and further define the impact of the pandemic on the population as a whole. As transmissibility rises:

- the timeliness of measures to limit spread becomes more critical (as the window of opportunity is smaller);
- the demand for health services rises more quickly;
- health services and response measures need to be scaled up more quickly;
- the peak burden and final total burden on the health system will be higher;
- the overall duration of the pandemic will be shorter;
- assessments and decisions will need to be made more quickly (epidemiological and individual).

Figure 1 provides an example of how previous respiratory disease outbreaks could be characterised in terms of clinical severity and human-to-human transmissibility.

**Figure 1: Contribution of transmissibility and severity on population impact of estimated range of COVID-19 to other respiratory outbreaks**



The significance of transmissibility will vary depending on the stage of progress of the outbreak. It should also be considered that, as the novel coronavirus outbreak is caused by a new virus, there will be high vulnerability in the population to the virus. There is no evidence of sustained human-to-human transmission in Australia and this is being carefully monitored and could change. The window of opportunity for measures aimed at controlling transmission are proving successful but may become more limited.

It is suspected that individuals with the novel coronavirus may be less infectious prior to the onset of symptoms than those with influenza. This would make isolation of identified cases more effective at reducing onward spread.

The capacity of the health system will also be considered to determine the degree to which systems will be able to manage the increased demand and which measures would need to be put in place to best use available resources.

Indicators such as notifications, hospitalisations and availability of ICU beds may be used to determine the transmissibility, clinical severity and health system capacity respectively.

### **2.7.3 A qualitative description of three different levels of outbreak impact**

Each outbreak is unique and the clinical severity and transmissibility is likely to vary each time. Health system capacity will vary between and within jurisdictions, according to the season and between different health services. To illustrate how differences in these three factors may impact differently on the community, and therefore require different approaches and levels of resources, three scenarios have been described in the following sections.

#### **Scenario one**

##### **If clinical severity is low**

The majority of cases are likely to experience mild to moderate clinical features. People in at-risk groups and those with comorbidities may experience more severe illness. Strategies to support at-risk groups, once they are identified, may be required (e.g. people with underlying illness, people with immunocompromised conditions, aged care, infants, Aboriginal and Torres Strait Islander peoples, remote communities). At the peak of the outbreak, and increasingly when transmissibility is higher, primary care and hospital services may become stretched in areas associated with respiratory illness and acute care. Existing legislation is likely to be sufficient to support activities. The level of impact on the community may be similar to severe seasonal influenza or the 2009 influenza A(H1N1) pandemic.

#### **Scenario two**

##### **If clinical severity is moderate**

People in at-risk groups may experience severe illness. As the number of cases grows the number of people presenting for medical care is likely to be higher than for severe seasonal influenza and primary care and hospital services will be under severe pressure, particularly in areas associated with respiratory illness and acute care. Non-urgent procedures and activities may need to be scaled back. Surge staffing and alternate models of clinical care, such as cohorting and/or establishment of flu-like clinics may need to be employed to cope with increased demands for healthcare. Pressure on health services will be more intense, rise more quickly and peak earlier as the transmissibility of the disease

increases. Healthcare staff may themselves be ill or have to care for ill family members, further exacerbating pressures on healthcare providers.

Additional strategies to support at-risk groups may be required (e.g. people with underlying illness, people with immunocompromised conditions, aged care, infants, Aboriginal and Torres Strait Islander peoples, remote communities). New and/or existing health emergency legislation may be needed to support outbreak response specific activities.

### **Scenario three**

#### **If clinical severity is high**

Widespread severe illness will cause concern and challenge the capacity of the health sector. Areas such as primary care, acute care, pharmacies, nurse practitioners and aged care facilities will be stretched to capacity to support essential care requirements. Heavy prioritisation will be essential within hospitals to maintain essential services and mortuary services will be under pressure. The demand for specialist equipment and personnel is likely to challenge capacity. Pressure on health services will be more intense, rise more quickly and peak earlier as the transmissibility of the disease increases. Healthcare staff may themselves be ill or have to care for ill family members, further exacerbating pressures on healthcare providers.

Secondary care services, such as blood services and diagnostic services will be challenged to maintain capacities and the community focus will be on maintaining essential services. Health emergency legislation may be needed to support outbreak specific activities. The level of impact may be similar to that of the 1918 H1N1 'Spanish flu'.

These scenarios characterise the impact on the Australian community as a whole.

## **2.8 Participating parties**

This plan is written for government decision makers and will be used to inform operational planning in state and territory governments and the broader Australian Government.

The primary parties to the COVID-19 Plan will be the Australian Government Department of Health (Department of Health) and State and Territory Health Departments.

The participation of, or coordination with other government agencies at Australian Government and State and Territory Government level will also be necessary to implement many of the activities in this Plan. Commitment to this process is captured in the National CD Plan. The Australian Government Department of Agriculture, Water and the Environment will be particularly important in the implementation of border health measures. The Department of Home Affairs (including Emergency Management Australia) and the Department of Prime Minister and Cabinet will also be involved.

Non-government parties, such as general practitioners (GPs), nurses and pharmacists will also be involved in responding to a pandemic. It is acknowledged that healthcare practices will rely on the hard work of teams of individuals to implement pandemic measures and that these teams will be made up of people with a broad range of skills.

## **2.9 Review and amendment**

The CMO, after appropriate consultation, may approve amendment to the COVID-19 Plan as needed to meet the current circumstances.

## 3. Escalation

This chapter explains when arrangements under the COVID-19 Plan will be used and how escalation through the COVID-19 Plan stages will occur.

### 3.1 Existing communicable disease arrangements

The novel coronavirus is a respiratory illness. GPs and other health providers, such as nurses, Aboriginal Community Controlled Health Services (ACCHSs), pharmacists and aged care providers manage the bulk of people with respiratory illnesses within the community. Public health units and communicable disease control services in state and territory health departments manage outbreak response, collect public health surveillance data, administer vaccination programs, develop and implement health promotion and public communications, and provide significant support to clinical services and aged care facilities. Ambulance services, hospital emergency and respiratory wards, and intensive care units support people with complications. Laboratories provide testing services, advise on management of resources and public health approaches, and participate in research. Surveillance systems and public health units investigate and support management of outbreaks and provide important public information on risk reducing strategies.

These systems are well developed and processes are refined continuously as outbreaks are managed each year.

### 3.2 Escalation from existing arrangements

These existing arrangements form the basis for the clinical and public health management of the novel coronavirus. Emergency management processes, in particular the Australian Government Crisis Management Framework (AGCMF), will be used as the basis of governance arrangements. Existing surveillance systems will be updated and adapted to monitor the emergence of novel coronavirus, and form the basis for gathering information to guide decision making throughout the outbreak.

While there are many similarities to pandemic influenza, there are also differences in managing a novel coronavirus outbreak. Common objectives to minimise transmission, morbidity and mortality will remain, but key areas in which the implementation of activities would differ are:

- ongoing characterisation of the virus and the clinical severity of the disease in the Australian context;
- increased importance of identification of cases and isolation activities (as it is suspected that individuals may be less infectious prior to the onset of symptoms, making isolation of identified cases more effective at reducing onward spread).
- coronaviruses spread more slowly than influenza, allowing a window of several days to identify and isolate cases while they are still infectious.
- case isolation will continue to be important to reduce spread through the whole course of the response.
- the likelihood that, due to the longer serial interval (time between successive cases in a chain of transmission), it will be necessary to sustain the response for longer. This will have significant implications for the sustainability of resources. It will also increase the importance of looking at alternative methods for control of transmission and carefully monitoring when actions should be scaled back or ceased.

Existing systems will need to be adapted and enhanced to support new priorities. Some systems may be extended (such as through surge staffing) and, where outside the normal scope, some will be augmented (through methods such as recruitment of additional expertise). The greater complexity of systems required to respond to the novel coronavirus outbreak will increase the need for national coordination.



The COVID-19 Plan provides an agreed approach to provision of a coordinated and consistent response and a decision to escalate under the COVID-19 Plan from existing arrangements will signal that participating parties should:

- commence use of agreed governance and communication arrangements to manage this type of threat;
- undertake their roles and responsibilities as detailed in this plan;
- advise stakeholders of the approach that will be taken by national, state and territory health departments to respond to the situation; and
- put in place a process to allocate resources and justify re-prioritisation of existing activities to support the outbreak response.

### 3.3 Escalation across stages

The plan is currently in the phase of Initial **Action** and can be elevated to Targeted **Action** stage if AHPPC considers this warranted by the circumstances.

#### *Triggers*

Examples of events that might warrant escalation include:

- declaration of a Public Health Emergency of International Concern (PHEIC) or a pandemic by the WHO; and
- advice from a credible source that sustained community transmission of a novel virus with pandemic potential has occurred.

The National Incident Room (NIR) in the Department of Health will function as the National Health Sector Emergency Operations Centre and the National Focal Point (NFP) under the International Health Regulations.

### 3.4 Activation of other plans

The COVID-19 Plan stages will be independent of activation of whole-of-government or jurisdictional plans.

While the COVID-19 Plan remains in Initial/Targeted Action or Standdown stages:

- the NFP in the Department of Health will liaise with the WHO;
- the NIR will provide agencies with regular Situation Reports;
- the NIR will advise relevant Australian Government and state and territory health services of any change of stage;
- the NIR will coordinate communications;
- The Department of Health will coordinate liaison with other Australian Government agencies;
- The Department of Health will advise the Minister for Health of progress under the Plan;
- S/T HD will coordinate liaison with other government parties and response stakeholders in their jurisdiction; and
- Communications will be conducted as outlined in 'Communications' below.

## 4. Governance

This chapter outlines the roles and responsibilities of stakeholders and key committees, and describes decision-making and consultation processes.

### 4.1 Roles and responsibilities

A clear understanding of the roles and responsibilities between parties responding to a novel coronavirus outbreak will support quick decision making and efficient, coordinated use of resources. This section summarises the roles and responsibilities of the Australian Government in key aspects of managing a novel coronavirus outbreak, the roles and responsibilities of the state and territory governments, and where roles and responsibilities are jointly shared by these two parties. To reinforce important linkages with these stakeholders, this chapter also outlines the broad roles of other health sector parties.

#### 4.1.1 Planning

Minimising the impact of a novel coronavirus outbreak on Australian communities and on the health system requires coordinated and careful planning of measures to control the spread of the disease. The Australian Government maintains the COVID-19 Plan to prepare for and respond to a novel coronavirus outbreak, with input from states and territories, and other health sector stakeholders. This plan will be regularly reviewed and updated as more information about the novel coronavirus is determined.

States and territories also develop consistent and comprehensive operational plans for the public health response, and the health service response within their jurisdictions.

Other health sector stakeholders are responsible for developing their own response plans in accordance with national and jurisdictional arrangements and for incorporating communicable disease outbreaks into overall business continuity plans.

At all levels, planning will consider what is needed to protect the most vulnerable members of our communities, and address the needs of special groups, such as the aged care sector and Aboriginal and Torres Strait Islander peoples.

#### 4.1.2 Surveillance

The Australian Government is responsible for developing and maintaining systems to monitor communicable disease activity domestically and internationally and for communicating relevant information. Once a novel coronavirus with pandemic potential has arrived in Australia, these systems will be used for monitoring and analysis. Working together with state and territory representatives, the Australian Government will assess the risk of any potential outbreak threats to inform decision making about appropriate actions.

State and territory governments are responsible for collecting surveillance data to contribute to the national picture and to inform the jurisdictional public health response.

Other health sector stakeholders will also play a key role in surveillance activities and contributing to the national characterisation and understanding of the novel coronavirus of concern.

#### 4.1.3 Provision of clinical services

The Australian Government will coordinate allocation of available national resources required for clinical care.

The Australian Government and state and territory governments will work together to develop new models of care to manage patients and agree on novel coronavirus triage criteria (if required); tailor infection control guidelines to the risks relevant to the virus as required; ensure provision of primary

health care is adapted to any changes in the needs of vulnerable groups during the outbreak; and consider and respond to requests for health assistance.

State and territory governments have primary responsibility for establishing and maintaining public health services, public hospitals and laboratories. They are responsible for the operational aspects of clinical care responses and have primary responsibility for the management of cases. They will collaborate with relevant organisations to fill identified service provision gaps; support hospitals in coping with increased demand by considering opening more beds, changing staff to patient ratios; cancelling elective procedures or working in partnership with local private hospitals to manage urgent cases where appropriate; implement new models of care as required; coordinate allocation within their jurisdiction of available resources required for clinical care; and where possible, share clinical resources where and when needed.

Other health care stakeholders are responsible for service provision and linking with and participating in the clinical care network by sharing resources; implementing national care guidelines (including triage protocols if required) and delivering outbreak control measures where required. They will implement patient triage, manage patients and provide after-hours care as required; coordinate locally between services; collaborate with state and territory health authorities to identify and fill local gaps in services, particularly where there are vulnerable populations and implement new models of care according to a novel coronavirus outbreak policy.

#### **4.1.4 Implementation of public health measures**

The Australian Government is responsible for ensuring the resources and systems required to mount an effective national response are readily available; for international border activities; and for ensuring that Australia meets its international obligations. This includes maintaining the NIR, the NMS and IHR core capacities including maintenance of the NFP.

The Australian Government will also be responsible for residential aged care facilities; working with other healthcare providers to set standards to promote the safety and security of people in aged care and other institutional settings; and establishing and maintaining infection control guidelines, healthcare safety and quality standards. The Australian Government will fast-track assessment and approval of a customised vaccine, should this become available; procure vaccines; develop a national novel coronavirus vaccination policy and a national novel coronavirus immunisation program; and communicate immunisation information on the program to the general public and health professionals.

The Australian Government and state and territory governments will work together to provide advice and leadership on the appropriate methods and timing for implementing public health measures. They will develop communication strategies and resources for novel coronavirus immunisation and coordinate implementation of novel coronavirus immunisation programs. They will also contribute to building linkages between human and animal health resources and activities.

State and territory governments are responsible for the operational aspects of public health responses. They will undertake contact tracing; coordinate distribution of antiviral drugs and disseminate protocols on the use of antivirals; implement social distancing measures as per national recommendations and local risk assessment; and implement infection control guidelines and healthcare safety and quality standards. They will establish systems to promote the safety and security of people in aged care and other institutional settings and support outbreak investigation and management in residential aged care facilities, schools, prisons and other institutions.

State and territory governments will develop and validate specific novel coronavirus tests; undertake novel coronavirus laboratory testing as required to monitor the outbreak and for individual patient care; implement testing protocols to support case management, surveillance needs and to preserve laboratory capacity; support and undertake novel coronavirus point of care testing if recommended.

State and territory governments will maintain IHR core capacities and communicate public health events of national significance to the NFP; support implementation of border measures by providing disease control expertise and health care services to ill travellers; implement the national novel coronavirus immunisation program (should one become available); manage jurisdictional distribution of the NMS and assess the need for a jurisdictional medical stockpile and, if relevant, establish and maintain it.

Other health sector stakeholders will contribute to IHR core capacities; provide input on needs related to national stockpile items; maintain stocks and use of, personal protective equipment as appropriate for infection control requirements; and report adverse events following immunisation or following the administration of antiviral drugs (should relevant antivirals become available) to the state health authority and/or the Therapeutic Goods Administration (TGA).

Other health sector stakeholders will implement infection control guidelines and healthcare safety and quality standards; and implement protocols and procedures to promote the safety and security of people in aged care and other institutional settings according to national standards. They will also administer novel coronavirus vaccine according to national guidelines (should one become available); and provide community education on novel coronavirus vaccination programs including education with hard-to-reach groups and at-risk populations.

#### **4.1.5 Researching, planning and building specific novel coronavirus outbreak control strategies**

The Australian Government will commission research on the effectiveness and impact of public health measures. National, state and territory governments will use this information to inform their plans. Other health sector stakeholders will provide advice on the feasibility and impact of novel coronavirus outbreak control measures; and support dissemination and implementation of national advice on the measures, such as the use of antiviral drugs and novel coronavirus vaccines.

#### **4.1.6 Communication**

The Australian Government is responsible for national communications to the public and the health care sector at a national level, with direct responsibility for communications with the primary care sector and at our international borders. It is also responsible for reporting to and liaison with the WHO as required under the IHR and sharing information from the WHO, from surveillance and other sources with relevant stakeholders. The Australian Government will also disseminate relevant tailored information to aged care and other residential facilities through approved providers and regulatory processes and liaise with Australian Government education authorities concerning public health measures related to schools.

The Australian Government and state and territory governments are jointly responsible for the sharing information on resource availability and providing advice on case and contact management, antiviral drug utilisation (if shown to be of benefit), quarantine/isolation and outbreak risk assessment.

State and territory governments are responsible for jurisdictional and local communications to the public and the health care sector. They are also responsible for reporting issues to the NIR which might require a coordinated response and/or as required for reporting under the IHR.

Other health care stakeholders have a responsibility to provide input into decision-making and to communicate novel coronavirus outbreak information and key messages to the public.

#### **4.1.7 Coordination**

The Australian Government will coordinate national novel coronavirus outbreak measures and allocate available national health resources across the country. It will support the health response in any jurisdiction, through AHPPC to coordinate assistance, if jurisdictional capacity becomes overwhelmed.

The Australian Government and state and territory governments will work together to consider surveillance, resource and political information to determine whether and when a national response is required; advise on thresholds for escalation; share information on resource availability and coordinate access to resources to maximise the effectiveness of the response.

State and territory governments will coordinate and provide novel coronavirus healthcare services including assessment and treatment centres as required.

Other health care stakeholders will deliver novel coronavirus outbreak health measures as part of the coordinated response and maintain business continuity of essential services.

#### **4.1.8 Standdown and evaluation**

The Australian Government will coordinate the stand down of enhanced measures; manage the transition of novel coronavirus outbreak specific processes into normal business arrangements; and undertake public communication regarding changing risk and the stand down of measures.

The Australian Government and state and territory governments will work together to determine when to cease or reduce measures and agree appropriate messaging for responders and the public concerning scaling down of measures.

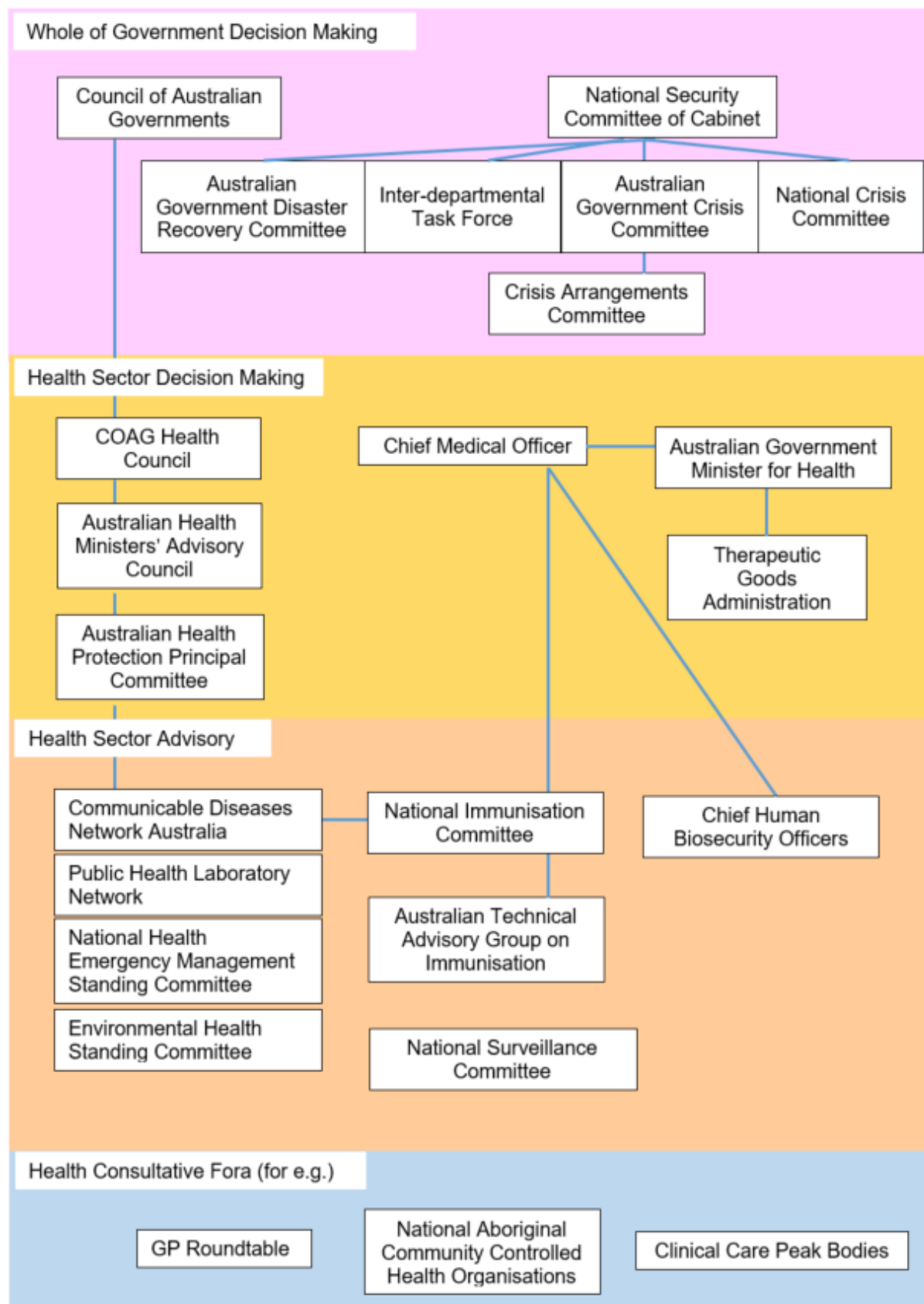
State and territory governments will implement stand down of measures taken within the state or territory; manage the transition of novel coronavirus outbreak specific processes into normal business arrangements; and undertake jurisdictional public communication regarding changing risk and stand down of novel coronavirus outbreak measures.

Other health care stakeholders will advise on the timing and impact of reducing enhanced clinical novel coronavirus outbreak services; support stand down of measures and manage the transition of novel coronavirus outbreak specific processes into business as usual arrangements; and participate in communicating public messages regarding changing risk and stand down of novel coronavirus outbreak measures.

All parties will be responsible for evaluating novel coronavirus outbreak processes and implementing changes as appropriate.

## 4.2 Decision making and consultation

**Figure 2: Whole of Government, health sector, health advisory and consultative committees involved in decision making for a novel coronavirus outbreak.**



The management of a novel coronavirus outbreak will require governments, health sector industry and the community to work together. Consultation will be essential to inform decision making, which will need to be rapid and coordinated.

#### **4.2.1 Whole of Government (WoG) decision making structure**

A severe novel coronavirus outbreak will disrupt Australia's social and economic functioning. Maintaining essential services may require a whole-of-government response, incorporating agencies at the Australian Government and state and territory government level. For a novel coronavirus outbreak, decision making and consultation at this level will be in line with existing emergency arrangements described in the AGCMF. The primary forum for coordinating the cross-government response will be the National Crisis Committee (NCC). The NCC will consolidate information and coordinate information exchange and advice to ministers. It will also coordinate ministerial decisions across the Australian Government, State and Territory and local governments. The Australian Government Crisis Committee (AGCC) will coordinate the response across the Commonwealth.

The National CD Plan outlines the roles and responsibilities of the Australian Government, States and Territories and Local Governments. It also details agreed coordination arrangements for the management of communicable diseases of national significance and their consequences.

When information obtained and activities implemented under the COVID-19 Plan may have implications outside the health sector, advice regarding this will be forwarded to the NCC for consideration.

#### **4.2.2 Ministerial responsibilities**

Under the AGCMF, the Australian Government Minister for Health is the lead minister for the Australian Government response to a serious infectious disease outbreak. As a member of the COAG Health Council (CHC), the Minister for Health is also involved in the approval of response activities, through the endorsement of plans and arrangements.

The Australian Government Minister for Health also has powers under the *Biosecurity Act 2015* to assist with managing the risk of an LHD entering, emerging or establishing itself in Australian territory. These include:

- Determining international entry requirements (and exit requirements)
- Determining preventative biosecurity measures
- Recommending the declaration of a human biosecurity emergency under the Act (and utilising the emergency powers once an emergency has been declared)

Should circumstances warrant it, the AGCMF notes that the Prime Minister may assume primary responsibility for leading the Government's response. Under these circumstances, the Prime Minister is also likely to consult with the leaders of affected states and territories to ensure a coordinated national response.

#### **4.2.3 Health sector decision making structure**

For the development of policy related to management of a novel coronavirus outbreak, the CHC represents the highest decision making body. AHPPC will manage implementation of the national health sector response, in consultation with relevant stakeholders, and provide health sector advice to the AGCC and NCC as appropriate.

#### **4.2.4 Health sector advisory groups**

The following key committees will support decision-making:

- PHLN will provide leadership in guiding human health microbiology and laboratory practice;
- CDNA will provide leadership in surveillance, the analysis of epidemiological information and strategies related to management of communicable disease;

- National Surveillance Committee (a standing committee under CDNA) will provide leadership in guiding the implementation of novel coronavirus specific surveillance activities and strategies;
- the National Immunisation Committee will provide leadership in guiding implementation of immunisation measures;
- Australian Technical Advisory Group on Immunisation will provide advice technical advice on immunisation issues; and
- Chief Human Biosecurity Officers (CHBOs) will provide advice to the CMO (as the DHB) on human biosecurity matters at the international border.

#### **4.2.5 Health sector consultation**

Consultation will be integral to decision making regarding the approach to managing a novel coronavirus outbreak. Wherever possible, this will be conducted through existing channels. Key advisory committees, in addition to providing expert advice will also be used as vehicles for consultation in their field of expertise.

Consultative fora and peak bodies, such as aged care peak bodies, key national primary care organisations, national nursing organisations, representatives of medical specialist colleges and pharmaceutical organisations will be used to reach key non-government health sector areas. Feedback from these organisations - which will reflect the on-the-ground experience of health sector and public concerns, and evidence of the effectiveness of approaches and specific interventions - will be input into decision-making processes to better tailor the response to community needs.

#### **4.2.6 Decision making processes under the COVID-19 Plan**

The COVID-19 Plan will guide the management of a novel coronavirus outbreak at the national health sector level, representing an approach agreed between the Australian Government and state and territory governments.

Key decisions within the scope of the COVID-19 Plan will primarily concern the following issues:

- the overall response approach;
- the appropriate stage for the COVID-19 Plan, according to the current circumstances;
- the selection of measures appropriate for implementation at that stage (including standdown of existing activities);
- key messages for communication measures; and
- coordination of sharing of resources.

Reflecting a flexible approach, choices may vary to reflect the jurisdictional context, particularly in relation to timing of implementation and stand down, however negotiation within COVID-19 Plan will ensure a coordinated and consistent approach.

#### **4.2.7 Selection of public health measures**

The selection of public health measures will be one of the most important functions of COVID-19 Plan. The following questions may be used to guide selection:

1. Will this action contribute to meeting the strategic objectives?
2. Will it be the best use of current resources?
3. Will this be proportionate to the likely impact of the novel coronavirus outbreak?
4. When would it be most effective to implement this measure?

To ensure that the appropriate expertise is available to support AHPPC, relevant health advisory bodies such as CDNA, PHLN or the Department of Health, will provide a set of recommendations for consideration at key decision points. Only a broad recommendation will be made for question 2, as this will depend on the resources available at the time in the Australian Government or relevant jurisdiction.



The continuing appropriateness of measures will be regularly reviewed as more information becomes available across the progress of the novel coronavirus outbreak. A regular set time for review (frequency will depend on the progress of the pandemic), such as weekly, will assist building awareness of changes made.

## 5. Implementation

This chapter identifies the recommended approach to managing a novel coronavirus outbreak in the emergency management areas of **Response**:

- Initial and Targeted Action; and
- Standdown.

Additional detail to support implementation at an operational level is provided in the Operational Plan at Part 2 of the COVID-19 Plan.

### 5.1 Response activities

#### 5.1.1 Initial Action stage

Initial activities will focus on:

- **minimising transmission;**
- **preparing and supporting health system needs;**
- **managing initial cases and contacts;**
- **identifying** and characterising the nature of the virus and the clinical severity of the disease within the Australian context;
- providing **information to support best practice health care** and to **empower the community and responders** to manage their own risk of exposure; and
- supporting effective **governance**.

By definition, a novel coronavirus would be associated with a relative lack of immunity within communities. Though the transmissibility of the disease will be an important limiting factor, the combination of this lack of immunity with the rapid movement possible through modern international transport systems make it likely that once a novel coronavirus achieves efficient human to human transmission, it will spread across the globe including the Australian population.

Many of the measures which can be applied in response to a novel coronavirus with pandemic potential must be implemented early to be most effective. Action should be taken before there is evidence of sustained transmission of the novel coronavirus disease within the Australian community, it will be important to commence measures as quickly as possible, even though, due to the novel nature of the virus, it is unlikely that we will yet have a good understanding of the epidemiology, clinical severity and virology of the disease. Action to identify and isolate early cases and quarantine contacts can minimise the risk of further spread and may control the outbreak.

Though information will initially be scarce, some predictions of the course of the disease and the demands it may make on our health systems and wider society can be made in comparison with past outbreaks of international concern (pandemic influenza, SARS, MERS in particular). Using this information, a list has been developed (see the Operational Plan) of measures which would be likely to effectively meet the objectives of the COVID-19 Plan in the absence of detailed knowledge of the disease.

As all outbreaks are different, at the time of implementation, the appropriateness of these recommended measures should be examined in the light of what is known of the current novel coronavirus, the vulnerability of the Australian population (particularly at-risk groups), and current resource constraints. To support and maintain health system capacity, consideration of measures to protect the healthcare workforce will be of key importance.

#### **5.1.1.1 *Proportionate response: Initial measures***

When initial measures are commenced, the likely lack of information about the disease will make it difficult to predict the level of impact. Evidence from overseas will give some indication, however this will not take into account the Australian context, and international reports of epidemiology, clinical severity and virology of the disease from overseas may be unreliable.

As the potential consequences of initially implementing measures aimed too low are more significant, the initial measures recommended below should be implemented at a level appropriate for a disease of moderately high impact. Measures will then be scaled up or down as more information becomes known. By reviewing measures regularly and early the consequences of aiming too high will be mitigated.

The risk of aiming at novel coronavirus outbreak of low impact and needing to scale up is that:

- the opportunity to manage the spread of the disease is lost; and
- death or severe morbidity (especially in at-risk groups) may be greater (as measures to reduce transmission, reduce clinical severity and raise awareness of symptoms by healthcare workers and the general public have not been fully employed).

The risk of aiming at a novel coronavirus outbreak of high impact and needing to scale down is that:

- resources may be wasted (used without much gain, or diverted to pandemic activities where they could have been better used elsewhere);
- undue stress and concern may be imposed on Healthcare workers and the community; and
- perception of having over-reacted may make stakeholders less willing to participate in future.

Activities which could be considered for the Initial Action Stage are outlined in the Operational Plan at Part 2 of the COVID-19 Plan.

#### **5.1.1.2 *Novel Coronavirus Vaccination***

Vaccination is an effective way to prevent infection with respiratory viruses such as influenza. However, with a novel coronavirus there is no vaccine currently available. As yet, there is also still no vaccine available for SARS or MERS. It is unlikely that a vaccine will be available during the course of a novel coronavirus pandemic, unless the pandemic is long lasting and vaccine development is extraordinarily fast. Developments in this area will be closely watched.

### **5.1.2 Targeted Action stage**

The Targeted Action stage will commence when there is sufficient information collected during the Initial Action stage to inform refinement of the novel coronavirus outbreak response measures already implemented. Measures will be regularly reviewed as more information becomes available.

Data on the clinical severity, transmissibility, epidemiology and antiviral resistance pattern (if antivirals are available) of the virus will inform decisions on effective and proportionate novel coronavirus outbreak response measures. CDNA/PHLN will provide advice to AHPPC on which individual measures should be:

- continued;
- modified (including scaled up or down); or
- wound down and ceased.

CDNA/PHLN will also provide a recommendation of any new measures which should be commenced. Where measures are to be ceased, an exit strategy will be included.

Targeted measures will focus on:

- ensuring a **proportionate response**;
- supporting and maintaining **quality care**;
- communications to **engage, empower and build confidence in the community**; and
- providing a **coordinated and consistent approach**.

The flexible approach of the COVID-19 Plan means Targeted Action measures need not be adopted by all jurisdictions concurrently. Similarly, measures may be implemented differently within different geographic regions of jurisdictions. Each jurisdiction will consider the recommendations made by CDNA/PHLN and select measures which meet their own requirements, reflecting the differing progress of the novel coronavirus outbreak, resource parameters and community needs in their jurisdiction.

As the outbreak becomes more widespread and the demands on resources increase, close tailoring of the selection of response measures to current needs and regular review of their effectiveness in contributing to the strategic objectives will be essential to promote the efficient use of available resources. Measures that fail to demonstrate this will be ceased.

Assessments of effectiveness will be based on available research, and on feedback from health sector stakeholders and the public. Review will be considered at key milestones, or as indicated by feedback received.

**Identification measures** will move to collecting core data from established surveillance systems in order to detect any changes in the epidemiology of those getting sick, the clinical severity of the disease or characteristics of the virus. Jurisdictions will continue to collect enhanced data and monitor for outbreaks in new settings.

**Communication measures** will continue to be important, following the same approach as outlined in the Initial Action section above. Key messages should be timely and consistent and reviewed regularly to ensure they reflect current information about the response, the disease itself and recommended management strategies (both for responders and the public).

Activities which could be considered for the Targeted Action Stage are outlined in the Operational Plan at Part 2 of the COVID-19 Plan.

#### **5.1.2.1 Proportionate response: Targeted measures**

Regularly **reviewing** measures **and tailoring** their use during this stage as more becomes known about the disease in the Australian context will allow measures to be adjusted to be more **appropriate to the level of risk**. It will also be possible and important to better tailor measures to the specific needs of our most vulnerable populations.

As Initial measures are aimed at responding to a novel coronavirus outbreak with a moderately high impact level, tailoring of measures in the Targeted Action stage is likely to involve scaling back.

### **5.1.3 Standdown Stage**

Individual activities will be regularly assessed and stood down when they no longer contribute to the COVID-19 Plan's goals. The **trigger** for the COVID-19 Plan as a whole to move into the Standdown stage will occur when advice from CDNA indicates that the outbreak has reached a level where it can be managed under normal business arrangements. As the risk and impact experienced will not be homogenous across Australia enhanced activities may need to continue longer with some vulnerable populations.

Standdown activities will focus on:

- supporting and maintaining **quality care**;
- **ceasing** activities that are no longer needed, and **transitioning** activities to normal business or interim arrangements;
- monitoring for a **second wave** of the outbreak;
- monitoring for the **development of resistance** to any pharmaceutical measures, if any are being used;
- communication activities to support the **return** from emergency response **to normal** business services; and
- **evaluating** systems and **revising** plans and procedures.

Enhanced arrangements place an additional burden on health systems and individuals and should be scaled back when no longer necessary. The purpose of the Standdown stage will be to manage the smooth withdrawal of enhanced arrangements and transition to seasonal systems and procedures.

Communication measures will be important to:

- reassure stakeholders that they will still have access to the support they need;
- shape awareness of the possibility of further outbreaks and the continuity into the following two to three years of seasonal influenza; and
- ensure that the public understand the virus is still circulating and that they therefore need to continue to be aware of measures to protect themselves at an individual level.

The evaluation of the response, and updating of/adaptation of systems, which is part of this stage ensures that as much as possible, the lessons from the pandemic can be applied to future outbreaks. As subsequent waves of the outbreak may occur, rapid implementation of evaluation processes is essential to preparedness.

It is likely that the health sector will continue to require support to enable services to “catch up”. The community may also require additional services to enable full psychological, social, economic, environmental and physical recovery from the effects of the novel coronavirus outbreak. At-risk groups may need additional support.

At some point the Department of Health will advise AHPPC that all enhanced measures have been transitioned to normal business arrangements. While acknowledging that Recovery activities will be taking place within the health sector, this will be the trigger for AHPPC to consider de-escalating the COVID-19 Plan to preparedness and monitoring activities, which will be ongoing until there is again a need to respond to a novel coronavirus outbreak.

Activities which could be considered for the Standdown Stage are outlined in the Operational Plan at Part 2 of the COVID-19 Plan.

## 5.2 Recovery activities

Wherever possible during the novel coronavirus outbreak, response activities will be selected and implemented in a manner most likely to promote robust recovery. Some communities and systems may be able to commence **Recovery** activities sooner than others.

The primary responsibility for managing the recovery process within the health sector will rest with state and territory governments. National coordination and support required during this stage will occur through existing emergency management channels.

The Australian Government Disaster Recovery Committee, chaired by the Department of Home Affairs will coordinate **Recovery** efforts at a whole of government level if required. Governments will work together with affected individuals, community groups and industry to restore services and community wellbeing.

### 5.3 Resilience

Building preparedness within Australia's health systems will contribute to the resilience and sustainability of our systems. The resilience of individuals will be promoted by empowering them to manage their own exposure to the disease through public messaging about:

- the status of the disease in Australia and internationally;
- hygiene and cough/sneeze etiquette;
- disease transmission;
- understanding of how to recognise the signs and symptoms of the disease and when to seek medical assistance; and
- access to support and advice, including mental health services.

To build resilience within our most vulnerable populations, communications within the health sector will be used to raise awareness of at-risk groups and their associated needs. Measures will also be implemented with consideration of necessary adaptations to meet the needs of these individuals and communities. The needs and challenges of communicating with low socio-economic communities, which may have reduced access to healthcare, will also be considered.

## 6. Communications

This chapter provides a guide to communication activities across stakeholders.

A comprehensive communications strategy, implemented across all stages of the outbreak, is a key component of a successful response to a novel coronavirus outbreak. As the presentation of a novel coronavirus outbreak in Australia will inevitably be complex and varied it will be a priority to put in place arrangements to support a consistent, informative message. The communications strategy described in this chapter is designed to reach the broad range of stakeholders involved in and affected by an outbreak, from health authorities and the medical profession, to the public and the media.

Sharing information between those managing the response will enable the coordination of resources, better inform decision makers and provide access to expert guidance on the application of response measures.

Communication with the public, through the media and other sources, will shape the public perception of risk and the way in which the public is engaged in measures to address the novel coronavirus outbreak.

### 6.1 Key principles:

The following key principles will be applied across all our communication activities:

- openness and transparency;
- accurate risk communication, including where there is uncertainty;
- communications as a two-way process;
- use of existing communication channels and protocols, where possible;
- consistent, clear messages;
- regular, timely provision of tailored information;
- early release of public messages;
- timely response to queries;
- use of social media where appropriate;
- use of specific communication methods to facilitate communication with vulnerable populations;
- flexible selection of methods appropriate to the situation at the time; and
- use of a wide range of communication methods to reach a broad audience.

It should be noted that, while this chapter makes reference to communication activities in different stages of the outbreak response, it is the goal of the COVID-19 Plan to maintain and enhance flexibility. Items from different stages may therefore be used concurrently or non-sequentially as their purpose demands.

### 6.2 Information gathering

Information about novel viruses in Australia and in other countries is collected routinely every year by the Australian Government and State and Territory Governments. Sources of such information may include seasonal influenza surveillance systems, Australian embassies, other governments, Australian international disease experts and the WHO, which provides information about novel viruses, or other viruses with pandemic potential, through communication systems such as the WHO Event Information Site.

As agreed under the IHR, Australia reports to the WHO any event of potential international public health concern, including specifically if there is novel coronavirus outbreak within Australia.

The information gathered from these sources is used to advise Australians who may be travelling abroad, those considering overseas travel, and to inform surveillance and control of the disease in Australia. Disease information will also be shared with stakeholders.

During the novel coronavirus outbreak, information will be gathered about the health sector itself, such as current health service capacity; whether the management of acutely unwell people with novel coronavirus has meant that other routine services have been ceased temporarily; and absenteeism among HCWs and/or support staff due to illness, caring for family or fear of infection, where possible. The information gathered will be critical to informing decisions about novel coronavirus outbreak response measures and for prioritising health services locally and at the state and national levels.

### 6.3 Sharing information between those involved in managing the response

**Audience:** This section is aimed at communication between Australian Government agencies, state and territory government agencies and other key stakeholders involved in providing a health sector response to a novel coronavirus outbreak.

**Purpose:** To support coordination of resources, better inform decision makers and provide access to expert guidance on the application of response measures.

**Aims:**

**Action (Initial & Targeted):**

- build awareness across the health sector of the most up-to-date and accurate information about the disease, to support effective diagnosis and treatment, and better informed management decisions;
- promote a consistent approach by ensuring all key parties have the same information, though recognising that disease spread may be variable across the country;
- support best practice by disseminating guidance in key areas developed by expert bodies, such as CDNA/PHLN;
- share effective strategies, avoiding the need for them to be developed separately by all parties;
- input feedback on the effectiveness of treatment options, side effects and other clinical/ public health information into decision making processes to support refining the approach;
- input feedback on how well the health care system is coping; and
- maintain trust and confidence.

**Standdown**

- continue to support awareness of the most up-to-date and accurate information about the disease, to support more effective diagnosis and treatment, and better informed management decisions; and
- clarify arrangements for transitioning to normal business.

#### 6.3.1 Challenges:

- Sharing information in a timely manner;
- Ensuring people are getting access to the information they need;
- Ensuring a consistent message across media and authorities;
- Consistent messaging within a flexible response where the response strategies are at different stages across the country;
- Communication of initial decisions even though information about the virus may be sparse and/or unreliable;
- Communication of the uncertainty of what the impact of the novel coronavirus outbreak will be;



- Initial information may be based on the behaviour of the disease in another country and not 100% relevant to the Australian context;
- Making sense of feedback, consolidating this and incorporating it into messaging; and
- Managing stakeholder expectations of when and how to receive information.

### **6.3.2 Australian Government and state and territory governments**

The Australian Government and state and territory governments will share information, via existing channels, about:

- the situation overseas;
- advice from international bodies, such as the WHO;
- the status and impact of the novel coronavirus outbreak in Australia;
- the epidemiology, severity and virology of the disease; the implementation and impact of measures to manage the response to the novel coronavirus outbreak; and
- deployment of the NMS.

Communication between Australian Government agencies relevant to the response will be coordinated by the Department of Health. Communication between relevant state and territory government agencies will be coordinated by state and territory health departments.

Cross government linkages are also supported by representation on the NCC, which would be convened by the Australian Government in the event of a major communicable disease outbreak.

Specific information on the status of the outbreak and key response documents will be posted on the [Department of Health homepage \(www.health.gov.au\)](http://www.health.gov.au).

### **6.3.3 National Incident Room**

The Department of Health's NIR provides a point of communication with the Australian Government for health incidents.

During the Initial Action, Targeted Action and Standdown stages the NIR will provide timely situation reports to relevant Australian Government agencies, state and territory health authorities and other relevant stakeholders.

### **6.3.4 Other key health stakeholders (healthcare workers, health and social service providers)**

Healthcare workers and providers need access to timely, accurate and comprehensive clinical information and advice in order to effectively manage patients; implement novel coronavirus outbreak control measures and minimise their own risk of exposure. Such advice will be provided by CDNA and other clinical groups as appropriate and endorsed by AHPPC.

National communication with healthcare workers will primarily be through existing channels via their relevant peak body. Peak body websites will be particularly important vehicles for disseminating information. Additionally, S/T HD will consolidate communication with healthcare workers and providers (both government and non-government, such as private hospitals) and include state and local level information via their own communication channels. Communication may either target clinical and/or administrative aspects of health services, according to the nature of the information to be delivered.

Novel coronavirus outbreak planning support and advice is available for GPs and other primary health care providers in fact sheets available on the Department of Health website.

Information from health service providers to the Department of Health and S/T HD about the impact of the novel coronavirus outbreak on their service capacity is essential to inform pandemic response decision making. These perceptions and experiences will be input into decision-making processes via surveys, consultation with peak bodies and broader consultative forums.

## 6.4 Public communications

**Audience:** This section considers communication by governments with the general public, businesses, the non-government sector, industry groups, and a range of other relevant stakeholders and audiences.

**Purpose:** To provide information to the public to inform their understanding of the risk, engage them effectively in public health measures and guide their own management of their exposure to risk.

As the key communication channels to the public are via television, radio, print, online and social media outlets, effective media engagement strategies will be required to ensure the key public messages are conveyed to the public.

### **Aims:**

#### **Initial & Targeted Action:**

- Build and maintain public trust and support by providing consistent, clear, informative public messaging;
- Ensure messages include: this is what we know; this is what we don't know; this is what we are doing; and this is what you can do;
- Encourage behaviours and attitudes that will contribute positively to reducing the spread of disease and minimise the psychological, social and economic impacts including assisting others (neighbours, family, friends etc.);
- Manage the disease threat by increasing uptake of recommended actions;
- Build public confidence by keeping people informed of the current situation and what is being done to address the impact of the outbreak and through transparency around resourcing and success of interventions; and
- Empower individuals by increasing their understanding of the seriousness of the disease; knowledge of what to do to avoid/minimise exposure; ability to recognise symptoms and knowledge of what to do if symptoms present.
- Ensure individuals, communities and specific stakeholders understand the reasons why interventions might be modified and tailored to best meet the needs of the situation and/or specific population groups;
- Support essential services; and
- Provide information to at-risk groups.

#### **Standdown:**

- Support transition to business as usual services; and
- Shape expectations of services and circumstances, such as the possibility of further outbreaks.

### **6.4.1 Challenges**

- Public concern may be high;
- Scientific knowledge will be limited at the beginning of the novel coronavirus outbreak;
- Uncertainty will be high;
- Balancing early release of public messages with accuracy of information;
- Balancing public release of information with privacy/confidentiality for those involved;
- Accurate communication of risk in a situation of uncertainty that is rapidly changing;
- Consistent messaging within a flexible response where the response strategies are at different stages across the country;
- Coordination and consistency of messaging where there are multiple spokespeople;
- Ensuring two-way communication;
- Meeting media requests in time to meet the needs of 24 hour news media; and
- Media outlets are commercial agencies and their prime purpose is not necessarily to provide consistent public health information.

Public communication provides an opportunity both to address any public concern caused by the pandemic and to engage the public in strategies to manage the impact of the disease. The dissemination of up to date, consistent and accurate information about the status of the disease outbreak overseas and in Australia can help people understand the real risk and make more informed decisions about work and travel, taking up health recommendations and planning for people in at-risk groups. Information about the implementation of activities and arrangements can build public confidence in the capacity of health services to manage the response.

Providing the public with information about the nature of the disease can empower individuals to take steps to reduce the risk to themselves and their families. This will both alleviate concern and lead to more appropriate use of recommended measures. Increasing rapid presentation of appropriate cases to a medical practitioner will lead to reduced morbidity and mortality. Reducing presentation of the 'worried well' will decrease the burden on health systems. Information gathered from the public about concerns, issues with measures and information gaps is also important to inform decision-making.

To take steps to manage their risk during a novel coronavirus outbreak, people will need to:

- Understand the seriousness of the disease;
- Know what to do to avoid/minimise exposure;
- Recognise symptoms; and
- Know what to do if symptoms present.

#### **6.4.2 Coordination: Developing a consistent message**

A wide range of information will be available to the public should a novel coronavirus outbreak occur. The Australian Government and State and Territory Governments will have to position themselves as authoritative sources from very early on in the outbreak. Enlisting the cooperation of key spokespeople in the non-government sector (e.g. university academics, the Australian Medical Association) will be important for building confidence in the response strategies.

A number of coordination mechanisms have been put in place to ensure consistency of public messaging. Guidelines and processes for the coordination of public information representing broad whole of government issues are outlined in the National CD Plan.

Key health sector novel coronavirus outbreak messages and advice regarding requirements for changes of communication strategies to reflect the progress of the outbreak will primarily be determined by AHPPC. AHPPC will develop these messages using recommendations from CDNA, PHLN and other advisory bodies.

The Department of Health will work closely with S/T HD Communication and Media Units; relevant Australian Government agencies, national medical colleges and associations, the National Aboriginal Community Controlled Health Organisation (NACCHO) and select parts of the private sector directly involved in emergency health management. It is coordinated by the Communication Branch of the Department of Health. Its role is to keep the public and the media informed during national health emergencies by providing consistent and coordinated media and public responses.

Communication regarding issues outside the health sector, such as school closures, will be managed by the NCC.

The Media Unit within the NIR will be a contact point for coordination with states and territories. Coordination of public communications within jurisdictions will be in accordance with jurisdictional arrangements.

Media communication regarding the Australian Government activities related to management of the novel coronavirus outbreak will be coordinated by the Department of Health Communication Branch, which will work with relevant Australian Government agencies to ensure a consistent, whole of government message.

### 6.4.3 Media engagement strategies

The media will be the main source of information for the public during a novel coronavirus outbreak. Building strong relationships with media contacts is essential to foster positive representation of response efforts and accurate relay of public health messages.

Media contacts will be notified early in the novel coronavirus outbreak of a media enquiry phone number managed by the NIR Media Unit, which will be available 24 hours a day, seven days a week. A shared email address will be established for quick response to media enquiries.

Key media engagement strategies that will be used in the various stages of the novel coronavirus outbreak may include:

- during the Initial Action and Targeted Action stages:
  - regularly update the [Department of Health homepage](http://www.health.gov.au) (www.health.gov.au) with situational information, important health messages, updates of case numbers and deaths, media alerts, media releases, transcripts of media interviews, streaming of commercials, print resources, communications materials, questions and answers, information on relevant social media links etc.;
  - use the Department of Health's existing social media accounts (Facebook, Twitter and YouTube) to provide up to date notifications on health emergency media opportunities and novel coronavirus outbreak information;
  - make available appropriate spokespeople for media interview;
  - develop and disseminate via the Internet pre-recorded broadcast quality radio and TV grabs using existing media release audio mailbox;
  - apply similar strategies within S/T HD;
  - procure a creative agency;
  - activate a media campaign targeting people affected and at high risk of infection with information on appropriate hygiene practices and prevention from contracting the disease;
  - paid advertising, including television, radio, print, out of home (GP clinics, transit media and shopping centres), and social/digital search (e.g. could consider a national QR code);
  - develop content for placement in community service radio (including ABC radio), in-flight announcements, airports, boarding passes, taxis and digital screens;
  - Consider communications through airline phone apps and any relevant health apps;
  - Television announcement banner alerts;
  - Partnership with radio stations (e.g. ABC Radio);
  - Updated information for travellers on the Smart Traveller website;
  - Information for ED and GP waiting room television screens;
  - Regular videos from the CMO or relevant health officials to be provided to media outlets which will be addressing things that arise, the use of masks, good hygiene and specifics for health professionals; and
  - Develop an online toolkit for S/T HD to access key resources (e.g. social media tiles, factsheets etc.); and
  - Key messages communicated to border agencies and airports/ airlines/ seaports/ shipping and cruise lines.
- during stand down, provide advice to the media of the transition to normal media engagement arrangements.

To promote presentation of a consistent message between government statements and media commentary, information will be made available regularly to the media from government sources both at regular predictable intervals and upon request. Information tailored to key audiences will also be produced where priority needs are identified.

#### **6.4.4 Spokespeople**

A range of spokespeople will be available during the response to the outbreak, including all Health Ministers, the CMO, Chief Health Officers, media unit representatives and spokespeople identified at the local level.

The relevant spokesperson will depend on the stage of the novel coronavirus outbreak and the aim of communications. When the focus of the message is related to events and activities in a specific jurisdiction, the spokesperson will be determined by that state/territory. When content is confined to Australian Government activities, the spokesperson will be identified by the NIR Media Unit. Where key groups are to be targeted, peak and representational bodies will be consulted, for example, NACCHO will assist in nominating appropriate spokespeople for Aboriginal and Torres Strait Islander communities.

Under the AGCMF, the Prime Minister may assume primary responsibility for leading the Government's response, including acting as primary Government spokesperson. Under these circumstances, the Prime Minister is also likely to consult with the leaders of affected states and territories to ensure a coordinated national response.

#### **6.4.5 Ensuring two way communication**

It is essential that public awareness and attitudes be monitored to inform refinement of public messaging. This is critical to achieving the right balance between motivating risk-mitigating behaviours by raising public awareness of potential risks, and reassurance that the situation is under control. It may be that different groups within the community are at opposite ends of this spectrum, and messages may then have to be targeted appropriately to manage this. Listening to the public also helps to identify community concerns, information gaps and misconceptions or misinformation, which can then be addressed within public communications. Communication with at-risk groups, such as Aboriginal and Torres Strait Islander or aged care communities, is particularly important to tailor measures to the needs of people with greater vulnerability.

Methods to gauge public awareness and attitudes that may be used include:

- market research on knowledge and attitudes to a novel coronavirus outbreak threat;
- comprehensive market research undertaken by the Department of Health at the outset and throughout the novel coronavirus outbreak;
- feedback from peak bodies via usual communication channels, such as the GP Roundtable, Clinical Stakeholders Forum, Aged Care providers' peak bodies, Primary Health Networks and NACCHO;
- monitoring of media sites by Media Units in NIR and S/T HD;
- monitoring of social media, including large, open social media sites;
- use of social media or an interactive health emergency website where members of the public can share content, comment and ask questions which will be answered online, based on an agreed "question and answer" formula; and
- feedback from a wide range of stakeholders regarding the impact and effectiveness of the pandemic response measures that have been undertaken obtained by the Department of Health and S/T HD.

#### **6.4.6 Other communication methods**

Information tailored to key audiences will be produced where priority needs are identified. Dissemination of this information will also be tailored to the specific audience, e.g. use of specialised Aboriginal and Torres Strait Islander media outlets to communicate key messages targeting people in remote Aboriginal and Torres Strait Islander communities.

Paid advertising may be used, particularly if there is a need to rapidly mobilise the community, such as for novel coronavirus outbreak vaccination.

Print resources which can be distributed directly to stakeholders who interact with the public will also be used widely, including information for patients from HCWs; information for families distributed via schools; information for travellers made available at travel agencies and airports; information distributed through organisations associated with mass travel for specific purposes such as international sporting events and religious gatherings etc. Printed and electronic information may also be displayed at targeted places such as GP clinics, travel agencies and airports. Materials can also be made readily available for responders and the public at a centralised web location e.g. Australian Government and S/T HD websites.

Social media messages can be used to deliver key messages (e.g. disease information, behaviours to be promoted, situation changes) in a timely manner to responders and the public. Social media messages can be updated on a regular basis to ensure currency of information. The use of existing social media trending tags may be considered to maximise the reach of social media messages.

The Department of Health and the Australian Government Department of Foreign Affairs and Trade will work together to provide information for Australians considering overseas travel and for Australians overseas when considering whether to return home.

HCWs play an important role in explaining and reassuring their clients about the novel coronavirus outbreak. Information provided to HCWs will include key messages for the public as well as provide greater detail about the rationale behind outbreak decisions to enable HCWs to appropriately counsel their clients.

#### **6.4.7 Supporting at-risk groups**

Communication will also be tailored to meet the needs ranging across our community, particularly those with a higher risk of complications from the disease. Support for mental health needs of vulnerable individuals and the community as a whole will also be considered. As important as tailoring of messages will be careful selection of channels of communication to ensure that messages are reaching as many groups across the population as possible. Engaging and supporting community leaders in relevant target groups will be a key strategy to promote implementation of desired practices and involvement in public health measures.

In the aged care sector the Department of Health will work closely with aged care providers. Aboriginal Medical Services and other services for Aboriginal and Torres Strait Islander peoples will support the needs of this vulnerable group. An Aboriginal and Torres Strait Islander clinical advisory group will be brought together and used to support communications to the Aboriginal and Torres Strait Islander community and to provide an avenue for feedback to inform decision making processes. The need for provision of advice in other languages, at the border, and domestically will also be considered. As infants are also likely to be a high risk group and a vector of disease, coordination with child care facilities is also important. Community outreach services, such as non-government organisations and churches will be used to support communication with vulnerable people who may not have access to mainstream health services.

# PART 2

## Operational Plan

This Operational Plan has been adapted from the AHMPPI Operational Plan. Though an influenza pandemic plan, the detailed guidance in the AHMPPI is used regularly as the basis for Australia's broader communicable disease planning. It is particularly relevant for respiratory disease outbreaks, such as the novel coronavirus and preliminary consultation supports that it remains broadly applicable.

The considerable investment in pandemic preparedness in the AHMPPI benefits from studies and mathematical modelling conducted on influenza and Sudden Acute Respiratory Syndrome (SARS), another coronavirus. Although the novel coronavirus is behaving differently in some ways to both influenza and SARS, the principles behind the response measures used to manage the response to the SARS outbreak and pandemic influenza are useful to inform this response.

The objective of the Operational Plan is to provide additional detail to support the implementation of activities under the COVID-19 Plan at an operational level. It can be used by planners prior to or during an outbreak as an operational checklist of activities that could be considered for implementation.

Across all activities the **Strategic Objectives** of this response will be to:

- Identifying and characterising the nature of the virus and the disease in the Australian context;
- Minimise transmissibility, morbidity and mortality;
- Minimise the burden on/ support health systems; and
- Inform, engage and empower the public.

## Initial action stage

Initial activities will focus on:

- **minimising transmission;**
- **preparing and supporting health system needs;**
- **managing initial cases;**
- **identifying** and characterising the nature of the virus and the disease within the Australian context;
- providing **information to support best practice health care** and to **empower the community and responders** to manage their own risk of exposure;
- **border measures;** and
- **supporting effective governance.**

In the Initial Action stage, the following measures could be considered for implementation:

### *Minimising transmission*

<b>Minimising transmission through:</b>	<ul style="list-style-type: none"> <li>• Border measures (see below);</li> <li>• Isolation of confirmed cases;</li> <li>• Quarantine of close contacts and suspected cases;</li> <li>• Case and contact management; and</li> <li>• Quarantine of repatriated nationals and approved foreign nationals upon arrival into Australia.</li> </ul>
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### *Preparing and supporting initial Health System needs & managing initial cases*

<b>Resources (HR &amp; stockpile)</b>	<ul style="list-style-type: none"> <li>• Provide PPE, as appropriate (healthcare workers/ border workers);</li> <li>• Organise delivery to points of use (states and territories);</li> <li>• Consider prioritisation of resources;</li> <li>• Maintain the NIR (staff, equipment, management systems);</li> <li>• Deploy stockpile items from storage sites to State and Territory delivery sites ready for use;</li> <li>• Monitor health system capacity;</li> <li>• Health system to prepare for potential need to engage surge staff.</li> <li>• Consider needs for additional support to health systems in remote communities;</li> <li>• Maintain essential health system activities.</li> </ul>
<b>Clinical care &amp; public health management</b>	<ul style="list-style-type: none"> <li>• Manage cases and contacts;</li> <li>• Encourage voluntary isolation of cases and quarantine of close contacts and suspected cases;</li> <li>• Monitor and support needs of at risk groups (when identified);</li> <li>• Encourage advance planning directives of aged care providers and residents;</li> <li>• Health system to prepare for potential need to engage surge staff;</li> <li>• Consider strategies to reduce routine hospital demand such as different models of healthcare provision;</li> <li>• Develop and disseminate triage algorithm;</li> <li>• Develop cohort strategy.</li> </ul>
<b>Clinical care &amp; public health management (cont.)</b>	<ul style="list-style-type: none"> <li>• Support outbreak investigation and management in residential care facilities, schools, prisons and other institutions;</li> <li>• Consider the need to implement alternative models of care to</li> </ul>



	minimise the burden on the health system for example, fever clinics.
<b>Infection control</b>	<ul style="list-style-type: none"> <li>• Confirm with responders the application of standard infection control strategies (or provide alternate advice if appropriate);</li> <li>• Provide advice to the public on respiratory hygiene and hand-washing.</li> </ul>

### *Identification*

<b>Surveillance</b>	<ul style="list-style-type: none"> <li>• Identify and describe the epidemiology, clinical severity and virology of the disease in Australia through enhanced surveillance of confirmed cases.</li> <li>• Conduct contact tracing (where need is identified);</li> <li>• Develop and refine case definitions as needed;</li> <li>• Confirm identification of at risk groups;</li> <li>• Analyse and report Australian and major trends in international data;</li> <li>• Maintain case notification system;</li> <li>• Activate academic studies using enhanced data to test assumptions; and</li> <li>• Monitor sustainability of surveillance systems.</li> </ul>
<b>Laboratory Capacity</b>	<ul style="list-style-type: none"> <li>• Isolate the virus;</li> <li>• Undertake laboratory testing as required to monitor the outbreak and for individual patient care;</li> <li>• Implement testing protocols to support case management, surveillance needs and to preserve laboratory capacity;</li> <li>• Maintain laboratory capacity/capability to detect/test for novel virus; and</li> <li>• Undertake specialist characterisation and genomic sequencing of the virus to understand its evolution and enable studies on antiviral susceptibility and vaccine development to occur.</li> </ul>

### *Communications*

Information should be provided as early as possible and acknowledge any associated uncertainty.

<b>Sharing information between responders</b>	<ul style="list-style-type: none"> <li>• Provide public health management guidance (e.g. Series of National Guidelines);</li> <li>• Provide clinical health management guidance (primary care and hospital based);</li> <li>• Share information on the status of disease spread and the current response;</li> <li>• Raise awareness of at risk groups (when identified);</li> <li>• provide any information to WHO required under International Health Regulations (IHR) reporting arrangements; and</li> <li>• Liaise with other international counterparts.</li> </ul>
<b>Public Communications</b>	<ul style="list-style-type: none"> <li>• Coordinate Whole-of-Government messaging to provide information on the status of disease spread and the current response.</li> <li>• Provide specific information for groups at risk or with specific needs when identified.(e.g. culturally and linguistically diverse (CALD),</li> </ul>

	<p>aged care or Aboriginal and Torres Strait Islander people, schools, suspected cases, universities and vocational education training sector, hospitality and tourism industry, employers, airline and air/seaport, health professionals).</p> <ul style="list-style-type: none"> <li>• Monitor feedback and refine communications to address issues and concerns identified;</li> <li>• Provide media with access to daily updates on the status of disease spread and the current response;</li> <li>• Provide access to background information.</li> <li>• Make spokespeople available;</li> <li>• Respond to media requests;</li> <li>• Provide advice on: <ul style="list-style-type: none"> <li>○ respiratory hygiene and hand-washing;</li> <li>○ mask wearing (if appropriate);</li> <li>○ how to find out more information; and</li> </ul> </li> <li>• Hotline details.</li> </ul>
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### ***Border measures***

<b>Border measures</b>	<ul style="list-style-type: none"> <li>• Implement enhanced border measures, such as enhanced entry screening, non-automatic pratique, preventative biosecurity measures</li> </ul>
<b>Communications</b>	<ul style="list-style-type: none"> <li>• Provide information to travellers through <ul style="list-style-type: none"> <li>○ in-flight and on-arrival announcements</li> <li>○ fact sheets (incoming travellers, border workers, airlines, cruise industry)</li> <li>○ communication materials (e.g. printed and electronic media) at the border; and</li> <li>○ social media.</li> </ul> </li> <li>• Provide guidance for border workers, the airline and maritime industry on: <ul style="list-style-type: none"> <li>○ the disease and personal risk</li> <li>○ respiratory hygiene and hand-washing</li> <li>○ appropriate use of PPE while assessing ill travelers; and</li> <li>○ where to find more information.</li> </ul> </li> </ul>
<b>Traveller clearances</b>	<ul style="list-style-type: none"> <li>• Maintain requirements for customs, immigration and biosecurity clearances (including for Australian Defence Force Personnel);</li> <li>• Enhance for travellers identified as potentially higher risk.</li> </ul>

## Governance

<b>AHPPC</b>	<ul style="list-style-type: none"><li>• Coordinate allocation of national resources to support quality care and public health measures, as needed;</li><li>• Consider whether any social distancing or border measures should be implemented and advise NCC as appropriate;</li><li>• Support the repatriation of Australians from overseas, as required;</li><li>• Manage requests for exit screening; and</li><li>• Coordinate provision of Australian Medical Assistance Teams in response to requests for international assistance (if appropriate).</li></ul>
<b>Whole of government</b>	<ul style="list-style-type: none"><li>• Convene the NCC and other relevant expert committees as required; and</li><li>• Minister for Health assumes emergency powers under the <i>Biosecurity Act 2015</i>, if required to support pandemic response measures.</li></ul>
<b>Legislation</b>	<ul style="list-style-type: none"><li>• Declare a human biosecurity emergency under the <i>Biosecurity Act 2015</i>, if required to support pandemic response measures (Governor General); and</li><li>• Undertake any state based legislative processes required to support implementation of disease control measures.</li></ul>
<b>International obligations</b>	<ul style="list-style-type: none"><li>• Meet IHR reporting requirements.</li></ul>

## Targeted action stage

The Targeted Action stage of response will commence when there is sufficient information collected about the virus to inform the refinement of the outbreak response measures already implemented, such as the scaling down or ceasing of some measures. The key objective of the Targeted Action stage is ensuring a **proportionate response** to the outbreak, so scarce resources are properly allocated where most needed and that the risk to susceptible people in the community is mitigated.

The effectiveness and appropriateness of measures taken will be regularly reviewed by the Australian Government in consultation with key committees and stakeholders, as more information on the characteristics of the virus becomes available.

Targeted measures will focus on:

- ensuring a **proportionate response**;
- supporting and maintaining **quality care**;
- communications to **engage, empower and build confidence in the community**; and
- providing a **coordinated and consistent approach**.

Identification measures will move to collecting core data from established surveillance systems in order to detect any changes in the epidemiology of those getting sick, the clinical severity of the disease or characteristics of the virus. Jurisdictions will continue to collect enhanced data on up to 10 cases per week and for outbreaks in new settings, to preserve the sustainability of laboratory testing capacity and other surveillance resources.

Communication measures will continue to be important, following the same approach as outlined in the Initial Action stage. Key messages should continue to be reviewed regularly to ensure they reflect current information about the response, the disease itself and recommended management strategies (both for responders and the public).

In the Targeted Action stage, the following measures could be considered for implementation:

### *Ensuring proportionate response*

<b>Border measures</b>	<ul style="list-style-type: none"><li>• Regularly reassess border measures implemented during the Initial Action stage for countries deemed high risk, in consultation with key committees and stakeholders such as CHBOs and AHPPC.</li></ul>
<b>Minimising transmission</b>	<ul style="list-style-type: none"><li>• Supporting isolation of identified cases and quarantine of suspected cases and close contacts; and</li><li>• Ongoing case and contact management, as required.</li></ul>

### *Supporting and maintaining quality care*

<b>Resources (HR &amp; Stockpile)</b>	<ul style="list-style-type: none"><li>• Monitor health system capacity and establish triggers and thresholds for when capacity will be overwhelmed;</li><li>• Health services will implement surge staff arrangements as needed (and where possible);</li><li>• Health services will prioritise services to best meet demand for acute care;</li><li>• State and territory health departments will undertake urgent assessment and coordination of available specialist equipment based on outbreak predictions and geographic spread;</li><li>• Maintain the NIR (staff, equipment, management systems).</li></ul>
<b>Resources (HR &amp; Stockpile) (cont.)</b>	<ul style="list-style-type: none"><li>• Provide PPE and/or vaccines (if available) as appropriate to healthcare workers and other approved stakeholders as deemed</li></ul>

	<p>necessary;</p> <ul style="list-style-type: none"> <li>• Distribute items from the NMS;</li> <li>• Provide additional support to health systems in remote communities as needed (and where possible); and</li> <li>• Tailor measures to the needs of remote communities (including remote Aboriginal and Torres Strait Islander communities)<sup>1</sup>. This may include arrangements for additional healthcare workers.</li> </ul>
<b>Clinical care &amp; public health management</b>	<ul style="list-style-type: none"> <li>• Isolation of confirmed cases;</li> <li>• Encourage voluntary quarantine of close contacts and suspected cases;</li> <li>• Triage and cohort patients, as necessary;</li> <li>• Manage contacts as agreed by CDNA and AHPPC;</li> <li>• Support outbreak investigation and management in residential care facilities, schools, prisons and other institutions;</li> <li>• Consider using different strategies to treat mild cases where resources are overwhelmed;</li> <li>• New models of care may be instituted to manage novel coronavirus patients, for example: <ul style="list-style-type: none"> <li>○ innovative methods for contact tracing and diagnostic testing (call centres, at-home specimen collection etc.);</li> <li>○ home based care, which may require contingency community services support (potentially telephone support);</li> <li>○ fever clinics staffed predominantly by nurses via management protocols, with onsite or telephone medical support; and</li> </ul> </li> <li>• Adjustment of ICU staffing ratios and opening of new ICU beds or negative pressure rooms, where available.</li> </ul>
<b>Infection control</b>	<ul style="list-style-type: none"> <li>• Isolation of confirmed cases, and quarantine of repatriated nationals and approved foreign nationals as required;</li> <li>• Encourage voluntary quarantine of close contacts and suspected cases;</li> <li>• Continue application of agreed infection control strategies appropriate to increasing knowledge of transmissibility; and</li> <li>• Continue to provide advice to the public on respiratory hygiene and hand-washing.</li> </ul>

## Governance

<b>AHPPC</b>	<ul style="list-style-type: none"> <li>• Services in each jurisdiction will provide information on their capacity to State and Territory Chief Health Officers (CHOs) to</li> </ul>
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<sup>1</sup> Note: Great distances will present difficulties for transport of resources, personnel, patients and communications. Some remote health care services will already be challenged by poor health hardware and high rates of overcrowding. The additional burden of even a mild pandemic will stress capacity. In combination with higher rates of chronic illness these factors predispose people in these areas to more severe outcomes from influenza. Cultural and environmental differences will influence the effectiveness of certain measures, such as home quarantine. This remoteness may however give greater opportunities for effectively managing transmission into the community.

	<p>allow state level coordination. In turn, CHOs will report to AHPPC to enable national coordination and sharing/allocation of resources where needed and where possible;</p> <ul style="list-style-type: none"> <li>• AHPPC members will work together to coordinate the <b>availability of resources</b> and to develop strategies for alternate sources where needed;</li> <li>• Where possible, AHPPC members will work together to <b>ensure all needs are met</b> and a <b>consistent approach and message</b> is maintained;</li> <li>• Discussion and negotiation through CDNA and AHPPC will achieve coordination of measures and provide a vehicle through which jurisdictions can negotiate approaches and ensure that when different <b>strategies are operating across jurisdictions</b> they are still <b>supportive</b> of each other;</li> <li>• Consider whether any border or social distancing measures should be implemented and advise AGCC/NCC as appropriate; and</li> <li>• Continue supporting the repatriation of Australians from overseas, if required.</li> </ul>
<b>WoG</b>	<ul style="list-style-type: none"> <li>• Make recommendations through WoG channels when implementation of measures outside the health sector should be considered, such as school or workplace closures, or cancellation of mass gatherings.</li> </ul>
<b>International obligations</b>	<ul style="list-style-type: none"> <li>• Meet IHR reporting requirements.</li> </ul>

## Standdown stage

Individual activities will be regularly assessed and stood down when they no longer contribute to the COVID-19 Plan's goals of the outbreak response. The **trigger** for the COVID-19 Plan response as a whole to move into the Standdown stage will occur when advice from CDNA indicates that the novel coronavirus outbreak has reached a level where it can be managed under normal healthcare arrangements.

Standdown activities will focus on:

- supporting and maintaining **quality care**;
- **ceasing** activities that are no longer needed, and **transitioning** activities to normal business or interim arrangements;
- monitoring for a **second wave** of the outbreak;
- monitoring for the development of resistance to any pharmaceutical measures, if any are being used;
- communication activities to support the **return from emergency response to normal** business services; and
- **evaluating** systems and **revising** plans and procedures.

In the Standdown stage, the following measures could be considered for implementation:

### Communications

<b>Sharing information between responders</b>	<ul style="list-style-type: none"><li>• Advise of the commencement of transition to normal arrangements and how this will be managed;</li><li>• Thank responders for their engagement in the response;</li><li>• Acknowledge the <b>Recovery</b> efforts that will be occurring;</li><li>• Provide information about the review process; and</li><li>• (At the end of Standdown) notify stakeholders of the transition to ongoing vigilance to ensure we are well placed to respond in future.</li></ul>
<b>Public communications</b>	<ul style="list-style-type: none"><li>• Coordinate public messaging through media networks;</li><li>• Notify the public that services will transition to normal arrangements and the reason for this;</li><li>• Provide specific information for groups at high risk or with specific needs (e.g. CALD, aged care or Aboriginal and Torres Strait Islander peoples) about the transition of services;</li><li>• Thank the public for their engagement in the response;</li><li>• Provide information about the review process;</li><li>• (At the end of Standdown) notify of the transition to ongoing vigilance to ensure we are well placed to respond in future;</li><li>• Monitor feedback and refine communications to address issues and concerns identified;</li><li>• Provide the media with access to information regarding the change of the status of disease spread and the transition of the response;</li><li>• Make spokespeople available; and</li><li>• Respond to media requests.</li></ul>

### Supporting and maintaining quality care

<b>Resources (stockpile)</b>	<ul style="list-style-type: none"><li>• Assess the status of stockpiles and equipment (PPE and antivirals, if used);</li></ul>
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	<ul style="list-style-type: none"> <li>Review processes and policies;</li> <li>Replenish stocks as appropriate; and</li> <li>Update plans and protocols in line with lessons observed.</li> </ul>
<b>Resources (HR)</b>	<ul style="list-style-type: none"> <li>Implement interim arrangements if required; and</li> <li>Support any resources that are depleted, in order to meet remaining demand.</li> </ul>
<b>Clinical care and public health management</b>	<ul style="list-style-type: none"> <li>Implement interim arrangements if required;</li> <li>Transition triage and cohorting systems;</li> <li>Resume elective procedures (hospitals);</li> <li>Resume non-urgent work (primary and secondary care);</li> <li>Review processes and policies; and</li> <li>Update plans and protocols in line with lessons observed.</li> </ul>
<b>Legislation</b>	<ul style="list-style-type: none"> <li>Prepare and action any legislative instruments required to return legislative powers to normal.</li> </ul>

### *Identification*

<b>Surveillance</b>	<ul style="list-style-type: none"> <li>Monitor for a second wave or change in the virus;</li> <li>Continue academic studies and analysis of data from both enhanced and routine surveillance systems as necessary;</li> <li>Review processes and policies; and</li> <li>Update surveillance plans in line with lessons observed.</li> </ul>
<b>Laboratory capacity</b>	<ul style="list-style-type: none"> <li>Monitor for a second wave or change in the virus, including monitoring the genomic evolution of the virus;</li> <li>Review processes and policies; and</li> <li>Update plans and protocols in line with lessons observed.</li> </ul>

### *Border activities*

<b>Border measures</b>	<ul style="list-style-type: none"> <li>Stand down enhanced border measures and return to business as usual human biosecurity arrangements.</li> </ul>
<b>Communications</b>	<ul style="list-style-type: none"> <li>Update in-flight and airport announcements to reflect transition;</li> <li>Implement signage (such as crawlers on customs screens or posters) explaining transition;</li> <li>Update social media messages for travellers (if used);</li> <li>Review any disease-specific communication materials;</li> <li>Review processes; and</li> <li>Update plans and protocols in line with lessons observed.</li> </ul>
<b>Liaison</b>	<ul style="list-style-type: none"> <li>Advise airline/airport, seaport/shipping industries and border agencies of transition to normal business arrangements.</li> </ul>

### *Governance*

<b>AHPPC</b>	<ul style="list-style-type: none"> <li>Services in each jurisdiction will provide information on their capacity to State and Territory Government CHOs to allow state level coordination. In turn, CHOs will report to AHPPC to enable national coordination and sharing and allocation of resources where needed and where possible;</li> <li>Coordinate the <b>availability of resources</b> and develop strategies for alternate sources where specific areas are depleted;</li> </ul>
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	<ul style="list-style-type: none"> <li>• <b>Ensure a consistent message</b> is maintained;</li> <li>• Coordinate the transition to Standdown, as this may differ among jurisdictions;</li> <li>• Direct and participate in review processes; and</li> <li>• Consider updating plans and protocols.</li> </ul>
<b>Whole of Government</b>	<ul style="list-style-type: none"> <li>• Make recommendations through WoG channels where implementation of measures outside the health sector should be stood down, such as school or workplace closures and enhanced border measures; and</li> <li>• Participate in WoG review processes.</li> </ul>
<b>International obligations</b>	<ul style="list-style-type: none"> <li>• Meet IHR reporting requirements.</li> </ul>

# PART 3

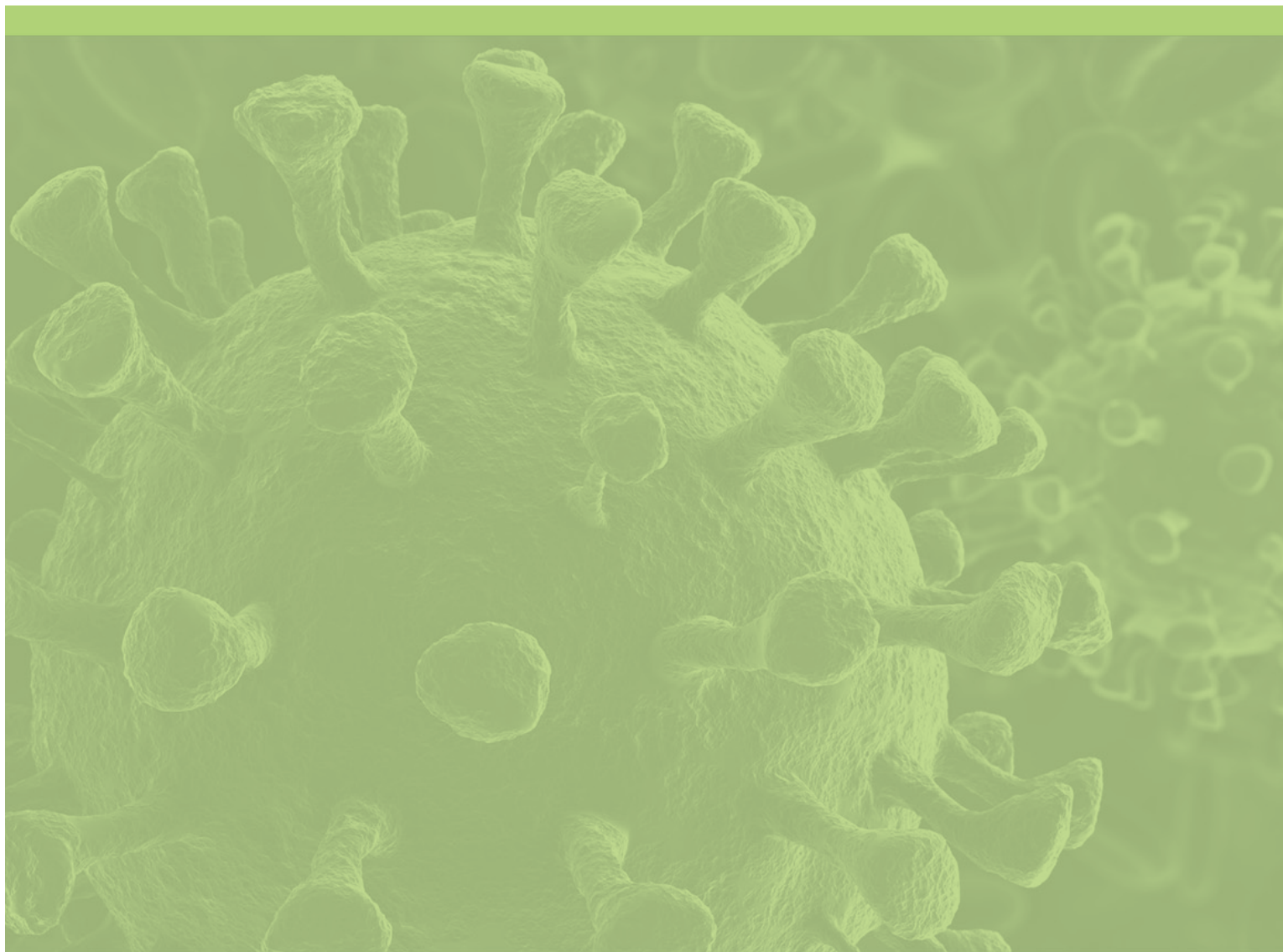
## Attachment A – Glossary

Term	Definition
<b>ACCHS</b>	Aboriginal Community Controlled Health Services. ACCHSs operate in the metropolitan, regional, rural and remote areas of all states and territories in Australia. ACCHSs are controlled by, and accountable to, Aboriginal people in those areas in which they operate. ACCHSs aim to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it.
<b>Acute Care</b>	Health services (usually hospitals) that provide care or treatment of people with short-term serious injury or illness. Medical conditions requiring acute care are typically periodic or temporary in nature, rather than long term.
<b>AGCC</b>	Australian Government Crisis Committee
<b>AGCMF</b>	Australian Government Crisis Management Framework
<b>Aged Care Peak Bodies</b>	Associations of groups or industries that advocate for and provide quality support, services, representation and policy development in the aged care sector.
<b>AHMPPI</b>	Australian Health Management Plan for Pandemic Influenza
<b>AHPPC</b>	Australian Health Protection Principal Committee
<b>At-Risk groups</b>	Groups at increased risk of experiencing complications from COVID-19.
<b>Australian Government</b>	The Federal Government of Australia
<b>CALD</b>	Culturally and linguistically diverse communities
<b>Case definition</b>	A set of uniform criteria used to define a disease for public health surveillance
<b>CDNA</b>	Communicable Diseases Network Australia
<b>CDPLAN</b>	Emergency Response Plan for Communicable Disease Incidents of National Significance
<b>CHBO</b>	Chief Human Biosecurity Officer
<b>CHC</b>	COAG Health Council
<b>CHO</b>	Chief Health Officer
<b>CMO</b>	Chief Medical Officer of Australia
<b>COAG</b>	Council of Australian Governments
<b>Commonwealth</b>	The governments of Australia – Australian Government and state and territory governments collectively
<b>Community transmission</b>	Community transmission is the passing of a disease

Term	Definition
	from an infected individual to another individual outside of a known group of contacts, and outside health care settings.
<b>Communicable</b>	Capable of spreading disease or a disease that is capable of spreading (also known as infectious).
<b>Contact tracing</b>	The process of identifying and managing people who have been 'in contact' with someone who has an infectious illness.
<b>Cough and sneeze etiquette</b>	Measures individuals can take when we cough, sneeze or blow our nose, to reduce the change of spreading the virus. This is sometimes referred to as respiratory hygiene.
<b>COVID-19</b>	<b>Coronavirus disease 2019.</b> An illness caused by the SARS-CoV-2 virus that was first identified in December 2019. Formerly known as 2019-nCoV.
<b>CSF</b>	Clinical Stakeholders Forum
<b>Department of Health</b>	Australian Government Department of Health
<b>DHB</b>	Director of Human Biosecurity (Australia's CMO)
<b>ECMO</b>	Extracorporeal membrane oxygenation
<b>Epidemic</b>	An outbreak or unusually high occurrence of a disease or illness in a population or area
<b>Fever clinic</b>	Fever clinics are specially planned facilities that will be set up during an outbreak for safe medical assessment and management of people with suspected COVID-19.
<b>GP</b>	General Practitioners
<b>GP Roundtable</b>	A consultative forum made up of GPs organised by the Department of Health.
<b>HCW</b>	Health Care Worker (defined as doctors, nurses, paramedics and other front line medical personnel)
<b>Health sector</b>	The health sector is government departments responsible for health, the public and private health system, in addition to the private and public health system, and health professionals.
<b>High Risk groups</b>	Groups at increased risk of experiencing complications from COVID-19.
<b>HR</b>	Human resources
<b>ICU</b>	Intensive Care Unit
<b>IHR</b>	<i>International Health Regulations 2005</i>
<b>Infectious</b>	Capable of spreading disease or a disease that is capable of spreading (also known as communicable).
<b>Isolation</b>	Separating people who are ill from those who are healthy to help stop the spread of an infectious/ communicable disease.

Term	Definition
<b>LHD</b>	Listed human disease. A disease which the DHB considers may be communicable and cause significant harm to health. LHDs are determined in the <i>Biosecurity (Listed Human Diseases) Determination 2016</i> , enabling a range of powers and measures to become available to manage the risk under the <i>Biosecurity Act 2015</i> .
<b>MERS</b>	Middle East respiratory syndrome. A viral respiratory illness caused by Middle East respiratory syndrome coronavirus (MERS-CoV).
<b>Morbidity</b>	State of disease. The term morbidity rate refers to the numbers of cases of illness in a population divided by the total population considered at risk of that illness.
<b>Mortality</b>	Mortality rate is the measure of the number of deaths (in general, or due to a specific cause) in a population scaled to the size of that population, per unit time.
<b>NACCHO</b>	National Aboriginal Community Controlled Health Organisations
<b>National</b>	The Australian Government, and State and Territory governments
<b>National CD Plan</b>	Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements
<b>National Surveillance Committee</b>	A standing committee under CDNA.
<b>NCC</b>	National Crisis Committee
<b>NFP</b>	The area or areas within the Department of Health, designated under the Act, as the IHR National Focal Point to liaise with and facilitate actions by national and international bodies to prevent, protect against, control and respond to a Public Health Event of National Significance or a Public Health Emergency of International Concern.
<b>NHS Act</b>	<i>National Health Security Act 2007</i>
<b>NIR</b>	Department of Health National Incident Room
<b>NMS</b>	The National Medical Stockpile. Administered by the Department of Health.
<b>NNDSS</b>	National Notifiable Diseases Surveillance System
<b>Non-automatic (negative) pratique</b>	Aircraft commanders must report the health status of passengers on board before landing, rather than the normal reporting by exception.
<b>Novel coronavirus</b>	A novel (new) coronavirus that has not been previously identified in humans or animals.
<b>NSC</b>	National Security Committee of Cabinet
<b>Pandemic</b>	An epidemic on a global scale.

Term	Definition
<b>PHLN</b>	Public Health Laboratory Network
<b>Point of care</b>	The place where three elements come together: the patient, the HCW, and care or treatment involving contact with the patient or his/her surroundings (WHO Guidelines on hygiene in healthcare)
<b>Post-exposure prophylaxis</b>	A dose or doses of a drug (usually antibiotic or antiviral) given immediately after exposure to a disease (such as influenza), but before onset of illness.
<b>PPE</b>	Personal Protective Equipment (gowns, gloves, masks)
<b>Primary care</b>	Health services providing initial care of a patient before they are referred to transferred elsewhere. General practice surgeries and emergency departments are common sites for primary care.
<b>Primary Health Networks</b>	Organisations that link and integrate parts of the health system to improve health outcomes, delivery of and access to health services for their local area.
<b>Public health unit</b>	Teams of specially qualified people who prevent or limit the spread of illness and disease, and improve the health of the community.
<b>Quarantine</b>	The limitation of freedom of movement for a period of time of well persons who are likely to have been exposed to the virus (contact) to prevent their contact with people who have not been exposed.
<b>Resilience</b>	The capacity to cope with stress or change, and capacity to adapt.
<b>S/T HD</b>	State and territory health departments
<b>SARS</b>	Severe acute respiratory syndrome. A viral respiratory illness caused by a coronavirus called SARS-associated coronavirus (SARS-CoV).
<b>SARS-CoV-2</b>	Severe acute respiratory syndrome coronavirus 2. The virus that causes COVID-19.
<b>Serial interval</b>	Average length of time between an initial primary case developing symptoms and subsequent secondary cases developing systems.
<b>SoNGs</b>	SoNGs Series of National Guidelines. CDNA National Guidelines for Public Health Units on the control of communicable diseases.
<b>TGA</b>	Therapeutic Goods Administration
<b>WHO</b>	World Health Organization
<b>WoG</b>	Whole of Government



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Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19 plan) endorsed by the Australian Health Protection Principal Committee (17 February 2020)

**VALUE (\$):** Nil

**LEAD AGENCY:** Health

**SUMMARY OF INITIATIVE**

On 27 February, the Government also fast tracked the Australian Health Sector Emergency Response Plan for Novel Coronavirus (the COVID-19 Plan). The plan was endorsed by the AHPPC on 17 February 2020 and published on the Department of Health website on 18 February 2020.

The COVID-19 Plan outlines how Australia's health sector will respond to a coronavirus outbreak.

The plan provides a tiered approach to responding to community outbreaks. Australia is currently in the first stage of the plan (Initial Action) and the plan outlines health sector responses and options for escalation.

Under a pandemic where coronavirus spreads in Australia, the Health Emergency Plan moves our actions from containment, to managing and limiting spread within Australia through measures such as:

- Epidemiological monitoring and contact management of patients
- Heightened border measures
- Communications to support best practice and community needs (e.g. through public health messaging particularly in public areas)
- Enhancing and supporting national testing capacity and capability
- Forward planning for pandemic, including:
  - Alternative Models of Care (e.g. fever clinics, designated hospitals and wards for coronavirus)
  - Sector specific plans (e.g. aged care, primary care, critical care, childcare, including closure and lock down of facilities)
  - Supporting essential research (e.g. priority funding for medical research)
  - Strengthening supply chains for key resources (e.g. personal protective equipment such as suits and masks)

**COVID-19 Commonwealth initiative summaries**

**COVID-19 Assistance to Pacific and Timor-Leste (3 March 2020)**

**VALUE (\$):** \$9.15 million

**LEAD AGENCY:** Department of Foreign Affairs and Trade

**SUMMARY OF INITIATIVE**

We are working closely with our Pacific neighbours, including with New Zealand, and with the WHO to keep the region safe from COVID-19. Minister Payne has approved \$9.15 million from DFAT's Emergency Fund to support COVID-19 preparedness and response activities, of which approximately \$8 million will be spent in the Pacific and Timor-Leste. We have responded quickly to a range of early requests for assistance from our Pacific partners in relation to laboratory diagnosis, personal protective equipment for healthcare workers, risk communication strategies, and national response planning and budgeting.

The funding includes up to \$6.65 million to respond to requests for PPE and technical assistance and up to \$1.5 million through Australian NGOs and the Australian Red Cross to conduct community-level risk communication, deliver public health messaging and support community-level outbreak preparedness measures that complement government-led measures.

The Victorian Infectious Diseases Reference Laboratory has been undertaking novel coronavirus testing while key regional laboratories put in place their own testing capacity with support from Australia, New Zealand and WHO [no cost to DFAT]. We have provided personal protective equipment and other medical supplies for healthcare workers in Papua New Guinea, Timor Leste, and Fiji.

DFAT has so far deployed two health experts to work with WHO's Pacific Technical Department in Suva and the Ministry of Health in Solomon Islands, and is planning additional deployments in other countries. Specialist advisers previously in place under Australia's Health Security Initiative for the Indo-Pacific region are playing important roles in national coronavirus preparedness in Samoa, Kiribati and Tuvalu, and at the Pacific Community [total cost \$2.4 million]. We have made budget provision to respond to other urgent requests for assistance as they arise.

In the context of our assisted departure flights from Wuhan, China, we uplifted eight students from Pacific island countries—seven from Vanuatu and one from Papua New Guinea—to Australia for quarantine en route to their home countries.

Australia is jointly funding, with New Zealand, WHO's Pacific regional COVID-19 response plan. Our contribution of \$1 million is helping Pacific island countries access essential medical supplies and providing surge capacity for WHO to respond to requests for advice.

We are now looking beyond our partner countries' immediate preparedness requirements and implementing a scalable response strategy covering preparedness, clinical surge response capacity and institutional partnerships between key Australian sources of public health and medical expertise and their regional counterparts. We have put in place contingency arrangements with the National Critical Care and Response Centre in Darwin, which manages the deployment of Australian Medical Assistance (AUSMAT) teams, to respond quickly and effectively to regional requests for assistance in the event of an outbreak.

**COVID-19 Commonwealth initiative summaries**

**MBS microbiology test for COVID-19, including pathology testing in Aged Care facilities (11 March 2020)**

**VALUE (\$):** \$170.2 million

**LEAD AGENCY:** Health

**SUMMARY OF INITIATIVE**

A new temporary item will be added to the Medicare Benefits Schedule (MBS) to provide accessible and rapid lab testing of severe acute respiratory syndrome coronavirus 2, the virus which causes COVID-19.

Rapid diagnosis is an important part of the Australian Government's strategy to contain the spread of COVID-19.

The MBS item will provide for a pathology (microbiology) test to determine if a patient has contracted COVID-19 or influenza.

All medical practitioners can use the item, which must be bulk billed.

This is a temporary item for six months. Disease progression in the community and advice from the Australian Health Protection Principal Committee will determine whether the item is required for a longer time.

A test can be obtained through a referral from a GP, a respiratory clinic or an onsite hospital emergency department or on the referral of any medical practitioner.

This and the accompanying aged care pathology testing measure will cost \$170 million over 2019-20 and 2020-21.

**Aged care component**

The Government will fund specialist "inreach" pathology testing for COVID-19 and influenza in residential aged care facilities.

Residents of aged care facilities with COVID-19 symptoms will be able to be tested without leaving the facility.

The risks to older Australians living in aged care facilities from COVID-19 are higher than the general population. It can also be more difficult to coordinate care and testing for people living in residential aged care.

This measure will provide a dedicated service to collect and test samples for people living in residential aged care. The services will be available quickly and efficiently, without additional administrative work for providers.

Australians living in residential aged care will benefit from this measure. If aged care providers are supported through outbreaks of COVID-19, by efficient, timely testing, the outcomes will be better for their residents, and for the health system as a whole.

**COVID-19 Commonwealth initiative summaries**

[\\$2.6 million for coronavirus research \(21 March 2020\)](#)

**VALUE (\$):** \$2.6 million (part of the \$2.4 billion package announced on 11 March)

**LEAD AGENCY:** Health

**SUMMARY OF INITIATIVE**

The Australian Government is investing more than \$2.6 million in cutting-edge diagnostics research at the Peter Doherty Institute for Infection and Immunity, to tackle the evolving novel coronavirus health emergency.

The funding, from the Medical Research Future Fund (MRFF), will be used to help maximise Australia's capacity to test patients for the coronavirus.

Four projects will be funded:

- The development of a new simpler Australian coronavirus pathology test that will address forecast extraction reagent supply issues through a technique that uses locally manufactured reagents and a different chemistry to current testing methodologies. This new methodology would enable a result within 30 minutes of receipt of a specimen with minimal manual handling.
- The development of new coronavirus testing protocols to enable more individuals to be tested simultaneously, while minimising the number of consumables used and maintain the current turnaround times. This is a one-step test which can be produced and carried out in Australia.
- The development of a deployment framework for newly approved coronavirus serology tests. Serology tests can be used to retrospectively diagnose patients who have recovered from the coronavirus or who have an asymptomatic infection.
- Post-market assessment of new coronavirus rapid screening tests to inform their best use.

This funding is part of the Government's \$2.4 billion COVID-19 National Health Plan announced by the Prime Minister on March 11.

**COVID-19 Commonwealth initiative summaries**

Expansion of coronavirus testing criteria (26 March 2020)

**VALUE (\$):** TBC

**LEAD AGENCY:** Health

**SUMMARY OF INITIATIVE**

To further protect Australia, National Cabinet agreed to an Australian Health Principal Protection Committee (AHPPC) recommendation to expand the current coronavirus testing criteria to include testing people with fever or acute respiratory infection in:

- all health workers
- all aged/residential care workers
- geographically localised areas where there is elevated risk of community transmission as defined by the local public health unit
- where no community transmission is occurring, high risk settings where there are two or more plausibly-linked cases, for example:
  - aged and residential care
  - rural and remote Aboriginal and Torres Strait Islander communities
  - detention centres/correctional facilities
  - boarding schools
  - military bases (including Navy ships) that have live-in accommodation.

Testing will be expanded to include hospitalised patients with fever and acute respiratory symptoms of unknown cause, at the discretion of the treating clinician.

This is the minimum testing criteria. States and territories have the discretion to expand their own criteria for testing if they have capacity.