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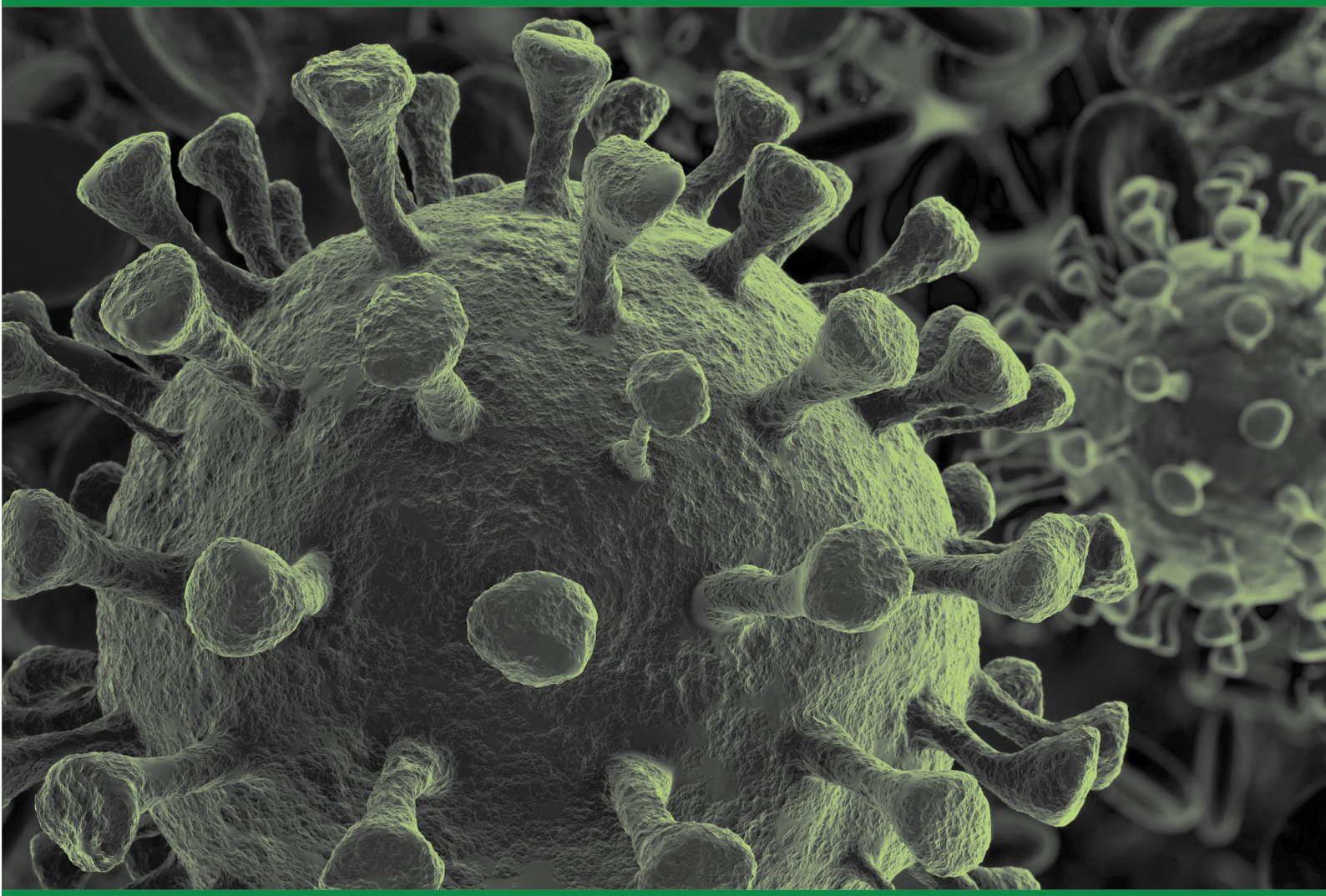

GUIDE TO THE ESTABLISHMENT OF AN AGED CARE HEALTH EMERGENCY RESPONSE OPERATIONS CENTRE

August 2020

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Executive Summary

Residential Aged Care Facilities1 (RACFs) are high-risk for outbreaks of COVID-19 when community transmission occurs. This can lead to significant morbidity and mortality of the vulnerable elderly population who reside in these settings. Following a resurgence of COVID-19 in Victoria, the Victorian Aged Care Response Centre (VACRC) was established to coordinate and provide support to outbreaks in RACFs. Applying the lessons learned from the VACRC, this guide provides a nationally consistent approach to the establishment and operation, within the affected state or territory, of an Aged Care Health Emergency Response Operations Centre (Operations Centre).

A scalable and flexible Operations Centre will be established in response to both small-scale and large-scale outbreaks in RACFs, where the RACF or state and territory capacity to manage an outbreak is under extreme stress. The Australian Health Protection Principal Committee (AHPPC) will evaluate the need for and recommend the establishment of an Operations Centre. The Minister for Health will approve the establishment of the Operations Centre and appoint a lead.

The Operations Centre is intended to operate in accordance with the Australasian Inter-Service Incident Management System (AIIMS). The Operations Centre will integrate into and assist existing state and territory emergency response and public health mechanisms. The Operations Centre will support coordination, surge capacity and capability, and resource allocation within RACFs.

State and territory public health units (PHUs) hold primary responsibility for outbreak management; the Operations Centre will augment and provide additional support as required. This guide is intended to operate alongside the Communicable Diseases Network Australia (CDNA) *National Guidelines or the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia*.

[1] Residential Aged Care Facilities include Commonwealth subsidised residential aged care facilities, Transition Care, Multi Purpose Services, Residential Respite and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

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Section 1: Context Setting

1.1 Purpose

The purpose of this paper is to provide a 'how to' guide for the establishment of a time limited, Australian Government led, state/territory-based, aged care health emergency response operations centre. This guide is intended to operate alongside the *CDNA National Guidelines or the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia*.

The immediate purpose of an operations centre is to supplement and boost state and territory capacity to respond to outbreaks of COVID-19 in residential aged care facilities (RACFs). RACFs are the priority focus, where boosting response capability could have a significant impact on reducing morbidity, mortality and disease transmission.

It is intended that this guide can be later adapted for other specific setting related outbreaks and/or community transmission of COVID-19 which may overwhelm a state/territory's response capability.

The key principles, structures and processes set out in this guide need to be **flexible** and **scalable** to best work with and integrate with the host state/territory health emergency response arrangements and setting specific requirements (for example, aged care). It is also important that the response, or the degree to which the operations centre is activated, is proportionate to the circumstances and local operational environment. For example, a different level of response may be implemented for one case in one RACF compared to 30 cases across a wide geographic area.

The Australian Government is committed to providing assistance to enhance the response to COVID-19. Depending on the needs at a point in time, the assistance that can be provided primarily takes the form of:

- People – assistance to coordinate surge workforce for the RACF or to boost the state/territory public health response; and
- Tangibles – requests can be made for assistance for example, to receive additional supplies of personal protective equipment (PPE) from the National Medical Stockpile (NMS) and IT equipment and software.

There are a number of key triggers that will signal the need for additional capacity through establishment of a health emergency operations centre or requests for other assistance. The triggers may vary according to the state of preparedness and response capacity across RACF, individual states and territories, and the status of the pandemic within local areas. The key triggers are:

- Where a state/territory capacity to respond is under extreme stress and/or may be exceeded;
- There is an outbreak in more than one RACF; or
- There is widespread or 'hot spots' of community transmission which escalates the risk to RACF.

Aged care providers are responsible for ensuring all residents continue to receive high quality and safe care and Public Health Units (PHUs) have primary responsibility for outbreak management. However, the aged care health emergency response operations centre is one of the ways intended to augment this approach and provide additional support to high-risk settings where required.

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1.2 Background

The COVID-19 pandemic has demonstrated across many countries, including here in Australia, that resurgence of transmission has the potential to rapidly spread and place additional pressure on state/territory response capacity and capability.

Additionally, high levels of community transmission can result in outbreaks in RACFs, where the most vulnerable cohort of the population reside.

As seen in New South Wales (NSW) and Victoria (VIC), these outbreaks can rapidly escalate leading to significant morbidity and mortality.

The establishment of the VACRC in July 2020, to coordinate and expand resources, has provided additional Australian Government, state or territory support to manage the substantial challenges associated with COVID-19 outbreaks in aged care facilities. This guide has been developed taking into account the key lessons learned from the NSW and Victorian experience.

Having a pre-agreed guide to assist in the establishment of aged care health emergency response operations centres will allow for more rapid response in the areas of greatest need with the broad aims to minimise morbidity, mortality and the burden on the health and aged care systems.

1.3 Principal Australian Government and State/Territory Responsibilities

The Australian Government has responsibility for system governance, policy, funding and regulation of aged care under the *Aged Care Act 1997*.

The States/Territories have constitutional responsibility for public health.

1.4 Authority/ Relevant Plans Activated

Under the **Australian Government Crisis Management Framework (AGCMF)**, The Minister for Health is the lead Minister in a domestic health crisis.

The **National Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)** sets out the arrangements and key roles and responsibilities to guide the health sector response to COVID-19.

Status of **COVID-19 Plan: ACTIVATED**

The Australian Government Disaster Response Plan (COMDISPLAN) is the vehicle for provision of non-financial assistance to the states/territories.

Status of **COMDISPLAN: ACTIVATED**

Types of assistance that can be provided under COMDISPLAN include:

- planning expertise;
- provision of mapping services;
- counselling;
- advice;
- management of external resources; and

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- physical assistance.

1.5 Process to seek assistance under COMDISPLAN

Requests for Australian Government non-financial assistance are made to Emergency Management Australia (EMA) for consideration. Following receipt of Ministerial approval for the provision of Australian Government non-financial assistance for a particular crisis, the Director General EMA is able to assist with the coordination of tasking appropriate agencies to provide the required assistance.

1.6 COVID-19 Response Objective

To save lives through improved health emergency response coordination which minimises disruption to the health system and to the aged care sector.

1.7 When should an aged care health emergency operations centre be established?

The primary trigger to establish an operations centre in line with this guidance document is when a RACF and/or state or territory's capacity to respond to and manage an outbreak of COVID-19 is under extreme stress or has been exceeded. There is reference to other triggers later in this document.

1.8 Operation Centre Core Function Objectives

The core functional objectives of the aged care health emergency response operations centres are to:

- provide a coordinated response mechanism to mobilise resources (for example, workforce and personal protective equipment) using existing mechanisms where possible and escalating priority if needed;
- provide additional surge capacity and capability to the host state/territory to rapidly respond to COVID-19 outbreaks in particular settings, such as aged care, or in growing clusters of community transmission in particular geographical areas;
- coordinate and allocate staffing including surge workforce as needed and ensure appropriate capacity and safety of surge staffing;
- effectively integrate with existing host state/territory health emergency response systems, in particular communication and reporting; and
- function within an emergency management framework using the AIIMS quality system.

1.9 Operation Centre Core Operational Objectives

The core operational objectives of the aged care health emergency response operations centres are to:

- establish and operate within the parameters of an emergency response quality system such as the AIIMS framework;

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- integrate with the command and control structure and systems of the host state or territory's emergency response operations centre;
- model state or territory command and control structures and systems within the operations centre;
- operate in the context of the emergency response 'comprehensive approach' and the continuum of preparedness, prevention, response and recovery (PPRR);
- assist the RACFs and state and territory PHU to implement appropriate public health and infection prevention and control measures to manage cases and minimise the risk of further disease transmission as per the *CDNA - National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia.*

1.10 Operation Centre Health Emergency Response Core Principles

The aged care health emergency operations centre should be underpinned by the following principles:

- Comply with all state/territory legislative and regulatory requirements;
- Carry out function with respect to ethical considerations/within an ethical framework e.g. AHPPC ethical framework (Annex G);
- Collaborate with the RACFs, PHUs and the Australian Government Department of Health (National Incident Room (NIR) and Aged Care) and Aged Care Quality and Safety Commission;
- Adopt or develop innovative solutions to enhance the response;
- Operations and response activities should be proportionate to the risk and scale of the outbreak;
- Keep processes and procedures as simple as possible so as not to over complicate the response;
- Transparency; and
- Accountability.

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1.11 Governance

Governance structures are critical to supporting responsiveness and timely decision-making.

As the health emergency operations centres are Australian Government led and the responsibility for aged care also rests with the Australian Government, the governance structure includes the following layers:

- The health emergency operations centre Incident Controller will report to the Secretary of the Department of Health through the Aged Care Group of the Australian Government Department of Health;

The health emergency operations centre governance structure must intersect with any operating state and territory based emergency and PHU governance arrangements to ensure optimal coordination of the response.

It is important that the operations centre functions are also included under the broader National Health Sector response to COVID-19 being led out of the Department of Health's **NIR** and informed by policies of the AHPPC and related committees.

Figure 1 is the governance structure used during the activation of the VVACRC. This model can be used in the establishment of new health emergency operations centres but individual tailoring may be required to suit the local situation and the different governance models used within individual state and territory health emergency response arrangements.

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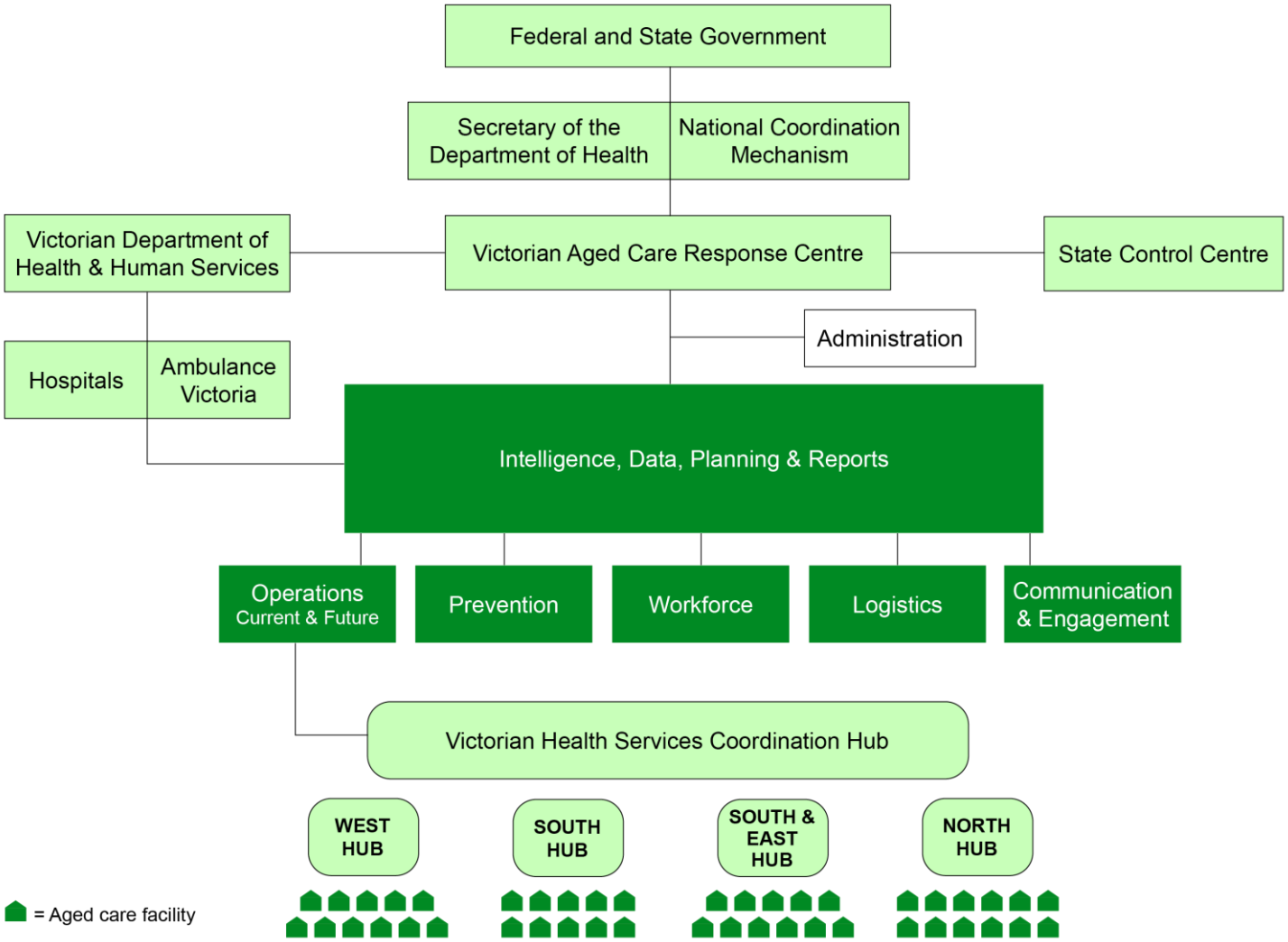
Figure 1: Example of governance structure used in VACRC



1.12 Legislative Framework and Regulatory Aspects

Although Australian Government legislation and regulations, and state and territory public health and emergency response laws provide a legislative framework to underpin actions that may be required to respond to COVID-19, measures will rely on voluntary compliance rather than legal enforcement wherever possible. The principal areas of legislation available to support pandemic actions are described below.

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.

Aged Care Act 1997

The *Aged Care Act 1997* (the Act) and associated Aged Care Principles set out the legislative framework for the funding and regulation of aged care, although services are also provided through contractual arrangements outside of the Act.

For residential care facilities, under the Aged Care Quality Standards (Quality Standards), aged care providers must have governance systems in place to assess, monitor and drive improvement in the quality and safety of the care and services they provide – including making sure consumers receive high quality and safe care and services.

- Under Personal Care and Clinical Care Standard 3(g) providers are required to minimise infection related risks through implementing standard and transmission-based precautions to prevent and control infection. Providers are expected to assess the risks of and take steps to prevent, detect and control the spread of infections at their residential services.
- There are established linkages between facility providers and the Australian Government Department of Health State Offices and state and territory PHUs to assist facilities to respond to outbreaks.
- The Quality Standards specify that facilities are required to have effective risk management systems and practices including but not limited to managing high impact, high prevalence risks associated with the care of consumers (Standard 8 Organisational Governance). The Aged Care Quality and Safety Commission expects that approved providers will plan for and manage internal and external emergencies and disasters.

Aged Care Quality and Safety Commission

- As the independent national regulator of Australian Government-funded aged care services, the Commission's role is to protect and enhance the safety, health, well-being and quality of life of older Australians receiving aged care.
- The Commission has undertaken a survey to identify facilities likely to be higher risk in terms of infection control and preparedness, as the thoroughness of an aged care provider's advance planning to prepare for a possible outbreak is fundamental to the effectiveness of their response.

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The Commission may issue a Notice to Agree (NTA) which sets out actions a provider is required to do (including necessary timeframes). Should a provider fail to agree, their approval to provide Australian Government subsidised aged care may be revoked. Once a provider has agreed to an NTA, they are required to do the actions they've agreed to. If they don't they may be sanctioned.

The Biosecurity Act 2015

The *Biosecurity Act 2015* authorises activities used to prevent the introduction and spread of target diseases into Australia. COVID-19 was made a Listed Human Disease under the Act early on in the pandemic to allow for the use of powers under 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. Australia's Chief Medical Officer (CMO) is the Director Human Biosecurity under the Act.

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 World Health Organization (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.

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) to allow for the importation and supply of products that have not been approved for use in Australia.

1.13 Existing Prevention, Preparedness and Response Capacity and Capability

Consistent with Australia's strategic approach to health emergency management, the COVID-Plan acknowledges the importance of seeing the management of a pandemic, like any hazard, within an ongoing cycle of activities in the four areas of:

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

Due to the rapid global escalation of the novel COVID-19 virus leading to the pandemic, the Australia response to COVID-19 commenced at the Response Stage – Initial Action, as described in the COVID-19 Plan. While the focus of this Guide is response operations, it is however, essential that consideration also be given to prevention strategies and preparedness planning that will in turn minimise the risk of outbreaks and for more rapid and coordinated response. The stronger our preparedness, the quicker we may recover and be more resilient. Further work is being undertaken with the aged care sector in the areas of prevention and preparedness and further details can be included in this Guide as measures are established and implemented.

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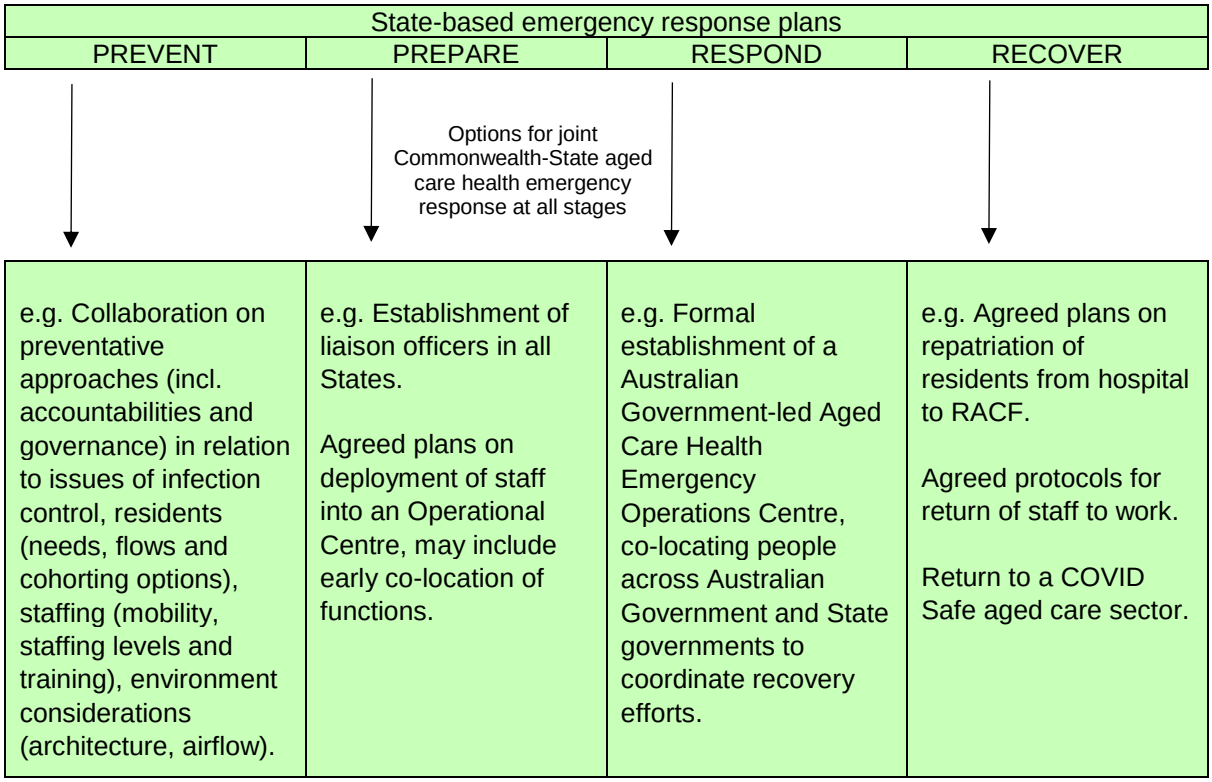
An Operations Centre, or components of an Operational Centre as outlined in this guide, could be established at any point that a state or territory in collaboration with the Australian Government deem required – prevention, preparation, response or recovery stage. The table below provides examples of the activities that may be undertaken at each stage:



Prevention

While there is no effective vaccine or specific treatment for COVID-19, prevention efforts need to focus on nationally agreed strategies to supress virus transmission through physical distancing and hygiene practices. An 'Industry Code for Visiting Residential Aged Care Homes during COVID-19' has been released to create a nationally consistent approach that ensures residents can receive visitors while minimising the risk of spreading COVID-19 (https://www.health.gov.au/resources/publications/industry-code-for-visiting-residential-aged-care-homes-during-covid-19). Ensuring all staff are trained in recommend infection prevention and control is also an important preventative strategy. In some instances, complete lockdown of the RACF has been a key strategy to protect the residents of RACF and to break the chain of disease transmission.

Preparedness

The Australian health emergency response system is in a perpetual state of preparedness, using lessons learned, monitoring evolving technology, scientific evidence and global best practice to build response capacity and capability.

For RACFs and operations centres the following are the key elements of preparedness:

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- establish pre-agreed arrangements by developing and maintaining plans an supporting evidence and guidance materials;
- research COVID-19 specific management strategies;
- ensure resources are available and ready for rapid response (people and things);
- monitor the course of the pandemic, and investigate outbreaks if they occur.

RACFs and aged care emergency operations centres should establish linkages and integrate with host state/territory preparedness arrangements.

Escalation from business as usual to a crisis environment (preparedness to response)

Existing arrangements form the basis for the clinical and public health management of COVID-19.

Common objectives to minimise transmission, morbidity and mortality will remain, but there will also be a need to:

- **Rapidly gather, synthesise and share information** on the pandemic to inform planning;
- **Mobilise, reallocate and coordinate resources (people and things e.g. PPE);**
- **Revise and update plans, procedures and processes based on the best available evidence and advice from local PHUs;** and
- **Communicate a consistent and timely message**, to engage staff, residents and their families effectively in pandemic response measures and to build trust and confidence when there is broader vulnerability.

Response

Where possible existing systems and processes should be used to respond to COVID-19.

The RACFs and state and territory PHUs are very experienced and are well practiced in communicable disease preparedness, prevention and response. There will be established systems, processes and procedures in place that the health emergency operations centre can adopt. For example, RACFs are at increased risk of and regularly experience outbreaks of influenza and gastrointestinal related illness each year and there would be available guidance material to adopt for COVID-19.

1.14 Risk Assessment

Assessing risk is critical to identify priority interventions, to inform health planning, and to contribute to the reduction of morbidity, mortality and disease transmission.

The operations centre must engage and maintain strong linkages with the NIR and its reporting products and the state and territory PHU to ensure access to the most up to date risk assessment information and epidemiological information. This will ensure a well-coordinated response that remains consistent and complementary to the overall national health sector response.

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Section 2: Operations Centre Structure and Operations

One of the most important functions of the Operations Centre is to work closely with the RACFs and state and territory PHUs to establish an effective early warning system. RACFs and the state or territory must report suspected cases and when a COVID-19 test is requested rather than waiting for the confirmed test result.

The Operations Centre will monitor and assess notifications (signals) and triage the signals in order to prioritise response actions to ensure the greatest effort is made to minimise transmission.

The structure and operation of the Operations Centre is designed to enhance response capacity and capability to rapidly address potential transmission signals.

2.1 Operations

The **Australasian Inter-Service Incident Management System (AIIMS)** is the nationally recognised system of incident management used by emergency service agencies including the Australian Government Department of Health's NIR, the Crisis Coordination Centre managed by EMA, as well as state and territory based emergency operation centres.

While the AIIMS provides the operational and staffing framework for emergency response, the parameters of the framework can be/should be customised to be fit for purpose for the health sector and public health response.

AIIMS is based on five key principles:

- **Management by objectives (objectives are described more fully above)** - all incident personnel must work towards one set of objectives, the Incident Controller, in consultation with the Incident Management Team, determines the desired outcomes of the incident. These are communicated to all involved. At any point in time, an incident can have only one set of objectives and one Incident Action Plan for achieving objectives.
- **Functional management** - The control system of AIIMS is based on a structure of delegation with five functional areas:
- **Control** - The management of all activities necessary for the resolution of an incident.
- **Planning** - The collection and analysis of information and the development of plans for the resolution of an incident.
- **Public Information** - Provision of warnings, information and advice to the public and liaison with the media and affected communities.
- **Operations** - The tasking and application of resources to achieve resolution of an incident.
- **Logistics** - The acquisition and provision of human and physical resources, facilities, services and materials to support achievement of incident objectives.
- **Span of control** - a concept that relates to the number of groups or individuals that can be successfully supervised by one person. During emergency incidents, the environment in which supervision is required can rapidly change and become dangerous if not managed effectively. Up to five reporting groups or individuals is considered to be desirable, as this maintains a supervisor's ability to effectively task, monitor and evaluate performance.

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- **Scalability** – each emergency does not require a full-scale response. The system allows for the build-up or down-scaling of resources and response activity. Response should also be proportional to the risks associated with the emergency.
- **Flexibility** – flexibility is required so that the response can be adapted to local capacities and capabilities and systems.
- **Unity of command** - subordinate members of a structure should all be responsible to a single commander.

2.2 Communications

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.

The following key principles will be applied across all 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.

Note that a key role of the communications activities is to ensure effective communication with RACF staff, families and residents. Please refer to the Australian Health Sector Emergency Response Plan for Novel Coronavirus (the COVID-19 Plan) for the overarching communications response.

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2.3 Operations Centre Team Constitution

The following team structure is based on the AIIMS structure and should be customised accordingly. Please refer to the example of Command Structure and Communications Pathways in VARC in figure 2.

2.3.1 Incident Commander

Single incident commander commands the incident response and is the decision-making final authority. The Incident Commander must report to the AHPPC.

2.3.2 Command Staff

Overall operations command is coordinated by the Health and Clinical lead.

- Safety Officer monitors safety conditions and develops measures for assuring the safety of all assigned personnel.
- Public information officer – serves as the conduit for information to and from internal and external stakeholders, including the media or other organisations seeking information directly from the incident or event.

2.3.3 Liaison Officers

- Liaison Officer are a crucial component of the health emergency operations centre that enable cross-communication, information sharing and effective coordination.
- There must be several appropriately experienced, senior health emergency operations centre liaison officers placed in the host state/territory health emergency operations centres.
- Liaison officers from the host state based health emergency operations centre should also be based with the aged care health emergency operations centre.
- The Liaison officers will be the primary contacts for supporting agencies outside the health sector, assisting at an incident for example, EMA.

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2.3.4 General Staff

- Operations Lead: Tasked with directing all actions to meet the incident objectives.
- Planning Lead: Tasked with the collection and display of incident information, primarily consisting of the status of all resources and overall status of the incident.
- Finance/Administration Lead: Tasked with tracking incident related costs, personnel records, requisitions, and administrating procurement contracts required by Logistics.
- Logistics Lead: Tasked with providing all resources, services, and support required by the incident.

2.3.5 Incident Command System

An Incident Command System (ICS) ensures a standardised approach to the command, control, and coordination of emergency response activities. ICS procedures should ideally be pre-established and agreed by participating agencies, and personnel should be well-trained prior to an incident. ICS is a system designed to be used or applied across the life of a response.

ICS is interdisciplinary and organisationally flexible to meet the following management challenges:

- Meets the needs of a state or territory to cope with incidents of any kind or complexity (i.e. it expands or contracts as needed).
- Allows personnel from a wide variety of agencies to meld rapidly into a common management structure with common terminology.
- Provide logistical and administrative support to operational staff.
- Be cost effective by avoiding duplication of efforts.
- Provide a unified, centrally authorised emergency organization.

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Figure 2: Example of Command Structure and Communications Pathways in VARC

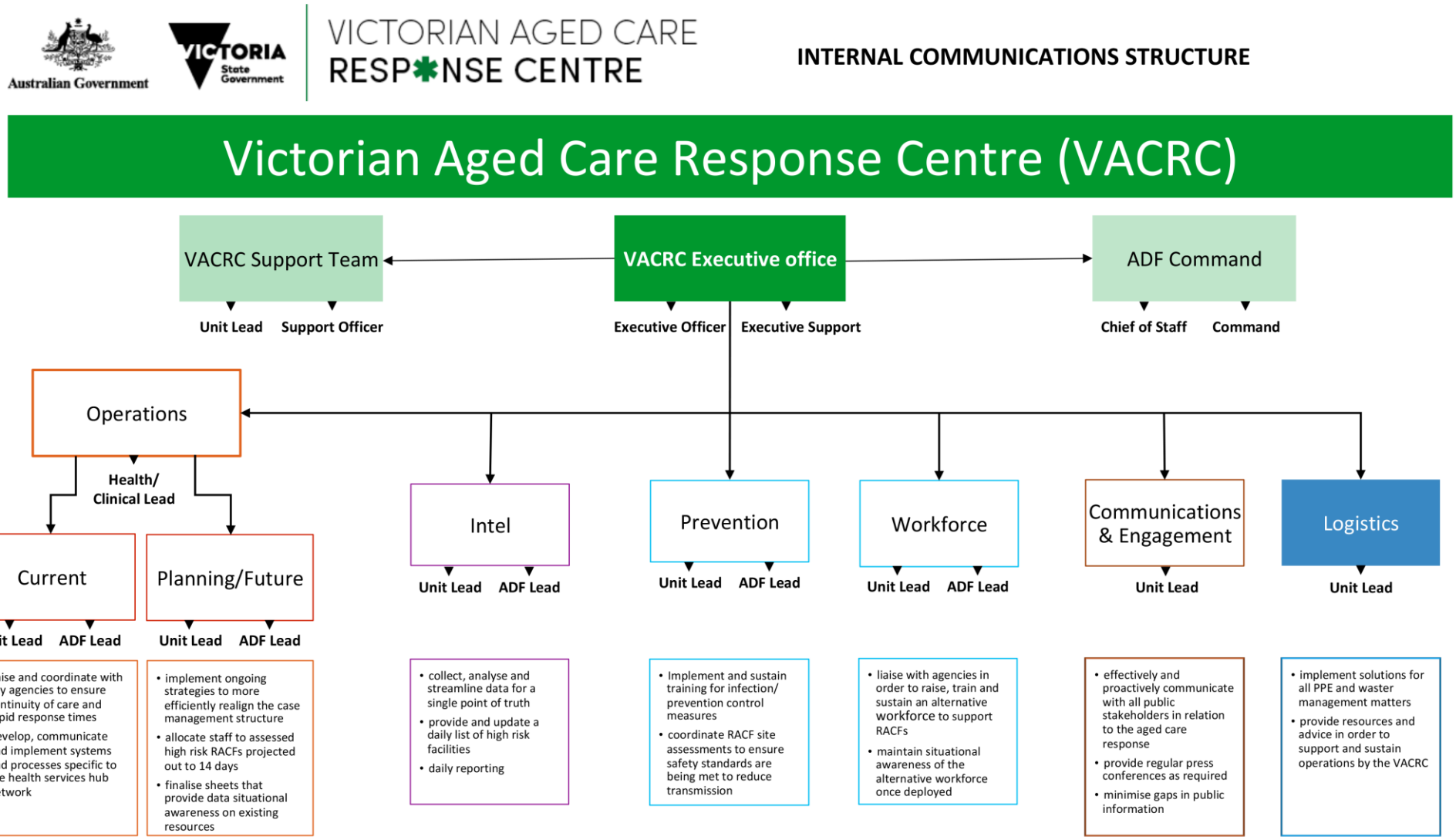
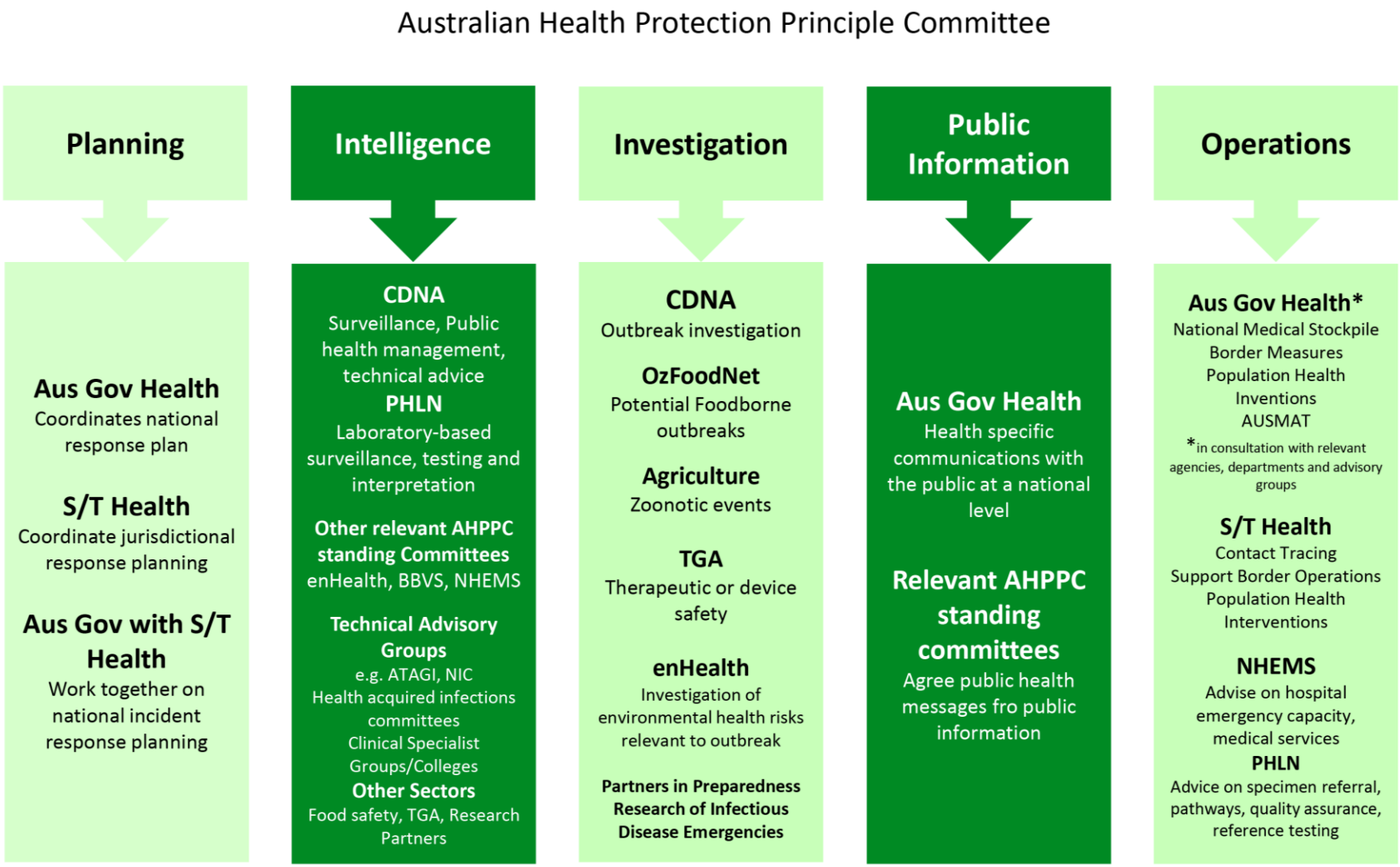


Figure 3: Key elements of Department of Health NIR functional groups. Response actions informed by AHPPC.



2.4 Incident Action Plans

An Incident Action Plan (IAPs) should be developed and approved by the local PHU and AHPPC. The IAP ensures a consistent and well-coordinated approach to achieving the objectives of the response.

The IAP is to be used by supervisors to communicate objectives to both operational and support personnel. The IAP should include measurable, strategic objectives set for achievement within a time frame.

All IAPs must have four elements:

- What do we want to do?
- Who is responsible for doing it?
- How do we communicate with each other?
- What is the procedure if someone is injured?

A model example that was prepared by Victoria can be found at:
https://www.dhhs.vic.gov.au/aged-care-sector-coronavirus-disease-covid-19

2.5 Common Terminology

The use of common terminology is an essential element in team cohesion and communications, both internally and with other organisations responding to the incident.

2.6 Management by objective

Incidents are managed by aiming towards specific objectives. Objectives should be ranked by priority; should be as specific as possible; must be attainable; and if possible given a working time-frame. Achievement of objectives requires the development and execution of strategies.

2.7 Flexible and modular organization

The ICS is organised to be flexible in such a way as to expand and contract as needed by the incident scope, resources and hazards. Command is established in a top-down fashion, with the most important and authoritative positions established first. Only positions that are required at the time should be established and as an incident scales down, roles can be closed off.

2.8 Triggers to scaling up operations (based on the Victorian experience):

There are five critical factors that can be used as triggers for the escalation of operation centre response and more intervention:

- Acute changes in case load;
- Staff (workforce and training);
- Stuff (PPE, waste management, testing etc);
- Space (IPC and cohorting); and
- System (Facility leadership and management).

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2.9 Access to Expert Advice

- There is a wealth of national expertise and experience that can be accessed to inform the response:
- AHPPC and its standing committees such as the:
  - National Health Emergency Management Standing Committee;
  - CDNA; and
  - Public Health Laboratory Network.
- EMA
- States/territories
  - PHUs; and
  - Emergency Operations Centre.
- Australian Government Department of Health:
  - NIR;
  - Ageing and Aged Care Group; and
  - Aged Care Quality and Safety Commission.
- Aged care sector (including peaks and providers of residential, home care and Australian Government Home Support Programme services).
- Health sector representatives.
- Public and private hospitals, allied health, workforce and where applicable, state aged care.

2.10 Co-dependencies

Where possible, the health emergency operations centre should function synergistically with:

- State and territory emergency operations centre.
- State and territory PHU.
- Contracted testing laboratories.
- Resident General Practitioners and other relevant medical practitioners.
- Australian Government Department of Health (NIR, and Aged Care Group).
- Aged Care Quality and Safety Commission.
- EMA.

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2.11 Recovery

The following pathway must be in place to support staff returning to a RACF after being furloughed:

- RACFs need to routinely make contact with furloughed staff member while they are absent from facility. These contacts are made to:
  - Check on mental wellbeing of staff.
  - Determine any concerns staff member has that may impede their return to work at the facility.
- The following clearances are required for furloughed staff to return to work:
  - For staff who are COVID-19 positive - medical clearance required by local PHU at Day 11 of quarantine. PHU provides certificate for staff member's clearance (COVID-19 positive 11 day's clearance).
  - For staff furloughed as close contact – Refer to CDNA guidance.
- Ensure any concerns of the staff member or facility are addressed prior to the staff member returning to work
- A re-orientation must be conducted on the staff member's return
  - Refresher training on PPE use, infection control, testing requirements.
  - On the ground procedures.

2.12 Return of hospitalised residents to residential aged care facilities

The COVID-19 CDNA National Guideline provides advice on release from hospital and active screening of new/returning residents.

The decision to return a resident from hospital to a residential care facility is premised on a number of factors, including:

- Infection risk posed by the individual.
- Ability of the residential care facility to manage infection prevention and control.
- The operating environment including the presence of community transmission and/ an active outbreak at the receiving RACF.

A multi-agency approach is required when assessing the ability of a residential care facility to receive returning residents and to safely manage infection prevention and control requirements and isolation. These agencies may include:

- The Operations Centre, if activated.
- Australian government – for its responsibility for aged care (Department of Health and the Aged Care Quality and Safety Commission).
- State government agencies – the state PHU for the management of the outbreak.
- The approved provider of the RACF.

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2.13 Restricted movement

Restricted people movement across facilities/suburbs/borders etc.

2.14 Contact Tracing

Contact tracing is key to slowing the spread of COVID-19 and helps protect individual's community.

Contact tracing slows the spread of COVID-19 by:

- Letting people know they may have been exposed to COVID-19 and should monitor their health for signs and symptoms of COVID-19.
- Helping people who may have been exposed to COVID-19 get tested.
- Asking people to self-isolate if they have COVID-19 or self-quarantine if they are a close contact.

Prioritising contact tracing of the health and aged care workforce in RACFs will be important.

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Section 3: Planning and Logistical Arrangements to Establish the Operations Centre

3.1 Triggers for establishing an Operations Centre

When a state or territory PHU requires assistance to respond to and manage outbreaks of COVID-19, they should notify the Australian Government Department of Health NIR. The Australian Government in close collaboration with the host state or territory, should prepare a business case to be submitted to the **AHPPC** for rapid advice around the scope and scale of the assistance required.

The scale and operations of the Operations Centre should be proportionate to the scale of the outbreak and the response capability of the RACF.

Potential triggers to establish an Operations Centre in line with this guidance document are:

- a RACF and/or state or territory capacity to respond to and manage an outbreak of COVID-19 is under extreme stress or has been exceeded; or
- there is significant community transmission in a localised area or across the whole state or territory leading to increased risk to RACFs; or
- a single RACF outbreak in the context of community transmission; or
- there is a confirmed outbreak in a RACF or a low but persistent rate of COVID-19 infection across RACFs; or
- a surge workforce is required to supplement the RACF workforce; or
- a single case of COVID-19 is confirmed in a resident, staff member or frequent attendee of a residential care facility/high-risk setting; or
- if additional financial assistance is required to enhance a RACF's or state or territory's capacity to respond; or
- any other circumstance deemed to require assistance to minimise the risk of COVID-19 by the Australian Government or the state or territory.

3.2 Flow of events to request establishment of an Aged Care Health Emergency Response Operations Centre

See Figure 4 (below) for the flow of events to request establishment of and aged care health emergency operations centre.

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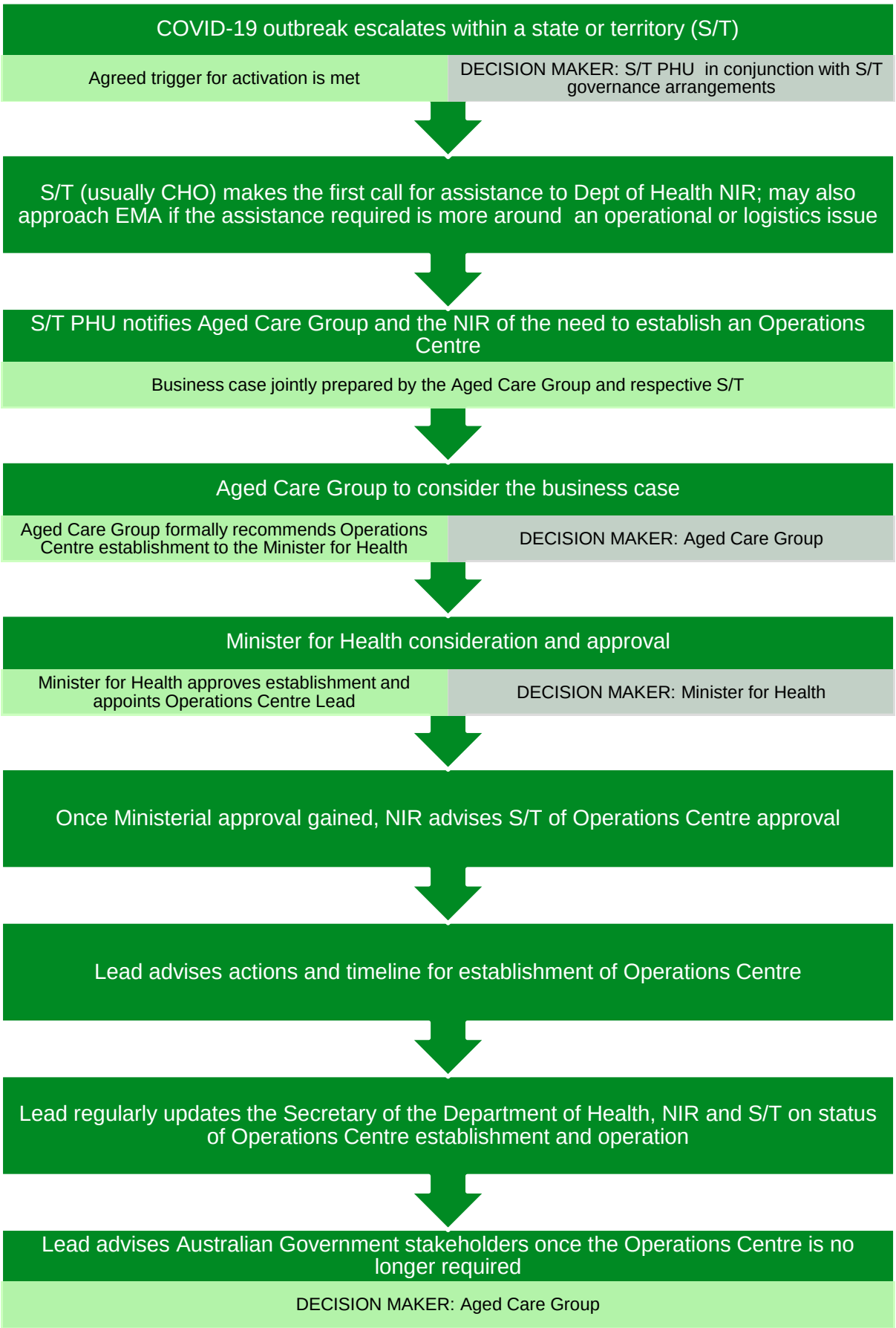

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3.3 Logistical arrangements

3.3.1 Choosing a Site

A site will need to be selected in close collaboration with the host state or territory and potentially local government.

On option would be to map current 'hot spots' of community transmission together with local residential care facilities to examine areas of high risk.

It is preferable that the operations centre be in close proximity to a high risk RACF or a facility with a confirmed outbreak, in a larger state or territory there may be logistical advantages to selecting a site closest to the largest distribution of high risk facilities.

3.3.2 Infrastructure

A site with sufficient space, and basic infrastructure such as desks, chairs, telephone and computers should be chosen on advice of local logistics experts.

3.3.3 Information Technology and Data Requirements

IT capability and cross-compatibility with RACF and state or territory systems should be explored in close collaboration with the host state/territory.

Key considerations should include:

- Compatibility/interoperability with state/territory and Australian Government systems;
- Common operating platform using web based approach for example, that used by the National Critical Care and Trauma Response Centre (NCCTRC);
- Minimise the need for manual data collection and reporting where possible; and
- Privacy and security safeguards

Data analytics and epidemiological analysis

In establishing a joint operational response, it is vital to use the same source of information to develop intelligence and provide timely briefings that are consistent across state, territory and the Australian Government.

Where possible, the Australian Government Department of Health will use the State or Territory notifiable disease surveillance system as the primary source of data on infections, hospitalisations and deaths in RACF residents and staff. Outputs of these surveillance data should be readily accessible to both the affected state or territory and the federal health department at the same time.

A joint centre should have epidemiological and data analytics support embedded within it from both the Australian Government and the State or Territory health department. The findings of outbreak investigations and health and logistic impact should be shared rapidly with both federal and state and territory governments as a matter of urgency.

There must be a system, preferably automated, that allows for the accurate recording, tracking and tracing of residents, staff and visitors to the RACFs to facilitate rapid isolation of the sick, quarantine

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of contacts and contact tracing, to minimise the risk of disease transmission. Integration with host state and territory systems is important to ensure efficient and coordinated contact tracing efforts.

3.3.4 Workforce Supply Mechanism

In determining how to utilise and stand up a surge workforce capacity, consideration should be given to the three primary workforce supply mechanisms:

- **Employment Platforms**: leveraging existing employment platforms to source local aged care, health and disability workforces;
- **State and Territory Governments**: sourcing nursing staff under the National Partnership Agreement (NPA) for inter-state deployment; and
- **Aged Care Approved Provider Staff**: sourcing spare aged care staffing capacity from aged care providers for inter-state deployment.

3.3.5 Employment Platforms

An emergency response may leverage the existing contracts between the Australian Government Department of Health and several employment platforms including Aspen Medical and Mable.

Australian Medical Assistance Teams (AusMats) can be deployed domestically as additional surge workforce. The Australian Government funded NCCTRC is responsible for managing the AusMat capability and maintains a database of appropriately skilled and trained workforce that includes doctors, nurses, logisticians, emergency response expert and public health experts and epidemiologists.

The Australian Defence Force can also deploy personnel and assets to boost capacity to respond.

3.3.6 State and Territory Government

An emergency response may also leverage the interstate deployment of nursing staff from other state and territory governments.

States and territories should consider establishing a forward scoping team to identify risks, source PPE, accommodation and transport and ensure the smooth deployment of staff and to provide a line of escalation for staff concerns, including site direction, risks and welfare checks.

The process to establish arrangements includes:

- negotiating the contractual requirements with the state and territory government as a Memorandum of Agreement;
- engaging internal and external legal advice/review;
- funding source;
- seeking commitment approval from the delegate; and
- offer and execute contract.

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3.3.7 Aged Care Approved Provider Staff

The National Aged Care Emergency Response (NACER) arrangements in place with aged care providers create a national pool of staff that can be deployed to assist aged care programs impacted by COVID-19, with a focus on residential aged care Victoria in the first instance.
See Annex D.

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ANNEX A: Roles and Responsibilities

Roles and responsibilities of the Australian Government, State and Territory Governments and the aged care sector during the response to COVID-19 as per the standard health emergency response stages

Roles	The Australian Government role is to:	The State and Territory Governments role is to:	The joint role of Australian Government and State and Territory Governments is to:	The role of aged care providers:
PREPAREDNESS **Overarching role:**	Determine how national systems across health and aged care can be adapted or established to respond to a COVID-19 pandemic. Formulate and maintain health care safety and quality standards and indicators. Maintain the NIR (Including staff, equipment, and management systems).	Determine how systems can be adapted or established to respond to a COVID-19 pandemic.	Respond to outbreaks of COVID-19 with RACFs (PHUs). Provide strategic advice to governments and other key bodies on public health actions to minimise the impact of communicable diseases in Australia and the region [CDNA]. Develop and maintain guidance for PHUs to respond to influenza infection (via the Series of National Guidelines (SoNGs) [CDNA]. Develop policy for PHU response to RACF outbreaks and develop guidance for RACF for COVID-19 outbreak prevention response [CDNA].	Adhere to Aged Care Quality Standards i.e. providers are expected to plan for, and manage internal and external emergencies and disasters.
STANDBY **Overarching role:**	Prepare national resources that may be needed to manage the pandemic. Coordinate information gathering and sharing about the virus and the emerging pandemic.	Prepare jurisdictional resources that may be needed to manage the pandemic. Coordinate communication at state and local levels according to national guidance.	Share information on resource availability [AHPPC]. Prepare guidance on case and contact management; chemoprophylaxis and education; vaccination; quarantine/isolation; risk	Prepare organisational personnel and resources for changes in demand and service use that may be required to manage the pandemic. (Business as Usual to crisis response)

Roles	The Australian Government role is to:	The State and Territory Governments role is to:	The joint role of Australian Government and State and Territory Governments is to:	The role of aged care providers:
	Manage international obligations and borders. The Australian Government Department of Health will provide your state or territory with a snapshot of the aged care sector such as location, names and numbers of RACFs and beds, and include any other critical facts and/or data that would assist your state or territory in understanding the local aged care environment	Support management of international borders by providing disease control expertise and health care services to ill travellers.	assessment; infection control and use of antivirals [CDNA]. Prepare advice where relevant on interventions outside the health sector, such as social distancing measures [CDNA/ AHPPC].	
	Support preparations in institutional settings to manage the pandemic.	Support preparations in institutional settings to manage the pandemic.	Support preparations in institutional settings to manage the pandemic.	Prepare to commence activities required to manage the pandemic.
RESPONSE INITIAL ACTION **Overarching role:**	Support coordination and communication when state or territory capacity is overwhelmed OR when an incident is multi-jurisdictional. Deliver PPE (including face masks and face shields) from the National Medical Stockpile to residential aged care facilities.	Undertake primary responsibility for the management of the public health response in states and territories, including management of cases; clinical care; contact management and public health measures. Request assistance if state or territory capacity is overwhelmed. Coordinate response and communication at state and	Share information on resource availability and coordinate access to resources to maximise the effectiveness of the response [AHPPC]. Provide guidance on case and contact management; chemoprophylaxis and education; vaccination; quarantine/isolation; risk assessment; infection control and use of antivirals [CDNA].	Aged care providers must immediately notify their local PHU, and the Australian Government Department of Health of a confirmed COVID-19 case. Establish an outbreak management team to direct, monitor and oversee the outbreak. Providers to put in place additional infection prevention and control measures.

Roles	The Australian Government role is to:	The State and Territory Governments role is to:	The joint role of Australian Government and State and Territory Governments is to:	The role of aged care providers:
		local levels according to national guidance. Triage and coordinate care for patients between other service providers [GPs, Emergency Departments (EDs), ACCHS, pharmacists, mental health workers etc.]	Provide advice where relevant on interventions outside the health sector, such as social distancing measures.	
RESPONSE TARGETED ACTION **Overarching role:**	Adjust any measures taken to take into account changes in surveillance information, equity and resource issues. Mitigate inequities where possible through planning processes.	Adjust any measures taken to take into account changes in surveillance information, equity and resource issues. Mitigate inequities where possible through planning processes.	Adjust any guidance given to taken to take into account changes in surveillance information, equity and resource issues.	Adjust any measures taken to take into account changes in guidance provided, equity and resource issues.
	Work with approved providers and regulatory structures of aged care to disseminate relevant tailored information. Liaise with S/T HD units with responsibilities related to the pandemic.	Investigate and support outbreak management. Disseminate relevant information.	Develop and maintain guidance concerning management of COVID-19 outbreaks in RACFs [CDNA].	Consider advice and adapt practices accordingly.
STANDDOWN **Overarching role:**	Coordinate the development and implementation of an exit strategy to stand down enhanced measures.	Implement exit strategy relevant to measures taken on by state and territory government officers and agencies.	Determine when to cease or alter enhanced measures [AHPPC]. Provide advice regarding stand-down of measures [CDNA].	Manage transition of services into normal arrangements (if altered).

Roles	The Australian Government role is to:	The State and Territory Governments role is to:	The joint role of Australian Government and State and Territory Governments is to:	The role of aged care providers:
	Consult across the Australian Government concerning scaling back of measures. Manage transition of processes into BAU arrangements.	Consult across jurisdictional government concerning scaling back of measures. Manage transition of services and processes into BAU arrangements.	Advise on appropriate messaging for responders and public concerning scaling down of measures [AHPPC].	
	Evaluate Australian Government pandemic processes. Implement changes as appropriate.	Evaluate jurisdictional pandemic processes. Implement changes as appropriate	Evaluate committee and governance processes. Implement changes as appropriate.	Evaluate organisation/practice/business processes. Implement changes as appropriate

More information on Whole of Government arrangements can be found in the Emergency Response Plan for Communicable Disease Incidents of National Significance (National CD Plan) – https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-CD-plan.htm

ANNEX B: Lessons learned from Victorian Experience

Key lessons learned from Victorian Operations Centre

Planning

- Every RACF needs a clear plan of action (which has been exercised), it needs to include escalation processes, clear role and responsibilities. Contingency plans for additional staffing including if management staff are unable to attend the facility.
- Copies of phone number of managers and approved provider need to be readily available.
- Contact details for cleaning, food supply, waste management contractors. Waste contract should have capacity to increase frequency on collection when waste production increase due to PPE use.
- Ensure there are generic passwords and access to IT systems for replacement staff.
- Systems to access secure areas, key, proximity passes need to be set up.
- All residents need to wear an ID bracelet (also useful if a transfer to hospital is required), if agency staff are employed they do not know who is who.
- In each residents room a pre packed bag with a copy of a current Advance Care Directives, medication chart, known allergies, a 24 hour supply of continence products (if required), any special care advice (e.g. if they react in certain ways, special toys etc), NOK and GP details.
- Facilities need to establish contact with the local public hospital, and ensure connect to geriatric in-reach.
- Plan to feed staff in an outbreak.

Workforce

Staff rosters need to be in teams or cohorts and allocated to designation areas so not all staff become close contacts in an outbreak Contemporary residents' records, including NOK, ACD status.

Facilities need to plan for a surge in staffing as the wearing of PPE needs more staff due to the delays caused by donning and doffing, and the need for more frequent breaks.

Staff need an areas to change out of uniforms before going home.

Facilities needs to plan for more front of house staff to contact families in an outbreak and take calls.

An accurate list of all staff who attended the facility with contact detail.

Infection Prevention and Control

Clean and dirty areas need to be identified, office areas, staff meals and staff bathrooms.

A resident cohorting plan areas for donning and doffing need to be agreed and tested.

Infection Prevention and Control

- Clean and dirty areas need to be identified, office areas, staff meals and staff bathrooms.
- A resident cohorting plan areas for donning and doffing need to be agreed and tested.

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Infection Control Training

- Practical in-person training in infection control and the use of PPE (donning and doffing) should be a requirement for the aged care workforce.
- Facility and staff training around other modes of infection prevention and control such as resident cohorting.

PPE

Consideration should be given to:

- a real time buddy system for donning and doffing PPE; and
- mask requirements following a threshold level of community transmission.

Visitation

Ensure that RACF's have alternative arrangements to keep family members connected with relatives in care to manage the risks of mental and emotional wellbeing.

Workforce screening / Measures to ensure staff don't work when ill

Consideration should be given to screening staff and visitors on entry to the facility as well as the enforcement and support of staff, to stay home when unwell.

Workforce

- Consideration should be given to the following when mobilising replacement/surge staff:
  - Profile and needs of the resident population
  - Staffing profile including management team and how this will be increased to allow for infection control and ongoing replacement of staff if further transmission occurs
  - Layout of the facility and feasibility of implementing cohorting arrangements
  - Handover procedures (resident records, advance care directives, access codes to medicines and equipment)

Contact Tracing

- Contact tracing of staff in aged care services needs to be done with urgency to reduce the potential of multiple staff members being considered close contacts. Accurate staff shift records are required.

Cohorting

- Aged care services must have a plan in place for cohorting residents which is ready to activate immediately to reduce transmission. Consideration needs to be given to on and offsite cohorting.

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Public and Private Hospital Capacity

- States and territories should consider their capacity to use public and private hospitals, including consideration of beds and staffing.

Communications

- Regular and specific communication with families, friends and loved ones in the event of a COVID-19 outbreak is critical. Consideration needs to be given to the processes to achieving this including establishing an outbound call service to families of residents in services that are locked down due to a COVID-19 outbreak.

The Victorian Operations Centre has identified five key factors that seem to influence outcomes for a RACF and can trigger the need for more intervention:

1 Acute changes in case load

2 Staff (workforce and training)

3 Stuff (PPE, waste management, testing etc.)

4 Space (IPC, cohorting and decanting)

5 System (Facility leadership and management)

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ANNEX C: Aged Care Case Management

This Case Management guidance applies to a non-health emergency situation but may be useful to adapt for emergency use in combination with CDNA guidance.

1. Case Managers

Case Managers will be appointed by the Australian Government Department of Health to ensure operators of a RACF are connected to the right avenues to seek assistance.

Case Managers are responsible for:

- taking carriage of cases that are identified as at extreme risk
- leading these cases supported by the existing case management team
- undertaking an integrated case management approach with support available from the Aged Care Quality and Safety Commission, State health department outbreak lead, Health Services Hub Lead, public health and Aged Care Emergency Response Centre (ACERC) particularly in respect of the management of residents (transfers, zoning options) and workforce.

Activities undertaken as part of this role include:

- Being the single point of contact for an aged care service.
- Ordering PPE for services.
- Being a conduit to identify workforce needs including clinical personnel, case workers, cleaners, catering, administrative staff etc.
- Linking to pathology testing where required.
- Generally helping the service problem solve.
- Inputting on the ground intelligence, identifying risks and issues requiring escalation.

The experience in Victoria is that scaling case management efforts to respond to a dramatic escalation in COVID-19 outbreaks is complex and requires careful planning, triage, case allocation and coordination. Case management and the structure of the State health system need to be closely aligned with the Response Centre to streamline points of contact.

2. Integration of Case Management and the public health response

Local PHUs

The PHU in each state or territory is the key governance and decision making forum to ensure a localised response to outbreak management and harness the health system capability, workforce surge and testing capacity. (In Victoria this is managed through four separate regionally based meetings rather than one all-encompassing meeting to reflect the four hubs model they have adopted).

The PHUs in each state or territory must allocate ACERC outbreak management leads (the health services system in Victoria is grouped into four metro hubs, each with a hub outbreak lead identified by DHHS to support the aged care response). These leads assist in activating the aged care response, liaise with the Australian Government leads and coordinate the system response. They will work from the Emergency Aged Care Response Centre.

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Australian Government

The Australian Government Department of Health will establish leads for the case management teams. These leads will align the case management teams with the health service system regions to ensure a coordinated outbreak management response. As cases increase, the Australian Government Department of Health will stand up new case management teams to manage an appropriate caseload.

Australian Government leads will interface with the ACERC Operations Lead through the outbreak management lead, except on an issues basis related to specific services.

Australian Government leads will chair the daily operations meetings. Where more than one Australian Government lead is involved, the lead with the most complex case will be chair the meeting.

The Aged Care Quality and Safety Commission (the Commission) will also allocate leads (in Victoria this is one in each of the four hubs).

Australian Government leads will work closely with the Commission lead to provide intelligence regarding aged care cases to inform regulatory decisions and support effective outbreak management.

The Australian Government Department of Health will establish a state-wide coordination team to:

- oversee Australian Government case management (governance, processes, administration);
- maintain an understanding of the State-specific context (consistency, best practice, trends, issues etc);
- coordinate allocations*, testing and rostering;
- coordinate reporting and briefings;
- case manage Home Care Packages and Australian Government Home Support Program outbreaks, monitor trends, issues and emerging risks; and
- provide a liaison point for the ACERC for State-wide issues and coordination.

** Allocations team will monitor workload distribution to ensure resourcing is matched to the needs in each region and new teams are established at threshold points (every 10-15 cases).*

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Template to align case management with health system hubs across key agencies

Hub	**Australian Government Leads - Case Management Teams**	**Emergency Response Centre/State health department - Outbreak Leads**	**Health Services Hub Aged Care Liaison lead**	**ACQSC Lead** (align with notices/ repatriation model)	**Public Health** (Opportunity for dedicated public health case and contact tracing operations team aligned within each hub catchment)
Hub #1 North Metro	Name Email Mobile Number				
Hub #2					
Hub #3					
Hub #4					
State-wide Coordination Team					

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ANNEX D: National Aged Care Emergency Response

The purpose of **National Aged Care Emergency Response** (NACER) is to:

- Seek experienced Registered Nurses, Enrolled Nurses, Personal Care Workers and Cleaners who are not in a COVID-19 vulnerable group (residential experience is highly desirable).
- Create a national pool of staff which can be deployed to assist aged care programs impacted by COVID-19, with a focus on residential aged care Victoria in the first instance.
- Aged care staff will temporarily be employed by Healthcare Australia who provide the necessary workers compensation and indemnity insurances which will provide staff, aged care providers and the Australian Government with some protection
- Direct resources to services impacted by COVID-19 based on priority, as established through the Response Centre.
- Providing national organisations, re-diverting staff to Victoria, with financial and logistical support to cover costs of travel, accommodation and a daily allowance.
- NACER staff are being offered an attractive remuneration package including $5,000 bonus, their casualised rate for hours worked for 38 hours for each week in quarantine and a daily travel allowance of $128.70.

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ANNEX E: Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission can provide information to assist in the management of the response such as:

- Provide intelligence insights and intelligence about the nature and circumstances of the services we regulate to support the co-ordination of government assistance and support to services affected at this time.
- Provide regular input about our regulatory intelligence and development of intelligence and reports (such as from national and targeted regulatory activities and provider performance history) and risk ratings of services.
- Amplify alerts and messages to provider and consumers of aged care services through our communication channels and actively and regularly engage with consumer peaks and provider representatives.
- Target monitoring activities to understand risks and to identify areas for improvement. The Commission can refer to other agencies for training and support. The Commission will escalate its regulatory response based on assessment of risk and evidence of failure in the quality and safety of care to consumers.
- Monitor and support for providers will focus on infection control and key risks to the quality and safety of care such as clinical governance, social isolation, mobility, nutrition, hydration and restraint.
- Provide quality and safety information from our risks-based monitoring of aged care services can inform the planning preparation, response and recovery elements

The important factor is that there is a system in place to drive operations. There is flexibility to add or remove elements to suit the response and the operational environment.

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ANNEX F: Key Plans and Reference Material

The Department of Health and the Aged Care Quality and Safety Commission (the Commission) have provided a number of resources to support aged care providers prepare for, and manage, an outbreak including:

Guidance

- AHPPC and CDNA's specific guidance for aged care services, particularly residential care facilities:
  - *Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities*
  - *Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities*

Factsheets

- Outbreak management in residential aged care facilities.
  - *https://www.health.gov.au/resources/publications/coronavirus-covid-19-outbreak-management-in-residential-care-facilities*
- First 24 hours – managing COVID-19 in a residential aged care facility
  - https://www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility

Training

- Online training for health and aged care workers in all settings. It covers the fundamentals of infection prevention and control of COVID-19.
  - https://www.health.gov.au/resources/apps-and-tools/covid-19-infection-control-training%C2

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ANNEX G: AHPPC Ethical Framework

Ethical framework

In 2008 the 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.

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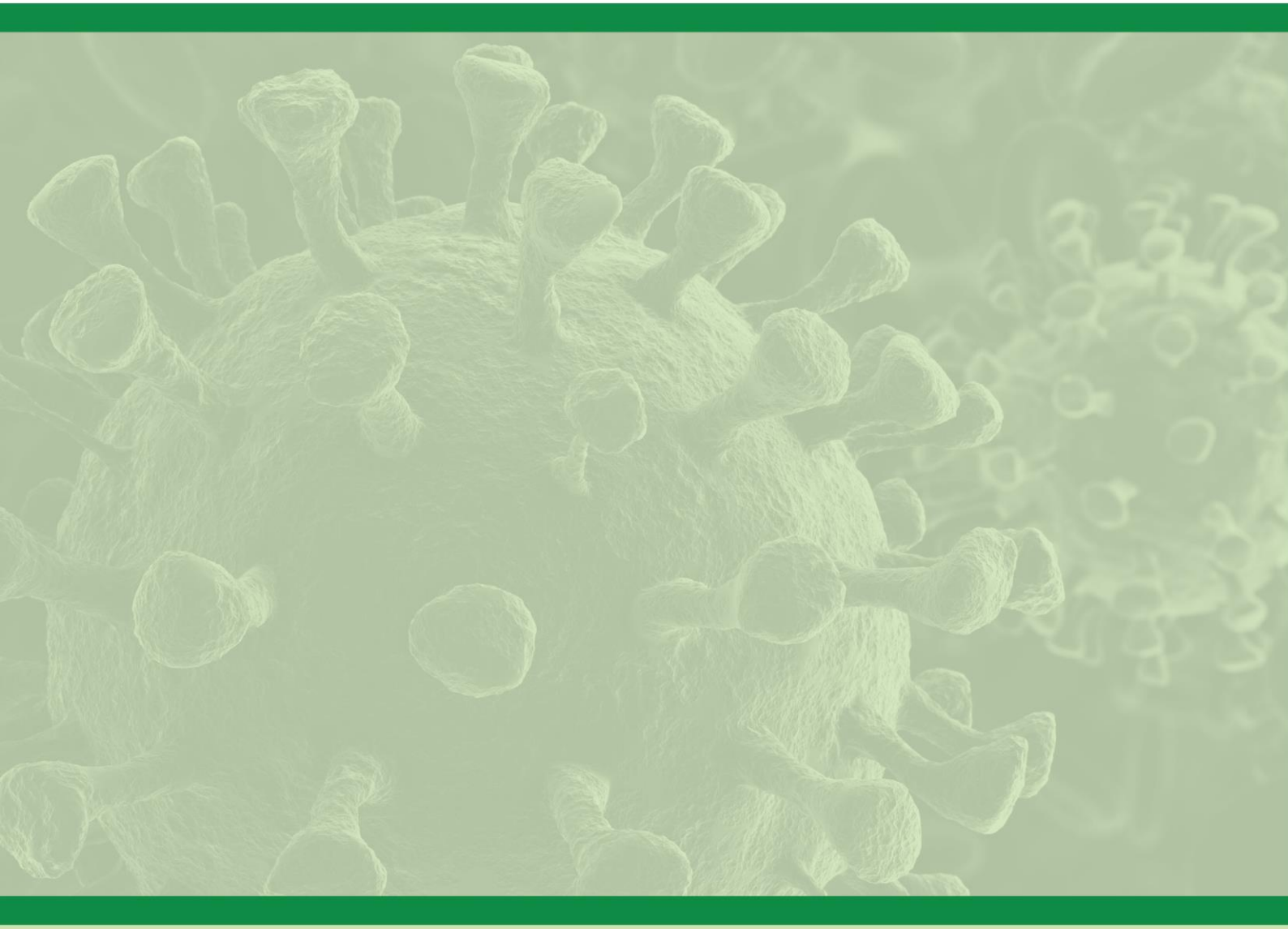

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