NSW Health Influenza Pandemic Plan

Summary The NSW Health Influenza Pandemic Plan provides guidance on a range of strategic response activities for NSW Health staff and agencies to effectively prepare for and respond to an influenza pandemic, in order to minimise the adverse health impacts on the NSW population and reduce the burden and disruption to health-related services in NSW.

Document type Policy Directive

Document number PD2016_016

Publication date 27 May 2016

Author branch Communicable Diseases

Branch contact 02 9391 9747

Review date 27 May 2023

Policy manual Not applicable

File number H15/9781-2

Previous reference N/A

Status Review

Functional group Corporate Administration - Governance
Clinical/Patient Services - Infectious Diseases
Population Health - Communicable Diseases, Disaster management
Personnel/Workforce - Workforce planning

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals, NSW Health Pathology

Distributed to Public Health System, Divisions of General Practice, Environmental Health Officers of Local Councils, Government Medical Officers, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres

Audience Administration;clinical;allied health;nursing;public health;senior executive and managers

Secretary, NSW Health

POLICY STATEMENT

NSW HEALTH INFLUENZA PANDEMIC PLAN

PURPOSE

The primary purpose of the NSW Health Influenza Pandemic Plan (the *Plan*) 2016 is to provide guidance to NSW Health staff and agencies on how to effectively prepare for and respond to an influenza pandemic, in order to minimise the adverse health impacts on the NSW population and reduce the burden and disruption to health-related services in NSW.

The *Plan* also aims to contribute to whole-of-government response activity to reduce the adverse social and economic impacts associated with an influenza pandemic in NSW.

The *Plan* is intended to be flexible enough to provide guidance on the response to a large outbreak of any highly transmissible respiratory pathogen with significant morbidity and mortality.

MANDATORY REQUIREMENTS

NSW Health agencies and services must ensure that District level and health facility level pandemic plans align with the planning assumptions, emergency management principles and planned strategic response activities outlined in the *Plan*. A pandemic plan checklist for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) is provided in Appendix 8 of the *Plan*.

IMPLEMENTATION

Preparing for and responding to an influenza pandemic is a whole-of-health responsibility. The *Plan* presents a range of state-level strategic options for NSW Health agencies and services in preparation for and response to an influenza pandemic, but does not provide operational detail.

Appendix 7 of the *Plan* outlines roles and responsibilities for all health-related agencies and services in NSW in preparation for and response to an influenza pandemic. Additional detail on roles and responsibilities for specific key response areas are provided throughout the document.

REVISION HISTORY

Version	Approved by	Amendment notes
May 2016 (PD2016_016)	Secretary, NSW Health	Replaces the 2010 version. Revised plan following the 2014 NSW HEALTHPLAN and the 2014 Australian Health Management Plan for Pandemic Influenza (AHMPPI). Final version recommended by the Chief Health Officer and endorsed by the Secretary and the State HSFAC.
August 2014 (PD2010_052)	Director General	Replaces the 2005 version. Revised plan following the H1N1 2009 pandemic.

ATTACHMENTS

1. NSW Health Influenza Pandemic Plan: Procedures.

NSW Health Influenza Pandemic Plan

NSW GOVERNMENT Health

Policy Directive

Issue date: May-2016

PD2016_016

AUTHORISATION

The *NSW Health Influenza Pandemic Plan* is a sub plan to the *NSW Human Influenza Pandemic Plan*. It details the specific health emergency arrangements to manage potential or actual outbreaks of pandemic influenza.

This plan is authorised in accordance with the provision of the NSW Public Health Act and associated Regulations.

SUPPORTED _____

Dr Ron Manning

State Health Services Functional Area Coordinator

ENDORSED _____

Dr Jeremy McAnulty

A/Chief Health Officer and Deputy Secretary, Population and Public Health

ENDORSED _____

Dr Kerry Chant

A/Secretary, NSW Health

TABLE OF CONTENTS

1 INTRODUCTION

This is the *NSW Health Influenza Pandemic Plan*. The plan provides a framework to aid the New South Wales health sector response to an influenza pandemic and to outbreaks of other respiratory pathogens with pandemic potential. The plan is always 'active'.

This plan provides a strategic outline of a range of possible NSW Health response activities that will need to be tailored during an influenza pandemic response.

Supporting documents for specific functional or technical areas of the pandemic response are maintained separately by individual NSW Health agencies.

The development of this sub plan has been informed by the following pandemic plans:

- National whole-of-government influenza pandemic plan – *National Action Plan for Human Influenza Pandemic (NAPHIP)*
- National health influenza pandemic plan – *Australian Health Management Plan for Pandemic Influenza (AHMPPI)*
- NSW whole-of-government influenza pandemic plan – *NSW Human Influenza Pandemic Plan (NSW HIPP).*

An influenza pandemic will have a sustained impact over many months and a specific pandemic plan and different organisational arrangements drawing on existing public health systems are required. The aim is to ensure overall management of the health system whilst responding to the pandemic.

This plan will be reviewed:

- On conclusion of an emergency during which this plan was implemented
- On the introduction of any major structural, organisational or legislative changes which affect NSW Health or key stakeholders
- Under direction from the Health Secretary or Chief Health Officer
- Every five years.

Throughout this plan, 'NSW Health' refers to the broader NSW public health system including NSW Ministry of Health (MoH), Local Health Districts (LHDs), Sydney Health Networks (SHNs), and other health agencies such as the Clinical Excellence Commission (CEC), the Agency for Clinical Innovation (ACI), and shared services.

2 INFLUENZA AND OTHER POTENTIAL PANDEMIC VIRUSES

The influenza virus causes an acute viral disease of the respiratory tract. Influenza is primarily spread person-to-person by inhalation of and/or contact with infectious droplets, produced by infected people when they cough or sneeze.

Typical signs and symptoms of influenza include: fever, cough, myalgia, sore throat, headache, fatigue and chills. Infection may also occur without symptoms. Severe influenza-related complications include viral pneumonia or secondary bacterial pneumonia. Influenza may also cause a deterioration of chronic diseases such as chronic obstructive pulmonary disease or congestive heart failure.

Influenza is generally categorised into three types - A, B, and C – with outbreaks of influenza A and B occurring regularly every year. Seasonal influenza vaccination is an important intervention to reduce morbidity and mortality for groups at risk of severe disease, as listed in the *Australian Immunisation Handbook*.

Influenza viruses are characterised by distinct differences in their surface proteins (antigens). Both influenza A and B strains have a tendency to mutate leading to small changes in these surface proteins (antigenic drift). Novel influenza strains with pandemic potential may emerge when one strain undergoes a large mutation affecting its surface proteins or when different strains mix their genes in an infected host through genetic re-assortment (antigenic shift).

Only novel influenza A viruses have been known to cause pandemics. However other respiratory viruses with pandemic potential might also emerge or re-emerge (such as SARS coronavirus).

The population health impact of an influenza pandemic is determined by how readily it can be transmitted (i.e. transmissibility) and the seriousness of the illness it causes (i.e. clinical severity). The most severe pandemics are associated with a new influenza A virus that is both highly transmissible and causes severe illness, such as the 1918 ‘Spanish Influenza’ pandemic. Pandemic influenza viruses that tend to cause milder illness can still have a major population health impact, as everyone in the community will be susceptible to infection (e.g. the 1957 A(H2N2) pandemic).

For a novel influenza virus to have pandemic potential it must meet three criteria:

- Humans have little or no pre-existing immunity against the virus
- The virus leads to disease in humans
- The virus has the capacity to spread efficiently from person to person.

This plan is designed to be flexible and adaptable enough to also guide the response during a severe influenza season or to another respiratory pathogen with pandemic potential. The key factors determining the specific response measures for a specific pathogen include its mode and ease of spread, whether it is transmissible prior to the onset of symptoms, and the severity of the illness it produces.

More information about pandemic influenza is available from NSW Health (*www.health.nsw.gov.au*) and the Department of Health (*www.health.gov.au*) websites.

3 KEY ASPECTS OF THE NSW RESPONSE

3.1 Objectives of the response

The key objectives of the pandemic response in NSW are to:

- Minimise transmission, morbidity and mortality of the pandemic virus in the NSW population
- Inform, engage and empower the public and health professionals to assist in the response to the pandemic
- Minimise the burden on the NSW Health system, health support services and partner agencies to respond to the pandemic
- Ensure that all health sectors work in partnership to provide a coordinated and timely response
- Maintain effective functioning across health services to manage other health issues during the pandemic response so as to achieve optimum health outcomes for the NSW population during a sustained influenza pandemic.

These objectives are in accordance with those outlined in the AHMPPI and NSW HIPP.

3.2 Principles guiding the NSW response

The principles guiding the overall pandemic response in NSW are as follows:

- ***Use of existing systems where possible*** – to avoid duplication and to ensure resilience of pandemic arrangements as far as possible (e.g. existing seasonal influenza surveillance systems, emergency department activity coordination).
- ***Flexible approach*** – to be responsive to the range of possible patterns of spread through NSW during a pandemic, and the spectrum of pandemic infections ranging from asymptomatic to severe illness.
- ***Proportionate response*** – to use pandemic response strategies that can be scaled up or down, proportionate to the clinical severity of the pandemic virus and to the needs of the NSW population.
- ***Recognising additional needs of at-risk and vulnerable groups*** – to ensure that additional health support is provided for groups at risk of severe disease, such as Aboriginal people and people with chronic conditions, and which recognises the needs of people from culturally and linguistically diverse backgrounds in NSW.
- ***National coordination*** – to work collaboratively with other jurisdictions to ensure national consistency in pandemic response measures wherever possible and be guided by the Australian Health Management Plan for Pandemic Influenza (AHMPPI).

3.3 Planning assumptions and scenarios

The NSW Health response will need to be flexible for a range of pandemic scenarios dependent on the clinical severity of infection caused by the pandemic virus, as summarised in Table 1.

Key planning considerations for a pandemic response include the following:

- ***Extended response time*** – healthcare services across the state need to be prepared for a marked increase in demand for healthcare services that may last an extended period of time.
- ***Unknown origin*** – a pandemic virus could emerge at any time of the year and anywhere in the world, including Australia. However, the most likely scenario is for a virus to emerge and be identified overseas, and then be imported into Australia by infected travellers over the next few weeks to months.
- ***Border screening ineffective*** – as infected travellers may have no symptoms on their arrival into Australia, border screening of incoming passengers is unlikely to be of benefit in preventing a pandemic influenza strain entering the country.
- ***Rapid community spread*** – a pandemic influenza virus may cause widespread community illness very quickly due to a short incubation period and the lack of existing immunity in the population. Once the pandemic strain enters NSW it is likely to spread to all parts of the state within a few weeks.
- ***Similar at-risk groups*** – it is reasonable to expect that population groups already known to be at increased risk of severe influenza infections will also be at increased risk during the next pandemic. The health needs of at-risk groups (such as pregnant women, people with chronic diseases) and communities with higher numbers of at-risk individuals (such as Aboriginal communities) need to be taken into account in planning for and responding to a pandemic.
- ***Early information critical for responses*** – epidemiological and clinical information about the novel virus – such as how severe the disease is, how readily it is passed from person to person, which people are most impacted (e.g. particular age groups, predisposing co-morbidities) – may be gained from both local and overseas experience. This evidence will, together with health service impact data, help to inform the implementation of health response strategies to minimise the rate of spread and reduce the overall impact of the pandemic.
- ***Multiple pandemic waves possible*** – experience with past pandemics suggests that there may be subsequent waves of infection in the months after the first wave dissipates. The impact of the pandemic virus in subsequent waves will be strongly influenced by the level of acquired immunity in the community and by decisions around influenza vaccination programmes.

Table 1: Planning scenarios for the NSW Health response to a pandemic

Level of clinical severity	Potential population health impacts	Potential health sector response measures/considerations [1]
Low E.g. pandemic virus causing mild illness with impact similar to a severe influenza season	• Majority of cases have illness of mild to moderate severity • At-risk groups may experience severe disease and death	• Early general public communications to inform and provide practical risk reduction measures • Targeted communications to groups at higher risk • Implement hospital surge management strategies to cope with increased demand as the outbreak spreads in the community • Close engagement with the primary care and community pharmacy sectors in response strategies
Medium E.g. pandemic virus causing mild to moderate illness in most but severe illness for different groups across the state	• Clinical presentations for influenza-like illness above what is expected for a severe influenza season • More severe disease and deaths in at-risk groups and young people • Healthcare staff absences may be high	• Social distancing measures may be considered • Early and frequent communications for the community and at-risk groups regarding response strategies • Optimise resources across health services to achieve overall health outcomes for the population • Consider implementing additional surge/demand management actions, such as delaying or reducing non-urgent activities, surge staffing, and alternative models of care • Continuing close engagement with the primary care and community pharmacy sectors in response strategies and consideration of alternative models of care • Diagnostic testing may need to be prioritised to effectively utilise resources • Antiviral and vaccine use focus on at-risk groups • Work with other government stakeholders to control spread
High E.g. pandemic virus causing severe illness across the state	• Clinical presentations for influenza-like illness may be very high in the population • Majority of cases in the community may experience severe illness • Death rates may be high for at-risk groups • Specialist and critical care capacity in hospitals may be challenged • Healthcare staff absences may be high	• Social distancing measures likely • Strong coordination and prioritisation to ensure hospitals maintain essential services • Surge staff strategies and alternate models of care to respond to high staff absences • Laboratory testing targeted to utilise resources effectively • Priority on supporting the health of at-risk groups, including Aboriginal people • Antiviral and vaccine policy may focus on preventing illness and transmission in the population • Potential use of overflow facilities within LHDs to support patient care and management, including residential care facilities and other suitable venues

[1] Note that lower level responses also apply in higher level scenarios.

4 GOVERNANCE ARRANGEMENTS

4.1 National governance

National arrangements are detailed in the *AHMPPI* and the *NAPHIP*. Department of Health (DoH) oversees the national pandemic response, collecting and analysing national surveillance data and managing the National Medical Stockpile.

The Australian Health Protection Principal Committee (AHPPC) coordinates inter-jurisdictional health preparedness and the response to the pandemic. The NSW Chief Health Officer represents NSW on AHPPC.

AHPPC is supported by groups such as the Communicable Diseases Network of Australia (CDNA) and the Public Health Laboratory Network (PHLN), both of which have NSW Health representatives.

4.2 NSW whole-of-government governance

The *NSW State Emergency Management Plan* (*EMPLAN)* and the *NSW Human Influenza Pandemic Plan* (sub plan to *EMPLAN*) identify NSW Health as the lead (combat) agency, with decision-making authority, for any human infectious disease emergency.

Unlike other emergencies where NSW Health involvement as a supporting agency is coordinated by the State Health Services Functional Area Coordinator (HSFAC), when NSW Health is the combat agency (i.e. during a pandemic), it is the Incident Controller who leads the response. The Incident Controller is the Health Secretary.

Where a coordinated whole-of-government response is required, the Incident Controller and the State HSFAC will liaise with the State Emergency Operations Controller (SEOCON), under the provisions of *EMPLAN*.

The *Human Influenza Pandemic Plan* enables the formation of a peak strategic and policy decision-making body, of which the Minister for Health, Health Secretary and Chief Health Officer will be key advisors, to coordinate the whole-of-government response to a pandemic.

4.3 NSW Health governance

A pandemic will be managed using existing systems and resources as far as possible. The Health Secretary, as Incident Controller, will have overarching responsibility for Health's response to a pandemic and will establish an incident management team to oversee the response across the Health system.

Core members of the State Pandemic Management Team include:

- Health Secretary (Chair)
- Chief Health Officer/ Deputy Secretary Population and Public Health
- State HSFAC

- Deputy Secretary – System Purchasing and Performance
- Deputy Secretary – Governance Workforce and Corporate
- Deputy Secretary – Strategy and Resources
- Director – Public Affairs, Ministry of Health
- Chief Executive – Agency for Clinical Innovation
- Chief Executive – Clinical Excellence Commission
- Chief Executive – HealthShare NSW
- Chief Executive – NSW Health Pathology
- Chief Executive representation from metropolitan and regional NSW local health districts
- Additional representatives may be invited as required.

Pandemic-specific response groups (e.g. system performance, public health) may be implemented by the State Pandemic Management Team to manage state-wide coordination of their respective portfolio areas. These groups may choose to use an incident management system such as AIIMS as the basis of operational management arrangements. To avoid duplication of advice, requests and activity, it is essential that relevant information is communicated across response groups.

NSW Health Chief Executives remain responsible for the operation of their health services and can draw on the support of the State Pandemic Management Team and local emergency management resources.

Existing emergency management arrangements described in NSW HEALTHPLAN (PD2014_012) are available to support coordination of whole-of-health resources or provision of expertise as needed, however, during a pandemic, the provisions of this plan override those of HEALTHPLAN.

The State HSFAC will assist with coordinating any required reporting to the State Emergency Management Committee (SEMC) and support the Incident Controller as required.

Table 2 below summarises the key NSW Health governance arrangements in NSW during a pandemic.

Table 2: NSW Health governance arrangements during the pandemic

Role	Responsibilities
Health Secretary (Incident Controller)	• Overarching responsibility for pandemic preparation, response and recovery • Chair of the State Pandemic Management Team • Participates in peak NSW whole-of-government pandemic strategic and policy decision-making bodies • Incident Controller responsibilities as per section 7, #706 *EMPLAN*
Chief Health Officer (CHO)	• Liaises with the Minister for Health and the Health Secretary to provide advice and make recommendations regarding response management • NSW representative on the Australian Health Protection Principal Committee • Member of the State Pandemic Management Team • Participates in peak NSW whole-of-government pandemic strategic and policy decision-making bodies
State Health Services Functional Area Coordinator	• Supports the Incident Controller as requested, including liaising with State Emergency Operations Controller (SEOCON) regarding whole of government support • Member of the State Pandemic Management Team
State Pandemic Management Team	• Coordinates strategic management of NSW Health's response to a pandemic • For membership see previous page
LHD/SHN Chief Executives	• Responsible for LHD/SHN preparation for, operational response to and recovery from a pandemic
LHD/SHN Health Service Functional Area Coordinators	• Support LHD Chief Executives with pandemic response activities as requested

5 PANDEMIC STAGES AND KEY RESPONSE STRATEGIES

The framework for pandemic management in NSW is one of *prevention*, *preparedness*, *response* and *recovery* (*PPRR*). This aligns with the response stages outlined in the *AHMPPI* and the NSW response arrangements detailed in this plan.

The *AHMPPI* response stages (summarised in Appendix 5) focus on pandemic preparedness and operational response for the health sector but also guide the whole-of-government response. The AHMPPI pandemic stages are independent of the global pandemic phases as declared by the World Health Organization (WHO).

A detailed summary of the key state-level NSW Health responsibilities at each stage of the pandemic are presented in Appendix 6.

5.1 Prevention

The period prior to the identification of a novel pandemic influenza strain affecting humans is an important time to optimise existing influenza surveillance systems and ensure they are applicable to pandemic responses. This includes laboratory surveillance to identify novel influenza strains with pandemic potential.

NSW Health also collaborates closely with the NSW Department for Primary Industries in its efforts to prevent and control outbreaks of influenza in animals to minimise the risk of transmission to humans.

5.2 Preparedness

During the preparedness stage, potential pandemic pathogens that have emerged would be under close monitoring and surveillance by international and national health agencies to allow a tailored and proportionate response.

Within NSW, pandemic preparedness requires active engagement and communication with a range of stakeholders including:

- Clinical groups in health facilities most affected, including emergency departments, infectious diseases, infection control and critical care
- Peak general practice groups and other primary care and pharmacy groups
- Other government agencies and community groups that may be impacted.

Preparedness of the health system requires development of the workforce, particularly through training in infection control and through participation in exercises testing responses to a range of pandemic scenarios.

Pandemic response capacity relies on, and builds upon, seasonal influenza response measures embedded in the health system. This includes robust infection control practices (such as hand-washing, respiratory etiquette, isolation of cases) and routine influenza vaccination for healthcare workers and at-risk populations. This also includes interventions to optimise emergency department performance at times of peak influenza activity in the community.

5.3 Response

Once a new human virus with pandemic potential has been identified a range of major pandemic response strategies will be considered. Under the AHMPPI, the response stage is delineated into four sub-stages including: *Standby, Initial action, Targeted action and Stand down* reflecting the need to tailor response activities according to the spread and impact of the pandemic virus in Australia.

The transition through pandemic response stages will be guided by emerging data on the clinical severity and transmissibility of the virus and its impact on the population. The decision to transition through the different stages will be taken by the Australian Government in consultation with states and territory jurisdictions. The

Health Secretary in consultation with the State Pandemic Management Team will determine the transition through different response stages in NSW.

The *Standby stage* may vary considerably in duration depending on the spread of the pandemic virus once it reaches Australia. It represents a period of time to ensure enhanced arrangements are in place to coordinate the early response to the pandemic in NSW; for example, communications, governance, surveillance and any border activities if appropriate.

During the *Initial action* stage, detailed clinical and epidemiological data are gathered to understand the nature of the virus and its potential impact in NSW.

During the *Targeted action* stage, as the pandemic becomes more widespread and the demand on health care services increases, tailoring response measures will require regular review of data from disease surveillance and from monitoring of health system and workforce impacts. The effectiveness of any interventions implemented will be assessed to help ensure that the best use is made of the resources available to achieve optimum health outcomes for the population.

During the *Stand down* stage, the decreasing impact of the pandemic may not be the same across geographical areas or population groups in NSW. Targeted response measures may still be required for some LHDs with higher activity, as other areas wind down their activities and move into recovery.

5.4 Recovery

The states and territory jurisdictions have primary responsibility for managing the *Recovery* stage. All NSW Health agencies will work together to support health services and community recovery.

Considerations for LHDs/SHNs and other NSW Health agencies during the recovery stage include the need to plan for services and staff to transition back to “normal” levels/duties. This is an important stage to conduct intra- and interagency evaluations and lessons learnt exercises and incorporate these lessons into future plans and strategic policies.

Auditing and replenishing stockpiles of essential medical supplies and equipment is also a key activity during the recovery stage.

6 ROLES AND RESPONSIBILITIES

The MoH, which for the purposes of this plan includes Health Protection NSW (HPNSW), is responsible for state-wide strategic planning and the implementation of key response activities for a pandemic through the State Pandemic Management Team. This will require close collaboration between all NSW Health and partner agencies.

Appendix 7 outlines the specific responsibilities of MoH Divisions and key NSW Health supporting agencies.

LHDs/SHNs are responsible for planning and delivering health services for their populations according to the principles outlined in this plan. An implementation checklist for LHDs/SHNs is provided in Appendix 8 to support the development of a district-level operational plan for a pandemic.

All NSW Health agencies must undertake regular training, exercises and have business continuity plans, policies and guidelines in place for a pandemic. During the response stage, all NSW Health agencies will be required to provide relevant expertise and advice according to their portfolio. It will be important during a pandemic response to seek feedback and disseminate information through key networks.

7 COMMUNICATION

Timely and accurate communication with the public, healthcare workers, government agencies and industry will assist with maintaining a coordinated and controlled response to a pandemic.

The *AHMPPI* contains information on the national coordination and sharing of information and strategies for how this information is communicated to health stakeholders and the public during the pandemic response.

7.1 Communicating with the public

At the national level, the coordination of the content, delivery and timing of communication messages for the public will be crucial for ensuring confidence in our response to the pandemic. The National Health Emergency Media Response Network (NHEMRN) is responsible for developing and disseminating national communication messages and adaptations for specific audiences.

The NHEMRN is made up of all state and territory health department media units, relevant government agencies, national medical colleges, National Aboriginal Community Controlled Health Organisation (NACCHO) and parts of the private sector directly involved in emergency management.

The Australian Government's Department of Foreign Affairs is responsible for issuing travel warnings to Australians during the pandemic.

In NSW the Public Information Functional Area Coordinator (PIFAC), established under *EMPLAN*, coordinates public information messages on behalf of all government agencies during a multi-agency coordinated emergency response. During a pandemic, the Health Communications Controller works closely with the PIFAC.

MoH Public Affairs Unit will coordinate the response to media enquiries, including the development and dissemination of key messages on behalf of NSW Health at the state level. MoH Strategic Relations and Communications Branch will be responsible for the development and dissemination of state-wide resources and healthcare awareness campaigns in collaboration with MoH Population and Public Health Division. MoH Public Affairs Division and Strategic Relations and Communications

Branch will support the Health Communications Controller to develop an integrated communication plan, including use of new media, to ensure coordination of all state-level communications during a pandemic.

The Health Communications Controller in close liaison with the PIFAC will coordinate the timing and release of national messages via NHEMRN during a pandemic.

Health content experts (e.g. public health or clinical services) will work with the Health Communications Controller to develop consistent state-wide public information messages delivered by a qualified spokesperson.

A pandemic can result in a large surge of inbound calls from the public to LHDs. LHDs should plan for options that help utilise existing local telecommunications infrastructure to manage demand as far as possible during a pandemic. If the surge of inbound calls to either the LHDs and/or MoH substantially increases, the Public Health Controller may activate contact centre capacity. The PIFAC in liaison with the Health Communications Controller may also activate the state Public Information Centre.

Some culturally and linguistically diverse (CALD) populations will require tailored and clear messages to address specific health concerns. MoH will work with health partner agencies, including the Aboriginal Health and Medical Research Council of NSW, NSW Multicultural Health Communication Service, NSW Refugee Health, community elders and leaders, to develop a consistent state-wide and coordinated approach to developing and disseminating information and resources for CALD groups during the pandemic.

LHDs should coordinate public messages of local relevance (including those specific for CALD populations) with the approval of the Health Communications Controller.

MoH will work with NSW Multicultural Health Communications Service to ensure that the state-wide NSW Health Care Interpreter Service is briefed as early as possible during a pandemic, so that it can respond accordingly to any increased demand for interpreter services.

7.2 Communicating within the NSW health system

During a pandemic, information about changes to specific aspects of the NSW pandemic response such as infection control recommendations, clinical services, and case definitions will need to be quickly and reliably communicated to healthcare workers, including staff working in NSW Health agencies, Aboriginal health services and community healthcare providers such as GPs and community pharmacies.

The State Pandemic Management Team will coordinate dissemination of relevant information to NSW Health agencies via key contacts (such as Chief Executives, Directors of Clinical Operations, LHD HSFACs, Public Health Unit (PHU) Directors or LHD emergency operations centres).

MoH in collaboration with the DoH will disseminate national messages regarding key pandemic response actions (e.g. change in pandemic stage) to general practitioners (GPs) and community pharmacies.

MoH communicates with the primary health care community (e.g. GPs, Aboriginal health services, community pharmacies) both through their peak bodies and existing reference groups and through direct communications, such as GP practice fax alerts. The National Health Services Directory may also be utilised for emailing information as required. MoH will continue to convene meetings with the peak private hospital groups and aged care facility agencies (e.g. Aged and Community Services NSW and ACT) to keep them informed about pandemic influenza planning developments and to encourage them to adopt appropriate pandemic management policies in their facilities.

The Centre for Aboriginal Health (NSW Health) will convene an Aboriginal Medical Services Advisory Group to consult with Aboriginal health services during a pandemic.

LHDs/SHNs are responsible for maintaining and utilising existing networks and channels of communication to notify local service providers, including any private hospitals, of any changes in key pandemic response activity during a pandemic. LHDs/SHNs are responsible for managing communication with their employees. These messages will complement those being released by the NSW and Australian governments but will add tailored local messages as appropriate.

7.3 Communicating with key government agencies and industry

The Health Communications Controller will liaise closely with cross-government agencies.

The PIFAC is responsible for coordinating communications to business and industry across NSW in consultation with the MoH and Health Communications Controller and other relevant agencies. This would ensure agencies or services providing contractual services to the NSW Health system (e.g. waste disposal and cleaning contractors) are adequately informed of any changes to the pandemic response in NSW.

8 MITIGATION OF TRANSMISSION

8.1 Infection control

The overall aim of infection control measures is to reduce exposure to and transmission of a pathogen. The *AHMPPI* outlines several infection control strategies for managing a pandemic virus in healthcare facilities and in the community.

There is good experimental evidence to demonstrate that influenza is transmitted directly through infectious droplets (i.e. from coughing and sneezing) or indirectly through contact with surfaces contaminated by respiratory droplets (e.g. skin, clothing or objects).

The risk of transmission can be greatly decreased by:

- Individual measures (e.g. hand hygiene and respiratory etiquette)
- Appropriate use of standard, contact and droplet infection control precautions

- Appropriate use of PPE (e.g. gloves, gowns, eye protection and respiratory protection, as appropriate)
- Organisational environmental measures, including: signage; triaging and patient management; isolation rooms and/or cohorting of patients; increased environmental cleaning; and staff vaccination when available.

8.2 Healthcare facilities

Many infection control methods are applied on an ongoing basis, as outlined in the NSW Health *Infection Control Policy* (PD2007_036). More stringent methods may be used across the health system during a pandemic, as outlined in *Minimising Transmission of Influenza in Healthcare Facilities guideline* (GL2010_006).

If there is a reasonable risk of airborne transmission, additional airborne precautions may need to be added to existing infection control measures in healthcare facilities.

In the setting of a pandemic with medium to high clinical severity, enhanced infection control (such as additional environmental cleaning) and isolation measures (e.g. visitor screening) may be recommended to protect at-risk inpatients from transmission of pandemic influenza within healthcare facilities. Minimum standards for environmental cleaning in healthcare facilities are outlined in the NSW Health *Environmental cleaning policy* (PD2012_061).

Through ongoing workforce training schemes, LHDs are responsible for ensuring all personnel working within facilities of their district are equipped with adequate infection control skills.

8.3 Community resources

Communication materials (e.g. pamphlets, online factsheets, mass media advertisements, social media campaigns and signage) in community settings can be effective tools for promoting good infection control practices in the community.

Members of the general community will also require information on strategies to minimise their risk of exposure to influenza and to reduce the risk that they will transmit the virus to others in households, schools, workplaces and public spaces. This may include guidance on early treatment to reduce the infective period.

MoH will work with LHDs to ensure this information is distributed to members of the general public through appropriate channels and in a timely fashion (see *Communication section*). Information provided to primary and community health care providers will include recommendations on clinical assessment and management, including infection control, laboratory testing, antiviral treatment and vaccination.

8.4 Social distancing

Social distancing is a community-level intervention to reduce normal physical and social population mixing in order to slow the spread of a pandemic throughout

society, as described in the *AHMPPI*. Minimising the number of contacts of an infectious case can help reduce transmission of the pandemic virus. A range of social distancing interventions are discussed in the *AHMPPI* (pgs. 143-152), including school and/or workplace closures, cancellation of mass gatherings and home isolation and quarantine of cases and contacts (see section below).

The decision to implement widespread and significant social distancing measures would be carefully considered by national and state whole-of-government processes. The implementation of social distancing measures in NSW would depend on the timing and stage of the pandemic response, along with the transmissibility and clinical severity of the pandemic virus.

Depending on the extent to which social distancing measures are applied, the effect on workforce absenteeism and the disruption to daily life may be considerable. The compliance with and benefits of social distancing measures are likely to be highest when the disease is clinically severe.

MoH in partnership with the PIFAC will develop and disseminate public messages emphasizing the rationale and importance of following social distancing procedures as appropriate.

8.5 Home isolation and quarantine

During a severe pandemic, symptomatic individuals may be recommended to remain in home or hospital isolation and this may be extended to exposed contacts (i.e. home quarantine). Both methods are important ways of reducing further virus transmission. Voluntary measures are preferred as compliance is generally high when the community is provided with the rationale behind the measures. Public health powers are an option to enforce quarantine or isolation and this may be considered in the context of a pandemic virus associated with severe clinical outcomes.

A key aspect of emergency preparedness is encouraging self, family and community resilience to improve individuals' ability to self-manage in home isolation (for cases) and quarantine (for contacts, if recommended). This may include the promotion and use of community resources such as a plan for a home emergency kit and emergency pantry list.

This guideline also outlines a range of strategies for health agencies on how to collect surveillance data from cases and contacts in home isolation and quarantine. This includes the use of phone calls and/or SMS systems, as well as NCIMS to collect and record epidemiological data.

Support in sourcing alternative accommodation for large numbers of people would be provided by the State Emergency Operations Controller under the arrangements detailed in the *NSW HIPP*. However, this is unlikely to be a useful measure during a pandemic and would only be recommended in extreme circumstances.

It is essential that the health and welfare needs of those in home isolation and quarantine are adequately addressed. Arrangements for accessing support from other NSW agencies are detailed in the *NSW HIPP*.

9 HEALTHCARE DELIVERY - FACILITIES

Hospitals and other healthcare facilities will need to consider a range of service options to enable them to continue to deliver optimal health outcomes to the population, both for pandemic and non-pandemic patients. Communications within and between LHDs to share information on approaches to service delivery will be important in identifying the best service delivery options for each facility.

During the pandemic response, CEs may wish to consider a range of healthcare facility models to assess, manage and treat pandemic patients according to the spread and potential impact of the virus.

- During the *Initial action* stage, when the pandemic virus has only just emerged in NSW, LHDs may wish to consider enhanced ED triage for patients presenting with ILI and/or respiratory complications.
- During the *Targeted action* stage, as the pandemic virus spreads more widely in the community, LHDs may need to consider alternative models of care that preserve the capacity of EDs to respond to other patients with acute care needs either within or outside of the facility.

LHDs/SHNs should liaise with private health and aged care about key response strategies utilised during a pandemic in NSW.

Private hospitals are encouraged to adopt pandemic planning and management policies similar to those outlined in this plan. Private hospitals providing public services should prepare their plan together with the relevant LHD.

LHDs should incorporate EDs, critical care units and PACs into their business continuity planning for responding to a pandemic. These business continuity plans should include consideration of the need for additional resources to support:

- Staffing in critical demand areas
- Infection control, including PPE
- Medical supplies and equipment (e.g. ventilator equipment and medications).

Facility managers in LHDs should review food and linen production and distribution requirements during a pandemic, in consultation with HealthShare NSW in order to support the clinical management of patients within healthcare facilities.

9.1 Clinical management

During a pandemic, demand for acute care is predicted to be very high. Adjustments may need to be made to the routine delivery of hospital services to maximize the benefit of scarce resources in the most effective and ethical way. Principles guiding the management of demand and capacity within healthcare services include:

- That care given to people will be maximised within the available resources
- Plans should be consistent with the aim of preserving and maintaining essential healthcare services
- Changes to service delivery and clinical protocols should reflect changes in local and/or regional demand where appropriate
- Decisions regarding surge capacity and demand management should be coordinated at a strategic level within the health care service to ensure consistency of approach
- That a phased approach be used in scaling back any healthcare services to ensure demand management reflects the pandemic impact at the time
- Coordination by Health system support staff to ensure cross-district consistency of access is maintained.

Prior to the pandemic, LHDs and SHNs should identify all acute services that they provide, how services might be prioritised and plan for alternative mechanisms of service delivery where necessary. This planning work should encompass all local health service providers.

In developing plans for healthcare demand management during a pandemic, LHDs and SHNs should consider inter-related elements of healthcare services, including:

- physical aspects of capacity (e.g. beds, wards and ventilation equipment)
- hospital staff numbers (e.g. of clinical, allied health and administrative staff) and ability for staff to cross over to other areas
- clinical services and protocols (e.g. types of services and models of care).

While governance for service delivery changes within LHDs rests with LHD Chief Executives, state-wide agreement will be sought wherever possible for any major changes to services, such as criteria for admission, triage or discharge, or new clinical management guidelines. This will be with the aim of promoting equitable delivery of healthcare across all districts.

Groups of specialist physicians (e.g. infectious diseases, maternal and newborn care and critical care) will be consulted to provide expert advice on the appropriate clinical management of patient groups.

9.2 Emergency departments (EDs)

EDs are a critical part of the hospital response to a pandemic in NSW. The level of response needed by EDs should be based on data on the epidemiology of the pandemic virus and the capacity of EDs to respond.

Guidance on clinical models of care and the role of ED staff during a pandemic are provided in the Australasian College of Emergency Medicine (ACEM) guidelines on the *Management of severe influenza, pandemic influenza and emerging respiratory illnesses in Australasian Emergency Departments.*

EDs will need to monitor capacity to manage suspect and/or infected patients throughout the pandemic to help inform LHD planning in regards to the establishment or stand down of different models of care. For example, the ACEM guidelines include consideration of advanced screening stations outside EDs, designated 'flu areas' within EDs and/or establishment of stand-alone PACs (see below).

9.3 Pandemic assessment centres

Pandemic Assessment Centres (PACs) are stand-alone facilities, separate (physically and operationally) from existing hospital EDs, which are used for triaging and assessing individuals with ILI. PACs provide one option for healthcare facilities to respond to increased patient demand during a pandemic but they may not be the most appropriate option for all facilities, particularly where alternative strategies already exist.

PACs may be activated by LHDs/SHNs at any time. The Health Secretary, in consultation with LHD CEs, may also direct the opening of PACs.

The purpose of PACs is to ensure:

- EDs and GP surgeries are not overwhelmed with suspected influenza cases and can continue, as far as possible, with their routine business
- Hospital-associated transmission of influenza is minimised by ensuring potentially infectious patients visiting the clinic are kept separate from other patients seeking care in the hospital facility
- A standardised method for assessing and managing patients is adopted
- Anti-viral medication is commenced as required.

In the preparation period, each LHD should identify appropriate sites and develop a staffing and resource plan for PACs. As far as possible, staff for PACs should not be drawn from existing ED staff, or from intensive care or specialist units. Consideration should be given to sites suitable for a range of pandemic scenarios, from mild to severe.

MoH provides guidance on the set-up, operation and resourcing of PACs to support LHDs during the pandemic. MoH will provide a standardised PAC patient form to enable appropriate assessment of patients and collection of data to inform the response at the LHD and state level.

To operate PACs efficiently, LHDs/SHNs will need to ensure there is adequate staffing, IT, network and internet access to enable collection and reporting of PAC service data. LHDs should consider how to inform local healthcare providers of PAC locations and operating hours should the need arise. Private hospitals with EDs may also consider having plans for establishing PACs.

9.4 Critical care services

Critical care services may experience a significant increase in demand for personnel, specialised equipment (e.g. ventilators) and beds. Careful and detailed planning is essential for managing demand in intensive care units (ICUs), high-dependency units, paediatric intensive care units (PICUs), neonate intensive care units (NICUs) and medical retrieval services, as these services operate at or near full capacity on a regular basis.

The standard treatment for pandemic patients will mainly consist of antiviral medication (if indicated and available), antibiotics for secondary pneumonia, and supportive care. The use of mechanical ventilation or extracorporeal membrane oxygenation (ECMO) as treatment modalities for individual patients remains a clinical decision.

Communication will be essential between all critical care services in LHDs/SHNs and MoH to help build an epidemiological profile of the novel virus within clinical settings. MoH will engage and obtain strategic advice from the Medical Controller, ACI (including the Critical Care Taskforce), and the Sydney Children's Hospitals Network (SCHN, including the Paediatric Controller) on the prioritisation and delivery of critical care services for adults and children during a pandemic.

Complex ethical and clinical treatment issues can occur during a pandemic, especially when healthcare demand exceeds supply. Strategies for managing capacity and ensuring evidence-based and equitable care for patients requiring intensive care are outlined in NSW Health policy *Influenza Pandemic – providing critical care* (PD2010_028).

LHDs/SHNs may choose to designate other hospital areas (e.g. operating theatres or general wards) as intensive care surge areas. Some children may be able to be treated and managed at adult hospitals.

9.5 Isolation spaces within healthcare facilities

Isolation spaces are an important component of isolating patients with communicable respiratory infections to contain further spread of the infection. If isolation of individuals is not possible, healthcare facilities may determine that isolation by cohort can occur. Purpose-built isolation spaces, as well as alternate facilities, may be used during a pandemic.

Further guidance on isolation and cohorting of patients to control outbreaks is provided in the NHMRC (2010) *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (see B3.2).

9.6 Hospital in the home

Hospital in the home (HITH) services allow a range of clinical conditions to be effectively and safely managed without a person needing to stay in hospital. HITH services are already provided by many LHDs and SHNs and may be used or

expanded during a pandemic response so that are sufficient beds available for patients who need to be in hospital for their care.

9.7 Overflow facilities

Overflow facilities are used to accommodate patients when it is impractical to manage them at home or in a hospital. Healthcare facilities, including private hospitals, would be used preferentially. However, schools, warehouses, convention centres, hotels or sports arenas may be alternative sites.

Overflow facilities may be needed during a long-lasting and/or large-scale health emergency. During a pandemic they may serve as facilities to care for the large additional number of patients requiring treatment and management. The care provided in overflow facilities is generally supportive rather than interventional.

Depending on the infrastructure, staff and capacity within LHDs, the care provided in overflow facilities could include:

- Acute care for cohorted patients
- Expanded ambulatory care (low-level care for non-pandemic patients)
- Palliative care (acute and low-level care).

Each LHD should identify initial overflow facility sites, and planning should detail the circumstances where and when overflow facilities would be established and how these facilities would be staffed appropriately. Geographic variability in attack rates may dictate that overflow facilities are not established in all LHDs simultaneously during a pandemic.

In the event of a severe and widespread pandemic in NSW, the Health Secretary may instruct LHD CEs to open overflow facilities to ensure delivery of essential health services.

9.8 Health workforce issues

Pandemics present significant workforce challenges for NSW Health. Different services may experience increased demand for staff at the same time (e.g. clinical, public health, administrative, support and human resources staff). Staff absenteeism during a pandemic has the potential to place significant further strain on the health workforce.

The risk of occupational acquisition of influenza infection by healthcare workers is low, relative to community settings. However, perceived safety at work is a critical determinant of staff willingness to work during pandemic events, particularly for workers responsible for the care of children in the home environment.

9.8.1 Staff management

A number of inter-related workforce issues have been identified as being particularly pertinent during a pandemic, including:

- The levels of personal protection deemed acceptable by healthcare workers
- Infection control and disease control issues directly impacting upon staff availability (such as quarantine of exposed workers)
- The availability of sufficient staff, including recruitment, retention and equitable allocation issues
- The capacity to support staff in preparing for, responding to and recovering from a pandemic.

Absenteeism levels will vary according to the severity, duration and timing of the pandemic. However, health services should prepare contingency human resource plans in the event of high levels of absenteeism. This should include both positions in critical health services and critical administration areas. Plans should be regularly disseminated and additional training may be needed to prepare staff to work under different conditions.

The *Public Health Workforce Surge Guidelines* (GL2014_003) have been developed to assist LHDs in understanding when and how to identify, recruit and utilise surge staff for public health aspects of the pandemic response.

To ensure continuity of government services during a pandemic, the NSW Government has a Memorandum of Understanding with Unions NSW which sets out employment conditions that would apply during the pandemic, including attendance, salary payments and ability to require staff to provide additional support outside their usual job description.

Human resource plans should:

- Advise staff that they may be called upon at short notice to temporarily work different hours, in a different location or in a different way
- Ensure staff are aware that requests for flexibility on their part will be made with regard to appropriate use of their skills and their award conditions (NB: only clinical staff should be assigned clinical roles during the pandemic)
- Determine minimum staffing levels sufficient to safely maintain services
- Identify part-time staff who can work additional hours
- Identify staff who are prepared to defer annual or long service leave
- Identify casual staff who can work additional hours (while at the same time appropriately managing worker fatigue)
- Identify displaced employees or those on ‘return to work’ plans who can be deployed
- Identify staff who have recently left the organisation and who can be temporarily engaged
- Identify staff who can provide non-clinical support and can be redeployed
- Identify agency resources which can be called upon

- Identify a manager/s and support staff to coordinate planning, communication, resource management and the orientation of staff.

Healthcare workers may believe that they are at increased risk of becoming infected themselves and/or transmitting infection to their friends and families. The adequacy of current Employee Assistance Programs and other systems to support the mental health needs of healthcare workers should be carefully considered and augmented if insufficient.

Managers in all NSW Health and affiliated organisations have a duty of care for staff under Work Health and Safety legislation to ensure that the exposure of healthcare workers to influenza is minimised, such as through appropriate infection control measures and use of PPE. Managers must ensure that all work health and safety risks are assessed and documented, in line with obligations under legislation.

Staff immunisation programs are an important risk mitigation strategy. All NSW Health agencies are required under the Policy Directive - *Occupational assessment, screening and vaccination against specified infectious diseases* (PD2011_005) - to ensure that staff in their district are appropriately screened and immunised (which includes offering seasonal influenza vaccination to all staff).

9.8.2 Education and training

The Health Education and Training Institute (HETI) will work in collaboration with MoH and LHDs to develop appropriate state-wide staff training programs relevant for the pandemic response. LHDs are responsible for regular delivery of staff education and training and for ensuring staff meet training requirements for pandemic preparedness and response as appropriate.

Specialised training may be required for the following groups:

- Front-line clinical healthcare staff such as paramedics and those working in EDs, ICUs and respiratory wards (e.g. refresher training in use of PPE)
- The public health workforce
- Laboratory services
- Primary healthcare and acute clinical staff
- Emergency services or other surge staff personnel supporting a pandemic vaccination clinic or overflow facility
- Clinical staff who will be assessing and managing patients in PACs (e.g. training in the use of clinical screening and triaging protocols).

In particular, critical care units including ICUs and High Dependency Units are staffed by personnel with specific medical or nursing intensive care training, many of whom work in more than one hospital, creating particular challenges for workforce surge. LHDs/SHNs must consider where to source additional personnel and provide additional training to ensure staff can work in intensive care (e.g. personnel trained in respiratory medicine or anaesthesia).

10 HEALTHCARE DELIVERY - COMMUNITY

Under *NSW HEALTHPLAN*, NSW Health may request assistance from health supporting agencies during a pandemic; these include residential care facilities, private health facilities, local government councils and primary healthcare networks. In preparation for a pandemic, MoH works with peak bodies, professional associations and other stakeholder groups to determine the most appropriate role for services that deliver healthcare within a community during a pandemic. Services may be asked to focus on maintaining core business or to take on specific pandemic-related roles depending on the severity of the pandemic.

Community healthcare providers may also be asked to participate in the deployment of alternative models of care to respond to clusters of illness in remote communities. The LHD in consultation with community health providers would be responsible for the implementation and operational management of alternative facilities or models of care in the community.

Other community healthcare providers (e.g. drug and alcohol services, dentists, physiotherapists or specialist rooms) should be prepared to implement screening, increase infection control and appropriately manage or defer attendance by people with ILI during a pandemic.

10.1 General practice

MoH works closely with primary care peak bodies in NSW to determine the most appropriate role for general practice during a pandemic. A key challenge for general practice will be the maintenance of routine services for patients when experiencing a potentially significant increase in demand during a pandemic. The Royal Australian College of General Practitioners (RACGP) has released the *Managing pandemic influenza in general practice* guidelines (as well as an implementation toolkit – see Appendix 4) which outline strategies to help GPs maintain business continuity during a pandemic. The RACGP has also developed Infection prevention and control standards for GPs and other community health providers which would be essential in the preparation and response to pandemic influenza.

LHDs/SHNs should work with their primary health networks to plan the local implementation of national and state pandemic response activities and to coordinate care between general practices and LHD facilities. GPs in rural and remote areas may have little support or relief available from other healthcare providers. LHDs/SHNs should consider and develop ways to work with GPs in rural and remote areas, and involve them in local pandemic planning. Additional roles for nursing staff in primary health networks in remote communities during a pandemic response should also be considered.

10.2 Community pharmacies

Community pharmacies may be asked to take on additional tasks or provide surge workforce capacity during a pandemic. Pharmacies are kept informed about

pandemic phase changes through engagement between MoH and the NSW Pharmacy Guild and provided with advice to inform their customers about treatment for ILI.

MoH will consult with the NSW Pharmacy Guild and LHDs/SHNs to help identify any additional tasks (e.g. assistance with distribution of oseltamivir suspension and other anti-viral medications) that may be requested from community pharmacies.

10.3 NSW Ambulance and patient transport

It is anticipated that the NSW Ambulance workload will increase during a pandemic. This will require enhanced triaging of all patients to ensure NSW Ambulance is able to maintain core service delivery to emergency cases. NSW Ambulance is also responsible for providing coordination and communication processes across the service during emergency or campaign type operations. This includes close liaison with the NSW Health Non-Emergency Patient Transport (NEPT) Hub for the expected increase in non-emergency patient transports. Specific command and control operational arrangements are detailed in NSW Ambulance operational plans.

The State HSFAC may request support from the State Emergency Operations Controller for moving large numbers of people to alternate accommodation (e.g. relocating people from the airport that have been exposed to the virus during a flight). NSW Ambulance personnel may be best placed to assist with moving smaller groups of people.

HealthShare NSW is responsible for ensuring pandemic readiness for all Greater Metropolitan NEPT services; including business continuity and surge staff planning. Operational interagency liaison will occur between NSW Ambulance and HealthShare NSW and frontline supervisors during a pandemic.

10.4 Mental health services

Mental health services need to continue to provide core services (e.g. inpatient acute care, rehabilitation and emergency psychiatric services) during a pandemic as well as providing extra support services for mental health workers, other healthcare workers and members of the broader community. Mental health NGOs, GPs, peak bodies and consumer and carer organisations will be key stakeholders in planning and preparedness.

Individuals may develop short or long-term mental health concerns as a result of community anxiety, prolonged isolation or other significant changes to daily life experienced during a pandemic. The particular mental health needs of specific populations must also be considered. It will be important to ensure clear, consistent and timely public communication is produced and disseminated to reduce anxiety.

The psychological issues for healthcare workers in a pandemic will be significant, requiring clear, consistent and frequent communication to reduce community anxiety associated with exposure in the workplace. Many patients with mental health concerns are managed by clinicians in primary care. Early communication between the local LHD and GPs will be important to ensure smooth continuity of care.

The NSW Health Mental Health Line will be briefed on the pandemic and will be the main point of contact for those wishing to access or consult with mental health services. MoH may also activate the Mental Health Disaster Help Line if a specific service is required or if there are large numbers of people seeking assistance.

In order to continue to provide core mental health services to patients, alternative delivery mechanisms may be needed, including telephone or internet consultations and/or alternative access points for medication monitoring. Any decision regarding reduction of services would need to be made in consultation with the Mental Health Controller following full consideration of risk factors and the level of support available in the community.

The MoH Mental Health and Drug & Alcohol Office and LHD Mental Health Directors remain actively involved in pandemic planning to ensure mental health services are incorporated into LHD planning (e.g. developing protocols for the treatment of acutely mentally ill patients with pandemic influenza).

10.5 Correctional and detention facilities in NSW

Corrective Services and Juvenile Justice NSW (as part of the Department of Justice NSW) are responsible for the operational management of services and programs to manage adult and juvenile offenders respectively in corrective facilities or in the community in NSW. The Justice Health and Forensic Mental Health Network (JH&FMHN) as a state-wide specialty NSW Health network, maintains guidelines on supporting the health of adult and juvenile offenders during an influenza pandemic in NSW.

Correctional facilities present unique challenges in relation to social distancing and mitigating the impact of a pandemic. A range of strategies including screening prior to transport, isolation and quarantine are implemented by the JH&FMHN in consultation with Corrective Services NSW, Juvenile Justice NSW, the Department of Justice and NSW Police. JH&FMHN health facility centres, while not linked to specific hospitals, may also serve as PACs in consultation with the relevant LHD.

Immigration detention facilities are the responsibility of the Australian Government; however some detention facilities are contractually operated and managed by private providers. In the event of an influenza pandemic affecting detainees within NSW immigration detention facilities, NSW Health would collaborate with the Commonwealth to implement a range of strategies to support the health of detainees, such as case and contact follow-up, management and treatment.

10.6 Schools and children's services

The NSW Department of Education is responsible for early childhood centres, public primary and secondary schools as well as some adult tertiary education centres such as campuses of TAFE NSW.

During a pandemic, early childhood centres and schools may be a focus of social distancing measures (during the *Standby* and/or *Initial action stage*) to reduce the community-level impact of pandemic influenza, as children typically have higher

infection rates, shed virus longer than adults and may be less capable of maintaining high levels of infection control (e.g. adequate hand washing).

It is important to note that school closures have only been shown to be moderately effective at reducing transmission rates and the timing and duration of closures would need to be carefully considered (see *AHMPPI*). Therefore a range of measures designed to help reduce social mixing of students in order to reduce transmission of the pandemic virus may be considered by MoH (e.g. cancellation of extra-curricular or after-school activities).

MoH would liaise closely with the NSW Department of Education, the Catholic Education Commission of NSW and the Association of Independent Schools of NSW to ensure the agreed implementation of any social distancing measures in early childhood centres and/or schools was timely, appropriate and communicated to relevant services and families in NSW.

10.7 Residential care facilities

People living in residential care facilities represent a potentially vulnerable population to the pandemic virus due to a variety of factors such as older age, disability, chronic illness and close living arrangements.

Most residential aged care services are the responsibility of the Australian Department of Social Services (DSS). However MoH and LHDs work closely with DSS and non-governmental organisations (e.g. Aged and Community Services NSW and ACT), facility managers and private providers in NSW on a regular basis to help protect the public health of residents through investigation and control of any infectious disease outbreaks.

All residential care facilities in NSW are encouraged to have plans in place for an influenza pandemic. CDNA maintains guidelines on the *Prevention and management of influenza outbreaks in residential care facilities*. Seasonal influenza outbreaks represent an opportunity for residential care facilities to test any plans, revise arrangements with health partners and incorporate any lessons learnt.

During a pandemic, MoH would work closely with the Commonwealth to ensure communications to residential care facilities in NSW regarding response strategies were coordinated in a timely and appropriate manner.

11 AT-RISK GROUPS

The *AHMPPI* acknowledges that some population groups will be at risk of severe morbidity or mortality from a pandemic virus. Depending on the clinical epidemiology of the pandemic virus, at-risk groups may include traditional seasonal influenza at-risk groups as listed in the *Australian Immunisation Handbook* , including infants, older people, people with chronic conditions, pregnant women and Aboriginal people.

Other population groups may also be at increased risk of influenza complications during an influenza pandemic because their health needs may not be met by

traditional or mainstream health services, or they may have difficulty accessing health services and emergency resources. This includes some people from culturally and linguistically diverse backgrounds, including refugees, and the homeless.

LHDs need to consider how to identify and support at-risk populations in their district to ensure timely and appropriate information and healthcare is given during a pandemic. This will include appropriate models of care for ensuring that at-risk groups can access anti-viral medication and/or vaccination during a pandemic. Engaging and building relationships with local GPs, multicultural health networks, community and other care providers will be important in preparing to support the health needs of at-risk groups during a pandemic.

11.1 People with chronic diseases

During a pandemic, MoH would work with the ACI, NSW Pharmacy Guild and LHDs/SHNs to ensure people with chronic conditions are adequately supported in the community to manage their conditions. Public messaging may be used to encourage people with chronic conditions to maintain their treatment and seek advice for exacerbations.

The NSW Chronic Disease Management Program (CDMP) is a free service delivered by LHDs which targets NSW adults who have difficulty managing their condition and are at risk of hospitalization. The CDMP model supports care coordination and integration across the primary health care sector. LHDs should work with local GPs and other community providers (e.g. pharmacies) to develop effective business continuity and workforce surge plans that explore the best use of the CDMP and/or alternative models of care that support people with chronic conditions in the community.

11.2 People from culturally and linguistically diverse (CALD) backgrounds

During a pandemic, MoH would leverage off existing relationships with the NSW Multicultural Health Communication Service, NSW Refugee Health Service and the NSW Healthcare Interpreters Service to ensure the health needs of people from CALD backgrounds are supported. These services provide established pathways of communicating with multicultural families, children and young people, older people and people living in rural areas.

Strategies to support culturally appropriate communication with CALD groups during a pandemic are outlined in the *Communications* section of this plan. MoH would also work with the NSW Multicultural Health Communication Service and NSW Refugee Health Service to ensure that other not-for-profit organisations (e.g. Ethnic Community Council) and ethnic medical associations (e.g. Australian Chinese and Vietnamese Medical Associations) are briefed on the key pandemic response strategies over time so that support services could be provided if appropriate. The NSW Community Relations Council can provide links with community leaders in different CALD groups across NSW if appropriate.

LHDs/SHNs should ensure district level pandemic plans incorporate profiling, mobilisation and health services appropriate for CALD groups during a pandemic. Partnership arrangements in the delivery of health services for CALD groups during a pandemic should also be outlined, such as non-governmental organisations, primary health networks and community outreach services.

It will be important to ensure CALD groups are aware of strategies that will help them mitigate any risk of contracting or transmitting pandemic influenza within their community, such as infection control practices and social distancing measures, and how to access locally appropriate health services for prevention or management of pandemic influenza (e.g. PACs and pandemic vaccination clinics). This might include promotion and use of multilingual resources, local interpreter services, bi-lingual GPs and local refugee health services (including paediatric clinics and refugee health nurses where available).

11.3 Other at-risk groups

Depending on the clinical epidemiology of the pandemic virus, other groups including infants, the elderly and pregnant women might also be at increased risk of severe morbidity and mortality.

Strategies to support the health needs of infants and the elderly in regards to outbreaks of pandemic influenza in early childhood centres and residential facilities are outlined in the *Healthcare delivery – community* section of this plan.

12 ABORIGINAL PEOPLE

Aboriginal communities are a particular focus for pandemic planning as they are characterised by having higher numbers of at-risk individuals (i.e. people at higher risk of severe complications from influenza infections) than the general community.

NSW Health also recognises the importance of embedding the needs and interests of Aboriginal people in the development, implementation and evaluation of all NSW Health initiatives, as described in the *Aboriginal Health Statement and Impact Guidelines* (PD2007_082). Consistent with the principle of working in partnerships, adequate and appropriate pandemic planning for Aboriginal communities will only be achieved through effective partnership arrangements.

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

LHDs must ensure that appropriate services are available to mitigate the impact of pandemic influenza in Aboriginal communities.

MoH works with the Aboriginal Health & Medical Research Council (AH&MRC) and LHDs to determine the most appropriate service delivery role for Aboriginal health services during a pandemic. Aboriginal Community Controlled Health Services (ACCHS) should be engaged through established partnership arrangements at a

district level. Collaborative planning arrangements with non-ACCHS providers of health and health-related services for Aboriginal people should also be developed and implemented.

PHUs and LHD Directors/Managers of Aboriginal Health can facilitate partnerships with ACCHSs for advice on pandemic planning and its cultural appropriateness for Aboriginal people and communities. The MoH Centre for Aboriginal Health is available as another source of advice on Aboriginal health policy and programs at the state level. Due to the strength of kinship and family relationships, LHDs also need to work with Aboriginal health services and community representatives to develop and promote appropriate social distancing methods.

MoH maintains detailed guidance on how these partnership arrangements with ACCHS and Aboriginal communities in NSW should work in regards to planning for and responding to a pandemic.

13 SURVEILLANCE AND MONITORING

CDNA is responsible for determining any national changes in the case definition of the pandemic virus to enable accurate identification of cases and contacts. The Chief Health Officer will advise LHDs, GPs and community pharmacies and other partner agencies of changes to the case definition. LHDs are responsible for informing health facilities as well as private hospitals and Aboriginal health services (in collaboration with the Centre for Aboriginal Health) within their district of changes.

MoH will be primarily responsible for conducting and coordinating surveillance data collection and timely reporting of data to DoH on behalf of NSW Health. DoH will facilitate development of data transfer protocols for this process and will feed back information and analyses to jurisdictions via CDNA and AHPPC. MoH will inform LHDs of any changes to surveillance arrangements as the pandemic progresses.

LHDs are responsible for conducting and coordinating the early and enhanced data collection on cases and contacts during the pandemic. This enhanced data collection is to be undertaken in parallel with the core responsibilities of LHDs during the pandemic, including the appropriate assessment, treatment and management of cases and contacts. Surveillance data will be a key component of health situation reports and reporting through any emergency operation centres established at state and LHD levels.

13.1 Surveillance arrangements

During the early response stage (i.e. *Initial action* stage), detailed data on individual confirmed cases and household contacts will be needed to inform the national and state response to the pandemic as described in the AHMPPI.

Intelligence gathering within Australia will be less important if there is high quality surveillance information available characterising the severity and transmissibility of the pandemic strain from the studies carried out overseas prior to the arrival of the pandemic virus into Australia.

As the pandemic progresses and community transmission becomes established (i.e. *Targeted action* stage) it will be less important and less feasible to identify and follow-up each new case and their contacts. Surveillance activities will then focus on monitoring the impact of the pandemic on the community in general and on the health system in particular.

As the pandemic response transitions to the *Stand down* and *Recovery* stages, the new virus may remain circulating in the population and potentially become a new seasonal influenza virus. It will be important to continue to monitor the pandemic virus for a second wave of infection and/or for antiviral resistance using routine surveillance systems.

13.2 Surveillance systems and data

Wherever possible, existing routine surveillance systems will be used during the pandemic. This approach aligns with the *AHMPPI* and the Population Health Surveillance Strategy NSW 2011 to 2020. Routine surveillance for human influenza occurs year-round in NSW but increases during the winter influenza season.

The following systems may be utilised during a pandemic:

- ***Virological surveillance*** – identifying and monitoring virus types and strains over time. Laboratories across NSW notify confirmed cases of influenza to PHUs. In addition, several public and private laboratories contribute a proportion of virological samples sent each year to the World Health Organization Collaborating Centre (WHO CC) for Reference and Research on Influenza (Melbourne) for monitoring antigenic changes in the influenza virus.
- ***Syndromic surveillance*** – monitoring and detecting any increased presentations for ILI in emergency departments or in the community through general practice. Current examples include the Public Health Real-time Emergency Department Surveillance System (PHREDSS) and eGPS, a program to monitor ILI consultations in sentinel GP practices.
- ***Clinical surveillance in hospitals*** – for monitoring hospitalisations or ICU admissions related to severe respiratory disease for adults or children. Current examples include FluCAN (the Influenza Complications Alert Network) and the Australian Paediatric Surveillance Unit.
- ***Case and outbreak notification*** - PHUs receive influenza notifications from laboratories and reports of outbreaks of ILI in institutions such as residential aged care facilities. Notification data are managed with the state-wide Notifiable Conditions Incident Management System (NCIMS).
- ***Mortality surveillance*** - Death registration data from the NSW Registry of Births, Deaths and Marriages are reviewed for deaths attributable to pneumonia and influenza on a weekly basis. Statistical estimates are then produced to predict the number of influenza-related deaths against a baseline estimate of deaths occurring each year.

- ***Initial action stage / First Few 100 surveillance*** – for a limited period at the start of pandemic, LHDs may be required to assist with the national effort to actively follow-up suspected and confirmed cases of pandemic influenza and their household contacts to examine transmissibility of the pandemic virus, the severity of infections and the groups at risk of severe disease. This enhanced data will be managed in NCIMS and shared with the National Notifiable Diseases Surveillance System (NNDSS) under existing arrangements.
- ***Health facility impact monitoring*** – data on the capacity of healthcare services to manage demand (e.g. ED presentations/admissions and bed/ventilation capacity). The Patient Flow Portal currently managed by MoH provides data on bed capacity and patient flow/transfers at the health facility level. Impacts on other areas such as on ED performance, surgical waiting lists, and staff absenteeism will also need to be monitored.
- ***Detailed clinical surveillance in intensive care units*** – for monitoring severity and clinical outcomes of patients admitted to ICU with suspected or confirmed influenza and/or viral pneumonia.
- ***Vaccine distribution and monitoring data*** – if and when a pandemic vaccine becomes available the current vaccine distribution and monitoring system may need to be enhanced to monitor the distribution and uptake of pandemic vaccines.
- ***Adverse event following immunisation (AEFI) surveillance*** – the existing AEFI system will be utilised by DoH and MoH to monitor adverse events associated with any new pandemic vaccine, particularly adverse events that may not have been detected in pre-licensure vaccine trials.

In addition, other surveillance data may need to be collected depending on the severity of the pandemic and the response strategies utilised in NSW, including:

- International border monitoring (if implemented)
- Workforce absenteeism monitoring.

During the pandemic, routine and enhanced data collection may also need to be supported by additional targeted research studies. These studies are likely to be coordinated at a national level. Pandemic research conducted in NSW will be subject to the capacity and interest of different agencies in NSW, including universities, research institutes, LHDs and other Health agencies.

13.3 International border surveillance

The Australian Government is responsible for developing and implementing policies relating to international border control activities. Roles and responsibilities relating to airports are outlined in the *National Pandemic Influenza Airport Border Operations Plan* (FLUBORDERPLAN).

The suite of border measures that the Australian Government may consider during a pandemic are outlined in the *AHMPPI*. The Australian Government has broad quarantine powers supported by legislation, as listed in Appendix 3.

MoH would respond to requests from the Australian Government via AHPPC to provide assistance with international border control and related risk management activities and the implementation of any measures in NSW. MoH would notify LHD Chief Executives of any border assistance required.

MoH routinely works with relevant LHDs to support Biosecurity Officers (Australian Department of Agriculture and Water Resources) with their border health screening work at international points of entry (airports and seaports) as needed, including providing training and assessing referrals.

MoH supports South East Sydney LHD to conduct the Airports and Seaports Human Biosecurity Program with a focus on cruise ships and Sydney International Airport. South East Sydney LHD would likely take a lead role in supporting border agencies at Sydney International Airport if additional border surveillance activities were recommended.

14 LABORATORY

At the national level, PHLN provides expertise and national guidelines for public health labs involved in microbiological testing.

NSW Health Pathology has primary responsibility for maintaining appropriate provision of laboratory services across NSW during a health emergency, including a pandemic. NSW Health Pathology response plans should be referred to for more detail on laboratory roles and responsibilities.

Supporting NSW guidelines for a laboratory response to an emergency may also be developed to help prepare public and private laboratories to respond to a health emergency such as an influenza pandemic.

14.1 Operational aspects of the laboratory response

In order to have an adequate state-wide capacity to detect novel pandemic viruses in humans, certain laboratories have the capability and capacity to develop tests for novel viruses with pandemic potential.

Diagnostic laboratories face a risk of high demand for diagnostic tests throughout the pandemic, and may also have to deal with increased staff absences. Laboratories should regularly review business continuity plans in order to ensure their capability and capacity to respond to a pandemic.

- During the *Initial action* stage of the pandemic (i.e. before the pandemic virus becomes widespread in NSW), the emphasis of laboratory testing will be on early, accurate diagnosis of all cases to identify and determine the spread of the virus across NSW, and to inform case and contact management.
- During the *Targeted action* stage (i.e. as the pandemic becomes more widespread), the pre-test probability of the pandemic virus being the cause of the illness becomes high. Clinicians will need to be advised to restrict testing to cases where the result will directly impact on clinical management.

- Experience from the pandemic in 2009 suggests that there may be particularly high demand on laboratory capacity when there is widespread influenza activity in the community, even following advice to clinicians. Some screening of test requests may be required to prioritise testing.
- During the later stages of a pandemic, testing should focus on cases admitted to hospital, particularly those in at-risk groups, where the outcome affects clinical management of the patient. Testing may also be used to monitor for strain drift and antiviral resistance.

Serological testing using a specific test for the pandemic virus may be useful for retrospective diagnosis, particularly for severely ill patients for whom specimens were not collected or were negative for the virus. Serological studies may be considered to inform a more robust estimate of the prevalence of infection, and assist in formulation of vaccine strategy.

15 ANTIVIRAL MEDICATIONS

Antiviral medication may be administered to cases to reduce the severity and duration of infection and to shorten the period when the patient is infectious. The medication is most effective if taken within 48 hours of symptom onset. Antiviral medications can be used for treatment of cases, and for both pre-exposure and post-exposure prophylaxis.

During a pandemic, antiviral medications, including those held within the National and NSW stockpiles, will be prioritised for treatment.

Widespread use of antiviral medications as prophylaxis (either pre-exposure or post-exposure) is not recommended as this may deplete a critical treatment resource. The limited use of anti-influenza medication as prophylaxis may be recommended by AHPPC for certain priority groups, such as at-risk contacts or healthcare workers treating pandemic influenza patients during a particularly severe pandemic.

MoH in consultation with LHDs, ACI and other clinical care networks will make decisions around prioritisation of antiviral medications for prophylaxis in NSW based on national recommendations.

Access to antiviral medication for young children pre-prepared as a suspension (i.e. in liquid form) is likely to be limited. If required, hospital pharmacies and some community pharmacies in NSW will be able to compound oral antiviral medication suspension. MoH would work with the peak pharmacy bodies and LHDs/SHNs to ensure access and timely distribution of this medication during a pandemic.

Recommendations for the use of antivirals in NSW will depend on the epidemiological and virological characteristics of the virus (e.g. severity, transmissibility, antiviral resistance, and antiviral efficacy), pre-existing immunity in the community, vaccine availability and logistical constraints.

MoH will provide LHDs, community pharmacies and primary health care providers with clear and timely guidance on antiviral medication use (e.g. agreed target groups, indications for use, dosage, precautions, storage, transport and disposal) as

early as possible during the pandemic response. Clinicians can search the NSW Health website for more information on these medications if needed.

The *State-wide Standing Order for Supply or Administration of Medication for Public Health Response* policy (PD2013_035) outlines the arrangements for NSW Health registered nurses to administer and/or supply antiviral medication to cases and contacts for the purpose of treatment or prophylaxis in the community, such as at PACs, residential aged care facilities, or schools.

16 VACCINATION

Vaccination against a novel pandemic virus is a key response activity outlined in the AHMPPI. As soon as a pandemic virus is identified, work begins to produce a customised pandemic vaccine. Due to the lead-time required to manufacture a new vaccine, it may take many months after the emergence of a pandemic before there is enough vaccine for the Australian population.

In addition to customised pandemic vaccines, candidate pandemic vaccines may be available from DoH. Candidate vaccine seed strains have been developed for the avian-origin and swine-origin influenza virus sub-types. The effectiveness of these vaccines will depend upon the match between the seed strain and influenza strain causing the pandemic.

The use of candidate vaccines will depend on many factors, including early virological data, timing and spread of infection in Australia, availability of vaccine and predicted impact of the pandemic. It might be decided these vaccines would be prioritised for at-risk groups and/or healthcare workers during the initial action response stage of the pandemic.

The principles of vaccine prioritisation for the states and territory jurisdictions will be discussed collaboratively through the AHPPC. DoH will coordinate distribution of pandemic vaccines to states and territories. MoH will coordinate the distribution of vaccine to nominated vaccine dispensers (e.g. LHDs/SHNs, GPs) in NSW.

The national pandemic vaccine distribution strategy will be influenced by the amount of vaccine available and the stage of the pandemic when it becomes available. If the vaccine only becomes available after the first wave of pandemic has passed then there will be a preference for using existing vaccine delivery systems, particularly involving general practice.

If an initial supply of a pandemic vaccine becomes available during a pandemic and is recommended to be distributed as part of the outbreak response then this likely to be most effectively delivered through LHDs and SHNs.

LHDs /SHNs are responsible for developing strategies to provide pandemic vaccination to the public within their district in the outbreak setting, in addition to their usual staff vaccination programmes.

Provision of both candidate and pandemic-specific vaccines can be via several models coordinated by LHDs/SHNs depending on the severity of the pandemic virus

and vaccine supply. MoH maintains guidelines for LHDs/SHNs regarding the establishment and operation of vaccination clinics during a pandemic.

LHDs/SHNs will be asked to plan for two vaccination scenarios according to MoH guidelines: (i) vaccination of priority groups with a candidate or pandemic-specific vaccine, (ii) mass vaccination for the wider LHD population with a pandemic specific vaccine. It will also be important that LHDs/SHNs consider the needs of at-risk groups in their population when planning vaccination clinics according to these scenarios

LHDs/SHNs should collaborate with local health service and community providers to plan for appropriate models of pandemic vaccine delivery that meet the needs of their population in accordance with MoH guidelines. This may include vaccination through general practice clinics, community centres (e.g. schools or sporting clubs) or through Aboriginal Community Controlled Health Services (ACCHS).

LHDs/SHNs will need to plan for appropriate vaccine clinic locations that allow for adequate crowd control, patient flow and space to facilitate patient assessment, vaccination and observation. LHDs/SHNs will also need to consider staffing arrangements to ensure adequate numbers of immunisers are available to participate in vaccination clinics.

Staff at general practices and community health centres – including GPs, practice nurses and nurse practitioners – represent a skilled workforce capable of supporting pandemic vaccine delivery and administration. LHDs/SHNs should work with primary health networks in their district to plan for inclusion of these staff in the delivery of vaccination clinics as appropriate. Community pharmacists registered in NSW to administer influenza vaccines may also be utilised.

A pandemic influenza vaccination campaign may overlap with the annual seasonal influenza campaign. MoH will provide any specific state-wide instructions about coordinating both vaccination campaigns simultaneously.

17 NATIONAL AND STATE MEDICAL STOCKPILES

Medical stockpiles are strategic reserves of medicine and equipment designed to allow rapid access to standardised items that may not be available in a timely manner through routine supply channels due to increased national or international demand.

The Australian Government is responsible for maintaining the National Medical Stockpile (NMS) and for developing related deployment plans for these items to states and territories. The Chief Health Officer is able to request deployments from the NMS. If national demand is significant, requests may need to be prioritised across the states and territory jurisdictions.

MoH maintains the State Medical Stockpile (SMS) of essential supplies, such as PPE and antiviral medications, for NSW and is responsible for developing deployment plans for these items to LHDs.

HealthShare NSW is responsible for routine procurement of goods and services for LHDs in NSW. During a pandemic, warehousing and distribution of health supplies and uptake of essential items will be monitored by HealthShare NSW. When essential items (e.g. PPE) are no longer available through routine procurement channels, MoH will provide advice to LHDs regarding requesting SMS items.

LHDs are responsible for planning local distribution of resources provided to LHD facilities. In some situations, MoH may ask LHDs to help distribute goods to other healthcare facilities within their area.

APPENDIX 1: ACRONYMS AND ABBREVIATIONS

ACI	Agency for Clinical Innovation
AH&MRC	Aboriginal Health & Medical Research Council
AHMPPI	Australian Health Management Plan for Pandemic Influenza
AHPPC	Australian Health Protection Principal Committee
CALD	Culturally and linguistically diverse
CDNA	Communicable Diseases Network Australia
CE	Chief Executive
DoH	Department of Health (Commonwealth)
EDs	Emergency departments
EMPLAN	NSW State Emergency Management Plan
GP	General practice
HEMU	Health Emergency Management Unit
HSFAC	Health Services Functional Area Coordinator
HPNSW	Health Protection NSW
ICU	Intensive care unit
ILI	Influenza-like illness
JH&FMH	Justice Health and Forensic Mental Health
LHD	Local health district
MoH	NSW Ministry of Health
NAPHIP	National Action Plan for Human Influenza Pandemic
NCIMS	Notifiable Conditions Incident Management System
NHEMRN	National Health Emergency Media Response Network
NMS	National Medical Stockpile
PHLN	Public Health Laboratory Network
PHREDSS	Public Health Real-time Emergency Department Surveillance System
PHU	Public health unit
PIFAC	Public Information Functional Area Coordinator
PPE	Personal protective equipment
SERM Act	State Emergency Rescue Management Act
SCHN	Sydney Children's Hospitals Network
SHN	Specialty health network
SMS	State Medical Stockpile
WHO	World Health Organization
WHOCC	WHO Collaborating Centre for Reference and Research on Influenza

APPENDIX 2: GLOSSARY

AIIMS	Australasian Inter-Service Incident Management System provides an emergency management structure that enables seamless integration of activities and resources of amongst and between agencies when applied to an emergency.
Antiviral medications	Antiviral medications decrease the severity and duration of influenza infections, and reduce the risk of illness in exposed individuals.
Combat agency	The agency identified in *EMPLAN* as the agency primarily responsible for controlling the response to a particular emergency (source: *SERM Act*).
Candidate pandemic vaccine	A vaccine based on a strain of influenza virus considered to have pandemic potential. This vaccine may provide partial protection if it develops into a pandemic strain that is easily transmissible between humans (source: *AHMPPI, 2014)*
Customised pandemic vaccine	A customised pandemic vaccine is a vaccine tailored to a specific pandemic virus strain. It cannot be developed until the next pandemic virus emerges (source: *AHMPPI 2014*).
Health services (NSW)	Health services refer to any medical, hospital, ambulance, paramedical, community health or environmental health service or any other service relating to the maintenance or improvement of the health, or restoration to health, of persons or the prevention of disease in or injury to persons in NSW(source: *Health Administration Act, 1982* No 135, pg. 2). This definition specifically refers to the administration of NSW Health services (see below).
First Few 100	FF100 is a surveillance protocol developed by the Australian Government for collection of detailed epidemiological and clinical data on the first few hundred confirmed cases (& their household contacts) of pandemic influenza (source: *AHMPPI 2014).*
NCIMS	Notifiable Conditions Incident Management System – routine database for recording and collecting epidemiological data on cases of notifiable diseases in NSW.
NSW Health	The expression “NSW Health” may be used to describe the Ministry and any other body and organisation under the control and direction of the Minister or the Health Secretary. This includes local health districts, pillars, shared services and other affiliated health agencies, such as NSW Ambulance, HealthShare NSW, Health Infrastructure, NSW Health Pathology, eHealth and St Vincent’s Health network.
NHEMRN	National Health Emergency Media Response Network – national peak committee (including jurisdictional health department communications teams) responsible for coordinating the development and dissemination of national communications during a pandemic. (source: *AHMPPI, 2014*).
Pandemic	A pandemic is an epidemic on a global scale. Only Type A influenza viruses have been known to cause influenza pandemics (source: *AHMPPI*, 2014).
Pandemic assessment centres (PACs)	PACs (formerly known as *flu clinics*) are specifically planned facilities that will be needed during a pandemic for medical assessment and management of people with suspected pandemic influenza (source: *AHMPPI 2014*).
Post-exposure prophylaxis	A dose/s of a drug (usually antibiotic or antiviral) given immediately after exposure to disease and before onset of illness (source: *AHMPPI,* 2014).
Pre-exposure prophylaxis	A dose/s of a drug (usually antibiotic or antiviral) given before exposure to a disease, to protect the person from being infected (source: *AHMPPI, 2014*).
Quarantine	The limitation of freedom of movement for a period of time of well persons who are likely to have been exposed to the virus to prevent their contact with people who have not been exposed (source: *AHMPPI, 2014*).
Sub plan	A sub plan is an action plan for a specific hazard, critical task or special event. It is prepared when the management arrangements necessary to deal with the effects of the hazard, or critical task or special events differ from the general coordination arrangements set out in the main or supporting plan for the area (source: *NSW EMPLAN*).
Surge capacity	Health service’s to expand beyond normal capacity to meet an increased demand for clinical care (source: *UK DH, Managing Demand and Capacity guidance, 2009*)

APPENDIX 3: LEGAL FRAMEWORK

There are several key pieces of legislation supporting the NSW response to a pandemic.

Australian Government legislation

The Quarantine Act 1908

This Act aims to prevent the introduction of specified diseases into Australia and prevent the spread of such diseases within Australia.

The Biosecurity Act 2015

The new Biosecurity Act will commence on 16 June 2016, replacing the Quarantine Act 1908. Just as with the Quarantine Act, the biosecurity legislation will be co-administered by the Ministers responsible for Agriculture and Health.

National Health Security Act 2007

This Act provides for the exchange of public health surveillance information between the Australian Government and the states and territories, and, where relevant, the WHO.

NSW legislation

State Emergency Rescue and Management Act 1989 (as amended)

This Act details the emergency management framework in NSW.

Public Health Act 2010 and Regulation 2012

This Act outlines public health management in NSW, including notifiable diseases and infectious disease emergencies.

Health Administration Act 1982

This Act establishes the Health Administration Corporation and outlines the functions of the NSW Minister of Health and Health Secretary.

Health Records and Information Privacy Act 2002 (as amended)

This Act governs the management of health information in the NSW public and private sectors.

Health Services Act 1997 (as amended)

This Act outlines the structure of the NSW public health system.

Local Government Act 1993 (as amended)

This Act governs the functions (including regulatory functions) of local councils in NSW.

Poisons and Therapeutic Goods Act 1966 (as amended)

This Act lists poisons and drugs of addiction and states that Australian Government therapeutic goods laws apply in NSW.

Poisons and Therapeutic Goods Regulation 2008 (as amended)

This Regulation supports the *Poisons and Therapeutic Goods Act 1966* and authorises the Health Secretary with powers for emergency medication supply.

Protection of the Environment Operations Act 1997 (as amended)

This Act is the key piece of environment protection legislation administered by the Environment Protection Authority and allows the Government to set out explicit protection of the environment policies.

Work Health and Safety Act 2011 (as amended)

This Act aims to protect workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from workplace practices.

APPENDIX 4: ASSOCIATED POLICIES AND GUIDELINES

International plans

World Health Organization's Global Influenza Programme

National plans

Australian Health Management Plan for Pandemic Influenza (AHMPPI)

Australian Immunisation Handbook

National Action Plan for Human Influenza Pandemic (NAPHIP)

National Pandemic Influenza Airport Border Operations Plan (FLUBORDERPLAN)

Sector-specific guidance

Australasian College of Emergency Medicine – *Management of Severe Influenza, Pandemic Influenza and Emerging Respiratory Illnesses in Australasian Emergency Departments*

Communicable Diseases Network Australia – *Influenza infection: national guidelines for public health units*

Communicable Diseases Network Australia – *A practical guide to assist in the prevention and management of influenza outbreaks in residential care facilities*

National Health and Medical Research Council (2010) *Australian Guidelines for the Prevention and Control of Infection in Healthcare*

Royal Australian College of General Practitioners – *Managing Pandemic Influenza in General Practice*

Royal Australian College of General Practitioners – *Pandemic flu kit – implementation guide*

Royal Australian College of General Practitioners – *Infection prevention and control standards*

NSW whole of government guidelines and policies

Memorandum of Understanding between NSW Government and Unions NSW in relation to an influenza pandemic

New South Wales State Emergency Management Plan (EMPLAN)

NSW Human Influenza Pandemic Plan

NSW Health guidelines and policies

(Check NSW Health website for most recent versions)

Aboriginal health impact statement and guidelines (PD2007_082)

Child Wellbeing and Child Protection Policies and Procedures for NSW Health (*PD2013_007*)

Emergency Management Arrangements for NSW Health (PD2012_067)

Environmental cleaning policy (PD2012_061)

Infection control policy (PD2007_036) *[or most current version]*

Influenza pandemic – providing critical care (PD2010_028)

Influenza – Minimising transmission of influenza in healthcare facilities: 2010 influenza season (GL2010_006)

Leave matters for the NSW Health service (PD2014_029)

Notification of infectious diseases under the Public Health Act 2010 (IB2013_010)

NSW HEALTHPLAN (PD2014_012)

NSW Hospital in the Home (HITH) guideline (GL2013_006)

Occupational assessment, screening and vaccination against specified infectious diseases (PD2011_005)

Public Health Workforce Surge Guidelines (GL2014_003)

Public Health Emergency Response Preparedness Minimum Standards (PD2013_039)

Public Health Field Response Guidelines (GL2014_001)

State-wide Standing Orders for the Supply or Administration of Medication for Public Health Response (PD2013_035)

APPENDIX 5: AUSTRALIAN PANDEMIC RESPONSE STAGES

Stage	Sub-stage	Key national-level response strategies
Preparedness* No novel strain detected (or emerging strain under initial investigation)		• Establish pre-agreed arrangements by developing and maintaining plans; • Research pandemic specific influenza management strategies; • Ensure resources are available and ready for rapid response; and • Monitor the emergence of diseases with pandemic potential, and investigate outbreaks if they occur.
Response	**Standby** Sustained community person to person transmission overseas	• Prepare to commence enhanced arrangements; • Identify and characterise the nature of the disease (commenced in Preparedness); and • Communications measures to raise awareness and confirm governance arrangements.
	Action Cases detected in Australia Sporadic cases and/or outbreaks occurring in the community Widespread person to person transmission in community	Action is divided into two groups of activities: Initial (when information about the disease is scarce) • Prepare and support health system needs; • Manage initial cases; • Identify and characterise the nature of the disease within the Australian context; • Provide information to support best practice health care and to empower the community and responders to manage their own risk of exposure; and • Support effective governance. Targeted (when enough is known about the disease to tailor measures to specific needs.) • Support and maintain quality care; • Ensure a proportionate response; • Communications to engage, empower and build confidence in the community; and • Provide a coordinated and consistent approach.
	Stand down Virus no longer presents a major public health threat	• Support and maintain quality care; • Cease activities that are no longer needed, and transition activities to seasonal or interim arrangements; • Monitor for a second wave of the outbreak; • Monitor for the development of antiviral resistance; • Communications activities to support the return from pandemic to normal business services; and • Evaluate systems and revise plans and procedures.

Source: Australian Health Management Plan for Pandemic Influenza 2014

* The Prevention stage, although not detailed here, represents an ongoing stage of alertness and preparation for the next pandemic. This includes close collaboration between the human and animal health sectors to monitor viruses with pandemic potential and regular exercising of existing response arrangements.

APPENDIX 6: NSW RESPONSE ACTIVITIES BY PANDEMIC STAGE

PREVENTION
• Monitor for emergence of potential pandemic pathogens • Contribute to regional and global influenza surveillance • Contribute to research on pandemic influenza mitigation strategies • Monitor emerging evidence on influenza treatment and influenza outbreak control measures
PREPAREDNESS
• Promote respiratory etiquette and hand hygiene practices to the general public, particularly in relation to annual influenza season messaging • Promote infection prevention and control practices with healthcare workers, and maintain high levels of infection control for usual respiratory pathogens • Develop, test, revise and exercise pandemic plans for the health sector and across government • Ensure the State Medical Stockpile (SMS) is maintained • Support the development and maintenance of a health workforce with skills necessary for rapid deployment during a pandemic • Support NSW Health agencies to develop operational plans • Engage with primary care providers (especially GPs), the community pharmacy sector and other stakeholders • Optimise hospital performance during peak seasonal influenza activity
RESPONSE **Standby -** *Sustained community person-to-person transmission of a novel virus overseas*
• Initiate emergency management arrangements as required • Check stockpiles, pre-deploy essential items and plan use of resources and medical stockpile items (e.g. PPE, antivirals and vaccines, and resources to support their administration) • Enhance surveillance activities that enable early characterisation of disease • Commence communications to mobilise health services, emergency responders and to inform the public about the pandemic and key response strategies • Awareness campaigns developed to reflect the age and cultures of at-risk groups • Consider appropriate telephony surge options for the NSW Health service, including the identification and training of additional communications staff • Review and consider appropriateness of social distancing measures • Ensure laboratory capability/capacity, including specimen collection and transport are ready • Review support arrangements for home isolation of cases and home quarantine of contacts • Prepare primary and secondary care services for anticipated surge in patients (e.g. use of triage protocols, plans for cohorting and using infection control protocols and resources)
RESPONSE **Initial action -** *initial cases detected in Australia. Intelligence about the disease is scarce*
• Provide clinical management and public health guidelines to support health system response • Provide information through the PIC and SEMC to support the whole-of-government response • Contribute to border control measures as appropriate • Support the implementation of the enhanced surveillance arrangements in LHDs for early characterisation of the pandemic virus (e.g. First Few 100 surveillance studies) • Provide antiviral medication for cases (treatment) and/or contacts (prophylaxis) as appropriate • Monitor workforce surge requirements and consider deployments of staff across LHDs and seek inter-jurisdictional support where necessary

- Communicate with the public and healthcare workers to inform them of early response and actions that can help mitigate risk of exposure
- Develop targeted messaging and education for sectors directly affected by pandemic response measures (e.g. schools, public transport)
- Support effective governance arrangements with NSW Health agencies and other sectors/networks
- Support the implementation of candidate vaccine programs in LHDs if appropriate
- Consider implementation of a range of social distancing measures
- Implement appropriate NSW Health telephony surge options
- Isolate early cases and contacts in healthcare settings or in the community
- Implement strategies that support the health of at-risk groups in the community
- Prepare and/or deploy alternative models of care in the LHDs
- Focus laboratory testing resources on early and accurate diagnosis of cases

RESPONSE
Targeted action – *widespread activity in the community. Response measures tailored to specific needs based on available intelligence.*

- Support and maintain quality of care across health services (e.g. implement triaging protocols for EDs and ICUs, re-enforcing infection control measures)
- Provide antiviral medication for cases (treatment) as appropriate
- Support the implementation and management of whole of hospital initiatives, including alternative models of care, where appropriate and feasible
- Support the implementation of vaccination clinics in LHDs as appropriate for pandemic vaccines
- Focus surveillance activity on collecting core data from routine established systems, including health system performance data
- Communicate with the public and healthcare workers to help them understand changes in the pandemic response and actions that will help mitigate risk of exposure
- Implement strategies that continue to support the health of at-risk groups in the community
- Monitor and support health workforce surge requirements to maintain healthcare services
- Continue to promote infection control measures for health care workers and public
- Prioritise influenza diagnostic testing for patients where results will affect clinical management.

RESPONSE
Stand down – *manage the withdrawal of response strategies and transition to inter-pandemic arrangements*

- Consider additional support for maintenance of services in areas disproportionately affected
- Determine whether to cease enhanced activities and health response measures
- Continue to ensure that core data is collected from routine surveillance systems - including monitoring for second wave and/or antiviral resistance
- Ensure communication activities support return to normal business
- Plan evaluation and/or pandemic review exercises where relevant

RECOVERY
Support the return to 'normal business' and recovery activity in the community

- Contribute to community recovery (via State Emergency Recovery Controller if activated)
- Ensure surge and support staff recruited to work during the pandemic response are briefed and supported to return to their normal duties across NSW Health and partner agencies
- Conduct debrief and evaluation activity to inform future plans and policies
- Consider preparations for a subsequent pandemic wave

APPENDIX 7: PANDEMIC ROLES AND RESPONSIBILITIES

Agency or organisation	Responsible for coordinating aspects of pandemic planning and response at the state level, including but not limited to:
Ministry of Health	
Population and Public Health Division and Health Protection NSW	• Coordinating surveillance and monitoring activity, including early enhanced case finding and contact tracing in the *Initial action* stage • Developing and implementing isolation and quarantine guidelines • Developing public health communication resources in collaboration with the Strategic Relations and Communications Branch (SR&CB) • Health service planning for at-risk groups and Aboriginal peoples • Implementing international border measures in consultation with the State Pandemic Management Team and relevant LHDs • Deploying and assisting in the delivery of pandemic vaccine programs • Providing guidance and support to laboratories • Managing stockpile strategy • Managing antiviral and vaccine distribution • Developing policies to support operational management • Developing and running exercises with relevant stakeholders to test and improve operational plans for the pandemic response • Ensuring state-wide coordination of the public health response through the Public Health Controller
System Purchasing and Performance Division	• Monitoring and reporting on the impact of the pandemic on health system performance • Coordinating with LHDs on the management of emergency departments and other pandemic-related services • Coordinating the sharing of key learnings between LHDs and troubleshooting resource sharing and optimal resource allocation • Monitoring the impact of the pandemic on elective surgery • Providing expert advice on patient flow and emergency departments for public hospitals across NSW in conjunction with the ACI
Governance, Workforce and Corporate Division	• Supporting communications with the private healthcare sector (e.g. private hospitals) in collaboration with LHDs and MoH • Providing advice on the supply and administration of pharmaceuticals, and supporting links and communications with the NSW Pharmacy Guild, NSW Therapeutic Advisory Committee and hospital pharmacies • Providing legal advice regarding emergency legislation and the healthcare response • Developing pandemic-related workforce planning strategies and initiatives, including occupational health and safety policies for NSW Health agencies • Liaison with unions and other workforce groups • Managing Ministerial/Parliamentary requirements • Implementing communication strategies and resources to help keep healthcare workers informed about the pandemic • Developing and distributing state-wide health communication resources in collaboration with Population and Public Health Division • Supporting development of public awareness/notice campaigns and resources during the pandemic in collaboration with the Public Affairs Unit

Strategy and Resources Division	• Providing support, where required, for negotiating inter-government or cross-jurisdictional assistance • Assisting in the identification of and supporting liaison with primary health networks and groups • Supporting the following technical areas including preparing guidance, monitoring and communicating with networks and providing spokespeople: paediatrics, family and maternal health, aged care, disability, mental health & drug and alcohol • Supporting close liaison between the Chief Paediatrician/Paediatric Controller, the LHDs and MoH Population and Public Health Division • Supporting the Mental Health Controller
Public Affairs Unit	• Liaising with the Public Information Functional Area Coordinator • Managing the response to all press enquiries • Preparing press releases • Preparing spokespeople for media appearances • Acting as the focal point for liaison with National Health Emergency Media Response Network
NSW Health agencies	
Clinical Excellence Commission	• Providing infection control and patient safety advice and expertise to MoH • Developing state-wide strategies and resources (including training modules to rapidly up-skill staff) to maintain high levels of compliance with infection control and patient safety recommendations • Monitoring of and communicating with relevant networks • Monitoring and responding to potential quality and safety issues
Agency for Clinical Innovation	• Maintaining links with key clinical networks and providing clinical expertise on patient care • Developing targeted communication for specific medical specialities • Serving as primary point of contact with and providing secretariat support to clinical networks, including identifying emerging issues with networks • Maintaining close liaison with the Medical Controller
Health Education and Training Institute	• Coordinating the development of state-wide education and training packages in agreement with LHDs and MoH • Providing advice on the suitability of current online training resources (e.g. infection control) and the options for “just-in-time” training for surge staff prior to the pandemic
Bureau of Health Information	• Redeploying surge staff during a pandemic (e.g. biostatistical and research staff) where possible • Considering additional targeted research studies in NSW

HealthShare NSW	• Ensuring the supply and delivery of food, hotel, linen and cleaning services are maintained during a pandemic for LHDs, including the public hospital system and PACs • Coordinating state-wide procurement of clinical supplies including pharmaceuticals, consumables and equipment • Monitoring and reporting on system usage of items in short supply • Identifying and providing medical and disability equipment support to people in the community during a pandemic (e.g. home oxygen) • Considering appropriate use of the Greater Metropolitan Non-Emergency Patient Transport services to support the pandemic • Supporting the HealthShare NSW Controller
E-Health	• Maintaining strategies and procedures that both minimise state-wide information communication technology (ICT) service failure and allow for effective support for increases in clinical demand for ICT services during a pandemic
Local health districts (LHDs) / specialty health networks (SHNs)[2]	• Preparing and maintaining arrangements for surge staff capacity across all NSW Health employment categories • Operating and/or deploying surveillance systems for pandemic data collection and reporting as appropriate (e.g. FF100 surveillance studies) • Implementing models of care that allow for delivery of antivirals and vaccines • Supporting and maintaining quality of care across health services and implementing infection control measures as appropriate • Ensuring cleaning and waste management services are appropriate for pandemic influenza • Preparing and implementing arrangements with the Aboriginal Community Controlled Health Services and other key partners that provide health support for at-risk groups in the population • Undertaking engagement and seeking agreement with local government councils on possible support roles during a pandemic (e.g. recruitment of staff to support surge strategies and assist with delivering pandemic vaccination clinics) • Coordinating targeted local communication and supporting communication of state-wide messages • Coordinating consistent content of local health facility pandemic plans

[2] For the purposes of this document when referring to LHDs we also include SHNs (i.e. Justice Health and Forensic Mental Health Network and the Sydney Children's Hospitals Network). However, there is recognition that the implementation of some emergency response activities may differ between LHDs and these two health entities due to a focus on providing healthcare for target at-risk groups within specific correctional or hospital settings respectively and with a lack of field deployment.

NSW Health Pathology	• Communicating with public and private laboratories across the state regarding pandemic response arrangements, including testing capability/capacity, specimen collection and transport, supplies of reagents and consumables and timely reporting of results to clients • Supporting public reference laboratories with resources for surge response • Ensuring reference centres provide support to other laboratories for acquisition of pandemic-specific testing capacity • Considering, in conjunction with Health partners, prioritisation/suspension of non-emergency testing and outsourcing to an alternative provider based on clinical advice and technical and workforce constraints • Liaising with interstate laboratories for local testing close to state borders • Supporting the Pathology Controller and close liaison with the Public Health Controller
NSW Ambulance	• Ensuring pandemic readiness for all ambulance services across NSW (e.g. business continuity and surge staff planning) • Supporting the Ambulance Controller and close liaison between the Public Health and Medical Controllers during a pandemic response • Coordinating aeromedical services during the pandemic • Responsible through the Ambulance Controller for coordination of patient transport as defined in *NSW HEALTHPLAN*

APPENDIX 8: CHECKLIST FOR LHD/SHN PANDEMIC PLAN

LHD Pandemic Plan				
Item	**Details**	**Completed**	**In Progress**	**Not Started**
Requirements of the plan	Currency - plan last revised (specify date)	…/…/…..	☐	☐
	Hierarchy - notes how the plan inter-relates to other relevant facility and LHD plans	☐	☐	☐
	Consistency – note how the plan relates to the LHD, state and national pandemic plans	☐	☐	☐
	Management by objectives – notes the objectives of the response at the district level	☐	☐	☐
	Roles and responsibilities – notes responsibilities of all stakeholders at the district level	☐	☐	☐
	Stages – outlines response activities at each stage of the pandemic response (i.e. prevention, preparedness, response, recovery)	☐	☐	☐
	Testing or exercises – outlines how and when (frequency) the plan and key response activities would be exercised	☐	☐	☐
Communication	Details networks for local dissemination of MoH information	☐	☐	☐
	Details how LHDs will communicate with private healthcare providers and other health partners in their district	☐	☐	☐
Surveillance and monitoring	Details arrangements for collection of enhanced data & follow up of first few cases and contacts of pandemic	☐	☐	☐
	Details arrangements for collection of key epidemiological and clinical data throughout the pandemic as agreed at the national and state level	☐	☐	☐
Laboratory arrangements	Identifies the process for the urgent transfer of clinical specimens to a reference laboratory	☐	☐	☐
Medical stockpiles	Describes arrangements to order, store and distribute national and/or state medical stockpile items locally within the district	☐	☐	☐
Mitigation of transmission	Includes reference to relevant national or state infection control guidelines, and/or gives specific instructions on how to implement these guidelines locally within the district	☐	☐	☐
	Details how local support will be provided to people in home isolation and quarantine (particularly early in the pandemic)	☐	☐	☐
Antiviral medications	Identifies how antiviral agents will be distributed and administered to patients according to MoH policy	☐	☐	☐
Vaccination	Details how vaccination clinics would be set up and operated with appropriate resources and staff	☐	☐	☐
Clinical management	Includes reference to guidelines or protocols for management of pandemic patients in health care facilities	☐	☐	☐

Clinical Management (ctd)	Includes reference to guidelines for the isolation / cohorting of large number of pandemic patients	☐	☐	☐
	Describes strategies to manage additional demand for clinical services at both the facility and LHD level	☐	☐	☐
Healthcare delivery-facilities	Includes plans for the screening and triage of pandemic patients through emergency departments	☐	☐	☐
	Includes reference to guidelines for the management of patients in critical care units (adults and children)	☐	☐	☐
	Includes detail on how pandemic and non-pandemic patients would be managed in facilities	☐	☐	☐
	Includes detail on the establishment, staffing, and resources required to operate a PAC	☐	☐	☐
	Considers alternative models of care for rural and remote healthcare providers	☐	☐	☐
Healthcare delivery - community	Plan specifically details the role of GPs, community pharmacies and primary health care networks	☐	☐	☐
	Plan considers how support might be provided to immigration detention facilities or other residential institutions for controlling outbreaks	☐	☐	☐
	Plan considers how support might be provided to local schools or early childhood centres for controlling outbreaks	☐	☐	☐
	Plan considers the role of community health providers in the maintenance of core mental health services	☐	☐	☐
Aboriginal people	Identifies way to engage and partner with Aboriginal Community Controlled Health Services in pandemic planning and response	☐	☐	☐
	Identifies way to provide appropriate models of care for Aboriginal peoples during a pandemic	☐	☐	☐
At-risk groups	Identifies ways to support the health needs of at-risk groups, such as people with chronic diseases and CALD groups during a pandemic.	☐	☐	☐
Workforce issues	Detail included on how on to manage staff shortages, particularly surge strategies for clinical and non-clinical staff	☐	☐	☐
	Identifies alternative workforce staff to assist critical areas during a pandemic response	☐	☐	☐
	Consideration of staff training needs and exercises	☐	☐	☐
Role of local government	Plan specifically details the support roles that local government councils will provide during a pandemic	☐	☐	☐
Recovery arrangements	Describes arrangements to return the health facility back to where it was prior to the emergency	☐	☐	☐
	Details arrangements to support staff welfare during the return to 'business as usual'	☐	☐	☐
	Details arrangements for conducting evaluation or lessons learnt exercises	☐	☐	☐