Northern Victorian
Emergency Management
Cluster Collaboration • Preparedness • Resilience

Northern Victorian Integrated

Pandemic Plan

Version 2.0 - July 2022

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Plan Review Cycle / Maintenance of the Plan

The plan will be reviewed every two years or after a pandemic episode by the Cluster Pandemic Committee and in consultation with the Northern Victorian Integrated Municipal Emergency Management Planning Committee (IMEMPC).

The Cluster Coordinating Council holds the master copy of the document and it is expected that agencies have internal processes in place to ensure distribution of the Plan within their organisation.

**As of 4 August 2022, the Pandemic Plan is deemed a sub-plan of the IMEMPC until further guidance is received from Emergency Management Victoria regarding plan classifications.*

This Plan is administered by the Northern Victorian Emergency Management Cluster, Cluster Coordinating Council, on behalf of the Northern Victorian Integrated Municipal Emergency Management Planning Committee.

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1 Abbreviations

AHMPPI	Australian Health Management Plan for Pandemic Influenza
AoO	Area of Operations – do we need to insert and align to the SEMP process
DH	Department of Health
DFFH	Department of Families, Fairness and Housing
EMV	Emergency Management Victoria
IMEMP	Integrated Municipal Emergency Management Plan
IMEMPC	Integrated Municipal Emergency Management Planning Committee
IPC	Infection Prevention and Control
IPP	Influenza Pandemic Plan
MEMO	Municipal Emergency Management Officer
MOC	Municipal Operations Centre
MRM	Municipal Recovery Manager
NVEMC	Northern Victorian Emergency Management Cluster - consisting of the municipalities of Central Goldfields, Loddon, Greater Bendigo, Mount Alexander and Campaspe.
NVIMEMPC	Northern Victorian Integrated Municipal Emergency Management Planning Committee
PHU	Public Health Unit
PC	Pandemic Coordinator
PPE	Personal Protective Equipment
RAT	Rapid Antigen Test
SEMP	State Emergency Management Plan
VIFM	Victorian Institute of Forensic Medicine
VHMPPI	Victorian Health Management Plan for Pandemic Influenza

2 Introduction

This document provides a framework and guidance for the NVEMC Shire Councils and other pandemic stakeholders in the municipalities to appropriately plan for and effectively respond to pandemic conditions. The plan is supported by a set of operational documents, including Pandemic Response Procedures and Business Continuity Plans.

All facts and figures cited in this plan have been taken from the Victorian Health Management Plan for Pandemic Influenza (VHMPPI) unless otherwise stated. Direction for pandemic will come largely from the Commonwealth and or State and local level of government will implement controls.

Pandemic is defined as an epidemic that is geographically widespread; occurring throughout a region or even throughout the world. A pandemic occurs when a new virus emerges and spreads around the world when:

1. Humans have little or no pre-existing immunity
2. The virus causes disease in humans, and
3. The virus has the capacity to spread readily or efficiently from person to person.

Pandemics have been experienced in the past and are expected to occur again in the future and the impact on the organisation and community in such an event can be devastating.

3 History of Pandemics

Previous pandemics have started abruptly without warning, swept through populations with rapid escalation, and left considerable damage in their wake.

The twentieth century had three recognised influenza pandemics (Spanish influenza 1918-19; Asian influenza 1957-58; and Hong Kong influenza 1968). All three pandemics were associated with increased mortality rates in Australia. The influenza pandemic of 1918-19 was unprecedented in terms of loss of human life – between 20 and 40 million people died worldwide, with the highest numbers of deaths among those aged between 20 and 40 years.

The Asian influenza of 1957-58 had infection rates reported to range between 20% to 70%, but case fatality rates were low, ranging from one in 2000 to one in 10,000 infections. Age-specific mortality rates showed that those aged over 65 years were most affected. The Hong Kong influenza was similar, with the highest mortality rates appearing in those over the age of 65 and infection rates of 25% to 30%.

A new H1N1 influenza virus derived from human, swine and avian strains was initially reported in April 2009 in Mexico and subsequently spread around the world. In Australia during 2009, there were 37,636 cases of pandemic (H1N1) influenza 2009, including 191 associated deaths. The median age of those dying was 53 years, compared to 83 years for seasonal influenza.

The current global coronavirus disease 2019 (COVID-19) is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first case of COVID-19 was reported in December 2019 in Wuhan, China and may have originated in an animal and mutated so it could cause illness in humans. The World Health Organisation declared a pandemic on 11 March 2020. The severity of

COVID-19 can range from unnoticeable to life-threatening respiratory failure. COVID-19 transmits when people breathe in air contaminated by droplets and small airborne particles. As of July 2022, more than 570 million cases have been confirmed, with more than 6.3 million confirmed deaths attributed to COVID-19[1].

The differences in past pandemics show the need for flexible contingency plans, capable of responding efficiently to any pandemic threat.

The following table outlines the history of pandemics in Australia over the past 200 years[2].

Virus	Year	Victoria		Australia	
		Cases	Deaths	Cases	Deaths
Smallpox	1790s – 1830s	n/a	45,000 75% of Indigenous population	n/a	n/a 50% of Indigenous population
'Russian flu'	1891	n/a	1,000	n/a	n/a
'Spanish flu'	1918–20	n/a	3,561	Up to 40% population	12,000–20,000
Polio	1937–38	2,096	118	4,555	274
'Asian flu'	1957	n/a	40	n/a	Approx. 70
HIV/AIDs and related illness	1981–2016	n/a	n/a	35,000	10,000
'Swine flu'	2009	3,089	26	6,725	84
COVID-19[3] ***as at July 2021**	2020-2022	21,779 total PCR tests	4,433	9.2 million	11,387

[1] "WHO Coronavirus (COVID19) Dashboard", World Health Organisation, last modified 27 July 202.

[2] B. Huf & H. Mclean (May 2020): Research Paper 'Epidemics and pandemics in Victoria: Historical perspectives' Parliament of Victoria website.

[3] "Coronavirus (Covid-19) case numbers and statistics'. Australian Government Department of Health, last modified 27 July 2022

4 Pandemic Planning Principles

These principles guide us to ensure our response is:

- To decreases risk of cross infection (flatten the curve)
  - Supports social distancing – 1.5 metres
  - Mask requirements
  - Strengthens infection control
  - Limits interaction with "others"
- Evidence based
- Aligned with organisation culture
- Focused on maintaining services and supporting vulnerable people, including with underlying health conditions, compromised immune systems, the elderly, Aboriginal and Torres Strait Islanders, and those from culturally and linguistically diverse communities.
- To decrease impact on economy

5 Aims & Objectives

5.1 Aims

- To assist in the prevention and reduction of the pandemic impacts on the community.
- To ensure response activities are consistent across the whole of government.
- To provide holistic relief support to the community throughout the pandemic
- To provide leadership and recovery assistance throughout the durations of the pandemic.
- To provide consistent current timely communication to staff, clients and community.
- Evaluate response of our actions on the community and impact on the local economy.

5.2 Objectives

- To be flexible and proportionate and can be scaled up and down as required.
- Preparedness - to reduce the impact on the community during a pandemic.
- Communication – develop media and communication messages and approaches relevant to target audiences, in line with whole of government messages, to inform the community and staff of any changes to normal municipal service delivery.
- Containment – prevent transmission, implement infection control measures, support tracing and provide support services to people who are isolated or quarantined within the municipality, as directed via State Govt / PHU.
- Maintain essential municipal services – provision for business continuity in the face of staff absenteeism or redeployment and rising demand on local government services.
- Response – to support community whilst trying to prevent spread and determine different ways of delivering service.
- Look at alternative ways to provide in home services where there is a family violence risk i.e. consult with client at another location (library, park).
- Relief – to ensure that the community receives vital resources and support to assist with response and recovery.

- Mass Vaccination – assist the State Government when requested in providing vaccination services to the community, if pandemic vaccine becomes available.
- Immunisation – continue to immunise and protect the community from preventable communicable disease.
- Community support and recovery – ensure a comprehensive approach to emergency recovery planning in the Municipal Emergency Management Plan, with specific focus on pandemic.
- Leadership – work together to put processes in place across the cluster whilst waiting for State/Commonwealth direction.
- We apply the mutually agreed principles in our overall decision making.

This Plan can be adapted to all types of communicable disease pandemics.

This Plan is to be used in conjunction with, and as a supplement to, existing emergency management plans in place within state, regional, municipal councils and the wider community.

6 Framework

6.1 Commonwealth plans

- Australian Health Management Plan for Pandemic Influenza (AHMPPI) – Australian Government Department of Health – August 2019.

6.2 State plans

- Victorian State Emergency Management Plan – September 2020
- Victorian Action Plan for Influenza Pandemic – August 2015
- Victorian Health Management Plan for Pandemic Influenza – Victorian Department of Health – October 2014
- The Whole of Government Communication Strategy
- Action plans for all government departments
- The Victorian Human Influenza Pandemic Plan – Community Support and Recovery Sub Plan.
- COVID19 Pandemic Plan for the Victorian Health Sector 2020
- Victorian Local Government Act 2020

6.3 Other plans

- Integrated Municipal Emergency Management Plan
- Business Continuity Plans
- Mass Vaccination Standard Operating Procedures

7 Roles

In the event of an emergency such as a pandemic it is the role of Local Government, as the closest level of government to the community, to work closely with the state governments to support preparedness, implementation of response measures and recovery, as well as communication of messages to the local community.

The following items are a high priority during a pandemic:

- Leadership and facilitation of a Community Relief & Recovery Committee.
- Gathering community intelligence to understand impacts and consequence management planning.
- Developing local responsive programs to support social and economic outcomes.
- Advocating for our community to the State and Federal Government.
- Continuation of the essential components of services provided to the community by Council e.g. aged care services, children's services, immunisation services (as relevant) where they can be provided within the confines outlined in this plan.
- Provision of services as outlined in the Integrated Municipal Emergency Management Plan, including relief and recovery assistance and referral.
- Provision and interpretation of public health information and education to the community.
- As an existing immunisation provider, in conjunction with other providers, support the delivery of a pandemic vaccination program (if / when vaccine is available) and continue to provide program for other communicable preventable disease.

Additional services will be provided on an as needs basis. The State Government will advise Council of any further assistance that may be required at a local level.

7.1 Pandemic Coordinator

Planning for a pandemic is a complex task, requiring input from a range of work areas and specialists to ensure a cohesive and effective response to and recovery from such an emergency. To address this, each Council will assign responsibility for coordinating pandemic planning to a Pandemic Coordinator and deputies as required . The Pandemic Coordinator and deputies will be appointed by Councils Executive Management Team.

The role could include:

- Leading the Pandemic Committee;
- Ensuring contingency for the role and relevant record keeping is established;
- Provision of regular communications with Council, senior management and staff;
- Liaise with municipal health care providers and Loddon Mallee PHU about the pandemic and involving them in the development of planned municipal arrangements;
- Leading research to identify vulnerable groups within the community;
- Liaising with senior managers and municipal business continuity planners to ensure the Municipal Business Continuity Plan has addressed the specific considerations likely to arise in a pandemic;
- Liaising with the Municipal Recovery Manager (MRM) in relation to specific community support and recovery considerations in a pandemic;

- Arranging exercises or workshops;
- Contributing to the local Relief & Recovery Committee.

7.2 Municipal Pandemic Committee

The role of the Pandemic Committee is to assist the Pandemic Coordinator to plan for a pandemic when it is imminent, respond to a pandemic and plan for recovery. The Committee will be activated when there are confirmed outbreaks within the region or when the State or surrounding local government area have been placed in lockdown. The Committee will need to ensure arrangements dovetail with existing emergency management and public health arrangements in the municipality and across Victoria. With this in mind, it is vital to ensure all issues are addressed and that there is a link to the important work being undertaken in other parts of the Council business, and other Agencies.

Representation on the Pandemic Committee should include:

- Members of the Executive Leadership Team depending on stage of emergency.
- Pandemic Coordinator;
- Environmental Health Officer;
- Work Health & Safety Officer;
- Municipal Emergency Management Officer (MEMO)
- Municipal Recovery Manager (MRM)
- Emergency Management Staff
- Communication/ Public Relations
- Representation and/or advice from the following areas of the municipal business when needed:
    - Human resources (especially with skill in work planning, industrial relations and financial management)
    - Economic development officer
    - IT management
    - Infrastructure management
    - Children (Early Years), Health and community care services and aged care (home support) services
    - Risk management and occupational health and safety services
    - Immunisation coordinator
    - Business Continuity representative

Each representative on the Committee should ensure they have several proxies who they keep well informed. This will provide contingency should they become sick and allow for regular breaks given a pandemic can continue for months to years. The Committee needs to monitor the health and safety of its members to ensure it can continue to fulfill its role over the longer term.

A Standing Agenda should be established for meetings to ensure key areas are continually addressed and actions followed up.

7.3 Communication Team

Local Government Communication Teams should ensure the following:

- Provide timely, accurate information according to State and Federal directives.
- Make sure information is accessible across a variety of mediums i.e. Website, Radio, Papers, Facebook.
- Provide transparent, consistent, responsive and empathetic messaging in local languages through trusted channels of communication.
- Disseminate important and/or urgent messages provided by the Victorian Department of Health (single source of truth).
- Share localised relief support information e.g. Local Govt Helpline details.
- Regularly review messaging and communication approaches to ensure information is supporting the community need.

7.4 Environmental Health Officers

- May be empowered to investigate, inspect and issue direction to comply with public health Directions or legislation per Public Health and Wellbeing Act / Reg powers.
- May be requested to investigate or contribute to intelligence for operation planning, intervention and response.
- Undertake rapid on-ground environmental needs assessment.
- Provide education and support on infection prevention and control (IPC) for Council, local businesses and community.
- May be requested to investigate and intervene on particular local clusters or outbreaks.
- Support organisation to sustain immunisation services.
- Sustain essential health protection services with a goal of minimising additional pressures on medical services and maintaining demand within hospital capacities.
- Supporting enforcement agencies with staffing and technical resources.
- Providing a conduit of information between health authorities and registered premises and key local contacts.
- Assist community support services where required with engagement, information and IPC guidance, and powers.
- Contribute IPC guidance to business continuity plan (BCP) development and implementation.
- Support organisational operations and planning with interpretation of epidemiological and pathogenesis information, and Direction and health legislation.
- Develop infection control and case management protocols for organisation in collaboration with WHS partners.
- Establish personal protective equipment (PPE) / Community Protective Equipment (CPE) supply requirements, acquire, store and dispense as required for organisation and emergency response operations.
- Facilitate health protection outreach programs with resource needs and information.
- Facilitating new business registration and business adaptation where appropriate.

*NOTE: Specific roles may differ slightly between Cluster councils.

7.5 Work Health & Safety Team/Business Continuity Team

- Monitor pandemic measures taken by the organisation in compliance with the OHS Act and Occupational Health and Safety Regulations 2017 and enquire into anything that poses or may pose a risk to the health or safety of staff and visitors.
- Acquire and keep knowledge of the pandemic situation.
- Follow advice from authoritative sources such as the State Department of Health and assist the organisation to quickly take steps to help implement relevant advice in the workplace.
- Make sure the organisation is properly resourced to manage WHS risks during the pandemic outbreak and check that the resources (PPE and infection control protocols) are being used.
- Review and update policies, procedures and reporting processes to ensure they address the risks of the pandemic.
- Ensure that new information and processes about the pandemic are communicated clearly to staff and processes are being followed i.e. signage, staff messaging.
- Provide instruction and training to workers on things they need to do to help manage the risk of the pandemic spreading in the workplace i.e. mask requirements, social distancing, density quotients in meeting rooms.
- Lead contact tracing responsibilities i.e. sign in /QR Code protocols around buildings.
- Appoint roaming Pandemic Marshalls to ensure compliance.
- Follow up with areas of non-compliance to ensure correct processes are followed.
- Liaise with Risk & Assurance Team for business continuity planning.
- Distribution point for Rapid Antigen Tests (RATs)

*NOTE: Specific roles may vary slightly between municipalities.

7.6 People Managers

- Adapting work plans
- Ensuring communication has reached staff
- Monitoring compliance within Unit
- Monitor the health and wellbeing of their staff
- Keep up to date with current restrictions

7.7 Municipal Recovery Support Officer

- Support recovery initiatives across the municipality focusing on businesses and community to cope and keep informed of imposed restrictions.
- Advise municipal Pandemic Committee of emerging trends and issues that need to be addressed.
- Assist in maintaining social connections.
- Involvement with food relief organisations to offer council support.
- Support the development of community engagement activities to advance community-based relief and recovery.
- Think innovatively to continue to support the community with impacts of mental health, loss of income, food insecurity.

7.8 Cluster Pandemic Committee

The Northern Victoria Emergency Management Cluster will form a Cluster Pandemic Committee. The Cluster Pandemic Committee will consist of:

- Pandemic Coordinators (and deputies) from each Council and appointed staff from their municipal Pandemic Committees;
- Representation from other community related health services;
    - Hospitals, Primary Health Network, Public Health Unit, Community Health;
    - Support services such as food relief, meals on wheels, home care, community nursing;
    - Regional DH representative;
    - Victoria Police
    - Recovery Agencies – Red Cross, VCC EM, Salvation Army
    - Community and business representatives, especially from special needs groups.

The Cluster Pandemic Committee will meet on a regular basis to share learnings, strategies and discuss emerging issues in their region.

8 Activation

8.1 Activation Protocol

The Pandemic Plan may be activated if any of the following occurs:

- a request is made by the State - State of Emergency declared.
- a request is made by the Control Agency (Department of Health),
- a request is made by the Victoria Police Municipal Emergency Response Coordinator (MERC) or Regional Emergency Response Coordinator (RERC);
- a request is made by Council's Chief Executive Officer or Executive Management Group,
- a request is made by the Municipal Emergency Management Officer (MEMO) or Municipal Recovery Manager (MRM).
- Council's Municipal Operations Centre is established in response to the pandemic.

Individual departments within Council may activate their Business Continuity Plans as necessary. It may be necessary that only some aspects of the plan are activated during a pandemic depending on the severity of the disease and the impact it has on the community and the needs of the community and the directions coming from the Chief Health Officer.

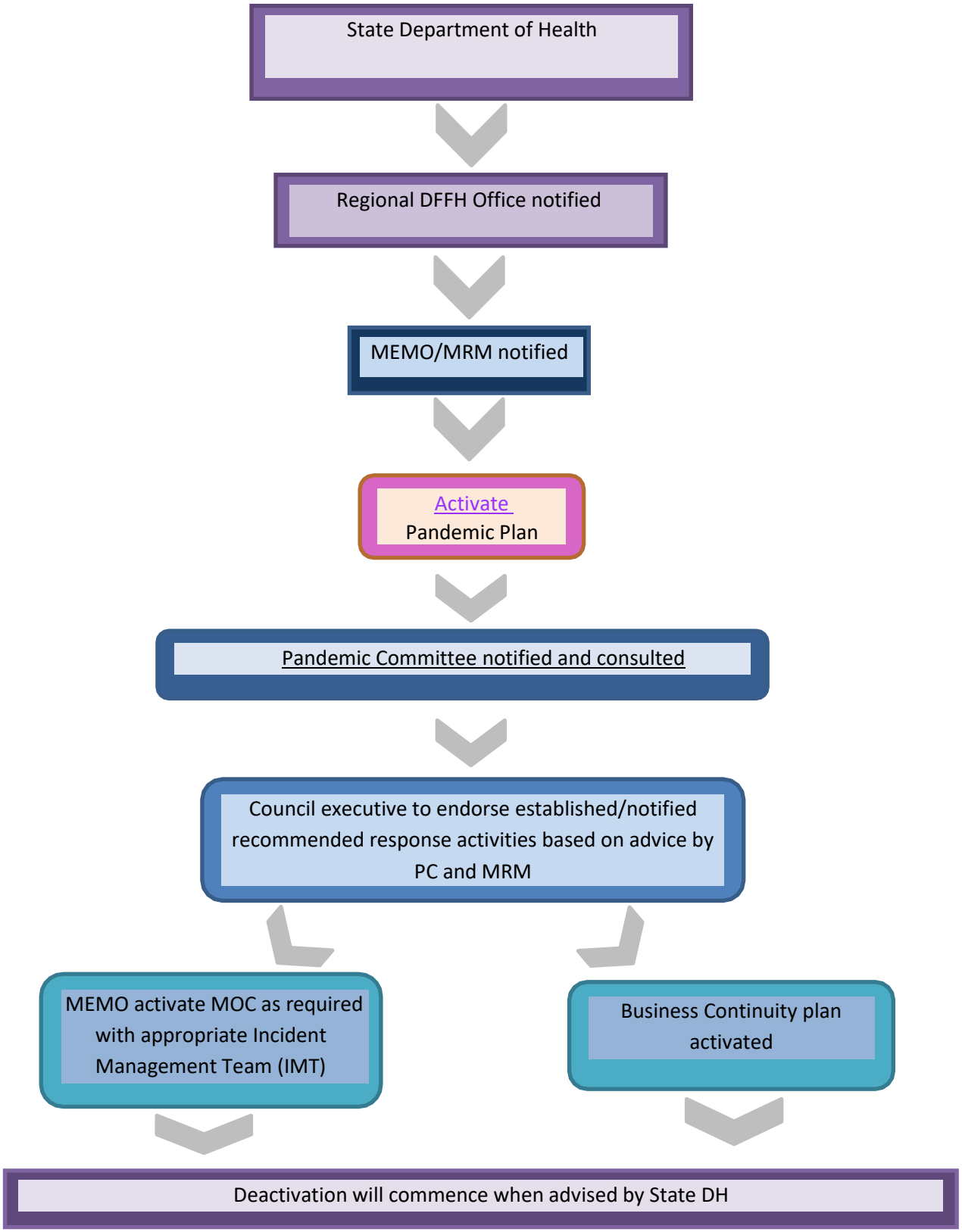
Each municipal Pandemic Committee will meet throughout the pandemic. This will most likely be virtually to avoid close contact and reduce the risk of the virus spreading.

Possible outcomes during/ after a pandemic for the committee to consider are shown in Appendix 1.

Council will implement the following strategies in the initial response to a pandemic:

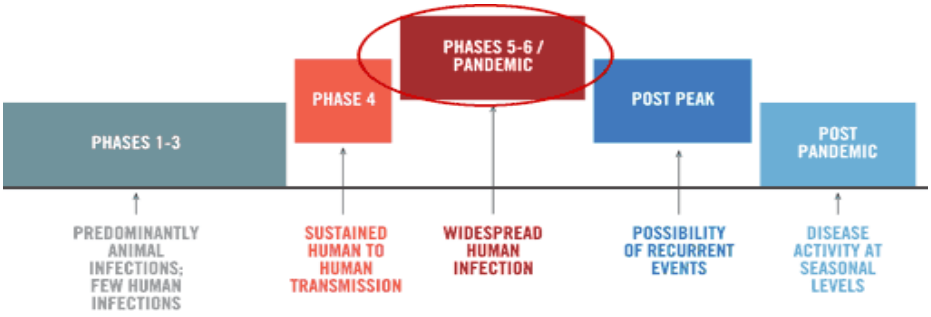
- Call a joint meeting of the Pandemic Committee and the Executive Leadership Team to oversee activity and provide advice. This will most likely be virtually to avoid close contact and reduce the risk of the virus spreading;
- Strengthen infectious disease control measures to minimise or prevent the spread in the workplace;
- Provide clear, timely and pro-active communication to staff including how Council is responding to the situation;
    - Have a system which stores staff emails (work & private) and/ or mobile numbers in all formats for quick distribution of communication.
- Provide clear, timely and pro-active communication to residents;
- Review and strengthen infectious disease control measures and exclusion policies in all Councils' childcare centres/kindergartens (as relevant), maternal and child health centres, immunisation services and other funded community services (e.g. home support – aged care);
- Enact Business Continuity Plan;
- Review individual service models to limit risks to staff and community by limiting person to person interaction, especially for workers in services deemed essential;
- Instigate Working from Home arrangements for staff where possible
- Provide personal protective equipment to staff (surgical masks, disposable gloves, eye protection etc.)

ACTIVATION PROTOCOL



9 Pandemic Phases / Stages

The World Health Organisation (WHO) has a set of pandemic phases that it uses to describe the global situation (phases 1–6).



The Australian pandemic phases are designed to describe the situation in Australia and to guide Australia's response. Thus, the Australian and the WHO phase may not always be the same and do not neatly align. Similarly, Victoria also defines pandemic status using a set of phases. These definitions align with the Australian definitions, but once again depending on the state of spread of a pandemic the Victorian phase may differ from the Australian and World phases.

During COVID-19 the Doherty Institute developed modelling to advise the National Plan to Australia's COVID Response.

Australian Pandemic Phases	
Phase A	**Vaccinate, Prepare and Pilot** *Continue to strongly suppress the virus for the purpose of minimising community transition.* Measures include: - Accelerate vaccination rates - Close international borders to keep COVID-19 out - Early, stringent and short lockdowns if outbreaks occur - Minimise cases in the community through effective test, trace and isolate capabilities - Inbound passenger caps temporarily reduced - Recognise and adopt the existing digital Medicare Vaccination Certificate
Phase B	**Vaccination Transition Phase** *This phase is triggered when **70%** of adults aged 16+ are fully vaccinated. *Seek to minimise serious illness, hospitalisation and facilities as a result of COVID-19 with low level restrictions.* Measures may include: - Minimise cases in the community through ongoing low-level restrictions - Lockdowns less likely but possible - Ease restrictions on vaccinated residents - Restore inbound passenger caps at previous level for unvaccinated returning travellers and larger caps for vaccinated returning travellers - Introduce new reduced quarantine arrangements for vaccinated residents

Phase C	**Vaccination Consolidation Phase** **This phase is triggered when **80%** of adults aged 16+ are fully vaccinated.* *Seek to minimise serious illness, hospitalisation and fatalities as a result of COVID-19 with baseline restrictions.* <u>Measures may include:</u> - Highly targeted lockdowns only - Continue vaccine booster programme - Exempt vaccinated residents from all domestic restrictions - Abolish caps on returning vaccinated Australians - Lift all restrictions on outbound travel for vaccinated Australians
Phase D	**Post-Vaccination Phase** *Manage COVID-19 consistent with public health management of other infectious diseases.* <u>Measures may include:</u> - Open international borders - Minimise cases in the community without ongoing restrictions or lockdowns - Boosters as necessary - Allow uncapped inbound arrivals for all vaccinated persons, without quarantine

During the COVID-19 Pandemic the Victorian Government developed a Roadmap for reopening the state in a safe, steady and sustainable steps and informed how the community sectors will be impacted. This outlaid the path out of restrictions and into a COVID normal way of living with the virus. At times there were separate roadmaps for metropolitan Melbourne and regional Victoria.

Australian Health Management Plan for Pandemic Influenza (AHMPPI) Stages

Preparedness		• Establish pre-agreed arrangements by developing and maintaining plans; • research pandemic specific influenza management strategies; • ensure resources are available and ready for rapid response; • monitor the emergence of diseases with pandemic potential, and investigate outbreaks if they occur.
Response	**Standby**	• Prepare to commence enhanced arrangements; • identify and characterise the nature of the disease (commenced in Preparedness); and • communicate to raise awareness and confirm governance arrangements.
	Action	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; • communicate to engage, empower and build confidence in the community; and • provide a coordinated and consistent approach.
	Standdown	• 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; • communicate to support the return from pandemic to normal business services; and • evaluate systems and revise plans and procedures.

Reference: Australian Health Management Plan for Pandemic Influenza

10 Possible Diseases & Transmission

The World Health Organisation has prioritised a list of diseases and pathogens for research and development in public health emergency context.

The WHO tool distinguishes which disease pose the greatest public health risk due to their epidemic potential and/or whether there is no or insufficient countermeasures

11 Action Plan Implementation

Appendix 2 contains checklists to assist Council staff to undertake required tasks during the following stages:

1. Preparedness
2. Standby
3. Initial Action
4. Activation
5. Stand-down.

12 Control Strategies

This plan identifies a number of strategies that may need to be undertaken in the event of a pandemic. Decision to enact these strategies will be aligned with the following principles:

- Decrease risk of cross infection
  - Supports social distancing
  - Strengthens infection control
  - Limits interaction with "others"
- Evidence based
- Aligned with our values
- Focus on maintaining services & supporting vulnerable people
- Decrease impact on economy

Depending on the transmission mode of the agent, varied control measures will be implemented to prevent/limit transmission. During a Pandemic, agencies within the Cluster Councils may be required to assist with control strategies appropriate to the nature of the contagion. This will be handled within existing Emergency Management arrangements.

12.1 Social distancing

Social distancing refers to various personal and physical infection control measures designed to reduce the risk of transmission between people. Measures need to be implemented appropriately and progressively at different phases of a pandemic, in order to maximise their benefits and limit any unnecessary impact on communities and business.

Moderate measures may include advising people to minimise physical contact and avoid large gatherings and public places.

Extreme measures might include closing schools, childcare centres, universities, workplaces, non-essential retail, recreational facilities, cancelling public events, home isolation or strict travel restrictions.

Consideration needs to be given to the more vulnerable staff/ members of community who are over 70 years, Aboriginal and Torres Strait Islander cohorts, immune suppressed or have a chronic condition who could be more susceptible to contracting the virus causing a detrimental effect on their health.

How to minimise transmission

- Avoid meeting people face to face – use on-line meetings and document systems to conduct business as much as possible, even when participants are in the same building.
- Avoid any unnecessary travel and cancel or defer non-essential meetings, gatherings, events, workshops and training sessions.
- If possible, arrange for employees to work from home or work variable hours to avoid crowding at the workplace.
- Stagger shift changes where one shift leaves the workplace before the new shift arrives. If possible, leave an interval before re-occupation of the workplace and ventilate the workplace between shifts by opening doors and windows or turning up the air-conditioning.
- Avoid public transport. Walk, cycle, drive a car or go early or late to avoid rush hour crowding on public transport.
- Bring lunch and eat it at your desk or away from others (avoid the lunchrooms and crowded restaurants). Introduce staggered lunchtimes so the numbers of people in the lunchroom are reduced.
- Do not congregate in tearooms or other areas where people socialise. Do what needs to be done and then leave the area.
- If a face-to-face meeting with people is unavoidable, minimise the meeting time, choose a large meeting room and sit at least 1.5 metres away from each other if possible; avoid shaking hands or hugging. Consider holding meetings in the open air.
- Set up systems where clients and customers can pre-order or request information via contactless delivery systems or click & collect options.
- Encourage staff to avoid large gatherings where they might come into contact with infectious people.

12.2 Limiting Mass Gatherings

Mass gatherings have the capacity to spread viruses among participants. Events that may be considered as mass gatherings include schools/education facilities, concerts, large sporting events, citizenship ceremonies, festivals, shopping centres, cinemas, nightclubs and places of worship.

In the event of a pandemic, mass gatherings organised within or by the Council will be reviewed in line with DH advice. DH will determine the approach based on the particular nature of the contagion and advise private business and event organisers of their obligation to close and cancel events. Event organised should be encouraged to develop processes to stand down or cancel an event rapidly in case they are requested to do so.
Worksites with a large number of staff in proximity may need to either stagger shifts to make sure they do not exceed the density quotient specified by DH and maintain the required social distancing recommendation, or may need to stand down workers until capacity can be safely increased. Large staff meetings should be held virtually.

12.3 Procedure for Supporting People Isolated in their home

During a pandemic, community members may be quarantined in their homes. Additional support may be required for members of the community who are quarantined in their homes who don't have any form of assistance (family or friends) or are at increased risk of domestic violence if isolating at home. Identification of these 'affected' people could be made by DH via their Help Line, requests for assistance through the Council Customer Service or referrals from members of the community. Initial consideration should be given as to the person's reasonable ability to remain quarantined in their home with limited support, with other options to be considered (e.g. hospital admission, relocation for safety).

Assistance provided by Councils will be dependent on each municipality's capacity and funding streams and they may not all be the same. Any assistance provided must take into consideration the control strategies identified in this plan, see section 11.1 and 11.2.

The following points will be considered by the municipalities when determining what assistance can be provided:

- council may have limited capacity to respond
- the least human contact is the underlying principle
- initial information provided should indicate:
    - health status
    - access to food and support
    - access to medication.
- the need to maintain regular phone contact and whether this is possible due to resourcing issues
- any deliveries of supplies (e.g.: food or medications) to be delivered to a pre-arranged collection point that minimises contact with the quarantined person/s.

12.4 Work from home / restricting work place entry

As a minimum, agencies will, via their Business Continuity Plan, determine the need to advise staff and visitors not to attend if they have symptoms of the pandemic or have been in contact with someone who has/d symptoms of the infection.

Employees shall be advised not to come to work when they are feeling unwell, particularly if they are exhibiting symptoms associated with the pandemic. Unwell employees will be advised to see a doctor and to stay at home until symptom free for the time determined by medical experts, and medical clearance has been provided.

Staff who have recovered from the pandemic related illness are unlikely to be re-infected (most will have natural immunity for a period of time) and will be encouraged to return to work as soon as medical clearance is provided or otherwise advised. In extreme cases it may be desirable that staff are not gathering in the same place. In this instance work from home (remote) practices may need to be authorised and then supported by the IT department and WHS staff.

12.5 Essential workers / Staff who cannot work from home

Modifications are required for staff who are deemed as an essential worker , as directed by State or organisation, or staff who cannot work from home and need to attend the workplace during a pandemic.

This includes:

- Contactless and traceable check in availability for example QR Code Check In.
- Additional cleaning of high touch points, computers, desks, communal areas.
- Provision of hand sanitiser at numerous locations.
- Provision of disposable face masks.
- Modification of environments to limit need to touch i.e. doors held open where possible.
- No sharing of food utensils, i.e. each person to bring their own cups, plates, knives, forks.
- Provision of sneeze guards installed at customer facing locations.
- Marking out of distance limits.
- Limitation on use of meeting rooms i.e. capacity reduced due to density quotient, doors left open, surfaces disinfected before and after use.

12.6 Virtual MOC operations

The IMEMP details arrangements for the normal operation of the Municipal Operations Centre (MOC). Should social isolation be considered as the most appropriate control strategy by the control agency, the MOC can still be managed by staff meeting on-line as well as logging onto Crisisworks remotely.

Communication via telephone rather than gathering in the predetermined MOC facility should also be considered. As a pandemic is likely to be long running, consideration should be given to incorporating the MOC role into a person's normal role. The long-running nature of pandemic also means the MOC may not need permanent full staffing.

12.7 Personal Protective Equipment (PPE) and Cleaning Supplies

Councils will maintain a limited stockpile of Personal Protective Equipment (PPE) for use by staff that have direct contact with the community during the pandemic.

This includes: disposable gloves, safety glasses and alcohol based hand sanitiser. Appropriate face masks (N95, KN95, P2, surgical masks) will be purchased as required.

These will be available to staff that have close contact with members of the community and with people who may be unwell. This includes personal carers in the aged and disability area, early years staff and maternal child health nurses, EHOs, local laws, parks staff, along with relief workers. These will be supplied to staff on an as needs basis at the discretion of the People Manager in consultation with relevant members of the Pandemic Committee.

Training should be provided to staff to ensure appropriate donning and disposal of PPE.

The reliability of suppliers to provide these services during a pandemic has been investigated and deliveries are usually available within 3-4 days, providing the items are available.

12.8 Food Delivery

AUSFOODPLAN-Pandemic addresses National food supply during a pandemic. The plan includes arrangements for grocery stores to implement social distancing, and continue to supply groceries, hygiene and sanitary products. The plan does not cover vulnerable communities that are sick or not able to get to stores. The role of food supply at the state level is shared between Department of Environment, Land, Water and Planning (DELWP) and Department of Health (DH). If local food deliveries are required, this will be managed within the existing Emergency Management arrangements.

Cluster Councils utilise different contractors and work with local food relief services and approved suppliers for the catering of delivered meals programs. Each Council keeps details of contractors and suppliers.

Councils maintain a list of approved suppliers or have arrangements in place with local supermarkets for the purchasing of products. Local food businesses located throughout the municipalities are able to provide catering for large numbers of people. If necessary these businesses will be contacted to assist in the provision of additional meals for isolated persons.

12.9 Council internal arrangements

Staff will be encouraged to regularly clean their own work areas, especially those that are shared with other members of staff. Focus will be on high contact areas such as computers, telephones, door handles, light switches and high traffic areas such as tea rooms and meeting rooms.

The collection of sharps has been considered and arrangements are in place for routine collections and deliveries of containers. An adequate supply of containers is on hand if deliveries cannot be made and secure storage is available for full containers to be stored until collection can be arranged. (This service is delivered by the Community Health Service in some municipalities).

12.10 Mass Vaccination

When a customised pandemic vaccine does become available, a mass vaccination program will be coordinated by the DH & PHU. Municipalities and GP networks may be asked to support DH by providing staff, facilities or promoting the vaccination program throughout the community. Refer to individual municipalities standard operating procedure for Mass Vaccination.

It is important that a provision of immunisations for other preventable communicable disease are also kept.

12.11 Mass fatality

The Victorian Institute of Forensic Medicine (VIFM) is responsible for all deceased persons where there is no Doctor's certification of death. The VIFM has a capacity for normal operations and surge capacity arrangements for a significant number of deceased persons. The VIFM will use the Disaster Victim Identification INTERPOL Guidelines to identify multiple bodies after a mass fatality (likely in a pandemic). Cultural sensitivities are taken into account and teams are briefed on local religious beliefs, cultural attitudes and practices and political systems.

Requests for assistance from VIFM would be made to Victoria Police and the Municipal Emergency Response Coordinator (MERC) would contact the Municipal Emergency Management Officer (MEMO).

12.12 Deactivation

When response activities are nearing completion, the Pandemic Committee in conjunction with the control agency will call together relevant relief and recovery agencies including the MEMO and the MRM to consult and agree on the timing and process of the response stand down.

Stand- down activities for agencies include:

- Liaise with agencies for up-to-date information.
- Implement agency plan for resumption of full business capacity.
- Restock inventory and resupply.
- Document financial expenditure and seek advice from your regional department in relation to any financial support packages available.
- Conduct structured debriefs for short, medium and prolonged terms.
- Review the Pandemic Plan and prepare for the next pandemic using lessons learnt.
- Continue recovery processes to assist the community.

(Appendix 2 - Action Plan Implementation – Section 5. Stand-down)

13 Impacts of a pandemic

Modelling the potential impacts of pandemics involves a high degree of uncertainty. Factors such as the virulence and infection rate of the next pandemic strain limit our abilities to characterise the next pandemic with any accuracy. It is, however, possible to model various pandemic scenarios given a series of pre-determined assumptions and limitations.

With COVID-19, Public health policies across countries have varied considerably with respect to the restrictiveness of interventions, the acceptance of widespread implementation, and presumed effectiveness in reducing disease transmission. Measures such as the detection and isolation of infected individuals, contact-tracing, quarantine measures, physical distancing, and closure of non-essential businesses have become major components of public health guidance, aiming to reduce the spread of further infection, and prevent health system strain.[3]

Negative impacts on the community as a result of prevention initiatives have predominantly been

- Loss of income – individuals, businesses, groups
- Food insecurity - including purchasing limits, increased demand, lack of/no stock and increase in food prices
- Social isolation
- Housing stress
- Increased risk of family violence
- Increasing rates of stress, anxiety and mental illness

Refer Appendix 1 – possible outcomes for consideration.

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[3] **Hartley D. Perencevich E.** Public health interventions for COVID-19: emerging evidence and implications for an evolving public health crisis *JAMA.* 2020; (Published online April 10, 2020)https://doi.org/10.1001/jama.2020.5910

The Victorian Health Management Plan for Pandemic Influenza (VHMPPI), October 2014, shows the following:

Pandemic Impact, unprepared vs prepared

	Pandemic as severe as the one that occurred in 1918 and we were not prepared and unable to respond	Pandemic as severe as that in 1918, but we were prepared and were able to respond effectively
Estimated population showing clinical signs of infection	40 per cent (2.2 million people)	**10 per cent (540,000 people)**
Estimated deaths	2.4 per cent of those affected would die (around 53,000 people)	**1.2 per cent of those clinically affected would die (around 6,500 people)**
Work absenteeism	50 per cent	**30 – 50 per cent**
Duration of the pandemic	Several waves each, lasting up to 12 weeks	**7 – 10 months, in a single wave**
Disruption of services	As long as two years	**7 – 10 months**

The table below shows the infection rates in the municipalities for a **severe** pandemic:

Municipality	Population	Infection rate (40% of the population) - Severe	Estimated fatality rate over the duration of the pandemic (2.4% of those infected)
Campaspe	38,735	15,494	**371**
Greater Bendigo	121,470	48,588	**1,166**
Central Goldfields	13,483	5,393	**129**
Loddon	7,759	3,103	**74**
Mount Alexander	20,253	8,101	**194**

Figures based on the 2021 Census of population and housing

The table below shows the infection rates in the municipalities for a **mild** pandemic:

Municipality	Population	Infection rate (10% of population) - mild	Estimated fatality rate over the duration of the pandemic (1.2% of those infected)
Campaspe	38,735	3,873	**46**
Greater Bendigo	121,470	12,147	**145**
Central Goldfields	13,483	1,348	**16**
Loddon	7,759	775	**9**
Mount Alexander	20,253	2,025	**24**

Figures based on the 2021 Census of population and housing

The VHMPPI states "While each pandemic is unique, the VHMPPI will consider the severity of illness caused by the virus and categorise it as low, moderate or high, based on the available evidence and emerging epidemiology.

Scenario 1: If clinical severity is low

The level of impact on the community may be similar to severe seasonal influenza or the 2009 H1N1 pandemic.

Scenario 2: If clinical severity is moderate

The number of people presenting for medical care is likely to be higher than for severe seasonal influenza. Pressure on health services will be more intense. The level of impact may be similar to the 1957 Asian influenza.

Scenario 3: If clinical severity is high

Widespread severe illness will cause concern and challenge the capacity of the health sector. The level of impact may be similar to the 1918 Spanish influenza.

Responses will be proportionate to the observed impact and may fall between these scenarios.

13.1 Mental health

Chaos, confusion, distress, isolation and trauma triggered by public health threats and emergencies can place enormous stress on the coping abilities of even the healthiest people. In the case of a pandemic, effects on mental health can occur regardless of whether an individual is directly affected by the pandemic, whether their family or close friends are affected or whether they are indirectly affected.

Widespread restriction of movement, social distancing measures and physical isolation/ lockdowns meant that the sudden loss of employment and social interaction, and the added stressors of moving to remote work or schooling have impacted the mental health of many Australians.

Individuals may develop mental health concerns following experiences with sick and dying loved ones, with prolonged isolation or with other significant changes to their daily lives. Existing mental health conditions such as depression, PTSD and substance misuse may worsen. These mental health effects may be long lasting.

13.2 Economic impact

Social distancing measures and business restrictions in an effort to curb a pandemic has a dramatic effect on employment, industry and the economy. International border closures have an immediate negative effect on the flow of overseas students and international tourism. Hospitality sectors are heavily affected due to the demise of tourism and loss of domestic business due to closures. Job loss in the hospitality and transport sector are usually the worst hit during a pandemic. Unemployment, job security and job loss can increase the likelihood of homelessness and food insecurity.
The economic impacts of a pandemic can produce secondary mental health effects that may increase suicide and alcohol death rates.

The effects of the COVID-19 pandemic have had significant impact on small business with border closures and lockdowns. A significant number of small businesses will not recover or even reopen which has a detrimental effect on communities, health and lifestyle.

13.3 Family violence

Disaster is no excuse for family violence
The Northern Victorian Integrated Municipal Emergency Management Planning Committee recognises that the risk and incidence of family violence increases significantly during and after an emergency. The Committee can play a vital role in preventing and reducing the impact of family violence during emergencies.

Family violence can affect anyone in our community, regardless of gender, age, socio-economic status, sexuality, culture, ethnicity or religion. During an emergency, many factors can increase the risk of family violence, including homelessness, financial stress, unemployment, drug and alcohol abuse and trauma. Family violence could be worse due to isolation and close proximity. violence can increase due to lockdown/ isolation strategies. None of these factors cause family violence, nor are they an excuse.

Family violence is driven by gender inequity, gender stereotypes and a culture of excusing violence. During emergencies, it is common for people to lapse into traditional gender roles of men as the protectors and women as protected. This is damaging to both genders, and the Committee is committed to promoting the involvement of both men and women in all aspects of the response and recovery phase.

Family violence can include physical assaults and a range of tactics including:

- Intimidation or coercion;
- Direct or indirect threats;
- Sexual assault;
- Emotional or psychological abuse;
- Financial control;
- Social abuse/isolation;
- Racial or spiritual abuse, and;
- Any behaviour that causes a person to fear for their safety and wellbeing.

In planning for and responding to emergencies, the Pandemic Committee will endeavour to:

- Openly and candidly acknowledge the heightened risk of family violence during and post emergencies;
- Dispel the notion that family violence is an acceptable response to stress and trauma, and that other issues should take priority during an emergency;
- Ensure incidences of family violence, or suspected family violence, are recorded and referred to support services and Victoria Police as appropriate;
- Look at alternative ways for staff to provide in home services where there is a family violence risk i.e. consult with client at another location (library, park);
- Provide mental health information to both men and women;
- Provide family violence information to both men and women;
- Provide women-friendly and men-friendly activities and outreach services;
- Target and tailor risk and recovery information for men and women when needed;
- Make use of existing social networks and gathering places, such as local venues and clubs, to distribute information across the community;
- Ensure that the local business industry is aware of the financial relief and support packages available.

It is vital, however, that Council is proactive to assess the impact of the pandemic on its own community and staff to determine which elements of this plan to activate. The impact of a pandemic on the local community may be very different to the experiences elsewhere in Australia.

Pandemics, like the 1918 Spanish Influenza and COVID-19, spread through regions of the world in subsequent waves. The pattern of waves originates mainly from human behaviour rather than from the virus diffusion itself [4]. It is important that Councils review and revise its guiding principles and strategies to minimise the effects of recurrent waves and any further infections, loss of life and economic damage in our community.

Council should act on advice from and in support of the Victorian Department of Health.

[4] Cacciapaglia, G., Cot, C. & Sannino, F. Multiwave pandemic dynamics explained: how to tame the next wave of infectious diseases. *Sci Rep* **11,** 6638 (2021). https://doi.org/10.1038/s41598-021-858

14 Health Services Planning

Individual Health Service providers will have their own pandemic arrangements. Refer to the State Pandemic Plan and the Regional Public Health Unit if/ when established.

A list of Hospitals, General Practices and Health Services are contained in the Cluster Contacts stored within Crisisworks (refer IMEMP for details).

15 Community Profile

This information is contained in Appendix 2 of the IMEMP – Municipal Statistics and Demographics.

16 Communication and Education

16.1 Community Education

A whole of Victorian Government communication strategy is produced by Department of Health (DH) to strengthen pandemic preparedness at state, regional and local level and ensure that timely, informative and consistent messages are provided to the wider community.

The Cluster Councils will not initiate any community education or public health control measures without guidance from the Department of Health. The Department of Health will provide information to all forms of media regarding good personal hygiene practices and precautions the public should be taking to protect themselves.

Cluster Councils will play the important role in interpretation of the communications for their local communities.

Refer to IMEMP for further information.

16.2 Education Materials

The Department of Health website provides information sheets on influenza pandemics, as well as posters in relation to coughing and sneezing and washing hands.
https://www.health.gov.au/

The Better Health Channel Flu Site contains all the information about influenza:
https://www.betterhealth.vic.gov.au/health/ConditionsAndTreatments/flu-influenza

Local provider websites may also contain information.

17 Community Support and Recovery

17.1 Responsibilities in recovery

Under the current emergency recovery arrangements, Emergency Management Victoria (EMV) is the lead agency for recovery in Victoria. Regionally, Department of Health (DH) leads recovery and Local Government plays a key role in assisting DH in the provision of services at a local level due to the close relationship Council has with the community. The IMEMP outlines arrangements in place in relation to the provision of aide and support in the event of an emergency.

Possible outcomes during/ after a pandemic for the Pandemic Committee to consider are shown in Appendix 1.

17.2 The role of Local Government

Local government has a pivotal role in assisting individuals and communities in the recovery phase of an emergency. The SEMP outlines the key activities carried out by local government in close conjunction with, or with direct support by, government departments.

Coordination with Regional DH and Municipal Recovery Managers (MRM) will be ongoing to discuss and assess the sharing and coordination of recovery resources. Refer to the State Emergency Management Plan– Emergency Management Agency Roles for full details on the planned arrangements for the management of community support and recovery and the community organisations and agencies that can assist.

17.3 Impact Assessments

Following an emergency it is important to conduct impact assessments as soon as possible to prioritise recovery activities for the community. During a pandemic, assessments of mitigation strategies and public health risks should be undertaken on a regular basis to ensure key messages are provided to the community in a timely manner, which will be very important in trying to contain the pandemic. Section 8 of the IMEMP explains the assessment process.

It is important to remember that other emergencies can occur during a pandemic therefore any response or recovery efforts need to incorporate pandemic control strategies in our planning.

17.4 Finance during recovery

Recording of accurate and comprehensive expenditure is referred to in the IMEMP. If required a dedicated cost number will be used by the Pandemic Committee to gather costings and later referred to the MEMO/MRM.

18 Helpful resources and fact sheets

Refer to the Better Health Channel for information:
https://www.betterhealth.vic.gov.au/health/ConditionsAndTreatments/flu-influenza

The Victorian Health website will provide information and fact sheets:
http://www.health.gov.au
https://www.health.gov.au/resources/collections/novel-coronavirus-2019-ncov-resources
https://www.dhhs.vic.gov.au/coronavirus

The World Health Organisation:
https://www.who.int/health-topics/influenza

Resources and fact sheets listed below can be found from the above websites:

RESOURCES
Pandemic Tool Kit
Pandemic Influenza
Victorian Action Plan for Pandemic Influenza

FACT SHEETS
How to fit and remove protective gloves
How to fit and remove a protective gown
How to fit and remove a surgical mask
How to fit and remove a P2 -N95 respirator
Protective eyewear
How to fit and remove personal protective equipment
Clean hands
Travel health – Have you recently returned from overseas?
Avian Influenza
Seasonal and pandemic influenza
Transmission of respiratory disease and managing the risk

19 Distribution List

Title	Organisation	Plan No.
Electronic database	Cluster Coordinating Council	1
Manager, Health Protection	Department of Health – Loddon Mallee Region	2
Manager, Emergency Management North Division	Department of Families, Fairness & Housing	3
Pandemic Coordinator / Emergency Management Coordinator	Mount Alexander Shire Council	4
Pandemic Coordinator / Emergency Management Coordinator	City of Greater Bendigo	5
Pandemic Coordinator / Emergency Management Coordinator	Central Goldfields Shire Council	6
Pandemic Coordinator / Emergency Management Coordinator	Loddon Shire Council	7
Pandemic Coordinator / Emergency Management Coordinator	Campaspe Shire Council	8

A copy of this Plan can be found on each Cluster Council's website.

20 Appendices

Appendix 1 - Community Support and Recovery

Possible outcomes for consideration

Impact as a result of a pandemic	Consequence to the community
Staff absenteeism	Reduced ability to deliver basic services e.g. home support (aged care and early years services). Loss of income. Extra stress on already struggling families
Death of employees	Loss of local knowledge, will take longer to train new person and restore the service, time for organisation to find new person
Decreased socialisation/ breakdown of community support mechanisms	Depression, loneliness
Increased pressure on services	Greater demand on resources, decrease in means of distribution. Current receivers of care may receive insufficient care
School closure	Parents of dependent children can't go to work. Teachers and school staff can't work. Economic loss
Increased need for information	Conflicting messages and misinformed social media groups can cause anxiousness and fear
Overloaded hospitals and medical centres	Reduced capacity to treat all patients, patients with minor problems less likely to be admitted
Animal abandonment	Abandonment of the animal originally responsible for carrying the flu. Fear of animals. Animal cruelty
Closure of public places	Reduced ability to buy supplies, loss of entertainment
Widespread economic disruption	Increase in crime. Stress on families. Businesses will struggle. Reduced ability to buy essential supplies. Reduced employment
Psychological health	Trauma, depression
Mental health	Survivor guilt

Vulnerable Groups

Existing Vulnerable groups	Ways affected
Children	More likely to contract a pandemic virus due to reduced natural immunity
People living in healthcare settings	Reduced natural immunity due to other health conditions Higher likelihood of infection and transmission due to close contact with others if infection control measures are not properly followed
Young families, especially single parent families	May need to manage a range of demands with minimum support
Older people, living alone without support	Isolation could cause deterioration in health and ability to function
Aboriginal and Torres Strait Islander	Higher rates of hospitalisation and death in ATSI aged 50 and over
Socially isolated	Lack of family and friends to provide personal or physical support. Lack of information could lead to anxiety
Physically isolated	Reduced ability to call on assistance from other members of the community, or from agencies
Unemployed	Lack of financial and physical resources may result in higher levels of disadvantage
People relying on external help	Existing support, such as home support, may be compromised
People living in an institutional setting	More exposed to the spread of disease, due to close living arrangements and sharing of facilities
People with existing disability, physical or mental illness	Existing support may be compromised. Higher risk of exposure to infection and psychological stressors
People with limited coping capability	Reduced capacity to manage life events
Substance dependent	Vulnerability if medical and other care arrangements are disrupted
Culturally and linguistically diverse communities (CALD)	Reduced understanding of potential risks and difficulty gaining access to information and resources
Financially disadvantaged, individuals and families on low incomes and/or high debt levels	May have limited access to goods and services. May not be able to stockpile, due to diminished supply and potential rising costs
Homeless	More exposed to the spread of disease, due to sharing of facilities. Lack of financial and physical resources may result in higher levels of disadvantage
People who use public transport	Higher likelihood of infection and transmission due to close contact with others

Emerging Vulnerable Groups

Emerging Vulnerable groups	Ways affected
People confined to their homes as a result of illness or quarantine	Lack of family and friends to provide adequate levels of care. Fear of being socially marginalised or stigmatised.
Children orphaned and without a carer, particularly where there is no alternative carer	Heightened levels of grief, anxiety, stress and trauma due to issues around housing and care. Potential dislocation and developmental effects.
Children whose parents become ill, particularly where there is no alternative carer	Heightened levels of grief, anxiety, stress and trauma. Increased vulnerability in the longer term.
Families where a pandemic bereavement has taken place	Heightened levels of grief, anxiety, stress and trauma.
People whose caregiver is sick and unable to care for them	Lack of alternative support could lead to general deterioration of health and wellbeing.
People who become unemployed, due to business closure or economic downturn	Lack of financial and physical resources and high debt levels, with minimum savings in reserve.
People on low incomes or otherwise economically vulnerable	Lack of financial and physical resources to manage consequences over an extended period of time.
The worried well—people whose physical health has not been affected by the virus but are worried or anxious about getting sick	High levels of anxiety due to fear of illness, death, unemployment and lack of access to services and information.
Families	Increased risk of family violence and breakdown of family unit, due to a shift in household dynamics. Children will lack social interaction, following school closures.
Small business owners	Significant reduction in demand in some sectors. Lack of resources to maintain financial viability during a downturn in the economy and/or unable to function due to absence of key personnel.
Health care workers and workers who are in close regular contact with members of the public	Exposure to risk of infection and potential isolation from family and support networks could increase stress and anxiety levels.

Appendix 2 – Action Plan Implementation Checklists

1. PREPAREDNESS – Planning Stage

STATUS – No novel strain of the virus has been detected.

PRIMARY OBJECTIVE - Plan and prepare for pandemic as part of normal risk management business.

RESPONSIBLE OFFICERS: Council Environmental Health Coordinators and Emergency Management staff.

PREPAREDNESS – Planning Stage		
Pandemic Coordination – Actions required		**Actioned Y/N**
1.	Review the Pandemic Plan and update any contact details or operating procedures every two years	
2.	Promote prevention activities such as: ▪ offering workplace seasonal influenza immunisation to staff ▪ promote good personal hygiene – hand hygiene and respiratory/cough etiquette ▪ staying away from work or public gatherings if symptomatic	
3.	Ensure all business continuity plans are current at all times	
4.	Promote seasonal influenza vaccination to vulnerable community members through the Community Care / Community Services and Early Years teams	
5.	Promote seasonal influenza vaccination to the broader community via the community newsletter, local newspaper and the council website	
6.	Check PPE stockpiles: ▪ What current levels of PPE gear do you have? ▪ Are masks, gloves and hand sanitisers within adequate use by date? ▪ Is current storage ok? If not what location will you store items?	
7.	Review of current Mass Vaccination clinics	
8.	Meet with Pandemic Committee to discuss organisational preparedness (if activated)	

2. STANDBY – Response Stage

STATUS - Sustained human-human transmission of a novel influenza virus has been detected overseas in one or more countries

PRIMARY OBJECTIVE – Commence arrangements to reduce the impact of a pandemic on the municipalities and increase vigilance for case detection.

RESPONSIBLE OFFICERS: Council Environmental Health Coordinators and Emergency Management staff, Pandemic Coordinator.

STANDBY – Response Stage		
Pandemic Coordination – Actions required		**Actioned Y/N**
1.	Each municipality to appoint Pandemic Coordinator and convene their Pandemic Committee to ensure the following occurs: ▪ maintain access to the Chief Health Officer's alerts to monitor the situation ▪ liaise with Department of Health and Human Services and other agencies.	
2.	Messages to staff should: ▪ explain the local status ▪ explain infection prevention arrangements and promote ongoing education regarding the minimizing of infection spread ▪ demonstrate the need for increased vigilance for case detection ▪ incorporate advice from Department of Health & Human Services. ▪ promote messages for employees to convey to fellow staff members, friends, family, clients and customers. ▪ provide the link to the Department of Health website and other pandemic information resources. ***Refer to Part 18 - Helpful Resources and Fact Sheets***	
3.	Confirm that the procedures to support people in home isolation are current and operable.	
4.	Meet with Risk and Safety Officer, or other responsible officer, to ensure Council's business continuity plan considers the impacts of a Pandemic.	
5.	Review stocks of Personal Protection Equipment (PPE) and make arrangements to increase capacity.	

3. INITIAL ACTION – Response Stage

STATUS - Novel influenza virus or pandemic virus detected in Australia with limited information available.

PRIMARY OBJECTIVE – Minimise transmission by implementing maximum infection control procedures and monitoring staff wellness.

RESPONSIBLE OFFICERS: Pandemic Coordinator, Council Environmental Health Officers and Emergency Management staff.

INITIAL ACTION – Response Stage		
Pandemic Coordination – Actions required		**Actioned Y/N**
1.	Alert Council staff of the situation and reinforce the infection control measures implemented in the previous stage. Additional advice to staff to also: ▪ stay away from work or public gatherings if symptomatic to minimise the risk of infecting others ▪ to seek medical advice if symptoms continue or get worse.	
2.	Maintain the communication activities initiated in the Standby Response stage.	
3.	Consider further arrangements for minimising the risk of infection in the workplace: ▪ implement remote work arrangements if applicable ▪ use alternate non face-to-face work arrangements ▪ introduce additional cleaning and disinfecting (handrails, door handles, lift controls, telephones, rubbish bins) ▪ use clear screens or PPE for staff in customer interactive roles ▪ encourage home quarantine for suspected cases.	

4. ACTIVATION/ ACTION – Response Stage

STATUS – The pandemic virus has entered the country and is spreading throughout the community. Enough is known about the disease to tailor measures to specific needs.

PRIMARY OBJECTIVE – Provide targeted support and quality care while maintaining business continuity.

RESPONSIBLE OFFICERS: Pandemic Coordinator, MEMO, MRM, Emergency Management Staff, Community Care / Community Services Coordinator.

ACTIVATION/ ACTION – Response Stage		
Pandemic Coordination – Actions required **Pandemic Virus infections are being reported in the local municipalities**		**Actioned Y/N**
1.	Maintain current infection control measures implemented in the Initial Action stage. If the severity of the virus is deemed high the following is recommended: ▪ public access to the Council offices be restricted ▪ promote social distancing ▪ PPE usage – the State controller will provide advice about the appropriate use of PPE.	
2.	Establish a Municipal Operations Centre and implement the following: ▪ conduct regular tele-conferences with DH, support agencies and neighbouring municipalities ▪ identify which parts of the relevant plan need to be implemented on advice from DH.	
3.	Implement procedures to continue delivery of the essential components of support for clients receiving funded services delivered by Council as per business continuity plans and determine capacity to provide support for people who are isolated in their homes.	
4.	Implement the procedure to establish and deliver community support services. The nature of these will vary, depending on the degree of impact. Similarly, how they are delivered (single gathering point for the community or on an individual basis) will also vary.	
5.	Liaise with the Business Continuity Team regarding measures to maintain critical Council service delivery.	
6.	Maintain communication with Council staff and the community.	
7.	Provide vaccination services to the priority community groups when requested by the DH. ***See Mass Vaccination Standard Operating Procedure***	
8.	The Pandemic Committee prepare for the recovery arrangements for the affected community (s) as the need arises. Liaise with the local health and other service providers to ensure these actions complement each other.	

5. STANDDOWN – Response Stage

STATUS – Pandemic subsiding and/or Vaccinations result in a protected population.

PRIMARY OBJECTIVE – The public health threat is managed within normal arrangements and monitoring for change is in place.

RESPONSIBLE OFFICERS: Pandemic Coordinator, MEMO, MRM, Emergency Management Team.

STANDDOWN – Response Stage		
Pandemic Coordination – Actions required Infection rate has dropped significantly		**Actioned Y/N**
1.	Stand-down: Initiate stand down procedures which include: ▪ reducing community support activities while maintaining quality care of funded clients ▪ cease activities that are no longer needed (e.g. the MOC) ▪ communicate these changes to staff and external agencies ▪ maintain basic infection control procedures ▪ monitor for a second wave of the outbreak and also for development of anti-viral resistance.	
2.	Liaise with the Municipal Recovery Manager regarding a hand-over from response to recovery operations. ***Refer to Council IMEMP – Emergency Recovery Plan for more detail on the recovery services likely to be required.***	
3.	Continue to coordinate vaccination sessions when requested by DH.	
4.	Participate in the Recovery Committees to determine the services and resources required to address the identified needs.	
5.	Conduct staff debriefs to determine: ▪ status of their psycho-social well-being ▪ effectiveness of the Pandemic Plan procedures.	
6.	Participate in regional operations debrief/s.	
7.	Recommend any changes to the IMEMPC in relation to the IMEMP, Pandemic Plan or Mass Vaccination Procedures. This may include improvements that have come from debriefs.	