Mission 1: Health Emergency

Mission Implementation Plan:

1. Scope
2. Mission implementation report
3. Supporting information

1. Health Emergency

Lead: Kym Peake

Leadership of the whole-of-government response to health crisis

SCOPE

This mission will cover

- Epidemiological modelling to inform WOVG planning
- Public health management and prevention
- Adaptation of healthcare delivery to 'new normal'
- COVID-19 testing - sites, guidelines, supply
- COVID-19 case quarantine, contact tracing & isolation
- COVID-19 case treatment and recovery
- Managing demand & safe continuity of care for BAU patients
- Marshalling & direction of public and private sector resources
- Health workforce - expansion, training, COVID-19 cases, union negotiations; protocols and guidance
- Infrastructure - expansion, upgrading, commissioning
- Health supply (chain) needs - equipment, PPE, consumables

KEY PRIORITIES

Establish effective control over the pandemic

- Identify, test and quarantine cases, with increasing community coverage
- Trace and isolate contacts, with increasing speed and sophistication
- Put in place key supports to enable safe quarantining and isolation
- Prevent the spread by providing public health guidance on advice of the Chief Health Officer, determining strength and duration of physical distancing measures, and determining when and how these measures are tightened or relaxed
- Securing necessary WOVG health equipment and supply to keep Victorians safe

Manage the health sector frontline response

- Minimise risk of COVID-19 transmission among patients & healthcare workforce
- Maximise system capacity (available beds, workforce, equipment, PPE) to meet expected demand, and maintain capacity on standby after containment
- Prevent and address physical & psychosocial pandemic impacts on the community
- Ensure safe access and continuity of care throughout the pandemic
- Consolidate system governance & management to ensure performance & resilience

NEXT LEVEL PRIORITIES

- Advice into National Cabinet and AHPPC (through office of CHO)
- Calling on and providing advice to police on tracing/isolation/lockdown support
- Modelling epidemiological scenarios and forecasts
- Monitoring financial implications on sector

INTERDEPENDENCIES

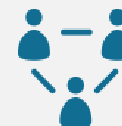
- Economic Emergency - to advise on impacts of public health measures
- Economic Supply chains - to assist with procurement and identify and free up supplies/ housing, venues for isolation
- Essential services - Police for contact tracing and isolation enforcement plus links of social services with health sector
- National Cabinet - coordination of national positions and population level advice/managing sector impacts

NOT IN SCOPE

- National and international information will be reported through the Critical Information Unit
- Public health communications will be managed through central comms

CAPABILITIES

- Health and public health policy and analytics - sits primarily within Health in DHHS, with pockets of expertise across Vic Gov
- Procurement/logistics skills - skills sit across Vic Gov, inside and outside Health
- Comms/workforce/IT - skills sit across Vic Gov
- Police and law enforcement



POSSIBILITIES FOR REGIONAL DEVOLUTION

- Health supply chain monitoring / Local allocation of resources
- Information sharing at a local level
- Local contact tracing/case isolation enforcement
- Hospital transfers

Mission 1 – Key decisions or issues to resolve

Insert summary slide

Impacts other missions

Item for decision

Item for information

Mission implementation report: Kym Peake

7. Implementation and planning report

Health Emergency Response - Pandemic containment

	Status	Wins	Progress	Roadblocks	Actions
Case detection, tracing and containment (Jacinda de Witts)		• **Community transmissions -** remain low • **Expanded COVID-19 testing program -** commenced on 27 April 2020, and as at 20/5 over 263,000 tests have been processed and returned • **New Rapid Response Units** launched 18/5	• Ongoing priority testing will be provided to teachers. The department is working with the Department of Jobs, Precincts and Regions to ensure that the testing program promotes access to testing to workers in food production and agriculture, meatworks, and other industries essential to our food supply chain. • Twenty Infection Prevention and Control (IPC) nurses have been deployed to form rapid response units, a program which will operate seven days a week on targeted prevention and outbreak management. Recruitment is underway to expand that core team. • The unit will rapidly deploy to the site of the outbreak to manage: - Interviews, case and contact tracing. Where necessary this will involve the requisitioning of any employer files; - Direction of isolation of people who test positive, and quarantine of their close contacts. Where it is not possible for people to isolate separately to their family at home, hotel accommodation will be provided; - Manage testing and active case finding; - Determine worksite closure requirements; and - Oversee infection prevention and control screening. • Units have commenced attending outbreak sites and undertaking prevention work.	• Close work will be required with other regulatory and enforcement bodies required to ensure worker and community safety, including the EPA and WorkSafe. • Strengthened regulatory response on outbreaks.	• Continue to report to CCC on public health system readiness
Public health interventions & communications (Jacinda de Witts)		• **Community is engaging positively** – the Victorian community is accepting and adhering to physical distancing measures.	• Effective quarantine of returned travellers and close contacts and isolation of cases • The quarantine program has supported over 10,000 returned travellers (17/5). The cumulative number of COVID-19 positive tests for hotel residents in quarantine as at 17/5 was 98 • The Victorian Centre for Data Insights suggests that Victorians are increasingly moving around more on foot in central Melbourne and while pedestrian traffic is increasing overall, it remains only about a quarter of pre-COVID-19 levels • Significant scaling up of public information capability, including website content development and call centre capability	• High demand for testing for people in quarantine for Day 3 and Day 11 • Consistency and timeliness of communications on interventions – these are being resolved to ensure community confidence retained	• Communication and messaging to community to be changed to reflect proposed changes to Directions as restrictions ease
Intelligence (Jacinda de Witts)		• **Effectiveness of strategies is being tracked** - ongoing modelling work and intelligence capability is now capturing and evaluating the impact of different public health interventions, including quarantine and isolation and physical distancing	• Extensive scale up of intelligence capability including transmission parameters and relevant surveillance indicators produced and outbreak and transmission network reporting • Periodic static and dynamic disease modelling to inform the effectiveness of restrictions • Efficient and accelerated case ascertainment and contact tracing	• Pattern of disease can change as outbreak evolves	• Expediting technology upgrades to support epidemiology and information surveillance capability • Procurement for scientific research underway with Melbourne institutes, academia and health services

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Mission implementation report: Kym Peake

7. Implementation and planning report

Health Emergency Response – Health system Response

Progress for scope items	Status	Wins	Progress	Roadblocks	Actions
Health service readiness (Terry Symonds) • System response (acute & community) to maintain essential service safety & access through peak demand (hospital cohorts & clustering). • Increase public beds and ICU capacity • Agreement with privates to increase capacity and sector sustainability • Engage with C-W to resolve primary care clinics, rural pathology sustainability • Expand MH and AOD support to respond to demand and novel challenges • Support continuity of care for non COVID-19 patients	Green	• **Hospital capacity expanded** - system response to manage demand and increase capacity agreed • **New models of care developed** – including telemedicine and out of hospital models • **Expansion of centralised reporting** for critical care utilisation • **Guidelines published** for essential acute and community-based services	• Private Hospital Funding Agreement (COVID-19) signed with 7 large group operators and 26 additional private hospital and day procedure center providers. • ICU central governance and system response underway with planning to increase ICU capacity to reflect anticipated demand. • Working with the Health Pandemic Leadership team on continuity and restoration of care for non -COVID patients, including through pooled capacity in geographic catchments, use of tele-health and home-based outreach for people with chronic disease	• Slow roll out of Commonwealth GP respiratory clinics • Rural pathology sustainability concerns with private providers • Return of aged care residents to facility following period of acute care. • Lack of flexibility in some regulatory settings • Lack of Commonwealth accountability for complex clients receiving primary care (e.g. pharmacotherapies) • Community disengagement with health care providers, leading to deferred care	• 4 week elective surgery plans • Systematic testing of healthcare workers and roll out of respiratory clinics and mobile services • Finalisation of all private hospital comprehensive agreements • In-reach models of care for RACS • Input to national mental health plan • Roll out and evaluation of new service models (including digital platforms) for community health, mental health and AOD COVID response & recovery • Implementation of medical research initiatives
Workforce readiness and support (Terry Symonds) • Develop targeted surge workforce strategies • Attracting additional workforce • Deliver training uplift for key skills • Promote safe working practices • Support workforce wellbeing, including with accommodation support when needed • Active engagement with unions to facilitate early resolution of workforce issues	Green	• **Workforce expanded** – 15,000 people registered interest in joining surge health workforce • **Agreement with private hospitals** – enables workforce flexibility • **Accommodation support** – for around 120 healthcare workers • **7,000 new training places** - upskill ICU workforce	• Developed workforce modelling to project workforce needs in pandemic scenarios • Establishment of PPE Taskforce to engage workforce on safety concerns • Assessment of skillsets of people registered on Working for Victoria health portal for future placements	• Obtaining regular data updates on current hospital workforce availability • Managing utilization of existing health system workforce against new surge requirements • Evolving processes to access accommodation support for healthcare workers	• Conversion of Working for Victoria – Health pool into rapid outbreak response capability • Ongoing delivery of expanded Hotels for Heroes program • Workforce pandemic scenario planning exercises – rural and metropolitan • New training courses on managing in COVID-19 environment • Weekly meetings with unions
Supply chain (Terry Symonds) • Develop strategies to ensure supply of appropriate PPE, equipment & testing consumables. • Assess & engage at-risk suppliers for critical procurement categories • Explore alternates including local production for most at-risk	Yellow	• **PPE ordered** to meet anticipated demand • More than **5000 ventilators ordered** • **State-wide purchasing and supply chain** established • **Secured local licensing agreement** for production of ventilators	• PPE taskforce established • PPE & ventilator deliveries underway. Assurance from private pathology provides on appropriate testing capacity. • Orders being placed to build stockpile of essential medicines	• Sovereign risk, supply chain risk may put orders at risk (being mitigated by overordering) • Limited supply of PPE for primary and aged care from Commonwealth	• Implementation of centralised procurement • Creation of a consolidated supply chain entity to drive greater efficiency and oversight of supply chain procurement and management • Centre for Disease Control models for CCC consideration • Working with Commonwealth to streamline PPE delivery for RACFs and primary care • Working with DJPR on local manufacturing opportunities

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7. Implementation and planning report

Health Emergency Response – State wide response

Progress for scope items	Status	Wins	Progress	Roadblocks	Actions
State Control and departmental emergency management response (Melissa Skilbeck)		• **Control of the public health hazard** – established control structures and maintained control • **Established Joint Intelligence Unit**	• Progressive development of control structures within the State Control Centre • Joint development of Joint intelligence function and outbreak management squads	▪ Refinement of control arrangements to accommodate length of emergency; interaction with missions; likely coincidence of multiple emergencies	• Further development of structures to maintain effective control in event of additional emergencies – through exercises and development new protocols for evacuation and relief arrangements in COVID
COVID-19 Accommodation Command (Melissa Skilbeck)		• **Mandatory quarantine program** – 10,000 returned travellers accommodated • **Emergency relief accommodation for cases/close contacts unable to isolate**	• DHHS, ADF and DJPR operating a mature program, now being further developed • Outbreak among night shift staff at COVID specific hotel led to move to another hotel • Separate hotel arranged for future cases/close contracts due to outbreaks unable to isolate effectively through hardship	• Limited availability of authorised officers to provide necessary detention notices, permissions and exits throughout quarantine period , and significant risk of losing current AO staffing as restrictions ease • Competing across the department and externally for access to staff to recruit to Operation Soteria, causing delays to release of key staff • Absence of reliable early notice and intelligence on arrivals – being addressed at national crisis centre level as repatriation flights increase - but worsened by renewed commercial flight schedules • Increasing number COVID cases found due to day 3/11 testing • Large number of families with around 600 children now in quarantine • Need to ensure distinction with those residing under Case and Close Contact Direction and those returned travelers under Detention Notice given difference in duty of care	• Advocacy to MCC to avoid lost participation of VPS as AOs and other essential COVID response staff • Systemic identification and changed contracting of most suitable hotel stock • Maturity of welfare support and incident reporting structure for returned travellers • With DJPR, identifying more suitable hotel stock with family rooms; engaging with M&CH for babies • Exploring hospital-supported COVID specific hotel for longer term use and improved infection control • Longer term staffing (6+ months) being established
RHPEM (Regulation, Health Protection and Emergency Management) coordination and Directions compliance (Melissa Skilbeck)		• **Maintain effective compliance framework** with VicPol cooperation • **Coordination cell** assists effective briefing and correspondence management	• MOU/ Process for referral completed with VicPol /VCGLR/DJCS/Worksafe for Direction 9 (workplaces) • Standing up investigative function to respond to Direction 9 (workplaces) • Enhancing data capture capabilities to improve decision making across command.	• Significant increase in volume of demands for 'exemptions' to quarantine despite minimal avenues to avoid mandatory quarantine if returned traveller • Complexity of risk management of cases travelling interstate after completion of quarantine • Resourcing for ongoing Authorised Officer roles and ongoing senior management roles • Sustainability of quarantine numbers dependent on AO numbers and options to change quarantine model and scope of statutory requirement for AO	• More active messaging of mandatory quarantine requirements and limited 'exceptional circumstances' for exemption • Use of new Case and Close Contacts Directions to manage post-quarantine risk • New AO training program launched – sourcing from airline industry staff stood down • Discussions with DET and DJPR across accommodation and enforcement commands on options for student quarantine
RHPEM essential regulation (Melisa Skilbeck)		• **Reduced essential non-COVID regulatory functions**	• Separate structure to maintain non-COVID public health response	• Limited supply of authorised officers means all existing public health and human service regulation functions currently subject to less safeguarding	• Above actions to maintain current and source alternative authorised officers (AO)

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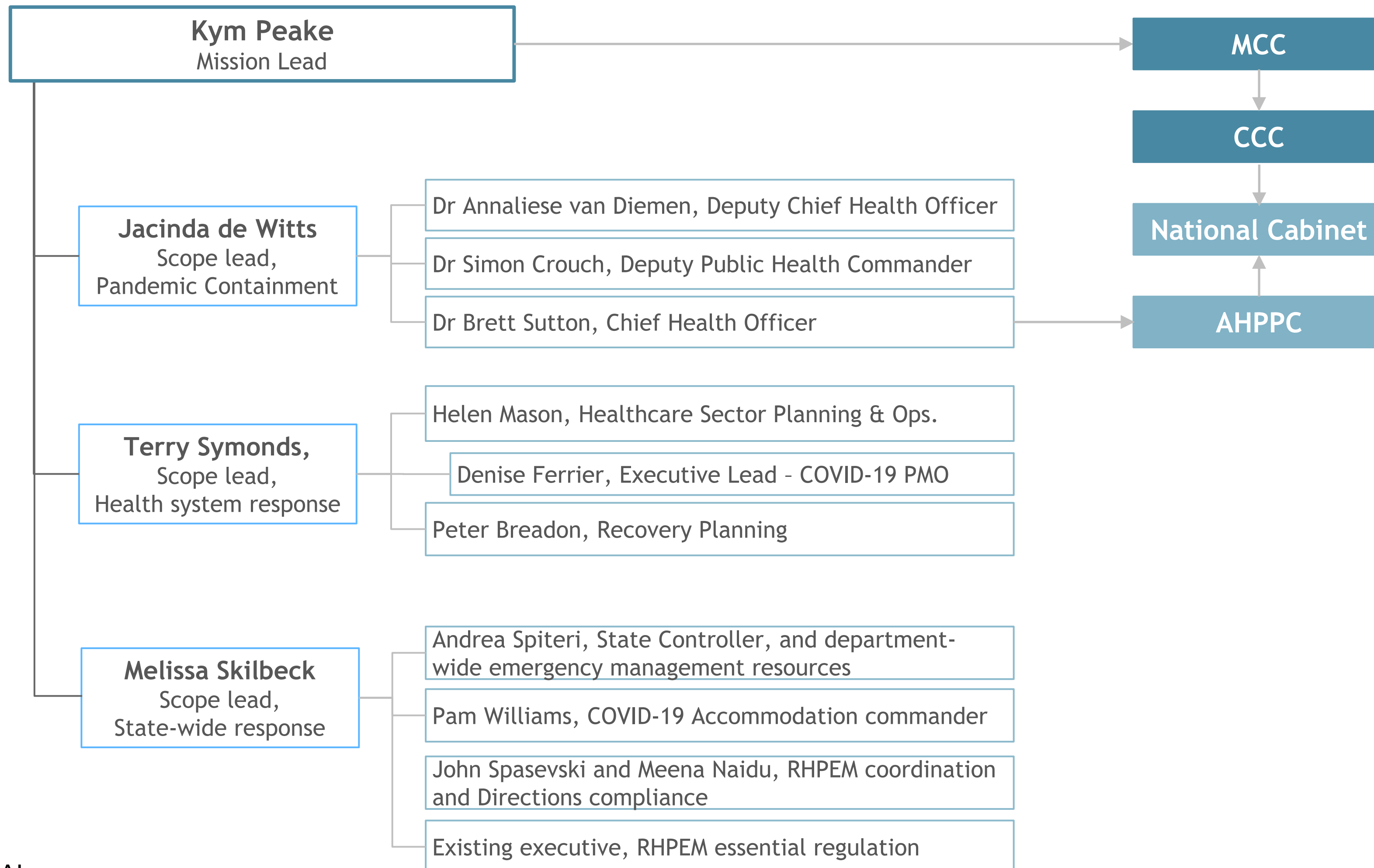
2. Mission structure and governance

Proposed structure



Governance

Services

- Hospitals (public & private)
- Public health
- Ambulance
- Community Health
- Aged Care
- Carers
- Mental Health
- Alcohol and other drugs
- Regulation
- Emergency Management

Ministerial Portfolios

- Minister Foley (Mental Health)
- Minister Donnellan (Child Protection & Disability, Ageing & Carers)

CCC Minister

- Minister Mikakos (Coordination of Health & Human Services - COVID-19)

3. Program logic: all mission activities are geared to achieve our core objectives of reducing the pandemic's impacts on health, the system & the broader community

Inputs

Ongoing epidemiological modelling showing expected pandemic impacts, policy effects & health system demand

Government policy decisions, protecting Victorians' health to preserve our society and economy, while balancing broader assessments of acceptability to the community; feasibility of implementation; and equitable impact of measures

Population adherence to public health measures

Outputs

Introduce preventive public health measures, recalibrated as pandemic, modelling & evidence evolve
- Rapidly grow testing and contact tracing capabilities to test, identify, isolate & cohort cases
- Implement broader containment measures, with public communication & community support
- Introduce prudent restrictions on patient, sector and worker access to healthcare facilities

Introduce dedicated care pathways for COVID-19 patients
- Rollout phone line services to triage patients and divert away from EDs / GPs as appropriate
- Embed 'cohorting' in hospital design - separating infected patients from others at every level of acuity

Maximise system capacity to absorb expected demand, flexing up / down as expected demand evolves
- Develop readiness to defer, stop and divert non-urgent care to free up capacity, as needed
- Contract and integrate all private hospital sector resources into the system response
- Procure all equipment and consumables (incl. PPE) needed to meet demand & deliver BAU care safely
- Expand and upskill workforce, making best use of skills and capacity through flexible workforce models
- Maximise physical system capacity by filling existing facilities and bringing online old & new facilities

Reorient care to safely meet old and new health needs, innovating for both current & future benefit
- Rapidly scale innovative home-based and remote care models that enable safe ongoing delivery of care
- Public communication to build confidence in continuing to access emergency and primary care
- Restore in-person care as feasible, balancing risks / benefits & prioritising the most vulnerable
- Proactively identify and address pandemic impacts on population and workforce health & wellbeing

Consolidate system governance & management to improve its current and future effectiveness
- Coordinate demand across the system to maximise specialisation, efficiency, timeliness & equity in care
- Consolidate & centralise mgmt. of the supply chain to build scale & allocate supplies where needed most
- Increase scale in system governance by clustering services (public and private) under regional leads
- Expanding collaborative research on the health impacts of, and responses to, COVID-19

Outcomes*

The spread of COVID-19 in Victoria is slowed

Minimise COVID-19 transmission in the provision of health care

Achieve new system capacity & capabilities needed to meet demand for care

→ Reduce the morbidity and mortality associated with COVID-19 and its long term health impacts

Achieve essential and safe care continuity for other patients, prioritising the most vulnerable

Prevent & address negative physical and psychosocial impacts of pandemic

Increase the health system's effectiveness and long-term resilience

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

** To be updated as final options & objectives crystallise in April*

4. Scope: the Health Emergency response has four phases, marked by agile decision-making to manage risk during uncertainty

Characterised by…	System response phase			
	1: Initial containment	2: Targeted action	3. Protect & reform*	4. Stand down & recovery
Uncertainty about pandemic impacts	High: extent and duration of state & national containment strategies were uncertain; effectiveness of these was to be based on population adherence which was unknown; modelling could not yet capture effects of these and was using international data, which predicts catastrophic impacts in their absence	Moderate: new modelling will be based on much more informative data (from local community transmission), and will give a sense of the effect of policy measures on demand. However there will be little certainty about the effect of *unwinding* individual measures on demand, and a lag between these changes and their impact.	Low: pandemic impacts on different groups and the effectiveness of policies in containing spread will be increasingly well-known at this point, from both local and international evidence.	Low: proven vaccinations will be rolled out, giving confidence that public health measures can be safely relaxed. Evidence on the long-term patient & population impacts to address will be emerging.
Approach to decision making	Rapid 'no regrets' preventive measures and system preparations to avoid the unmitigated demand scenario predicted by modelling	Precautionary preservation of public health measures until preconditions are met, then cautious adjustment of them, while continuing to protect public safety, and keeping expanded health system capacity on standby.	Ongoing work to sustain containment measures, maintain contingency system capacity, prevent & cauterise harms, realign care delivery to the 'new normal', & consolidate system improvements	Cautious exit from remaining measures, social re-opening & sustained infection control, with work to build long-term system resilience.
Timing (approx.)	January (first international case arrivals) → Mid-April (modelling capturing policy impacts)	End-April (forward public health strategy ready) → August (clear understanding of strategy impacts)	June (system ready to broaden focus) → 2022 (manageable reform pace needed)	2021 (if vaccine available) → 2023 (system recovery ongoing)

*Note this phase would displace the original Stage 3 ("Peak Action Stage" in the COVID-19 Pandemic plan) *if* the pandemic remains well-controlled and the original Stage 3 does not eventuate. This however remains a possibility

5. Scope lead responsibilities: leads will deliver priority actions across each of the four key phases

Key scopes	System response phase			
	1: Initial containment	2: Targeted action	3. Protect & reform	4. Stand down & recovery
1. **Pandemic containment**	• Maximise case detection within testing constraints • Trace contacts and contain clusters • Arrest exponential growth in community	• Broaden testing across the community • Scale up contact tracing capabilities through technology, recruitment and training • Agree decision making framework for careful release of public health measures over time • Agree roadmap for restoration of health services and targeted research capability	• Sustain and refine measures for quarantining cases and isolating contacts • Implement agreed approach to lift public health restrictions, protecting vulnerable people with targeted support & PPE • Progressively introduce testing for antibodies & virus vulnerability as they become available	• Roll out vaccination, prioritising the most vulnerable • Sustain and strengthen public health, diagnostic research and routine testing capability
2. **Health sector response**	*Manage demand* • Minimise virus transmission in healthcare • Limit non-urgent care to free up capacity • Implement COVID-19 care pathways • Develop care continuity plans • Scale up role of primary care providers (pharmacy, GP, community health) *Expand and coordinate capacity* • Expand system capacity • Centralise supply chain & demand mgmt. • Increase scale in sector governance	*Manage demand* • Recalibrate sector restrictions (e.g. visitors) to reflect emerging PPE certainty • Progressively phase back in non-urgent care • Shift to spatially distanced models of care (scaling up home-based care & telehealth) • Anticipate & respond in a targeted way to pandemic impacts on health & wellbeing (including managing risks of deferred care) • Increase support for vulnerable groups with barriers to complying with spatial distancing *Expand and coordinate capacity* • Use extra capacity to run catch-up blitzes • Concentrate COVID-19 care in key centres	• Make virtual & home care a new normal • Build workforce staffing and skill flexibility to manage shortages • Establish governance for geographic clusters of health services • Health system research on long term impacts of COVID & impact of new service models on access and appropriate care • Implement the first COVID-19 mental health package • Increase scale across the supply chain and in procurement processes • Advance Royal Commission reforms in mental health aligned to pandemic response • *For more detail on mental health priorities, see next slide*	• Address new physical & mental health needs directly and indirectly arising from pandemic • Unwind surge capacity arrangements, while maintaining an uplift in ICU capacity and effective innovations in governance and models of care • *For more detail on mental health priorities, see next slide*
3. **State-wide response**	Aligning compliance measures with public health directions (all stages) • Implementing and managing emergency accommodation to support safe quarantining and isolation (stages 2-3)			

5. Scope lead responsibilities: Health sector response priority actions - mental health

Key scopes	System response phase	
	3. Protect & reform	4. Stand down & recovery

2. **Health sector response (mental health)**	• **Evaluating and planning to sustain service improvements that have emerged during early stages of COVID-19, focusing on:**
	  • An expanded role of peer workforces and connection with lived experience leaders
	  • Use of digital technology and Telehealth, while ensuring appropriate guidelines and quality and safety frameworks are in place, and actively involve carers
	  • Community and home-based models of care, especially for people with chronic conditions
	  • Supported housing responses for people living with mental illness to avoid homelessness.
	• **Advocating through national cabinet for:**
	  • Support peer workforce and carers for example, through education and training for families and carers, individual support and advocacy; and infrastructure support to peer workforce
	  • Ongoing coordination between primary and acute care and substance use treatments to support the missing middle and prevent people's mental health deteriorating and reaching crisis
	  • Continued work to expand the reach and capacity of primary mental health support services and continued commitment to implement mental health hubs in the community
	  • Sustainable commonwealth mental health funding, including to maintain successful online models of care to continue to provide services appropriately, especially for receptive younger cohorts
		• **Planning targeted state and national improvements in the recovery phase, including through advocacy to national cabinet for:**
		  • Broader population wellbeing and support for programs that are preventative and rebuild community connections
		  • Increased primary health services to provide population wide mental health support.
		  • Workforce wellbeing, including Employee Assistance Programs and therapeutic supports (as well as peer to peer programs) for healthcare workers where risk of Post-Traumatic Stress Disorder in years to come
		  • Employment services (especially disability employment services) having a strong role in supporting people with established and emergent mental health conditions to access work
		  • More assertive focus on those at risk of suicide and universal access to aftercare support for people who have expressed self-harm or attempted suicide
		  • Establishment of safe spaces people can access as alternatives to emergency departments.
		  • Assertive Community Mental Health follow up to reduce a return to reliance on hospital beds in mental health units
		  • Larger efforts on referral pathways to community mental health teams from other agencies who may be seeing clients at risk due to COVID-19 (including Centrelink/employment programs etc)
		  • a governance mechanism like the Australian Health Protection Principal Committee to drive and advise national cabinet on progress
		  • Common data dashboards and performance monitoring at national, jurisdiction and local levels, incorporating predictive modelling
		  • A strong research and quality and safety mechanism to capture and translate evidence and innovation into more sustained practice change

6. Example implementation approach
Health System Response in Phase 1

Key work	System response in Phase 1 (Initial Containment)		
	Key actions required	**CCC decisions needed**	**Measures of success**

1. Manage demand	• **Minimise sector-based virus transmission**
	  • Expand delivery of remote & home-based care to limit transmission risk
	  • Put in place prudent restrictions on visitor access to care facilities
	  • Maintain strict stand down rules with accom. support for health workers
	  • Hotlines to triage patients and divert mild cases away from EDs / GPs
	  • Cohort moderate / severe patients away from others at every level of acuity
	• **Free up capacity by limiting non-urgent care & preventing admissions**
	  • Cancel all non-urgent elective surgeries, dental care & breast screening
	  • Stop / divert less acute care to the community as safe and appropriate
	  • Scale up services to prevent hospital admissions & reduce length of stay
		• Future support for capital investment to permanently scale up alternative models of care (telehealth, home care)
		• Support and investment to adapt, preserve and extend access and protections for most vulnerable (incl. Aboriginal Victorians)
		• Future adjustments to care diversion / deferral settings
			• Most care that can be safely provided through alternative (virtual / home-based) models, is
			• Healthcare occupational infections reduced to zero (best-practice international benchmark)
			• Cross-patient infection reduced to international best-practice benchmarks
			• Most care that reduces capacity needed by pandemic response and can be safely diverted / deferred, is
			• Access to care is safely adapted and fully maintained for our most vulnerable people, incl. Aboriginal Victorians
			• Avoidable admissions and length of stay decline

2. Optimise capacity	• Build up scope for **primary care** to support the response, leveraging community health, amending pharmacy regulations, and accrediting GP respiratory clinics
	• Contract and integrate all **private hospital sector** resources into the system response, and establish sector governance for their effective use
	• Procure all **equipment and consumables** (incl. PPE) needed to meet expected COVID-19 demand & to also deliver un-deferred BAU care safely
	• Expand **workforce FTE** (redeployment, recruitment, fast-tracking re-registration, deferring leave, increasing hours) and **skills** (training, e-learning and simulation); maximising both through flexible workforce models
	• Expand physical system capacity by **maximising use of existing facilities** (bring online flex capacity, and repurpose facilities freed up by diversion with capital works as needed); (re)commissioning inactive infrastructure, and converting non-hospital facilities such as the Melbourne exhibition centre as needed
	• Consolidate & centralise mgmt. of the **supply chain** (procurement, warehousing, distribution, pathology) to build scale & allocate supplies where needed most
	• Simplify **governance** by clustering services (public & private) under local leads
	• Monitoring quality indicators to avoid risks of deferred care, including through public communication to maintain consumer confidence in accessing critical &
		• Investment for critical supplies, acute care capacity and workforce
		• Optioning and investment for further infrastructure capacity
		• Support to work through industrial barriers to meeting demand needs
		• Support for further supply chain consolidation
		• Support for enhanced governance - including cluster governance, quality indicators and collaborative research
		• Support for any further regulatory amendments (e.g. pharmacy)
			• Total system capacity needed to meet expected demand and deliver urgent BAU care is secured, incl. sufficient:
			  • PPE to keep all healthcare workers safe
			  • equipment to meet acute & critical demand
			  • acute & ICU bed capacity across all facilities
			  • workforce FTE
			  • workforce skills
			• Private hospital capacity is appropriately leveraged
			• All services have supplies they need, at competitive prices, and allocated across sector according to need
			• Provider governance is streamlined, with full coordination and collaboration between members of locality clusters
			• Primary and critical care is accessed by people with non-COVID health needs