Decision Extract

Decision Extract for the CRISIS COUNCIL OF CABINET Meeting held on **Wednesday, 08 July 2020 at 8:00 PM**
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Decision Extract Details

Requested By CCC214
Position
Department(s)
Purpose Relevant to responsibilities

Decision Extract Text

Coordination of Environment, Land, Water and Planning - COVID-19 (L. Neville, MP) / Coordination of Health and Human Services - COVID-19 (J. Mikakos, MLC) / Coordination of Justice and Community Safety - COVID-19 (J. Hennessy, MP)

2. CCC214 COVID-19 mandatory quarantine accommodation program

(Agreed)

The Crisis Council of Cabinet:

1. **Approved** accountability for delivery of the hotel quarantine program transferring from the Minister for Health to the Attorney-General as soon as possible, to be delivered by the Department of Justice and Community Safety (DJCS) upon necessary administrative and governance arrangements being finalised.
2. **Approved** the approach to hotel quarantine management, subject to endorsement from the Public Health Team, DHHS of the system design and infection control protocols.
3. **Agreed** that to reduce the risk of infection and cross contamination, stringent operational procedures must include limiting staff to work at one hotel quarantine site only, and clearly enforcing that staff will not work shifts in correctional settings or hospital settings while they are employed through the hotel program, and must be tested before returning to normal duties.
4. **Noted** that Corrections Victoria assumed progressive responsibility for resident supervision functions for hotel quarantine from 2 July. Subject to the consolidation of guests, all hotel quarantine facilities with residents will be under the responsibility of Corrections Victoria post step in on 9 July 2020, with no private security on-site managing returned travellers who have not tested positive for COVID-19.
5. **Noted** that different arrangements are in place at the existing hotel being used to accommodate people in the mandatory quarantine accommodation program, Hotel Brady, who have tested positive for COVID-19 and that this will involve use of the Alfred's existing health security contract with Spotless.
6. **Noted** that DHHS is exploring options for the Grand Chancellor hotel to be used for positive cases from the public housing towers (hotel has a capacity of 135 rooms), and that this will also involve the use of the Alfred and an alternative service provider.
7. **Noted** that Victoria has flagged with the Commonwealth a likely further delay to the return of international flights and that a decision will be made in due course.
8. **Noted** the update on arrangements with Alfred Health, including the review of Infection Prevention and Control activity in the hotels.

9. **Noted** and agree that the Department of Justice and Community Safety is incurring costs in relation to the delivery of the hotel quarantine program, including resident supervision services in the hotels, and that a further submission will be brought to CCC seeking funding to cover the first three months of new supervision arrangements.

Economic Package Options

No.	Entity/Portfolio Initiative	Estimated cashflow ($ million) 19-20	20-21	21-22	22-23	23-24	5yr total
	Core economic support package						
1							
2							

This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry

Economic Package Options

No.	Entity/Portfolio Initiative	Estimated cashflow ($ million) 19-20	20-21	21-22	22-23	23-24	5yr total
3							
4A	**This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry**						
4B							

Economic Package Options							
		Estimated cashflow ($ million)					5yr total
No.	Entity/Portfolio Initiative	19-20	20-21	21-22	22-23	23-24	
5							
6	**This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry**						
7							

Economic Package Options

No.	Entity/Portfolio Initiative			Estimated cashflow ($ million) 19-20	20-21	21-22	22-23	23-24	5yr total
8	This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry								
9	**$80M accommodation package to support key workers and provide emergency accommodation to people in need** This initiative proposes government reserves up to 30% of current hotel rooms for a period of three months and negotiates accommodation arrangements through other potential providers including universities and councils. Funding would be held in contingency pending development of implementation arrangements.	**Fiscal impact**	Net impact	-80	0	0	0	0	-80
		Benefit to businesses	Cash benefit	+80	0	0	0	0	0
10	This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry								
11									

National cabinet papers received overnight and updated red

From: Paul Scarmozzino (DPC) <paul.scarmozzino@dpc.vic.gov.au>
To: @minstaff.vic.gov.au>; (VICMIN) <imceaex-_o=exchangelabs_ou=exchange+20administrative+20group+20+28fydibohf23spdlt+29_cn=recipients_cn=4f2015ac6eee46c3ae6ef23c9a50f7d4-vic2873@ausprd01.prod.outlook.com>; Chris Eccles (DPC) <chris.eccles@dpc.vic.gov.au>
Cc: Tabitha Frith (DPC) <tabitha.frith@dpc.vic.gov.au>; Sam Trobe (DPC) <sam.trobe@dpc.vic.gov.au>; Kate Houghton (DPC) <kate.houghton@dpc.vic.gov.au>
Date: Fri, 27 Mar 2020 08:18:54 +1100
Attachments: This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry National Cabinet Annotated Agenda - 27 March 2020 (update 8AM).docx (70.66 kB)

Hi All

Attached are updated papers received over night for This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry

Attached is an updated Annotated agenda reflecting those changes.

Hard copies of packs will be delivered soon.

Thanks

Paul

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Submission No.	CCC202
Copy No.	

Submission to: **Crisis Council of Cabinet**

Submission Title: **Alternative supervision model for COVID-19 hotel quarantine**

Submission Type: **Matter for Endorsement**

Portfolios: **Coordination of Justice and Community Safety – COVID-19**
Coordination of Health and Human Services – COVID-19

Mission: **Public Health Resilience**

SUBMISSION PROPOSAL

Recommendations:

That the Crisis Council of Cabinet (CCC):

1. **Approve** the alternative approach to providing supervision services for Operation Soteria (the COVID-19 hotel quarantine program) to remove the reliance on private security providers and leverage the strengths of relevant departments detailed in paragraph [6].
2. **Approve** extending detention by up to 10 days for overseas travellers in quarantine where this is warranted by the public health risk.
3. **Note** that a phased approach is required to implement the alternative model.
4. **Note** the additional infection prevention and control measures being taken across all workforces in the quarantine program.
5. **Note** the options for mandating or incentivising testing in hotel quarantine settings, and more broadly in community hot-spots.
6. **Note** that funding will be required for the Department of Justice and Community Safety (DJCS) to implement the model and that this will be outlined in a future submission to CCC.

Objectives:

1. To outline the proposed alternative approach to the supervision of hotel quarantine for returned travellers to manage the risk of coronavirus entering the Victorian community, and the improved public health outcomes and additional level of infection prevention and control it will deliver.
2. To outline a phased approach to implementation, with a first phase able to be quickly implemented and embedded while further work is undertaken by DJCS and Department of Health and Human Services (DHHS) in preparation for phase two.
3. To highlight the risks posed by this model, and that DJCS will require funding to implement the alternative model and manage related risks.

Key Issues:

Hotel quarantine for returning international travellers has been a key element of government's response to COVID-19, but there have been issues with its operation.

1. The quarantining of overseas arrivals in hotels has been demonstrated to be an effective mechanism for preventing and managing COVID-19 in Victoria. More than 20,000 travellers have spent 14 days in quarantine in up to 20 hotels located in the Melbourne CBD and at the airport.
2. DHHS currently has overall accountability for delivery of the hotel quarantine scheme. However, current operations utilise a combination of DHHS staff, Department of Jobs, Precincts and Regions (DJPR) staff, private security contractors, contract nurses and hotel support staff. This model has been built through a series of contractual arrangements across multiple departments, and security subcontracting arrangements.
3. Robust operational procedures have been developed to support all elements of the hotel quarantine, from arrival to departure, including health, welfare, safety, infection control and response to other risks. Plans, policies and guidelines have been supported with inductions, training and contractual discussions, to seek compliance across all staff.
4. Despite this, incidents of non-compliance with infection prevention and control and physical distancing requirements, particularly from security subcontractors, have resulted in outbreaks in hotel quarantine.
5. The highest risk activities in hotel quarantine are:
    a. inconsistent application and use of personal protective equipment (PPE)
    b. goods handling, particularly luggage
    c. entry and exits of large numbers of quarantined people
    d. provision of fresh air, exercise breaks for quarantined people
    e. swabbing and other medical procedures.

In response, DHHS is putting in place comprehensive infection prevention and control strategies across all workforces in COVID-19 quarantine.

6. Three key strategies relating to workforce, services and oversight and on-site screening and surveillance are underway to ensure effective infection prevention and control and increased compliance with policies and procedures in quarantine hotels: engagement of expert providers of education, training, and services; staff screening and testing; and an auditing regime aim to maintain safe and healthy workers and guests during hotel quarantine.

    Comprehensive approach to improving the infection prevention and control knowledge and practices of the hotel quarantine workforce

    a. ***Education and training*** – all staff and contractors across all sites are provided comprehensive information and training materials tailored to the hotel quarantine context, developed by Alfred Health and DHHS Infection Prevention Cell. All staff are required to undertake regular training in infection prevention and control, the correct use of PPE and other key protective measures, conducted by the DHHS Outbreak Squad and Infection Prevention Cell. Face to

face infection prevention and control training has commenced for all staff across all shifts and on multiple days per week, with videos and other training aids tailored for this workforce. This will be supplemented by additional training provided by DJCS, including alignment with PPE requirements in custodial facilities, refresher training for professional boundaries, communication and de-escalation.

b. ***Briefing –*** all staff will be briefed in infection prevention at the commencement of every shift, with regular reminders during shifts. Briefings are provided by on-site nurses with Infection Prevention training and/or staff who have been trained to deliver the Infection prevention messages. This is complemented by prominent communication materials and signage provided in all hotels.

c. ***Behavioural change –*** the Department of Premier and Cabinet's (DPC) Behavioural Insights Team has been engaged to develop more tailored material reflecting the diverse workforce and variable educational levels within the hotel workforce.

d. ***Rostering –*** movement of staff between hotels will be restricted to reduce the potential of outbreaks across the whole program and to provide business continuity protection in the case of an outbreak. Implementation commenced on 23 June 2020 with security staff.

On-site screening and surveillance testing

e. ***Temperature and symptom screening*** – all staff are now being temperature checked and assessed for potential symptoms by on-site nurses at the start of every shift. Those identified as unwell are sent home and requested to be tested.

f. ***Surveillance testing –*** Alfred Health is developing a surveillance program to undertake regular random voluntary testing of the hotel quarantine workforce.

Provision of expert services and auditing

g. ***Clinical and Infection Prevention and Control services*** - Alfred Health is being contracted to provide coordinated clinical and infection prevent and control services for hotel quarantine. This has commenced in one hotel and includes use of a cleaning contractor with experience in "hospital-grade" infection prevention and control. DHHS is working with Alfred to progressively introduce these services across all of quarantine hotels.

h. ***Auditing –*** DHHS's Infection Prevention and Control Cell – and then Alfred Health once onboard across all sites – is conducting regular audits of all quarantine hotels, including on site reviews and clinical risk and infection prevention and control assessments to ensure continuous improvement.

An alternative, whole-of-government approach to the supervision of returned travellers in hotel quarantine offers a more disciplined approach to infection control.

7. An alternative model has been developed to provide more effective infection control in Victoria's hotel quarantine system. Under the proposed model, DHHS (and the Minister for Health) will retain overall accountability for delivery of the hotel quarantine scheme.
8. The proposed approach will streamline arrangements in a phased approach and gradually remove the reliance on private security providers. It will leverage the strengths of relevant departments through allocation of the following key responsibilities:

a. *Regulation of Detention Direction and Notice*, including specific issuance of detention notices per person, permissions provided for any movement in/out of designated rooms, daily verification that conditions of public health risk per person warrant continued detention, administration and implementation of any changes to the place of detention as approved by CHO's delegate – provided by Authorised Officers of the Department of Health and Human Services (DHHS) and local governments
b. *Health, welfare and hotel services* including meeting traveller needs, daily welfare checks, specialised welfare and referral service and nursing and mental health services – provided by DHHS employees in partnership with Alfred Health staff and contractors experienced in hospital grade infection control, including introducing Customer Service Officers (CSOs) from health services (including orderlies and hospital ancillary staff) to reduce the activities required of other staff, including supervision staff.
c. *Supervision, consisting of monitoring and DHHS Authorised Officer-approved internal escort of people in hotel quarantine* – provided by Residential Support Officers employed by the Department of Justice and Community Safety (DJCS) to gradually replace reliance on private security operators. DJCS staff will have no authorised powers at hotels and will perform non-contact functions.
d. *Enforcement* – provided as required by Victoria Police and Protective Service Officers (PSOs), who would be responsible for responding to public order instances and enforcement of CHO directions. Victoria Police and PSOs would also conduct regular spot checks for compliance with CHO directions in hotels.

9. DHHS will enter into Memoranda of Understanding with DJCS and Victoria Police to clarify roles and responsibilities under the model. The proposed changes to the hotel quarantine model will be made under the current emergency management governance arrangements as part of Operation Soteria and will continue reporting into the State Control Centre.

It may be possible to mandate, or better incentivise, COVID-19 testing compliance for people in hotel quarantine

10. There have been reports that 30% of returned travellers who are confined to quarantine hotel detention in Victoria have refused to take COVID-19 tests. NSW has today introduced mandatory testing for returned travellers.
11. The emergency powers in the *Public Health and Wellbeing Act 2008* (**PHWA**) allow for similar mandated testing for returned travellers to Victoria if there is strong medical evidence of the infection and transmission risk that new arrivals present, and that compulsory testing is necessary to mitigate those risks.
12. Mandating testing could be done by way of a CHO direction under s200(1)(d) if the CHO (or authorised officer) determined it was reasonably necessary to protect public health.
13. The CHO can rely on non-emergency powers in the PHWA to mandate testing in individual cases. If the CHO believes that a person has, or has been exposed to, an infectious disease, he may make an examination and testing order in respect of that person under s113 of the PHWA. Use of this power requires an assessment of individual circumstances however and cannot be ordered in respect of a class (such as returned travellers).
14. The consequences for a returned traveller who refuses a compulsory a test could include:
    a. Fines: a failure to comply with mandated testing would be a breach of a CHO direction and therefore punishable by fine.

b. Longer detention: if there is a medical basis to support it, it may be necessary to detain new arrivals who refuse to comply with testing for a longer period than 14 days. Those who comply would therefore be eligible for early release (potentially after 14 days). Detention cannot be used as a punishment however, so the medical basis for requiring longer detention is essential. Absent medical evidence, this would carry a high risk of legal challenge.

15. As an alternative to mandating testing, it may also be possible to incentivise people in hotel quarantine to agree to testing by:
    a. having differentiated practices for those in detention who agree to testing and those who do not, eg. those who submit to testing are given increased movement rights and access to outdoor spaces. This would require medical evidence to support the appropriateness of restrictions.
    b. imposing tighter restrictions, such as requiring self-isolation or stay-at-home directions, upon people who have refused testing in detention, which would be effective upon their release. This would need to be supported by medical evidence of the need for such measures.
16. Additional options to reduce the risks of challenge and increase the flexibility of tools available to mandate or encourage compliance are under consideration. This could include using powers under the *Emergency Management Act* (which would require the declaration of a state of disaster) to suspend particular requirements under the PHWA – for example, by suspending the requirement to give individual detention notices every 24 hours to those in hotel quarantine, or suspending particular requirements in the *Charter of Human Rights and Responsibilities Act* that intensify the support required for those in hotel quarantine.
17. There are also opportunities to more strongly communicate the request of travellers to be COVID-19 tested under current arrangements, including:
    a. blunter messaging in scripts and information sheets about testing. By comparison, while NSW doesn't use mandatory language, their language gives less optionality that Victoria's current requests
    b. using saliva testing for children as quarantine nurses report that parents do refuse for their children to undergo swab testing
    c. extend detention by up to 10 days to cover the incubation and infection period, where this is warranted by the public health risk.

Similar measures to mandate or incentivise testing could be applied to people who live in identified community 'hot spots'

18. Mandated testing of people who live in community 'hot spots' could also be ordered under the same emergency powers, if supported by appropriate medical evidence. This is likely to carry a higher risk of legal challenge that mandating testing for returned travellers.
19. To minimise the risks of challenge, there would need to be strong medical evidence of the increased risk in the particular area, and clear epidemiological evidence of the connection between place of residence and infection risk. The more confined and targeted the areas, the lower the risk of legal challenge, eg. LGAs are quite broad and it will be harder to show the medical basis.

20. Similarly, the non-emergency powers to require testing could also be relied upon in individual cases where there is a basis to believe that a person has been exposed to COVID-19, eg. if they live with someone who has tested positive.
21. The consequences for people who refuse mandated tests could include:
    a. Fines: a failure to comply with mandated testing would be a breach of a CHO direction and therefore punishable by fine.
    b. Detention orders: imposing detention orders on people who refuse to take tests would require an individual assessment in each case of the risk they pose, and whether there are alternative options to mitigate that risk. There fact that a person resides in a particular postcode, for example, is unlikely to provide a lawful basis for detention, however if there are other factors (such as likely exposure from friends or family, or contact with known outbreak location) then there may be a basis for detention to be ordered if testing is refused.
22. Options to incentivise higher testing rates in hot spots, short of mandatory testing, include heightened restrictions imposing tighter restrictions, such as a stay-at-home directions, on those residing in hot spots who have not submitted to testing.

DJCS is well placed to quickly mobilise an effective, disciplined and well-trained workforce to deliver the supervision function.

23. DJCS's experience in managing emergency response and Victoria's prison and youth justice systems will be leveraged to ensure the supervision function can be delivered efficiently and effectively. Leveraging existing expertise within the department and recent experience responding to COVID-19 across the justice system, DJCS can implement an enhanced staffing model, with appropriate oversight of staff, and mobilise a professional, well-trained workforce to deliver the supervision function in accordance with infection prevention and control requirements.
24. The new Residential Support Officer (RSO) supervision workforce will be recruited primarily from existing DJCS workforces or contracted agencies, including principally the corrections workforce, meaning that staff will already have relevant skills and experience. For example, corrections staff have skills in supervision, communication, de-escalation and conflict management. They are bound by the Victorian Public Service Code of Conduct and are skilled in maintaining professional boundaries, working with diverse members of the public and the care of vulnerable individuals.
25. Further, throughout the pandemic, DJCS has demonstrated its capacity to deliver high quality and effective infection prevention and control responses, in line with expert health advice from the CHO and independent infection prevention and control experts. Quarantine, staff screening and other infection prevention measures have been in place in Victorian prisons since early March 2020. To date, these measures have been effective in protecting custodial settings from COVID-19. These measures also mean that corrections staff are already familiar with and practised in infection prevention and control measures, including correct use of personal protective equipment (PPE) and working alongside health staff to support people suspected to have COVID-19.
26. DJCS would establish and embed these workplace health protections in the hotel quarantine environment hotel to ensure workplace safety and industrial consistency, in line with public health infection prevention and control requirements. This will

complement intensive face to face infection prevention and control training and symptom screening of all quarantine staff already being implemented by DHHS.

27. This will include development of an improved staffing model, with enhanced oversight of RSOs, more efficient rostering and integration with health and hotel services staff to reduce infection risk exposure for all staff. Corrections staff engaged as RSOs will not be able to exercise any power under the *Corrections Act 1986* in the hotel quarantine environment. RSOs will be identified through a customer-focused uniform branded with the DJCS logo, distinct from custodial uniforms. Therefore, RSOs will escalate to Victoria Police any incident requiring control, restraint or intervention powers, including enforcement of CHO directions.

28. An experienced prison General Manager from the Corrections Victoria custodial environment has been identified as the Department's operational lead for the Supervisory function (reporting through to the Commissioner, Corrections Victoria). While it is expected that the majority of staff will be sourced from the corrections environment, expressions of interest will be sought from a broad range of suitably skilled workforces across DJCS, including Sheriffs Officers. All workers will be provided with appropriate training and will be supervised by corrections staff, to ensure consistency and quality in service provision. Steps will be taken to mitigate the risk of undermining the delivery of other frontline services provided by DJCS through the expression of interest process.

29. Victoria Police will continue to respond to any instances where intervention is required with people in quarantine, and perform regular spot checks for compliance with CHO directions to quarantine hotels. Victoria Police would also continue to support movement of travellers on entry and exit and attend to manage any relevant risks or incidents.

30. Having regard to the size of the existing workforce available to DJCS for the purposes of the Supervisory function (e.g. casual staff not currently being fully utilised by Corrections Victoria), it is not possible to staff up to the full complement from the date of the commencement of the alternative approach. Further, attempting to do so in such a constrained timeline would also create significant implementation and operational risks. It is therefore proposed that the RSO workforce build up over time to be able to replace the current contracted security staff. Based on the existing security workforce model, it is expected that this could result in up to 1000 DJCS workers being deployed across 20 hotels on any one day. Subject to endorsement, DJCS would immediately mobilise to review the staffing and operating model requirements.

31. Depending on the final supervision staffing model and the interest and availability of DJCS staff, contracted staff could continue to play a role. It is anticipated that any contracted supervision staff would be supervised by RSOs directly employed and trained by DJCS, including a DJCS team leader at each site. This enhanced supervision model would help to ensure compliance with infection prevention control, social distancing and other CHO directions by all staff.

Subject to CCC's endorsement, the proposed alternative workforce approach would be implemented in two phases.

Phase One – Staged transition to DJCS RSO workforce

32. Phase one of implementation would involve a phased transition of the supervision function from a private security contractor workforce to a DCJS RSO workforce. Phase One would commence in four priority hotels. The approach would scale up over time depending on the availability of staff and contract negotiations with existing private security contractors by DHHS. DHHS is already partnering with Alfred Health to be able to use their Customer Support Officers with experience in working in hospital environments. These experienced officers can be relied upon to support the transition period, as implementation is progressively rolled out.

33. Subject to CCC's endorsement of this submission, DJCS would progress further work to develop an operational and staffing model designed to reduce infection risk based on Corrections Victoria's current approach in custodial settings. This will require detailed engagement with the Community and Public Sector Union (CPSU). Subject to reaching agreement with the CPSU, rapid internal recruitment and training of RSOs would commence immediately.

34. It is anticipated that Phase One could commence approximately two weeks after endorsement of this submission, to enable enough time to mobilise the workforce and provide training. Alongside this, DJCS will take steps to ensure maintenance of other frontline service delivery while staff are deployed as RSOs.

Phase Two – Developing a sustainable and enduring delivery model

35. Phase Two will involve transition to a new sustainable whole-of-government model of supervision of hotel quarantine that can be maintained for an extended period of time (up to 12 months). A more detailed overview of Phase Two will be provided in a future submission to CCC. However, it is intended that:

    a. The new model will better utilise supervision staff and will be less resource intensive.

    b. Lessons from Phase One will inform refinements to recruitment and training of staff. Phase Two will provide an opportunity to consider any necessary recruitment uplift, including recruitment of staff on longer-term assignments (up to 12 months) and identification of potential additional workforces with appropriate skillsets.

36. In addition, DHHS is continuing to pursue operational improvements and options to simplify the legal framework (for example by reducing the reliance on Authorised Officers by enabling them to issue general quarantine orders to returning travellers rather than each individual), which could support a more sustainable delivery model.

Additional funding will be required to implement the model, and this will be the subject of a future submission to CCC

37. The proposed model is likely to significantly enhance the efficacy of the hotel quarantine program and reduce the costs associated with COVID-19 infections. However, the model, including Phase One, cannot be implemented by DJCS within existing resources. DJCS has not been allocated any funding to deliver services in relation to the hotel quarantine program and will incur significant expenses in mobilising the RSO workforce.

38. A more detailed funding breakdown will be provided in a future submission to CCC, but indicative expenses associated with DJCS delivering the supervision function include (but are not limited to):

    a. Incentives to attract and retain skilled and experienced staff, including funding for gratuity payments and penalty rates – this is likely to be required to incentivise the Corrections Victoria workforce to take on roles as RSOs. The CPSU is also likely to strongly advocate for such an incentive, for which there is a precedent in other contexts (e.g. Corrections Victoria staff taking on roles in the Youth Justice system).

    b. Training, uniforms, mobile phones, meals and incidental costs for RSOs.

    c. Accommodation for RSOs, as required, to manage the risk of spreading infection, particularly among families of RSOs (including for appropriate quarantine periods as required at the end of an RSO's employment). RSOs and their families are not currently eligible for the Hotels for Heroes program.

    d. Backfill for RSOs' usual places of employment within DJCS where relevant.

    e. Special leave provisions for RSOs required to be absent from work for 14 days before returning to their usual employment (for example, custodial officers in prisons would not be able to return to work in a prison without an appropriate period of time between working at the hotel and returning to work at the prison to ensure the ongoing safety and security of Victoria's custodial facilities).

39. However, these costs may be off-set by the reduction of security contract costs. The proposed model will also provide an additional level of infection prevention and control that warrants further investment.

Risks:

1. The RSO workforce will draw heavily on the corrections workforce from Victoria's public prisons. If there was a significant outbreak of COVID-19 in prisons, or in the community, impacting on workforce availability, there is a risk that there would be insufficient workers to fulfil all required functions. If an outbreak resulted in fewer staff in prisons, there is a risk that out-of-cell hours would need to be reduced. This risk is mitigated somewhat by existing infection prevention and control measures in prisons.
2. If a corrections employee was engaged as an RSO contracted COVID-19, there could be a risk of introducing COVID-19 into prisons. This risk will be managed through strict infection prevention and control protocols in hotel quarantine sites. It will be further managed by requiring all RSOs to be absent from work for 14 days between working at a hotel site and returning to their usual place of employment. As DJCS remains the employer of RSOs, it will be able to enforce compliance with this requirement. The introduction of special leave provisions will ensure that DJCS staff are not disadvantaged by this.
3. There is a risk that it will be difficult to recruit enough DJCS staff into RSO roles, if there is a perceived risk of infection, particularly among staff who live in regional locations. This risk can be mitigated through providing competitive wages and conditions, and ensuring the funding model includes measures such as alternative accommodation to manage infection risks and incentivise regional staff to work at these sites.

4. Private security staff currently supervising hotel quarantine have contracted COVID-19 and have transmitted it to their contacts. There is a risk that DJCS staff could similarly contract COVID-19 in the same environment, although steps will be taken to minimise the risk. All DJCS staff will be provided with information and training in complying with infection prevention control, social distancing and other CHO directions. DJCS Team Leaders will be responsible for supporting and monitoring compliance.

5. Corrections staff are trained to manage prisoners and respond to incidents as required, and are given powers under the *Corrections Act 1986* to do so. For example, s 23(2) gives prison officers the power, where necessary, to use reasonable force to compel a prisoner to obey an order given by the prison officer. While RSOs will not have these powers, there is a small risk that staff may attempt to manage an incident in a hotel quarantine environment in the same way that they would manage it in a prison, instead of referring the incident to Victoria Police. While the risk is small, the consequences would be significant. Robust recruitment processes, clear communication of expectations and roles, operating model changes (such as working in pairs), high quality supervision and swift consequences for any unacceptable behaviour (including removal of the staff member as an RSO where appropriate) will be used to manage this risk.

6. There is a risk that the use of custodial staff to supervise people in quarantine could be seen to impact upon the right to liberty enshrined in section 21 of the *Victorian Charter of Human Rights and Responsibilities*. However, having the supervision function provided by custodial staff instead of private security contractors will not change the quarantine regime, which has already been deemed justifiable by the CCC. Effective public messaging that the staff will be engaged in a new role and unable to exercise any power under the *Corrections Act 1986* as part of their role in the hotel quarantine environment will help to correct any misperception.

Support/Criticism:

1. There is likely to be public support for additional measures to strengthen the management of COVID-19 outbreak risks related to hotel quarantine.

2. There may be some public concern about the utilisation of corrections staff in hotel quarantine (including concern from those held within protective quarantine), particularly if there isn't effective public messaging that the staff will not be able to exercise any power under the *Corrections Act 1986* as part of their role in the hotel quarantine environment. However, some members of the public are likely to support a strong approach to addressing the risk of transmission of coronavirus from hotel quarantine.

3. It is likely that the CPSU will be concerned about workplace health and safety risks for staff working in hotel quarantine, as well as the potential for inadequate staffing levels in prison as a result of diversion of staff. Active consultation with the CPSU on the model, and demonstrating robust risk assessment and management processes, will be a pre-implementation priority.

Submission No.	
Copy No.	

Submission to: **Crisis Council of Cabinet**

Submission Title: **CoViD 19 Emergency Accommodation Framework**

Submission Type: **Matter for Endorsement**

Portfolio/s: **Coordination of Health & Human Services & Coordination of Jobs, Precincts and Regions**

Mission/s: **Essential Services Continuity – People**

SUBMISSION PROPOSAL

Recommendation(s):

That the Crisis Council of Cabinet (CCC):

1. **Agree** that DHHS will coordinate the placement of accommodation support requests across DHHS, DJCS and DET, while DJPR will retain responsibility for acquiring appropriate accommodation supply based on demand.
2. **Note** the current target of 5,000 rooms was intended for a range of priority cohorts, but will now be insufficient to meet the demands of returning travellers and the Hotels for Heroes program, and **agree** that the Minister for Jobs, Innovation and Trade will be responsible for flexibly procuring further accommodation within the original $80 million allocation to respond to demand.
3. **Endorse** the current service model and costings for returning travellers as described at Attachment A.
4. **Agree** to extend eligibility for the Hotels for Heroes program to any healthcare worker who wishes to self-isolate at a hotel, subject to costings being agreed with the Treasurer and the Premier.
5. **Note** the $80 million based on current service models will be exhausted by the hotel quarantine and Hotels for Heroes programs in 1.5 to 2.7 months. Early modelling indicates that providing accommodation for other identified cohorts (see Attachment B) would cost up to a further $150 million.
6. **Endorse** an additional investment of $20 million for the Minister for Jobs, Innovation and Trade and the Minister for Health to commence procuring suitable accommodation for family violence victims.
7. **Agree** that the Ministers will return within 4 weeks with a further costed proposal for other vulnerable cohorts and to extend the Hotels for Heroes program to other first-responders and critical workforces, including Victoria Police, youth justice, corrections and workers in residential aged care and disability settings.

8. **Note** that the CCC will be provided with regular updates on the performance of the COVID-19 emergency accommodation program.

Objectives:

1. To protect public health and reduce the spread and impact of COVID-19 by providing suitable accommodation for priority cohorts who do not have existing access to accommodation where they can safely self-isolate or self-quarantine.
2. To support the continued viability of Victoria's tourism and accommodation industry through the COVID health emergency and beyond.

Key Issues:

Current COVID-19 accommodation support arrangements

1. On 20 March, ERC approved $80 million for the Minister for Jobs, Innovation and Trade to secure and operate up to 5,000 hotel rooms and other accommodation.
2. DJPR has secured 4,870 hotel rooms across 23 providers, spread across Melbourne CBD, metropolitan and regional Victoria, at a cost of $20 million per month.

Other cohort requirements met to date

3. The Hotels for Heroes program was announced on 5 April 2020, allowing eligible health workers to request accommodation support if they cannot safely self-isolate or self-quarantine at home. A $20 million allocation from the original $80 million investment has been earmarked for this purpose. This would allow up to 8,000 eligible healthcare workers to be accommodated based on DJPR negotiated rates.
4. It is proposed to extend the eligibility criteria for health workers to enable any healthcare worker who wishes to self-isolate in a hotel to do so. Costings for this extension will be agreed with the Premier and Treasurer.
5. This submission seeks an additional $20 million to centrally procure additional accommodation for family violence victims.
6. On 7 April 2020, the Treasurer approved reprioritisation of $8.8 million of the original $80 million allocation to support people who are rough sleeping or homeless to self-isolate and recover from COVID-19. This has not been included in the current cost and demand modelling.

Accommodation supply, demand and costings pressures

7. As at 12am 7 April 2020, 1,850 international arrivals have been quarantined (see Attachment C for more detail on hotel utilisation). Demand for existing stock is anticipated to spike this week as additional repatriation flights are directed to Melbourne and healthcare workers start to access the Hotels for Heroes program.
8. Additional repatriation flights could double the number of daily arrivals and will require rapid recruitment of additional concierge and Authorised Officer resources from across government. As demand for these resources increase, there will be less opportunities to provide supervised recreational opportunities for quarantined travellers.
9. Currently, hotel and other ancillary costs (security, groceries allowance, couriers, call centre, hospital grade cleaning etc.) total around $4,700 per international arrival quarantined for 14 days, excluding DHHS and DOT costs. The cost for eligible healthcare

workers is around $2,500 per 14-day stay and would increase if other supports and services are required. Further costs would be incurred for rooms used by onsite nurses or left unutilised (around 10 per cent of all rooms).

10. Based on these estimates and the three demand scenarios for quarantined travellers and healthcare workers at Attachment A, the allocated $80 million will be exhausted in around 1.5 to 2.7 months. Over three months, costs for these two cohorts are estimated to be $112.2 million in the low scenario, $146.2 million in the medium scenario and $180.4 million in the high scenario. It will also require 5,450 to 8,000 rooms to be contracted.
11. This will leave no additional capacity to meet the emergency accommodation needs and public health requirements for priority cohorts including vulnerable Victorians who are either not connected to service supports or cannot access these supports due to provider or service system continuity failure.
12. These vulnerable cohorts include clients with complex needs who may be common clients across a range of community and justice services. These clients face significant barriers in accessing services and maintaining a stable housing environment. These cohorts, some of whom are the responsibility of the State to support, are at high risk of contracting and spreading COVID-19 creating a wider public health risk as well as risks to their own health.
13. There will also be no capacity to expand the Hotels for Heroes program to other frontline workforces such as police, youth justice, corrections and residential aged care and disability care staff.
14. A table of the full list of cohorts requiring temporary accommodation, their needs and what is known about the projected demand for each cohort is at Attachment B.

Decision-making on supply and accommodation acquisition

15. The original ERC decision stipulated that the $80 million allocation for procuring temporary accommodation could be used to secure up to 5,000 rooms. With the increasing demand for rooms related to repatriation flights as well as other target cohorts, this level of stock will not be sufficient. DJPR requires greater flexibility to procure more rooms as needed within the agreed funding amount.
16. DJPR will continue to consult with and inform the Australian Hotel Industry Association (AHIA) on all additional accommodation supply for the purposes of quarantining travellers and a range of community cohorts. DJPR will also actively seek the AHIA's support for decision-making on specific accommodation providers and consider alternative options that the AHIA might put forward.

Decision-making and prioritisation of additional cohorts for accommodation

17. To provide capacity to service other accommodation needs, it is recommended that a further submission is provided to CCC as soon as possible to extend accommodation to other priority cohorts including vulnerable Victorians who are either not connected to service supports or cannot access these supports due to provider or service system continuity failure related to COVID-19. This will be available for eligible clients across DHHS, DJCS and DET funded and directly delivered services.
18. It is also recommended that CCC request ministers return with a costed proposal to open the Hotels for Heroes program to other frontline emergency and critical workforce at risk

of COVID exposure while working, such as Victoria Police, youth justice and corrections staff as well as patient facing residential aged and disability care workers.

19. DHHS will contract a third-party provider of an integrated accommodation booking engine and call centre functionality in collaboration with DJPR, to support the potential scale of centralised placement activity required. Significant demand for emergency accommodation placements outside of the traveller quarantine and Hotels for Heroes programs should not be released until this system is operational. DHHS and DJPR will work with the third-party provider to include eligibility requirements in the booking engine for placement and agreed protocols and reporting to DJPR to assist with provider management and sourcing.

Roles and responsibilities

20. Roles and responsibilities for the hotel quarantine program have been shared by DJPR, SCC, DHHS and Victoria Police.
21. As the emergency accommodation program expands to cater to other cohorts, DJPR should continue to retain its responsibility for sourcing accommodation and managing industry and accommodation provider relationships, while DHHS will retain its responsibility for the specific needs of different cohorts in its remit, and health advice around COVID-19 precautions.
22. Under the new framework key roles and responsibilities will be:
    a. DHHS will coordinate the day-to-day placement of eligible accommodation support requests across DHHS, DJCS and DET portfolio responsibilities.
    b. DHHS will procure a third-party provider of an integrated accommodation booking engine and call centre functionality, to support the potential scale of centralised placement activity required. DHHS will provide staff to work with the booking provider to assess accommodation and other support needs of complex client requests, if not referred from an existing service provider or another government agency who has already conducted an eligibility, risk and needs assessment.
    c. DJPR will work with DHHS to strategically source appropriate accommodation supply based on forecast and actual requirements.
    d. DJCS and DET will be responsible for briefing on their client requirements for hotel placement, and for making other special arrangements as needed.
    e. CCC will have overall oversight and direction of emergency accommodation allocations while the COVID Health Emergency is in place. CCC will use the SCC to make operational decisions including prioritisation of demand when insufficient supply if rationing becomes necessary. These decisions will be executed in line with CCC decisions on the use of a central mechanism to manage demand (coordinated by DHHS) and supply (sourced by DJPR). Other parts of Government seeking to access the COVID accommodation support program for their clients will use this process.

Next steps and related activities

23. Regular updates on emergency accommodation demand and supply will be provided to CCC with critical issues escalated to the Minister for Health as needed.

24. DHHS will contract a third-party provider of an integrated accommodation booking engine and call centre functionality to support centralised placement of people with different needs into appropriate accommodation.
25. Subject to a decision on funding to extend temporary accommodation for other cohorts, DHHS will develop a more detailed allocation plan to bring back to CCC.
26. Portfolio ministers and responsible departments will continue to pursue activities that strengthen the ability of Victorians to safely remain in their current place of residence or other transitional options to reduce pressure on emergency accommodation program.

Risks:

1. If this submission is not supported the current funding and room allocation will not be sufficient to meet demand from different priority cohorts creating public health, personal safety and community safety risks.
2. There is a risk that announcement of a broad-based accommodation support program creates expectations that all eligible cohorts will be accommodated and reduce the incentive for individuals, employers and funded service organisations to plan and activate their own organisational and sector continuity plans. This can be managed by clear communication to sectors and across government.

Support/Criticism:

1. Access to government funded accommodation support where no other option exists would be welcomed by providers of health, community and justice services.
2. Continued bulk purchasing of accommodation by government will provide certainty to the accommodation industry.

FUNDING

Table 1: Output/operating funding ($ million)

i. *Financial impact out*	*2019-20*	*2020-21*	*2021-22*	*2022-23*	*2023-24*	*5-year total*	*Ongoing*
Component a	20.000	0.000	0.000	0.000	0.000	0.000	0.000
Component b	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Subtotal gross output	**20.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Offset from internal reprioritisation	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Offset from other sources (e.g. new revenue, trust fund, Commonwealth funding) – please insert rows to specify each separately if possible	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Subtotal offsets	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Net impact output	**20.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**

Table 2: Asset/capital funding ($ million)

Financial impact (capital)	*2019-20*	*2020-21*	*2021-22*	*2022-23*	*2023-24*	*5-year total*	*2024-25*	*2025-26*	*TEI*
Component a	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Component b	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Risk allocation	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Contingency allocation	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Subtotal gross capital	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Offset from other sources (e.g. proceeds from asset sales, trust accounts, Commonwealth funding) – please insert rows to specify each separately if possible	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Net impact capital	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**

Table 3: Lease liability if applicable ($ million)

Financial impact	*2019-20*	*2020-21*	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Recognition of lease liability	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**

Relevant DTF Relationship Manager(s) and the Department have agreed to the costings in this submission:

☐ **Yes** ☐ **No**

Attachment A - Scenarios for accommodation demand and costings

Notes

- **Costs.** Hotel and other ancillary costs (excluding DHHS and DOT-related costs) are around $4,700 per international arrival quarantined. Costs for healthcare workers are around $2,500 per person, and would increase if other supports and services are required. Three months of costs are modelled below.
- **Quarantine of international arrivals.** The number of repatriation flights arriving in Melbourne will impact the number of hotel rooms required for quarantine, as well as starting up new routes to bring Australians back. Currently, around 150-200 passengers are arriving each day on average.
- **Healthcare workers.** The government announced that the Hotel for Heroes program is open to 8,000 healthcare workers.

	Quarantine of international arrivals	Hotels for heroes (healthcare workers)	Family violence (under consideration)	Hotel rooms required to be contracted	Total cost
	14 day stay: ✓ Hotel room and meals ✓ Security ✓ Call centre ✓ Groceries and couriers ✓ Laundry and linen ✓ On site hotel check-in and support ✓ CPV to return home ✓ Hospital grade cleaning ✓ Contingency for sick individuals who need to stay longer ? DHHS costs TBC ? DOT costs TBC	17 day stay: ✓ Hotel room and meals ✓ Hospital grade cleaning ? DHHS costs	17 day stay: ✓ Hotel room and meals ✓ Hospital grade cleaning ? DHHS costs	Includes a 10% buffer of rooms to be used by staff (e.g. nurses) and unutilised rooms, including those on 'red floors' for individuals with COVID-19	
Low scenario	**$21.7M per month** • 200 people per day / 6,000 people per month • Average over first week of the quarantine program	**$6.7M per month** • 2,666 people per month/average	**$6.7M per month (TBC)**	**5,450 rooms** **$2.3M for buffer rooms per month**	**$37.4M per month** **$112.2M over three months**
Medium scenario	**$32.5M per month** • 300 people per day / 9,000 people per month • 3 additional large repatriation flights a week	**$6.7M per month** • 2,666 people per month/average	**$6.7M per month (TBC)**	**6,730 rooms** **$2.9M for buffer rooms per month**	**$48.7M per month** **$146.2M over three months**
High scenario	**$43.4M per month** • 400 people per day / 12,000 people per month • 6 additional large repatriation flights a week	**$6.7M per month** • 2,666 people per month/average	**$6.7M per month (TBC)**	**8,000 rooms** **$3.4M for buffer rooms per month**	**$60.1M per month** **$180.4M over three months**

Potential cohorts in scope

Cohort	Dept/Agency	Accommodation needs	What we know about demand
Incoming international passengers	DHHS/DJPR	• Security on premises • Essential goods (groceries, pharmaceuticals)	5,000 rooms for international quarantine purposes
Health care workers	DHHS	Hospital workers and paramedics already in scope, potential to extend to residential aged care.	8,000 rooms made available
Justice essential workforce	DJCS/VicPol	For Correctional, Youth Justice, Police and emergency services staff - as per healthcare workers,	1,000 rooms made available
People experiencing domestic violence	DHHS/DJCS	• Secure premises • Reception staff trained not to give out client info • Assurance of no FV perpetrators in proximate rooms	TBC
Family violence perpetrators	DJCS	• Secure premises • Reception staff trained not to give out client info	TBC
People at risk of homelessness	DHHS	• Secure premises	TBC
People with mental health issues	DHHS	• Safety and security adjustments to physical infrastructure, (e.g. ability to safely secure people inside (restrictive practices)	TBC
Disability clients in supported accommodation or where their carer becomes unwell	DHHS	• Universal access requirements • Accessible infrastructure (e.g. accessible showers, wider doors, particular beds, no stairs) • People who are immunocompromised to have separate accommodation • Co-location with carers 24/7 for group home residents (with some requiring 2:1 support)	TBC
People exiting the justice system (for example, people to be released from prison), and those on statutory orders	DJCS	For exiting correctional facilities: • Secure premises and minimising co-location of clients where possible • Essential goods (e.g. food) may be required for some individuals • Access to additional facilities (e.g. meeting rooms) to provide health, social and justice services and supports. For those on community based orders: • Accommodation should not be mobile (e.g. mobile homes / caravans) • For a small cohort, Government may require the ability to safely secure people inside (e.g. provision of security personnel) • Essential goods (e.g. food) may be required for some individuals • Access to additional facilities (e.g. meeting rooms) to provide health, social and justice services and supports.	7,500 clients until end of June 2020 estimated
People who were sentenced in a correctional facility and have been released on a health permit	DJCS	• Accommodation should not be mobile (e.g. mobile homes / caravans) • Government may require the ability to safely secure people inside. Where this is required, Government may work with providers to discuss options (e.g. provision of security personnel) • Essential goods (e.g. food) may be required for some individuals. • Access to additional facilities (e.g. meeting rooms) to provide health, social and justice services and supports.	TBC
Children in out of home care	DHHS/DJCS	• Capacity to co-locate • Security of premises • For children – cots, high chairs, play spaces, child safe requirements	TBC
DET request	DET	• Secure premises	50-80 students across a 16 week period

Demand and cost projections – vulnerable cohorts

Cohort	Month 1 (April)	Month 2 (May)	Month 3 (June)	Total people	Total cost – low ($M)	Total cost – medium ($M)
Vulnerable groups – total	**5,549**	**177,3**	**17,267**	**40,579**	**103.5**	**146.1**
DHHS clients	3,313	11,256	10,942	25,511	65.1	91.9
DJCS clients	2,236	6,507	6,325	15,068	38.4	54.2
DET clients	TBC	TBC	TBC	TBC	TBC	TBC

Key modelling notes:

- In each cohort type, service users have been segmented to identify sub-cohorts who require accommodation supports only. This significantly reduces cohort groups for disability and mental health clients
- A 20% discount rate has been applied to all DJCS and DHHS cohort numbers to account for common clients
- COVID infection and exposure profiles driving month to month figures based on COVID spread modelling from DHHS public health
- Low scenario: all stays costed as 17 day stay @ $150 per night, to cover 14 day average stay with 3 day contingency to cover extended stays if cannot immediately exit as well as contingency for bio clean and other costs.
- Medium scenario: all stays costed as 24 day stay @ $150 per night, to cover 21 day average stay with 3 day contingency. Sensitivity modelled as a 14 day stay may be unrealistic for vulnerable cohorts for whom it may take longer to arrange suitable exit options.

Attachment C - Quarantine of international arrivals: rooms occupied as at 12am 7 April

Property name	Rooms contracted	People in hotels	Rooms occupied	Reserved for red zones and staff	Rooms remaining
Crown Metropol	550	454	365	26	159
Crown Promenade	400	449	338	26	36
Crowne Plaza Melbourne	400	359	286	80	34
Pan Pacific Melbourne	370	372	276	28	66
Mercure Welcome Melbourne	330	151	108	31	191
Parkroyal Melbourne Airport	190	65	53	32	105
Four Point by Sheraton, Melbourne Docklands	250	0	0	TBC	250
Melbourne Marriott Hotel	170	0	0	TBC	170
Holiday Inn Melbourne Airport	180	0	0	TBC	180
Novotel Melbourne on Collins	380	0	0	TBC	380
Travelodge Hotel Melbourne Docklands	286	0	0	TBC	286
Travelodge Hotel Melbourne Southbank	260	0	0	TBC	260
Batmans Hill on Collins	170	0	0	TBC	170
Total hotels that meet DHHS requirements for quarantine	**3936**	**1850**	**1426**	**223**	**2287**
Mid City Hotel Ballarat	60	0	0	TBC	60
Novotel Melbourne Glen Waverley	190	0	0	TBC	190
All Seasons Resort Hotel Bendigo	70	0	0	TBC	70
Novotel Geelong	108	0	0	TBC	108
Peppers, The Sands Torquay	66	0	0	TBC	66
Rydges Geelong	120	0	0	TBC	120
Rydges On Swanston	95	0	0	TBC	95
Vibe Hotel Marysville	85	0	0	TBC	85
Zagame's House	90	0	0	TBC	90
Bell Tower Inn	50	0	0	TBC	50
Total hotels that do not meet DHHS requirements for quarantine	**934**	**0**	**0**	**TBC**	**934**
Total hotels contracted	**4870**	**1774**	**1163**		**3707**

National Cabinet Meeting

Friday 27 March 2020

Annotated Agenda

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3. Health Update

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B) Returning travellers

- DPC anticipates the Chief Medical Officer (CMO) will outline the changes in case numbers of COVID-19 that have been a result of returning travellers or close contacts with returning travellers.
- The CMO may also outline what impact travel restrictions are expected to have on case numbers going forward, noting the lag time before cases are identified.
- The report *may* recommend that all returning travellers self-isolate in hotels, rather than go home, if the household has more than one person. The capacity of hotels, who pays and dislocation of families are important considerations in the discussion.

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Submission No.	CCC180
Copy No.	

Submission to: **Crisis Council of Cabinet**

Submission Title: **Public Health Resilience Dashboard - Update**

Submission Type: **Matter for Noting**

Portfolio: **Minister for Health**

Mission: **Public Health Resilience**

SUBMISSION PROPOSAL

Recommendations:

That Crisis Council of Cabinet (CCC):

1. **Note** the data contained in the Public Health Resilience Dashboard (**Attachment 1**), including these key insights from current data:

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d. sustained high numbers of returned travellers; and

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2. **Note** the dashboard includes This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry more granular metrics will be included in future dashboards.
3.
4. This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry

Objectives:

1. To advise the CCC on current key measures in relation to the Public Health Resilience Dashboard and actions being taken to promote compliance, testing and public health messaging.

Key Issues:

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Public health response

8. This decline in key metrics has necessitated the reintroduction of some restrictions on gatherings and slowed some of the planned easing of restrictions.
9. In addition, a significant public health communications and compliance response is underway. It has seven key workstreams – This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry

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greater enforcement and improved surveillance at hotels, all underpinned by an enhanced data driven response.
10. The Minister for Health will bring to CCC a detailed paper on these actions, but some key items are highlighted below.

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Returned Travellers

37. As at 21 June, 2,801 returned travellers were in mandatory quarantine, bringing the cumulative total to 17,792. As at 20 June, 38 COVID-19 positive cases (does not include close contacts) were in mandatory hotel quarantine.
38. There have been some behavioural challenges for some staff at the quarantine hotels, in particular the recent Stamford Plaza outbreak has involved staff not following guidelines and socially mixing.
39. The Outbreak team has attended the Stamford Plaza and is undertaking intensive training for staff and contractors across all shifts. This includes infection, prevention and control and the correct use of personal protective equipment and other key protective measures.
40. Temperature and symptom testing for all staff prior to entry at all hotel sites has commenced. There will also be an increased police presence to reinforce compliance, and the underlying security model is being reviewed and changes are expected.

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Attachment 1

Public Health Resilience Dashboard

Cabinet-in-Confidence – 23 June 2020

Contents

This material has been redacted on the basis that it is irrelevant to the COVID-19 Hotel Quarantine Inquiry

Returned travellers

- Numbers of entries and exits from quarantine
- Quarantine and isolation supports

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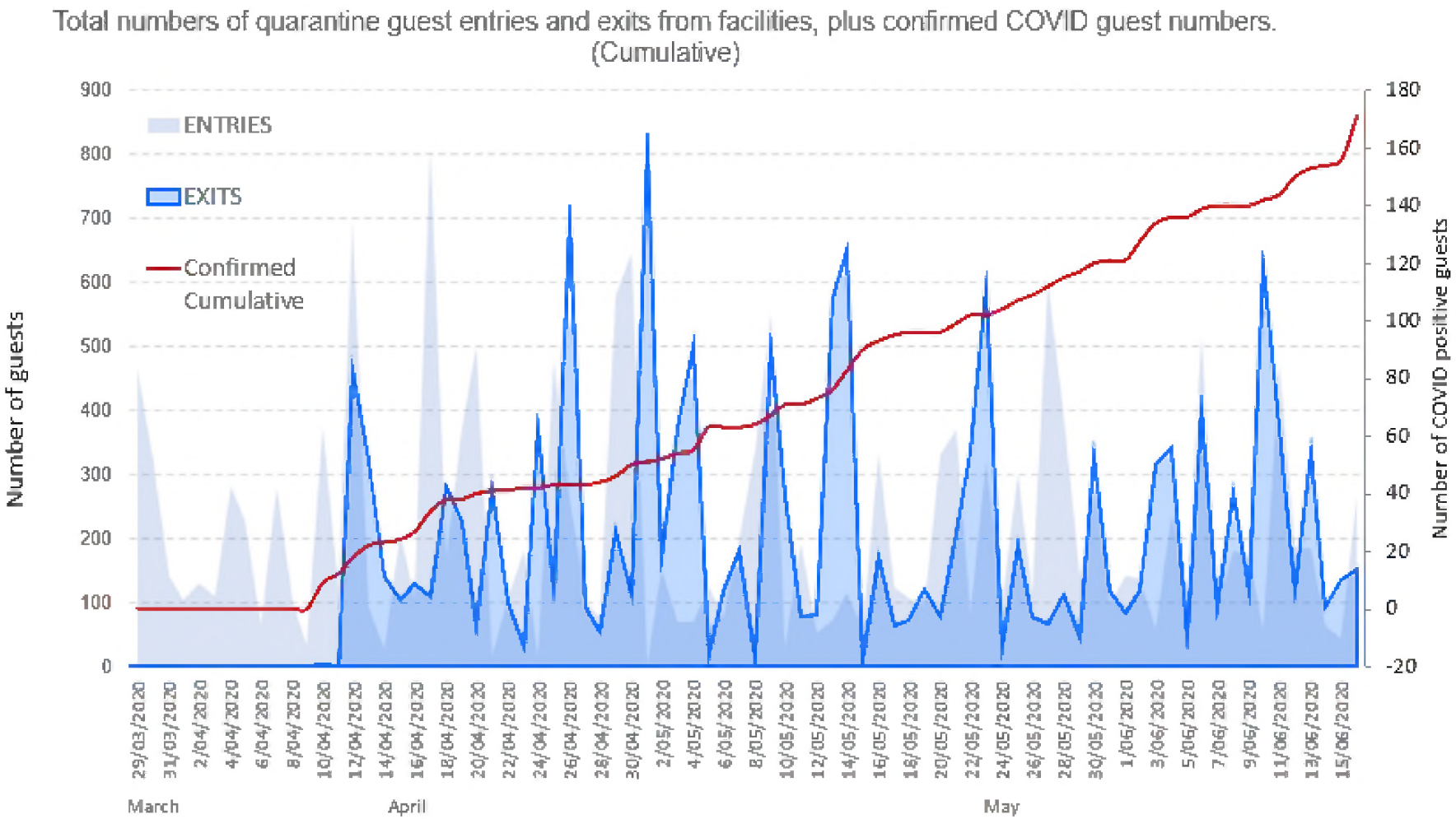
Attachment 1

Quarantine of returned travellers



Attachment 1

Quarantine and isolation supports

Indicator	Result
Total number of welfare surveys completed 11 - 17 June	1,223
Number of referrals for support or services made by Welfare Check Team 11 - 17 June	199
Estimated daily number of DHHS workers rostered at hotels (including Authorised Officers), ports (including Authorised Officers), Operation Soteria Emergency Operations Centre and case assessment and referral support (does not include medical or nursing staff in hotels, contracted hotel security, agency support staff, GSS Call Centre or State Control Centre)	131 (rostered over 24 hours 17 June 2020)
Estimated number of healthcare (medical, nursing and mental health nursing) workers rostered at hotels	306 (rostered over 24 hours 17 June 2020)
Total number of returned travellers currently in mandatory quarantine as at 17 June	2,682
Cumulative number of returned travellers that have been in mandatory quarantine as at 17 June	17,344
Note: Reporting for "Relief packages delivered to self-isolating or self-quarantining Victorians" is discontinued as this function has been transferred out of DHHS.	

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