Pandemic Sub-plan

Sub-plan to the Queensland Health Disaster and Emergency Incident Plan (QHDISPLAN)

DELIVERING FOR QUEENSLAND
Queensland Government

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Pandemic Sub-plan

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Disclaimer

Snapshot: *Pandemic Sub-plan*

Purpose

The purpose of the Queensland Health *Pandemic Sub-plan* (the sub-plan) is to provide an outline of Queensland Health's systems, governance and mechanisms for the prevention of, preparedness for, response to and recovery from a pathogen of pandemic potential.

Scope

The sub-plan adopts an all-hazards, collaborative, and multidisciplinary One Health approach, recognising the interconnectedness of humans, animals, and the environment. It is based on respiratory pathogens as the most likely pathogen of pandemic potential and does not include detailed actions or operational response procedures for specific pathogens.

The sub-plan recognises that the same systems, capacities, knowledge, and tools can be leveraged and applied for groups of pathogens based on their mode of transmission. Once an emerging pathogen is detected, a pathogen-specific incident assessment and response plan would be developed (see Appendix 6.1).

Authority

The sub-plan is issued under the authority of the Director-General as a hazard-specific plan of the interim *Queensland State Disaster Management Plan* and sub-plan to the *Queensland Health Disaster and Emergency Incident Plan*. The sub-plan is supported by the *Queensland Whole of Government Pandemic Plan* and the *Queensland Health Public Health Sub-plan*.

Primary agency

Queensland Health is the primary agency responsible for the hazard of pandemic. The sub-plan articulates the roles and responsibilities of Queensland Health in the context of Queensland's disaster management arrangements.

Activation

Activation of the sub-plan may be considered by the Director-General or their delegate when:

- the Australian Government Department of Health, Disability and Ageing notifies the emergence of a pathogen of pandemic potential in Australia or overseas or
- there is a potential or actual threat of a pathogen of pandemic potential overwhelming the health system.

The strategic objectives across all activities of the sub-plan are to:

- minimise transmissibility, morbidity and mortality associated with a pathogen of pandemic potential
- minimise the burden on the health system and impacts to the public and
- inform, engage and empower the public to adopt protective measures to prevent disease.

Triggers for escalation and de-escalation of the sub-plan are outlined in section 4.

Authority

The Queensland Health *Pandemic Sub-plan* is issued under the authority of the Director-General and is a sub-plan to the *Queensland Health Disaster and Emergency Incident Plan*. Queensland Health is the primary agency for this hazard-specific plan under the interim *Queensland State Disaster Management Plan*.

Review requirements

The sub-plan shall be reviewed:

- Annually as a minor review, with amendments made based on potential impact and importance, otherwise a major review will be conducted every three years.
- Following structural or organisational changes impacting Queensland Health operations.
- Following legislative changes affecting Queensland Health operations.
- Following changes in state or federal nomenclature or arrangements.
- Following activation, a debriefing process, lessons management process or a major exercise.

Version control

This sub-plan will be updated electronically and available on the Queensland Health intranet and internet sites. The electronic copy is the current and master copy. Printed copies are uncontrolled. When an amendment is made to the sub-plan, the amendment will be recorded in the version control schedule.

Date	Amendment	Version	Approver
2018	Previous version – referred to as the *Pandemic Influenza Plan*	-	
2025	*Pandemic Influenza Plan* reviewed and redrafted as the *Pandemic Sub-plan*	1.0	

Contents

1 Introduction

1.1 Purpose

The purpose of the *Pandemic Sub-plan* (the sub-plan) is to provide an outline of Queensland Health's systems, governance and mechanisms to prevent, prepare for, respond to and recover from a pathogen of pandemic potential.

1.2 Scope

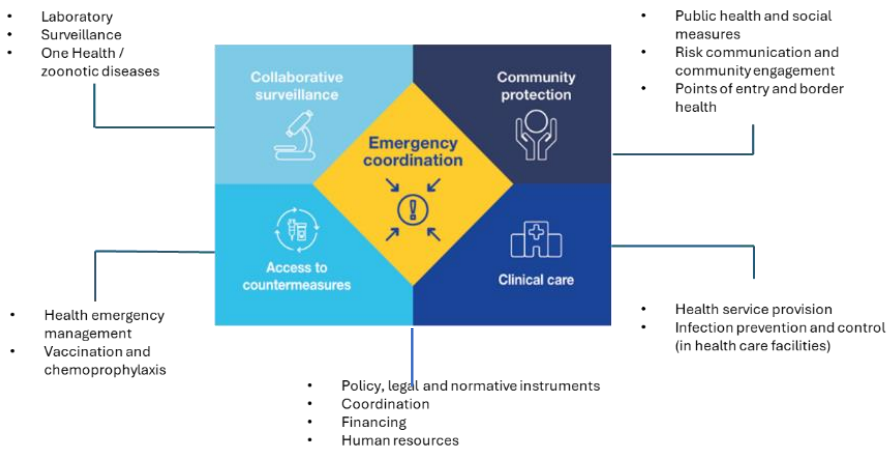
This is a hazard-specific sub-plan of the interim *Queensland State Disaster Management Plan* (QSDMP)[1], a sub-plan of the *Queensland Health Disaster and Emergency Incident Plan* (QHDISPLAN) [2] and is supported by the *Queensland Whole of Government Pandemic Plan*[3] and the *Queensland Health Public Health Sub-plan*[4].

The sub-plan adopts an all-hazards, collaborative, and multidisciplinary One Health approach, recognising the interconnectedness of humans, animals, and the environment. It aligns with national and state emergency risk management strategies to effectively address and mitigate risks.

The sub-plan is based on respiratory pathogens of pandemic potential and does not include detailed actions or operational response procedures for specific pathogens. Once an emerging pathogen is detected, a pathogen-specific incident assessment and response plan would be developed; this would account for both the context at the time and pathogen-related parameters such as mode of transmission, transmissibility and clinical severity (see Appendix 6.1).

Following the COVID-19 pandemic, the World Health Organization (WHO) analysed the framework for health emergencies as applied to the response to translate the learnings to action.[5] The sub-plan aligns with the WHO *Preparedness and Resilience for Emerging Threats* (PRET)[6] framework to improve pandemic preparedness. PRET recognises that the same systems, capacities, knowledge, and tools can be leveraged and applied for groups of pathogens based on their mode of transmission. These capacities may be organised across five components for health emergency preparedness, response and resilience (see Figure 1).

Figure 1: Five components for health emergency preparedness, response and resilience[a]



[a] Figure reproduced from Preparedness and resilience for emerging threats module 1: planning for respiratory pathogen pandemics. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO

2 Governance

2.1 National

Australia is committed to strengthening the global health system to prevent and respond to future pandemics through a One Health approach by:

- building on lessons learned from the COVID-19 pandemic
- participating in updates to the *International Health Regulations* (2005)
- taking part in negotiations on a new pandemic treaty agreement.[7]

The national response will be guided by the *Emergency response plan for communicable disease incidents of national significance: national arrangements* (National CD Plan)[8] and the complementary *Emergency response plan for communicable disease incidents of national significance* (CD Plan)[9] for the health sector response. The CD Plan, maintained by the Australian Government, outlines the state and national roles and responsibilities for preparedness and response to a communicable disease incident of national significance (CDINS).

Decision-making for the pandemic health response will be informed by the overarching leadership of the Australian Health Protection Committee (AHPC) and the support of relevant sub-committees including:

- Communicable Diseases Network of Australia (CDNA)
- Public Health Laboratory Network
- Environmental Health Standing Committee (enHealth)
- National Health Emergency Management Sub-committee.

Where disease-specific plans exist, such as the *Australian Health Management Plan for Pandemic Influenza* (AHMPPI) and the *National Polio Emergency Response Plan*, these are the primary plans used in response to specific incidents. Where no disease-specific plan exists, the CD Plan is considered the primary response plan.

2.2 State

The QHDISPLAN and the *Queensland Health Incident Management System (QHIMS) Guideline*[10] provide the arrangements and framework for disaster and emergency incident management in Queensland Health, as aligned with the interim QSDMP and the *Australasian Inter-Service Incident Management System*.

Activation of the sub-plan is the trigger for activation of Hospital and Health Service (HHS) pandemic arrangements if they have not already been activated, based on a local risk assessment. Concurrently, Queensland Health's disaster and emergency incident arrangements will be activated via the QHDISPLAN and the *Public Health Sub-plan*, including the establishment of incident management team/s (IMT) to operate within the State Health Emergency Coordination Centre (SHECC), the state Public Health Emergency Operations Centre (PHEOC), the HHS PHEOC and Health Emergency Operations Centres when activated.

Under a level three public health incident, the Public Health Unit (PHU) within an HHS will have a lead role in a pandemic across all stages. Some PHUs will undertake this role across multiple HHSs in collaboration with the executive leadership and disaster management arrangements of the QHDISPLAN.

HHSs will need to contribute to intelligence products to inform response planning, including situation reports (SITREPs) that are used to provide situational awareness, describe health service capacity[b] and bed status.

The sub-plan activities are underpinned by the principles of risk management. The following should be identified to inform risk assessments and planning:

- Priorities and options for preparedness, response and recovery
- Priority populations
- Opportunities for capability and capacity development
- Residual risks and thresholds.

Under the *Public Records Act 2023*, Queensland Health has a legal and regulatory responsibility for the creation, management, retention and disposal of public records.[11] To meet Queensland Health's obligations during a response to an emergency, full and accurate records that provide reliable and authentic evidence of events, activities and decisions must be created and maintained in an approved recordkeeping system. These records must be kept for the required retention period in accordance with an authorised retention and disposal schedule and cannot be disposed without authorised approval.

Queensland Health's roles and responsibilities for a pandemic are detailed in Appendix 6.2.

3 Planning considerations and assumptions

Planning for a pandemic when little is known about the disease is based on a range of assumptions using the available scientific and medical evidence for decision making. Assumptions must be reassessed as the pandemic progresses, and more is known about the disease.

The sub-plan is based on existing disaster management arrangements and assumes all existing prevention, preparedness, response and recovery activities; and business continuity considerations continue to apply, where relevant.

Queensland Health will maintain, exercise and revise the sub-plan and participate in an expert advisory capacity to whole-of-government planning as required.

3.1 Approach for planning

The Queensland Health approach for planning and the specific strategies of the sub-plan has been informed by the AHMPPI, lessons identified from the COVID-19 pandemic and international and national guidance. The findings of the Commonwealth Government *COVID-19 Response Inquiry Report*[12] identify that future pandemic plans should provide a framework that can be added to with information relating to types of infectious threats, depending on the risk profile, transmission routes and who is most impacted. It is anticipated that future reviews of related national plans would address the findings of the COVID-19 response inquiry, and this sub-plan would be reviewed to align with the national plans.

[b] Capacity reporting may include staff impacted, supply issues, groups or stakeholders that have been briefed.

Key factors that influence the Queensland Health pandemic planning approach include:

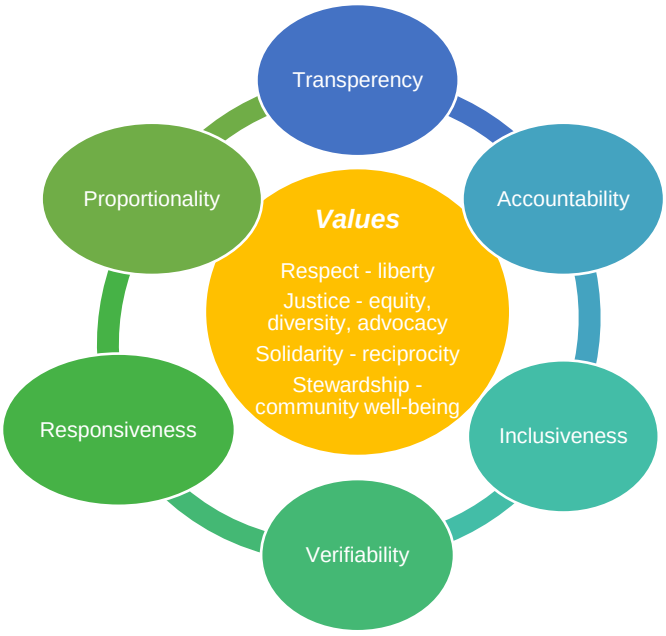
- **Focus and flexibility** – focus on a respiratory pathogen of pandemic potential with the flexibility to apply the framework to other pathogens based on their mode of transmission.
- **Scalable and proportionate** – appropriate to the level of risk and impact a pathogen of pandemic potential is likely to have on the community including priority populations.
- **Engagement** – capitalise on existing whole-of-government and multi-sectorial emergency management arrangements by developing and maintaining stronger links with other government agencies, non- government health services and the community.
- **Compliance and evidence** – a health system response based on the principles of emergency risk management for health in compliance with Queensland, Australian and international laws, and robust evidence-informed decision making.
- **Intelligence** – clear guidance, monitoring and reporting on the surveillance and management of pathogens of pandemic potential.
- **Communication** – a key tool to ensure timely, clear, accurate and transparent information is provided to the health sector, stakeholders, the community and media.

3.2 Principles and ethical considerations

The Australian and Queensland Governments will have to make many difficult decisions during a pandemic about a wide range of response and recovery issues. In 2020, to guide ethically informed decision making and policy development during the COVID-19 pandemic, and for future pandemics, the National Health and Medical Research Council (NHMRC) led the development of an ethics framework, *Decision making for pandemics: an ethics framework.*[13]

The framework provides a set of values and principles to consider and guide the process of formulating, justifying and implementing proposed decisions. The values and principles are not intended to be prescriptive for ethical decision making but reflect a process of reflection, integration and balancing of multiple imperatives and demands. Whilst the values may not be applicable in all circumstances, the procedural principles guide how to implement the decision based on the values (see Figure 2).

Figure 2: Decision making for pandemics: an ethics framework



3.3 Legal and policy considerations

In the event of a public health emergency involving a communicable disease, various state and national legislation provides a legal framework to support measures that may be required to mitigate the threat (see Appendix 6.3). Specifically, the *Disaster Management Act 2003* (Qld) and the *Public Health Act 2005* (Qld) provide the legislative basis for disaster and public health incident management arrangements in Queensland.

Additional legislative powers are available in the event of a public health emergency. These powers must only be implemented in accordance with the relevant legislation. Proper consideration will be given to human rights to ensure the measures are necessary, justifiable, and proportionate. It is unlawful for a public entity to fail to comply with these obligations. The epidemiology and clinical features of the pathogen and its potential impact on the population at local, state and national levels would inform Queensland Health's advice to the Minister for Health for a decision on declaring a public health emergency.

Queensland Health maintains health service directives to ensure preparation for and response to disasters and emergency incidents[14], including public health incidents[15], in a coordinated manner across the state and HHSs.

3.4 Indigenous data governance

In the event of a pandemic, ethical data practices should include recognition of Indigenous data governance principles, as outlined in the *Framework for Governance of Indigenous Data*[16]. Efforts will be made to engage with Aboriginal and Torres Strait Islander people and communities in the management and use of data, including transparency around data collection and sharing. Consideration will be given to supporting community access to relevant health data to support local decision making during the pandemic response.

4 Sub-plan activation and escalation

The *Queensland Whole of Government Pandemic Plan* identifies that for a disease to have pandemic potential it must meet three criteria:

1. Humans have little or no pre-existing immunity to the causative pathogen.
2. Infection with the pathogen usually leads to disease in humans.
3. The pathogen has the capacity to spread efficiently from person to person.

The impact of a pandemic depends on how sick the pathogen makes people (clinical severity), the ability of the pathogen to spread between people (transmissibility), the capacity of the health system, the effectiveness of interventions and the vulnerability of the population.

4.1 Activation of sub-plan

The sub-plan is activated by the Director-General (DG) or the delegated State Health Coordinator (SHC). Activation of the sub-plan would automatically trigger activation of the QHDISPLAN and may lead to the activation of the SHECC.

The *QHIMS Guideline* provides guidance on contemporary practices for the management of disasters and incidents impacting the health system. The public health incident response structure would be established under the *Public Health Sub-plan*, including activation of the state PHEOC and HHS arrangements.

When the SHECC is activated, the SHC:

- notifies the State Disaster Coordination Centre (SDCC), all HHSs, the Department of Health (the department) divisions, the Queensland Ambulance Service (QAS) and the QAS State Operations Coordination Centre (SOCC), that the SHECC has been activated
- coordinates the Queensland Health response and liaises with the department, HHSs and the SDCC
- identifies if the response required is beyond Queensland Health's capabilities and requests support or assistance from other state agencies or national agencies (through SDCC) or health departments of other jurisdictions (through the AHPC).

4.2 Triggers for escalation and de-escalation

The *CD Plan* for the national health sector response provides a guide for Queensland Health's planning to support implementation of activities across the operational stages of preparedness, response and recovery. Aligning with the *CD Plan*, the strategic objectives across all activities of the sub-plan are to:

- minimise transmission, morbidity and mortality associated with a pathogen of pandemic potential
- minimise the burden on the health system and impacts to the public
- inform, engage and empower the public to adopt protective measures to prevent disease or minimise its impact.

Situational assessments will be continuous at local, state and national level and in consideration of the global impacts of the pandemic. At a state level, the intelligence gathering, monitoring and reporting may lead to adjustment of response measures through consideration of factors including emergency department presentations, bed capacity, deaths, furloughed staff and ambulance demand.

The SHC will be advised by the intelligence functions of the state PHEOC and SHECC to inform decision making for response and potential activation of policy measures including declaring a public health event of state significance.

At a national level, the AHPC on advice of the CDNA, CDNA sub-committees, and the interim Australian Centre for Disease Control (CDC), working with state and territory governments, will be responsible for emergency health management, including national and international disease surveillance to inform escalation and de-escalation of response.

The SHC will recommend an escalation or de-escalation of activation to the DG and the Minister for Health. The response will then be communicated to internal and external stakeholders and the public.

Table 2: Examples of triggers for transitioning between operational stages[c]

CD Plan Stage	Sub-stage *(QLD stage)*	Trigger to move to stage/sub-stage (examples)
Prevention	**Prevention** ***(Prevention)***	• Continuous effort to minimise risk and impact (business as usual).
Preparedness	**Preparedness** ***(Preparedness)***	• Continuous monitoring for the emergence of pathogens of pandemic potential.
Response	**Standby** ***(Alert, Lean Forward)***	• Alert received from an Australian Government entity that sustained community transmission of a pathogen of pandemic potential has occurred overseas and poses a risk to Australia. • Warning of a potential pandemic received from the WHO to an Australian Government entity e.g. AHPC.
	Initial action ***(Stand Up)***	• First case/s detected in Australia. • Declaration by the WHO of a Public Health Emergency of International Concern. • National and state declaration of public health emergency. • National declaration of a CDINS.
	Targeted action ***(Stand Up)***	• Information available about the disease allowing targeted measures that consider broader socioeconomic impacts dependent on: – at risk population/s; or – cases, deaths and hospitalisations; or – vaccination coverage and its effect on transmission, including in sub-populations; or – health system capacity; or – availability and effectiveness of pharmaceutical measures. • Amplification and widespread community transmission of the pathogen in Australia and risk for Queensland.
	Stand Down ***(Stand Down)***	• Sustained global reduction in cases, deaths, or hospitalisations. • National advice that the pandemic has reached a level where it can be managed under more routine arrangements. • Termination of the Public Health Emergency of International Concern by the WHO. • Termination of national and state emergency declarations.
Recovery	**Recovery** ***(Recovery)***	• Enhanced measures begin transition to routine arrangements and response moves to prevention and preparedness. *NB: Recovery may be a staggered process across the health system and affected locations.*

[c] Adapted from CD Plan, Queensland Whole of Government Pandemic Plan p.10, WHO PRET-Module 1: Annex 6 p.90, AHMPPI: Attachment D-Decision Support Map

5 Implementation

5.1 Prevention

Prevention[d] must be continuous and an integral business as usual activity. The *WHO Pandemic Agreement*[17] recognises the importance of strengthening pandemic prevention and coordinated multisectoral surveillance in accordance with the public health priorities of the *International Health Regulations*, including:

- preventing emerging and re-emerging infectious disease at the human-animal-environment interface
- preventing infectious disease transmission between animals and humans including zoonotic disease spill-over
- coordinated multisectoral surveillance to detect and conduct risk assessment of pathogens with pandemic potential and those pathogens that are resistant to antimicrobial agents
- effective routine immunisation programs including increasing public awareness of the importance of immunisation
- infection prevention and control (IPC) measures
- surveillance, risk assessment and prevention of vector-borne diseases that may lead to pandemic emergencies
- measures to address public health risks associated with the emergence and spread of pathogens that are resistant to antimicrobial agents.

5.2 Preparedness

Mitigating the risk that a pandemic may cause to the community requires continuous quality preparedness activities to ensure readiness for an emerging threat and transition through stages of response. Preparedness may include:

- enhancing human health surveillance programs
- collaboration across the human, animal and environmental health sectors including biosecurity measures, local vector control activities and animal disease prevention; and surveillance programs
- engaging with and promoting public health and social measures to the community including physical distancing, staying at home when sick, respiratory and hand hygiene etiquette, mask wearing, ensuring vaccinations are up to date etc.
- considering the impact of public health and social measures on mental health and developing appropriate mitigation and support strategies
- monitoring emerging evidence of novel pathogens
- ensuring targeted, timely and transparent information is provided to the community and priority populations
- communication at all levels of government and
- reviewing and testing operational plans, including surge workforce.

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[d] The sub-plan acknowledges that communicable disease prevention and control is a continuous activity, including for identified pathogens of pandemic potential. The sub-plan considers prevention as a state of business-as-usual activity continuing into the preparedness, response and recovery stages.

Several activities outlined in this section will be critical to continue and adapt across the response stage, including surveillance, communication and workforce capacity.

5.2.1 Surveillance

National

The Australian Government has systems and processes in place to monitor, analyse and communicate an emerging threat of a pathogen of pandemic potential, internationally and within Australia. In the context of national and jurisdictional intelligence for a response to a pandemic, the principles of Indigenous Data Sovereignty are acknowledged throughout all phases of the data lifecycle, including collection, use and disclosure.

The interim Australian CDC is initially focused on preparing for public health emergencies, improving the national public health surveillance system and building capability in One Health and health security. The interim Australian CDC will maintain situational awareness of regional neighbours where pandemic strains are more likely to emerge, through surveillance systems and early response to clusters of pathogens with pandemic potential. Monitoring of an emerging threat is informed by global collaborative efforts to assess and prioritise a pathogen's risk as a pathogen of pandemic potential.[18]

The Queensland Government will work with the Australian Government to contribute intelligence to the national surveillance initiatives and inform the public health response. Queensland Health is a jurisdictional member of the National Respiratory Infections Surveillance Committee, a subcommittee of the CDNA, and contributes to the development and maintenance of surveillance systems to detect and monitor clinical, epidemiological, transmission, severity and burden of acute respiratory infections (ARI), including an epidemic or pandemic. Queensland Health will provide notifiable conditions data to the Australian Government through the National Notifiable Diseases Surveillance System under existing data agreements.

Routinely collected ARI notifications data on the Queensland Health Notifiable Conditions Register (NCR) will be used as an early warning signal and to meet the information requirements to inform public health actions during all stages of a pandemic. Queensland ARI surveillance data are published in the *Australian Respiratory Surveillance Report* by the interim Australian CDC.

State

Queensland Health is continually working on enhancing its integrated surveillance capabilities. This includes accessing real-time data from emergency departments, linking data from multiple sources and sharing intelligence with internal and external stakeholders through a data lakehouse specifically designed for analysing and reporting data to support decision making. Queensland Health also collaborates with external agencies including state and national government agencies and academia on forecasting trends, gathering epidemic intelligence and modelling exercises.

Collaborative surveillance activity for emerging zoonotic pathogens is undertaken through representation on CDNA, enHealth and under a Memorandum of Understanding (MoU) between relevant Queensland government agencies including the Department of Health, the Department of Primary Industries and the Department of State Development, Infrastructure and Planning. The purpose of the MoU is to enable sharing of information to facilitate the execution of the parties' duties for the management of zoonotic incidents.

Queensland Health publishes weekly surveillance reports for ARI to monitor trends such as notifications and hospitalisations. ARI surveillance reporting includes dashboards and automated reports using real-time data to assist in signal detection based on various metrics. This intelligence will be enriched to include additional data sources through data linkage to understand the impact of a pandemic and public health response. For example, immunisation records from the Australian Immunisation Register (AIR), hospitalisation data, mortality data, geographical and First Nations people specific data. Further strengthening of Geographical Information Systems capacity will improve the epidemiological overview, coordination, decision making and communication with regional and remote communities, especially First Nations communities.

Collection of case and contact data, including enhanced surveillance data of early cases, is the responsibility of the HHSs. Notifiable conditions are identified in Schedule 1 of the Public Health Regulation 2018. Case data are collected in the Notifiable Conditions System (NoCS), analysed by the intelligence function of the response, and provide additional information on the epidemiology of the emergent pathogen to inform the state and/or national response.

NoCS will capture critical epidemiological parameters and be flexible with data fields customisable for specific conditions as required, such as during the COVID-19 pandemic. Additional data is sourced from external systems and agencies, including mortality data sourced from the Registry of Births, Deaths and Marriages and updated in NoCS. Data on test positivity for ARIs are also used to understand access to healthcare facilities and health behaviours. NoCS is flexible to capture testing data including negative test results and has been used to report on test positivity rate.

Strengthening technical and operational capacities of existing wastewater surveillance will also maximise the benefit of the data to provide early detection or genomic characterisation of emerging and re-emerging pathogens when clinical testing is low or disease symptoms are mild or absent, thereby complementing the conventional surveillance of pathogens of pandemic potential. Legislative provisions related to data sharing must be considered if extending existing programs.

Laboratory surveillance and response

The Public and Environmental Health Reference Laboratories (PEHRL) performs genomic surveillance for COVID-19 and influenza viruses. COVID-19 genomic surveillance is conducted on clinical and wastewater samples to identify new variants and clusters. Influenza genomic surveillance provides an overview of the genetic diversity and monitors viral genetic changes suggesting resistance to viral therapies or divergence from vaccine strains. Genomic surveillance reports are published by the PEHRL.[19]

Samples for genomic surveillance are prioritised on various risk factors such as cases at hospitals and residential aged care facilities. Clusters identified from genomic surveillance are communicated by PEHRL internally to inform the public health response. Notable genotypic/phenotypic changes, e.g. the emergence of new variants, will be reviewed in conjunction with epidemiological data to assess and inform risks to public health including transmissibility or disease severity, and may prompt further epidemiological investigations to measure their associated impacts.

Queensland Health leads a laboratory reference group and engages with public and private laboratories. The group is a forum for consulting on criteria for notification of communicable diseases and diagnostic technologies that impact on notification criteria. This ensures our surveillance system is capturing notifiable conditions for timely detection of outbreaks and clusters and to respond to emerging public health threats.

5.2.2 Communication

Clear, relevant and consistent communication is crucial to ensuring Queenslanders are informed and engaged to understand the vital steps they must take to help minimise the spread and impact of the pathogen. Communications need to shape Queenslanders' perceptions around the pandemic, including their level of risk and the management of it, and meaningfully engage them to undertake necessary protective behaviours during the various stages of a pandemic. Communications should include evidence of the rationale for recommendations in appropriate language and formats to support accessibility, trust and confidence and counter misinformation.

In the event of a pandemic, Queensland Health has a lead role to coordinate public and other stakeholder information provision. Working alongside the Public Information Capability (PIC) of the SDCC and supported by the Crisis Communication Network (CCN), as the primary agency Queensland Health plays a key role in setting the direction for the whole of government response (Figure 3). If required, the Department of Premier and Cabinet will lead the establishment of the Crisis Communication Taskforce and the Stakeholder Engagement Taskforce to support the primary agency during a pandemic response.

Figure 3: Queensland Government issues and crisis communication response framework[e]

Depending on the scale of the event, Queensland Health media and communication advice and support is led by the Strategic Communications Branch (SCB) or the media and communication function of the HHSs. SHECC, in collaboration with SCB and the state PHEOC, may provide guidance and distribute communication and resources to HHSs and other stakeholders based on advice from the Australian Government.

SCB will work across Queensland Health to begin planning activities in the preparedness stage and prepare the public for the impact of the disease, its management and how they should respond. Broader Australian and Queensland Government plans, including the *National CD Plan*, the *CD Plan* and the *Queensland Whole of Government Pandemic Plan*, provide structured communication strategies to ensure consistent and coordinated information dissemination.

[e] Reproduced from the *Queensland Whole of Government Pandemic Plan*, Annexure 1

Queensland Health communications strategies will be developed with local HHS communications teams; and in consultation with the Health Contact Centre (HCC) and Smart Services Queensland to outline:

- relevant public sentiment and insights
- communications challenges
- strategic approach, guiding principles, objectives, and evaluation measures
- key audiences and channels
- messaging framework, core communications activities and the delivery rhythm throughout the phases of the pandemic
- key information sources.

Specific communication plans will be developed in partnership with relevant stakeholders across health services, and these may include expert advisory groups and networks, local elders, community leaders, and communities to support priority populations. It is critical to identify communication challenges via input from stakeholders and priority populations that must be considered to ensure information is accessible and appropriate for all members of the community. Subsequent communications plans may be developed to support specific aspects of the health response, such as the rollout of a vaccination program or implementation of other public health and social measures.

5.2.3 National medical stockpile

The National Medical Stockpile (NMS)[20] provides a national reserve capacity of medicines, vaccines and other immunisation medicines, and equipment that can be rapidly deployed in the event of a pandemic. The NMS is designed to supplement existing medical stock held within each state/territory to support continuity of service during periods of extremely high global and national demand.

The Australian Government Department of Health, Disability and Ageing is responsible for maintenance and deployment plans relevant to the NMS. In the event of a pandemic, the NMS deployment process for supplies will be communicated to relevant stakeholders, particularly where they differ from the usual process for NMS supply.[21]

5.2.4 Workforce capacity

The department and HHSs are responsible for maintaining a core workforce with the skills and knowledge necessary to prepare for and respond to disasters and emergency incidents, including a pandemic. The *Queensland Disaster Management Training Framework*[22] provides disaster management stakeholders with a framework and associated consistent training to support an all-hazard and all-agencies approach that enables effective collaboration and interoperability during emergencies.

The Queensland Health *Public Health Workforce Strategy 2024-2032*[23] includes actions to ensure the workforce has capacity to effectively respond to public health emergencies such as pandemics. The workforce required for a pandemic response is likely to exceed the core workforce and the department and HHSs should plan for surge capacity, including where to source staff, what skills are required, how to orientate/train staff, accreditation/credentialing and when to stand down the surge workforce. This may include allocation of clinical and administrative staff into public health units to assist with contact tracing in the initial response, or movement of clinical staff within hospitals and community health to deal with increased demand on acute services.

System access and training considerations may include:

- QHIMS disaster and emergency incident management online modules (*in development*)
- data applications and systems e.g. NoCS and AIR
- enhanced data analytics e.g. reporting dashboard using Power BI, ArcGIS, REDCap
- contact tracing officer appointment
- emergency officer authorisation/appointment
- information and records management.

It should be noted that staff absence and public health measures are likely to impact the availability of staff for surge capacity in the event of a pandemic and HHSs should consider the likely impact when planning, including which disciplines and workforces are least likely to be impacted by subsequent increased clinical, administrative and other workload and therefore should be prioritised for training and upskilling. Development and maintenance of a surge workforce plan would assist the HHS to rapidly respond to required workforce capacity in the event of increased workload across the health system and staff absences throughout a pandemic.

During a pandemic, the Chief Executive, Public Service Commission may issue a directive outlining staff arrangements specific to the event, including leave applicable to public servants. The DG may apply the provisions of this directive to Queensland Health employees. This decision will be based on the clinical severity and transmissibility of the pathogen.

5.2.5 Health service capacity and provision

A pandemic presents a unique challenge to the health system in managing and maintaining workforce capacity for the ongoing delivery of essential health services. Queensland Health will identify and implement strategies for disease prevention and to manage demand for community health and hospital service provision in a pandemic, including the management of staff absenteeism. HHSs will be required to maintain or increase bed capacity through assessing planned care, modifying staffing ratios, and implementing new models of care. For roles that are not clinical and public-facing, work from home arrangements may be considered to decrease the risk of disease transmission, absenteeism and to provide accommodation for an incoming surge workforce.

The resource requirements and/or impacts of a pandemic may require business continuity plans to be activated in parallel with disaster and emergency plans. Queensland Health will have in place emergency preparedness and continuity management plans that incorporate aspects specific to a pandemic where required. This will primarily be to manage surges in staffing requirements to provide continuity of essential health services to the community, or to maintain critical business functions in cases of impact to facilities or systems.

Additionally, Queensland Health will maintain and enhance effective partnerships with primary care providers, including GPs, Primary Health Networks and Aboriginal and Torres Strait Islander community-controlled health organisations that will be critical to ensure access to preventative and clinical care in the community close to people's homes.

5.2.6 Priority populations

Prevention and preparedness activity must consider the specific response required for priority populations and the models of care which may support these cohorts. Factors that can influence the vulnerability of individuals and populations that may place them at higher risk of complications from infection with the pathogen include overall health status and clinical risk factors of individuals, families and communities. Broader factors such as socio-demographic, geographic, socio-economic and cultural determinants of health need to be considered in supporting priority populations. Priority populations will be identified as adequate epidemiological data becomes available but may include:

- First Nations peoples
- older Queenslanders and residents of aged-care homes
- people with pre-existing illnesses and/or conditions
- people from culturally and linguistically diverse backgrounds.
- pregnant women
- infants and young children
- children in out of home care
- people in correctional settings
- people with disability including people with disability living in congregate care settings
- homeless people and people at risk of homelessness.

A key pandemic preparedness activity is establishing pre-agreed arrangements that are acceptable and appropriate to the identified priority populations by developing and maintaining plans and guidelines in partnership with stakeholders across health services, expert advisory groups and networks, local elders, leaders and communities. Appendix 6.4 outlines specific considerations for priority populations and provides links to existing state and national resources.

5.3 Response

There are a range of response measures that could be considered in a pandemic under current legislative provisions or that may require legislative amendments to give effect. However, a key determinant will be the characteristics of the pathogen and its likely impact on the population. In all stages of a pandemic, measures that are implemented to protect the community should be justified based on risk and aim to minimise restriction and harm to the community.

This section includes likely response measures based on previous large-scale outbreaks and pandemics, but there may be other measures not described here that warrant consideration based on the characteristics of the pathogen of pandemic potential.

Response measures, particularly public health, social and border measures may impact the mental health of individuals and communities. The risk to mental health must be considered when determining response measures and appropriate mitigation strategies implemented and continued through the recovery phase.

5.3.1 Public health measures

Case and contact management

Queensland Health maintains, reviews and updates a repository of state and national guidelines and other resources for notifiable and other communicable conditions.[24] The guidelines provide consistent statewide advice and guidance to HHSs, including public health management guidelines for case and contact management. Where a novel pathogen is identified, guidance will be modified and/or developed through the CDNA and specifically through the Queensland incident assessment and response plan including identifying the responsibilities and accountabilities of agencies.

When little is known about the impact of a novel pathogen, measures to reduce transmission may include isolation of cases and, depending on the likely health impacts, quarantine of their contacts. As enhanced surveillance information becomes available to inform decision-making, management of cases and contacts may be modified according to the epidemiology of the disease, effectiveness of interventions, vulnerability of the community, acceptability of the public health and social measures by the community and the capacity of the health system.

Within the HHSs, hospital/facility staff are responsible for appropriately isolating cases within the healthcare setting. Pre-hospital transport arrangements for suspected or confirmed cases must be conducted according to Queensland Health guidelines and in collaboration with the QAS where required. The PHU is responsible for the appropriate isolation of cases and quarantining of contacts within the community. Responsibilities may include cross-agency liaison via local arrangements to ensure support for people going into home restriction, including access to accommodation and welfare support providers.

Early identification of new cases and persons potentially exposed to a confirmed case is critical to enable rapid public health measures to be implemented. The intensity of contact tracing and public health measures should reflect the goal to either eliminate the pathogen or to control outbreaks and limit the spread. Ultimately, effective contact tracing can provide valuable time for governments to develop and rollout vaccinations or treatments before the disease becomes widespread or is controlled.

The case and contact definitions for the purposes of contact tracing, provision of prophylaxis and management will be outlined in the interim or specific *CDNA National Guidelines for Public Health Units* unless alternate advice is issued at the time of the pandemic.[25]

Where contact tracing is a recommended public health response, the demand for contact tracing officers (CTOs) may rapidly exceed capacity. If an escalated contact tracing response is required, the department is responsible for having a system in place to rapidly train and appoint CTOs under the *Public Health Act 2005*. It is noted that in addition to enhanced HHS models, central-based models for contact tracing may also be required if numbers are too great to be managed at an individual HHS level.

5.3.2 Social measures

Social measures are an individual and community-level intervention to prevent transmission and slow the spread of an infectious disease throughout the population. The decision to implement social measures may be made externally to Queensland Health and may be in response to managing an outbreak in a specific setting.

Social measures include mask wearing, hygiene measures (e.g. handwashing) and reducing normal physical and social population mixing (e.g. workplace and school closures, cancellation of mass gatherings). Implementing social measures is determined by factors including transmissibility of the pathogen and availability of immunisation medicines. Appropriate communication with the community and priority populations is critical for effectiveness of these measures.

5.3.3 Border measures

The Australian Government will decide whether to implement international border measures to minimise transmission of a pathogen of pandemic potential into the Australian community. The Australian Government has the responsibility for implementing measures including pandemic-specific communication for passengers and staff on inbound and outbound flights and ships. This communication may provide travel advice regarding high-risk locations and raise awareness of symptoms and public health and social measures.

In the event the Australian Government advises entry/exit screening is required, HHSs may be required to deploy staff to any international or domestic borders, including international airports and seaports and collaborate with other HHSs and agencies via SHECC to manage border control within workforce capacity. Furthermore, strategies for the management of state and territory land borders may need to be coordinated via SHECC across HHSs.

Regular biosecurity functions at point of entry will continue to occur, including flagging of travellers with illness and reporting to Human Biosecurity Officers for assessment, treatment and quarantine if necessary.

5.3.4 Pharmaceutical measures

During the initial response stage of a pandemic, public health and pharmaceutical measures, where available and effective, are the principal prevention and containment strategies pending the availability of a candidate or customised immunisation medicine. The Australian Government will prioritise assessment and approval of the customised pandemic immunisation medicine; procure immunisation medicines; develop a national pandemic immunisation policy and program; and communicate immunisation information on the program to the general public and health professionals.

Interventions involving antimicrobial agents and immunisation medicines can play a significant role in reducing morbidity and mortality. Pharmaceutical measures, depending on the evidence and emerging epidemiology, may include the following:

- Antimicrobials for treatment of cases
- Antimicrobials for post-exposure prophylaxis of contacts and/or at-risk groups
- Antimicrobials for pre-exposure prophylaxis of healthcare workers
- Candidate pandemic immunisation medicine (a vaccine or other immunisation medicine based on a strain of the pathogen considered to have pandemic potential)
- Customised pandemic immunisation medicine (a vaccine or other immunisation medicine based on the actual pandemic pathogen strain).

Antimicrobials

Antimicrobials are medications (including antibiotics, antivirals, and antifungals) that can be used for treatment of infected cases and sometimes for prophylaxis of priority populations. Implementation of the appropriate strategy for use of antimicrobials will depend on:

- antimicrobial susceptibility
- the stage of the pandemic
- the epidemiological characteristics of the pathogen
- antimicrobial supply and practicalities such as logistics of antimicrobial delivery.

During the initial action stage, little may be known about the clinical severity of the pathogen and the working assumption would be to prepare for a moderate to high morbidity and mortality scenario. As surveillance information becomes available, the antimicrobial strategy may be modified to manage the specific pandemic more effectively. For example, in a pandemic with high mortality and morbidity, preventing illness in as many individuals as possible is important to reduce transmission to others and maintain the health workforce. When severity is lower, protecting those at risk of severe outcomes becomes the focus.

Immunisation medicines

Immunisation is a key strategy to manage a pandemic. The aim of a mass immunisation program is to administer an immunisation medicine (such as a vaccine) to the target population in a short timeframe to prevent infection or reduce illness in individuals. The ability of a mass immunisation program to impact population transmission will depend on a multitude of factors including characteristics of the pathogen, the stage of the pandemic and the severity of disease and whether, for a novel pathogen, a customised immunisation medicine becomes available before widespread transmission has occurred.

Immunisation uptake should be enabled in priority populations, those that may transmit respiratory pathogens to priority populations, essential service workers (especially health care workers) and the community. Persons with either direct or indirect contact with potentially infected animals may be considered an at-risk group for transmission where a zoonotic pathogen demonstrates pandemic potential through sustained person-to-person transmission. Queensland Health will collaborate with the animal health sector to facilitate a One Health approach via the existing interdepartmental arrangements.

In the event of the availability of a candidate or customised immunisation medicine to a novel pathogen, the Australian Government will provide direction on mass immunisation to target populations dependent upon the epidemiology of the disease and highest risk factors. Specialist advice regarding novel vaccines will be provided by the Australian Technical Advisory Group on Immunisation with support from the National Centre for Immunisation Research and Surveillance.

Use of existing services within the community will be the primary method to provide immunisation. Community-based service providers may include GPs, pharmacists, local government, and First Nations health services. It is likely HHSs will be required to deliver mass immunisation of target groups within Queensland and it may be necessary to establish or support models of care which enable immunisation of priority populations. Data that needs to be collected on AIR includes immunisation medicine administration, and adverse events following immunisation. Immunisation records from the AIR could be linked to case data on NoCS to identify high-risk unvaccinated groups for targeted public health follow-up.

5.3.5 Infection prevention and control measures

IPC measures are detailed in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2024)[26] and the *CDNA National Guidelines for Public Health Units*. The Australian guidelines provide evidence-based recommendations for critical aspects of IPC practices in healthcare settings. State and local guidance on IPC in non-clinical settings will also be required for settings including, but not limited to, schools, correctional facilities, border screening areas, accommodation venues, transport vehicles and facilities laundering linen and clothes.

The appropriateness of IPC practices for a novel pathogen will be reviewed by the CDNA and advice provided to HHSs via the state PHEOC and SHECC. The department may also develop and provide guidance[27] and resources in consultation with expert advisory groups to assist HHSs with their IPC programs[28] and development of local IPC action plans.

IPC measures in a healthcare setting may include:

- eliminating source of infection, for example:
  - increased/modified cleaning measures
  - cleaning of a contaminated air conditioning system
  - use of telemedicine to eliminate exposure to potentially infectious patients
  - restricting entry of potentially infectious healthcare workers and visitors to a health service.
- preventing further transmission, for example:
  - effective hand hygiene to remove infectious material from hands
  - isolating or cohorting cases or contacts, including staff
  - screening and monitoring contacts
  - closure of beds or wards
  - reinforcing standard precautions and appropriate use of transmission-based precautions
  - alteration of indoor environments to increase ventilation or filter air
  - modifying internal and external patient transportation strategies.

Stock of personal protective equipment (PPE) and other supplies and equipment required to respond to emergencies may include:

- surgical masks; particulate filter respirators; protective eyewear/eye shields; gowns and gloves
- intensive care equipment and consumables
- specialised drugs and pharmaceuticals
- hand hygiene products and detergent disinfectant cleaning solutions
- medical gases
- critical pathology supplies.

5.4 Recovery

Recovery is not a linear or a staged process and activities will depend on the severity of the pandemic, the affect to communities, and the level of coordinated response required. There is a transition phase from response, but recovery planning and execution must commence in the preparedness stage and be applied across stages depending on need. For example, planning for the integration of new disease management into usual business including consideration for workforce, clinical practice and ongoing surveillance; and communicating with and supporting the community to resume daily life without enhanced public health and social measures. Mental health strategies implemented in the response phase should be continued and evaluated through the recovery phase.

A lessons management process, including debriefing and evaluation, of the pandemic stages should begin during the active response to ensure actions are effective, evidence-based, worthwhile, economical, ethical, and equitable. An evaluation process can assist with identifying low value high workload actions and changing processes to maximise the available workforce and impact on pandemic response and ensures that beneficial activities are sustained post-pandemic in a business-as-usual environment. Considerations for workforce needs post-pandemic in relation to fatigue, health and wellbeing and leave management must be integrated from preparedness and applied across the response. The outcomes of the recovery process are critical to aid future pandemic response.

6 Appendices

6.1 Incident assessment and response plan – communicable disease

Purpose

The incident assessment and response plan is an immediate planning exercise to facilitate logical decision -making processes with analysis of relevant incident factors specific to communicable disease risk and coordination of functions towards the development of the most appropriate course of action.

Short time periods and other imperatives will preclude a complete analysis of the incident. The incident assessment and response plan will guide decisiveness and enable rapid execution of response strategies and production of pathogen specific response plans, and/or supportive plans such as a pathogen specific interim surveillance plan.

Process

The incident assessment and response plan process steps are:

1. **Situation review** – awareness of the communicable disease incident through intelligence / information gathering and consideration of the total operating environment.
2. **Incident analysis, aim and objective setting** – development and documentation of clear and concise aim and objectives in alignment with the incident analysis.
3. **Response strategies** – development and/or identification of a range of response strategies that will focus and direct main efforts in alignment with incident objectives.
4. **Decision and execution** – planned issue of state-wide main or supporting plans, orders or direction.

Supporting documents

The assessment and response plan should be informed by current clinical evidence and guidelines including:

- *Queensland Health Incident Management System Guideline*
- Queensland Health communicable disease control guidelines
- CDNA *Series of National Guidelines* (SoNGs)
- State and national incident response plans

Incident assessment and response plan - communicable disease		
Date:	**Version:**	**Incident lead:**
Public health incident: ☐ No notice ☐ Minimal notice ☐ With notice ☐ After the fact		

1.0. Situation review

1.1 Pathogen/agent and host factors

• Describe the pathogen or agent.
• Characterise current understanding of the pathogen's ability to infect and cause disease considering:
  – infectivity, amount of pathogen required to establish an infection (infectious dose)
  – pathogenicity or virulence factors associated with severe disease
  – incubation and duration of infectious period
  – reported attack rates and case fatality rates
  – known disease complications.
• Consider rapid literature review where understanding of pathogen is limited.
• Identify susceptible/vulnerable populations.
• Describe current immunisation rates or active immunity levels if applicable.
• Seek epidemiological update.
• Outline knowledge gaps and limitations.	

1.2 Transmission

• Describe the mode of transmission of the pathogen or agent, considering the known chain of infection.
  – Direct – contact, droplet, aerosol/airborne, bite or environmental exposure.
  – Indirect – vector or inanimate object/fomite responsible for transmission of the infectious agent from reservoir or infected host to susceptible host.
• Vector characteristics.
• Potential for reservoir/carrier.
• Describe the impact of clinical disease on transmission, informing exposure period, incubation and period of communicability.
• Identify environmental factors contributing to emergence or transmission.	

1.3 Laboratory aspects

• Describe laboratory diagnosis of infection. • Does testing identify the pathogen or agent directly or is testing identifying suggested infection? • Identify key laboratories. • Describe specimen collection and handling requirements. • Is there a validated screening test for the condition?	

1.4 Applicable standards / existing control structures	
• Identify current resources to inform response, including: – Queensland Health Disaster Management Plans – Public Health Sub-plan – Applicable CDNA SoNGs – Queensland Health Communicable disease control guidelines – International guidelines • Highlight current legislative or other authority framework governing the situation and the limitations to current legislative provisions. • Identify limits to current knowledge/skills/authority and key resources for situation.	
1.5 Operational and logistical assessment	
• Identify essential staff for response. • Identify capability gaps – required capabilities that response staff do not have e.g. IT systems, training. • Identify and prepare response to specific operational actions e.g. access to National Medical Stockpile. • Define and prioritise critical business functions. • Consider when to activate or terminate Business Continuity Plans (BCPs). • Continually evaluate and identify low-value high-workload measures and adjust processes accordingly.	
1.6 Response context	
• Identify anticipated public concern and media interest considering community sensitivity, history of the condition, past management, or attitudes. • Describe anticipated service delivery impact and needs of the affected and priority populations. • Consider expectations and assumptions that must be made as a part of incident response planning but may disrupt the plan if they are not met. • Identified stakeholders who will be supporting the response.	

2.0. Incident analysis, aim and objective setting

Aim:

Objectives:

3.0. Response strategy	
3.1 Case management	
• Develop and record agreed case definition/s, noting epidemiological, clinical or and/or laboratory information. • Summarise case management including: – isolation/restriction – treatment/pharmaceutical measures – monitoring – applied IPC principles	
3.2 Contact tracing	
• Identify contact tracing strategy considering the following: – information provision and dissemination – required resources – IPC – chemoprophylaxis/immunisation (pre or post exposure or immunity) – restrictions or quarantine – enforcement – ongoing passive or active surveillance requirements.	
3.3 Source control / additional investigations	
• Describe additional source control or investigations to be undertaken such as environmental inspection of a premise. • Detail process for compliance monitoring and provision of external support. • Describe social measures including physical distancing strategies etc. to be considered • Detail implementation process for legislative requirements of response practices such as isolation and quarantine orders, releasing people from quarantine etc. • Provide support to organisations regarding risk management and local operations (e.g. airports, cruise terminals, hotels etc.).	
3.4 Public health messaging	
• Consider developing a communications strategy, including most effective route, target audience, plans to ensure technical accuracy and timeliness. • Prepare holding and reactive media statements. • Establish key preventative public health messages and identify spokesperson/people to lead these. • Ensure transparency of and evidence for decision-making.	

3.5 Surveillance strategy	
• Develop a human surveillance plan, considering routine or enhanced notifiable disease surveillance (passive or active surveillance) of cases and/or contacts. • Develop an animal and/or environmental surveillance plan where required e.g. mosquito, wastewater. • Conduct active surveillance/active case finding activities. • Identify the need for event-based surveillance. • Conduct planned surveillance data analysis. • Conduct surveillance in healthcare facilities and congregate settings. • Identify relevant databases in use e.g. NoCS and other IT resources required. • Disseminate surveillance information to key stakeholders as appropriate for awareness and action.	
3.6 Stakeholder engagement	
• Who are our stakeholders and how are we working with them? • Establish roles/capacity/legal authority/governance between response stakeholders internally or externally in anticipation of outputs. • Describe current communication links between local, state and national response (if applicable). • Identify Queensland Health membership in response meeting, i.e CDNA or EAG.	
3.7 Incident command	
☐ IMT convened Date: Public health incident level _____ ☐ BCPs activated and monitored ☐ *Public Health Sub plan* activated Response stage _____ ☐ Describe the national response status e.g. (CDPLAN in response, CDINS announced)	
4.0. Decision and execution	
• Establish ongoing situational review and adjustment to the incident action plan. • State plans to be produced, revised and implemented and/or intent identified to issue directives, orders, or instructions.	

6.2 Queensland Health roles and responsibilities

Queensland Health is the primary agency for a pandemic response, working in collaboration with other Queensland government departments at state and local levels. As the primary agency, Queensland Health has significant responsibility but is not responsible for all activity.

Relevant documents have been referenced across the sub-plan that outline responsibilities within the Queensland disaster and emergency management arrangements and framework. For roles and responsibilities of other state government agencies, refer to the interim QSDMP and the QHDISPLAN.

Function	Roles and responsibilities
Office of the Director-General	• The DG is responsible for appointing the SHC. • The Disaster Management Branch has custodianship of SHECC and leads statewide governance and planning for disaster and emergency incident management. • Assist IMTs to implement the sub-plan across the health system.
Population Health Division	• Lead Queensland Health strategic planning for pandemic preparedness and response. • The Chief Health Officer (CHO) provides high-level medical advice to the DG and the Minister for Health on issues including health policy and legislative matters associated with the health and safety of Queenslanders. • Support the CHO to provide strategic advice and guidance on a range of matters relevant to the health of Queenslanders and to discharge the statutory obligations of the role. • Ensure coordinated, accurate and timely advice is available to the CHO through partnerships and engagement across the department, HHSs and other government departments and agencies. • Inform clinical and public health decision-making at state and national level by analysing and reporting on statewide data (e.g. enhanced surveillance, clinical data, health service capacity, medical stockpile levels/consumable use, and vaccination numbers). • Provide timely public health intelligence (data and analytics) to inform appropriate prevention and control measures. • Develop and disseminate IPC, public health and clinical resources to the health care sector. • Consult with expert advisory groups including statewide clinical networks to provide expert strategic public health advice to inform preparedness and high-level decision-making during response. • Contribute to strategic planning for pandemic preparedness and response for state-wide services which may include mental health, alcohol and other drugs, innovative health service delivery and professional issues (medical, nursing, health practitioners, dental and allied health).

Function	Roles and responsibilities
Clinical Support Queensland	• Provide public health laboratory services including diagnostics and genomics. • Provide clinical support services to assist HHSs to deliver care during a pandemic e.g. pharmaceutical and equipment supply. • Manage PPE supplies within storage facilities and distribute to HHSs as required. • Distribute pandemic immunisation medicine/s and resources to the health sector as directed by the Australian Government.
Clinical Excellence Queensland	• Clinical Excellence Queensland incorporates the HCC, the Queensland Virtual Hospital (QVH) and the Mental Health and Other Drugs Branch (MHAODB) – HCC provides 24/7 multidisciplinary health assessment and information services to Queenslanders using phone and online delivery models. HCC can provide activation of health alert services, rapid response campaigns and contact tracing. – QVH provides system-level capability to identify virtual care models and opportunities to scale virtual care, building upon existing services and technical capability. – MHAODB supports the statewide development, delivery and enhancement of safe, quality, evidence-based clinical and non-clinical services in mental health.
Corporate Services Division	• Contribute to strategic planning for pandemic preparedness and response in the areas of strategic communications, law, human resources (including payroll and recruitment), contestability, strategic financial policy, health infrastructure and governance.
eHealth Queensland	• Contribute to strategic planning for pandemic preparedness and response for the maintenance of state-wide (enterprise) and local IT applications and systems—e.g. pathology database. • Maintain and ensure that IT applications and systems have high availability and resilience including AUSLAB/AUSCARE, Queensland Health Electronic Publishing Service, Queensland Health Enterprise Reporting Service, Clinical and Business Intelligence services, Picture Archive and Communication System, internet access and services, directories and PowerBI services, cyber security and IT support. • Develop new systems or solutions if needed and/or modifying/improving current systems.
Strategic Communications Branch	• Monitor mainstream and social media and develop and disseminate appropriate messages to counter misinformation and disinformation.
System, Policy, and Planning Division	• Contribute to strategic planning for pandemic preparedness and response in the areas of high-level business strategy and policy for Queensland Health, First Nations health, priority populations and state and Commonwealth funding.

Function	Roles and responsibilities
Queensland Ambulance Service	• Perform the role and responsibilities as identified in the interim QSDMP including: – to collaborate with HHSs to manage the interaction between the services provided by QAS and health services provided by HHSs – perform other functions given to the service under the *Ambulance Act 1991* or another Act; and to perform functions incidental to its other functions. • Prepare to and provide timely and quality ambulance services which meet the needs of the community. • Provide, operate, and maintain ambulance service delivery during disasters and other related activities. • Provide transport for persons requiring attention at medical or health care facilities. • Participate with other emergency services in counter disaster planning, including collaboration with HHSs and active membership of state, District and Local Disaster groups. • Coordinate all volunteer first aid groups during a disaster.
Hospital and Health Services: • Cairns and Hinterland • Central Queensland • Central West • Children's Health Queensland • Darling Downs • Gold Coast • Mackay • Metro North • Metro South • North West • South West • Sunshine Coast • Torres and Cape • Townsville • West Moreton • Wide Bay	• Conduct surveillance, case outbreak and contact identification and management, including contact tracing. • Assemble/consult with expert advisory groups as required. • Collect and provide data for state and national situational awareness and action e.g. enhanced surveillance, clinical data, human and material resource capacity. • Act as the lead agency on the Local and District Disaster Management Group. • Proactively liaise and collaborate with local government, non-government agencies, private hospitals and primary healthcare providers and as required. • Invoke powers under relevant legislation as directed by the SHC. • Develop and maintain business continuity plans. • Develop and maintain a plan for surge workforce capacity. • Develop and maintain response plans in collaboration with key stakeholders. • Ensure capacity within PHU; IPC and infectious diseases to provide expert advice and outbreak management within healthcare facilities and across the community. • Maintain PPE, antimicrobial and other pharmaceutical stock levels. • Assess need and maintain appropriate isolation bed and ward availability to treat and isolate cases. • Liaise with local government agencies regarding non-health needs of people in isolation or quarantine. • Implement pharmaceutical and public health measures including managing isolation and associated regulatory activities, where enacted. • Establish and maintain testing clinics and mass vaccination clinics within health care settings and in the community as required.

6.3 Legislative framework

Governing and related legislation[f]	
International	International Health Regulations 2005
Commonwealth (Cth)	*Biosecurity Act 2015*
	Therapeutic Goods Act 1989
State	*Disaster Management Act 2003*
	Hospital and Health Boards Act 2011
	Medicines and Poisons Act 2019
	Private Health Facilities Act 1999
	Public Health Act 2005
	Workplace Health and Safety Act 2011
Other relevant legislation	*Disability Services Act 2006* (Qld) *Human Rights Act 2019* (Qld) *Information Privacy Act* 2009 (Qld) *Mental Health Act 2016* (Qld) *National Health Security Act 2007* (Cth) *Privacy Act 1988* (Cth) *Public Records Act 2023* (Qld) *Public Safety Preservation Act 1986* (Qld) *State Transport Act 1938* (Qld)

[f] This table does not include subordinate legislation

6.4 Priority populations

First Nations people

First Nations people experience an increased risk of both severe diseases requiring hospitalisation and death when compared to non-First Nations people. The increased risk may be attributed to a higher prevalence of chronic disease, environmental and living conditions and access to health services. First Nations people are at risk of being disproportionately impacted by a pandemic pathogen if an outbreak were to occur in a community. However, the COVID-19 pandemic showed that with good preparedness, communication, First Nations leadership and enhancing the First Nations workforce, the increased risk can be managed to minimise hospitalisation and death. Shared decision making and self-determination at all stages of the pandemic are essential.

Culturally appropriate local planning, communication and activity is paramount, and it is recommended that Council Mayors, community members or delegates are involved with the appropriate local disaster management group and outbreak control teams to ensure community consultation and engagement. Collaboration with neighbouring communities should be considered due to potential mobility of the population.

The priority reforms of the *National Agreement on Closing the Gap 2020*[29] should underpin pandemic response to ensure Aboriginal and Torres Strait islander peoples are true partners. At all stages of planning, guidance on better working with First Nations communities is provided by the First Nations Health Office, Department of Health, including through resources developed for the COVID-19 pandemic.

Older Queenslanders and residents of aged-care homes

Older Queenslanders have an increased risk of becoming ill from diseases and being more vulnerable to serious complications. This includes those who are living in residential aged care, who have health conditions or who have a disability and need extra support. (NB. Sometimes older people may be less vulnerable and protected to a degree, for example with existing immunity to a re-emerging pathogen that circulated before younger people were born). Older people may also be more socially isolated and adversely affected by quarantine requirements and mandated lock downs, requiring greater welfare and social support. Those most at risk of becoming very unwell if they are infected include:

- people aged 65 years and over
- people with chronic medical conditions
- people with compromised immune systems
- Aboriginal and Torres Strait Islander people aged 50 years and over.

People with pre-existing illnesses and/or conditions

People with pre-existing illnesses and/or conditions—such as cardiovascular disease, diabetes, respiratory disorders, mental health conditions or weakened immune systems— may be at increased risk of severe disease and complications from a pathogen of pandemic potential.

These individuals often experience more rapid disease progression, longer recovery times, and higher rates of hospitalisation or death. In a pandemic, special considerations must be made to ensure they have timely access to medical care, medications, and clear public health information. Health systems must prioritise continuity of care, minimise exposure risks (e.g., through telehealth or home-based services), consider approaches to prevention measures and integrate these groups into vaccination, testing, and treatment strategies to reduce morbidity and protect healthcare capacity.

Culturally and linguistically diverse groups

People from culturally and linguistically diverse (CALD) backgrounds are a broad and diverse group of individuals with unique life experiences and healthcare needs. Not all people from CALD backgrounds will experience barriers to health-engagement. However, some communities may require targeted strategies to access health information and services, including vaccination.

Barriers that people from CALD backgrounds may experience include:

- Navigating the health system
- Language and literacy
- Social determinants and inequities
- Cultural practices and norms, including cultural understandings of health
- Visa and residency status, including access to Medicare.

Important considerations for a culturally appropriate pandemic response include:

- Online and telehealth tools for information and bookings that are accessible to people from CALD backgrounds.
- Access to information in the preferred language, via interpreters and translated information.
- Improving health literacy via culturally targeted engagement and information.

Empowering and partnering with community organisations and community leaders for ideas on how to better engage populations in a response.

Pregnant women and pregnant people

Pregnant women and pregnant people are at a high risk of severe consequences of ARIs like influenza, with the risk of complications increasing in the later stages of pregnancy. Hospital and community-based models for antenatal, perinatal and post-natal care should aim to mitigate the risk of maternal infection. Early identification and management of pregnant women, pregnant people and their close contacts in healthcare and household settings can mitigate the risk of both maternal and neonatal infection. When a pathogen is novel, there may be very limited evidence regarding the potential harms and severity to the developing foetus.

Antiviral therapy may be likely to be recommended for treatment and prophylaxis throughout pregnancy because of the high risk of severe influenza. Influenza vaccination is recommended for all pregnant women and pregnant people at any stage of pregnancy, particularly those who will be in the 2nd or 3rd trimester during the influenza season. Influenza vaccination during pregnancy can protect infants after birth.[30]

Infants and young children

Infants and young children are potentially more vulnerable, depending on what the pathogen is, due to their underdeveloped immune systems and relative lack of physiological reserve. They may also be too young to have been immunised or receive candidate and customised pandemic immunisation medicines. Protecting this vulnerable population will require communication with parents, caregivers and health services.

Children in out of home care

Children in out-of-home care (OOHC) aged 0-17 years, young people in transition from OOHC (16-21 years) or who have transitioned (up to 25 years), have poorer life outcomes, including health and mental health, than their peers who have not been in OOHC. For children on Child Protection Orders, the State of Queensland, through the Department of Families, Seniors, Disability Services and Child Safety (Child Safety), has specific legislative responsibilities for their care and protection of these children. Cooperation and planning with Child Safety is required to plan responses for children and young people in OOHC, their families and carers.

The over-representation of Aboriginal and Torres Strait Islander children in child protection may also need consideration for pandemic responses. Children may become vulnerable to involvement with statutory child protection systems if their parent or carer becomes incapacitated due to becoming sick. Consideration needs to be given to support parents/carers to put appropriate plans in place to ensure their children are cared for and avoid engagement with the statutory child protection system should they become ill.

People in correctional facilities

People in prison may have substantial and complex health needs, which are often chronic. People who spend time in prison experience higher rates of homelessness, unemployment, mental health disorders, chronic physical health conditions and communicable disease infection than the general population. People in prison are known to be more vulnerable to being exposed to infections due to the often overcrowded and close living conditions within prison settings.

Children and young people in youth detention centres may have similarly complex health needs to the adult prisoner population, experiencing higher rates of physical ill health (both communicable and non-communicable diseases) and mental ill health than the general population. The median length of time spent in a youth detention centre is around one month, in comparison to four months in adult prisons. This may require consideration when planning for the spread of disease when transitioning from a custodial setting to the community.

People with disability including people with disability living in congregate care settings

Some people with disability could have more serious complications following infection depending on the nature of their disability and other medical history, especially if they:

- have high support needs and cannot physically distance
- have pre-existing health conditions such as a respiratory condition, a compromised immune system, heart disease, or diabetes
- face challenges in accessing equitable healthcare services and healthcare information
- have a disruption to their regular medication and services
- are aged 70 years and over
- are a First Nations person aged 50 years and over
- are living in supported accommodation or group residential settings.

Where social measures may be implemented, people who are dependent on support persons (e.g. family, other carers or paid support workers) will be permitted to continue accessing necessary supports, including having a support person accompany them to access healthcare services.

Homeless people and people at risk of homelessness

Many people experiencing homelessness live in congregate living settings—be it formal (e.g. shelters or halfway houses) or informal (e.g. encampments or abandoned buildings)—and might not have regular access to basic hygiene supplies or showering facilities, all of which could facilitate disease transmission.

People experiencing homelessness aged younger than 65 years have all-cause mortality that is much higher than that of the general population. Infection might further increase this mortality disparity.

Many people experiencing homelessness have pre-existing mental and physical health conditions, engage in high rates of problematic substance use, are more transient and geographically mobile, and often have less access to health care and health information, all of which could lead to potential problems with screening, quarantining, and treating people during a pandemic, including immunisation.

People experiencing homelessness are not a homogeneous group and strategies targeting this cohort will need additional consideration for specific cohorts such as First Nations people, individuals from culturally and linguistically diverse backgrounds, young people and people with disability.

7 Abbreviations

AHMPPI	Australian Health Management Plan for Pandemic Influenza
AHPC	Australian Health Protection Committee
AIR	Australian Immunisation Register
ARI	Acute respiratory infections
BCP	Business Continuity Plan
CALD	Culturally and linguistically diverse
CCN	Crisis Communications Network
CDC	Centre for Disease Control
CDINS	Communicable Disease Incident of National Significance
CDNA	Communicable Diseases Network Australia
CD Plan	Emergency response plan for communicable disease incidents of national significance
CHO	Chief Health Officer
Cth	Commonwealth
CTO	Contact tracing officer
DG	Director-General
enHealth	Environmental Health Standing Committee
HCC	Health Contact Centre
HHB	Hospital and Health Board
HHS	Hospital and Health Service
IMT	Incident Management Team
IPC	Infection, Prevention and Control
MHAODB	Mental Health, Alcohol and Other Drugs Branch
MoU	Memorandum of Understanding
NCR	Notifiable Conditions Register
NHMRC	National Health and Medical Research Council
NMS	National Medical Stockpile
NoCS	Notifiable Conditions System
OOHC	Out of home care
PHEOC	Public Health Emergency Operations Centre

PHU	Public Health Unit
PIC	Public Information Capability
PRET	Preparedness and Resilience for Emerging Threats
PPE	Personal protective equipment
QAS	Queensland Ambulance Service
QHDISPLAN	Queensland Health Disaster and Emergency Incident Plan
QHIMS	Queensland Health Incident Management System
Qld	Queensland
QSDMP	Queensland State Disaster Management Plan
QVH	Queensland Virtual Hospital
SCB	Strategic Communications Branch
SDCC	State Disaster Coordination Centre
SHC	State Health Coordinator
SHECC	State Health Emergency Coordination Centre
SITREP	Situation Report
SOCC	State Operations Coordination Centre
SoNGs	Series of National Guidelines
WHO	World Health Organization

8 Glossary

Term	Definition
All hazards	Planning and responding to a wide range of potential threats, both natural and human-caused, using a common framework and principles, rather than having separate plans for each specific hazard.
Case	A person who meets the definition for a specified disease.
Communicable disease	An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal or inanimate source to a susceptible host; either directly or indirectly through an intermediate plant or animal host, through a vector or through contact with the inanimate environment.
Communicable disease incident of national significance	A communicable disease incident that requires implementation of national policy, interventions and public messaging, or deployment of Commonwealth or inter-jurisdictional resources to assist affected jurisdictions.[g]
Contact	A person who meets the definition for being exposed to a person that is a confirmed case.
Department of Health	Responsible for the overall management of the public health system in Queensland, including monitoring the performance of HHSs.
Epidemiology	The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.
Hospital and Health Services	Independent statutory bodies that are responsible for the delivery of health services in their local area in Queensland.
Isolation	A period of seclusion for a person that is a confirmed case until they meet the definition for not being infectious with the disease.
One Health approach	Recognises that the health of humans is closely linked and interdependent with the health of domestic and wild animals, as well as plants and the wider environment (including ecosystems), aiming for a sustainable balance, and uses an integrated multisectoral and transdisciplinary approach to pandemic prevention preparedness and response, which contributes to sustainable development in an equitable manner.[h]
Pathogen of pandemic potential	Bacteria, viruses and other microorganisms that are likely highly transmissible and capable of wide, uncontrollable spread in

[g] Emergency Response Plan for Communicable Disease Incidents of National Significance
[h] WHO Pandemic Agreement, 20 May 2025

Term	Definition
	human populations and highly virulent, making them likely to cause significant morbidity and/or mortality in humans.[i] [j]
Public health	The organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, for the population as a whole or population sub-groups.
Public health emergency	An event or a series of events that has contributed to, or may contribute to, serious adverse effects on the health of persons in Queensland.[k]
State Public Health Emergency Operations Centre	A department-led emergency operations centre activated to manage a level 3 public health incident, including a pandemic. When activated, the department's public health IMT operates within the state PHEOC and may activate independently to the SHECC. However, when the SHECC is activated, the state PHEOC reports into the SHECC.
Surveillance	In public health surveillance refers to the continuous, systematic collection, analysis and interpretation of health-related data.
Public health measures	Non-pharmaceutical interventions that aim to reduce the risk and scale of transmission of infectious diseases by reducing exposure and/or making them safer to protect the health and well-being of individuals and communities.
Public health unit	A health service that focuses on preventing disease, promoting and protecting health at a population level including by: • coordinating disease control initiatives, including response to and notification of disease outbreaks • undertaking a range of environmental health initiatives • providing specialist public health advice and • collaborating with stakeholders to plan and implement effective public health programs.
Quarantine	A period of seclusion for a person that may have been exposed to a disease that incorporates the timeframe for development of the disease.
Queensland Health	The Department of Health and 16 HHSs, governed by Hospital and Health Boards (HHBs). The relationship between the department and HHSs is governed by the *Hospital and Health Board Act* 2011 and service agreements.

[i] Research Involving Enhanced Potential Pandemic Pathogens | National Institutes of Health (NIH)
[j] Prioritization Pathogens | WHO
[k] *Public Health Act 2005* Chapter 8 Section 315

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