Australian Industry Group

Applications to vary the Health Sector Awards – Paid Pandemic Leave

Reply Submission
(AM2020/13)

18 June 2020

AM2020/13 APPLICATIONS TO VARY HEALTH SECTOR AWARDS – PAID PANDEMIC LEAVE

1. INTRODUCTION

1. The Australian Industry Group (**Ai Group**) files this submission in accordance with directions issued by the Fair Work Commission (**Commission**) on 13 May 2020.

2. The submission responds to material filed by the Australian Council of Trade Unions (**ACTU**) and various unions (collectively, **Applicants**) in support of applications (**Applications**) made to vary numerous awards to introduce new entitlements to paid pandemic leave (**Proposed Clauses**). Of the awards that are the subject of the Applications, Ai Group has a relevant interest in the following:

   (a) The *Aged Care Award 2010* (**Aged Care Award**);

   (b) The *Health Professionals and Support Services Award 2010* (**HPSS Award**);

   (c) The *Medical Practitioners Award 2020* (**MP Award**);

   (d) The *Nurses Award 2010* (**Nurses Award**); and

   (e) The *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHCDS Award**).

   (collectively, **Relevant Awards**).

3. Ai Group opposes the Applications.

4. In the submissions that follow, we deal with the key contentions advanced by the Applicants in support of the Applications and outline the bases for our opposition.

2. THE APPLICANTS' CASE

5. The Proposed Clauses sought by the Applicants are in the following terms:

X.2.1 Paid pandemic leave

(a) Subject to X.2.1(b), (c) and (d), any employee is entitled to take up to 2 weeks' leave on each occasion the employee is:

(i) required by government or medical authorities to self isolate;

(ii) required by their employer to self isolate;

(iii) required on the advice of a medical practitioner to self isolate;

(iv) awaiting the results of a COVID-19 test; or

(v) is prevented from working by measures taken by government or medical authorities in response to the COVID-19 pandemic.

And [sic] is entitled to a paid day of leave on each occasion the employee is tested for COVID-19, save where such test is performed at the employee's usual workplace and counted as working time.

(b) Except where X.2.1(a)(ii) applies, the employee must give their employer notice of the taking of leave under clause X.2.1(a) and of the reason the employee requires the leave, as soon as practicable (which may be after the leave has started).

(c) Except where X.2.1(a)(ii) applies, an employee who has given their employer notice of taking leave under clause X.2.1(a) must, if required by the employer, give the employer evidence that would satisfy a reasonable person that the leave is taken for a reason given in clause X.2.1(a).

(d) A period of leave under clause X.2.1(a) must start before 28 September 2020, but may end after that date.

(e) Leave taken under clause X.2.1(a) does not affect any other paid or unpaid leave entitlement of the employee and counts as service for the purposes of entitlements under this award and the NES.

(f) For an employee other than a casual, leave taken under clause X.2.1(a) shall be paid at the employee's base rate of pay for the employee's ordinary hours of work in the period of leave.

(g) For a casual employee, pay for leave taken under clause X.2.1(a) shall be calculated on the average weekly pay received by the employee in the previous 6 months, or where the employee has been employed for the last 6 months, for the duration of their employment.

X.2.3 Special leave where an employee contracts COVID-19

(a) If an employee is diagnosed with COVID-19, the employee must inform their employer of that diagnosis.

(b) Upon being informed of an employee's diagnosis with COVID-19, the employer must allow the worker to be absent from work, and not perform work, without loss of pay, until the employee has had medical clearance to return to work.

(c) For a casual employee, pay for leave taken under clause X.2.3(b) shall be calculated on the average weekly pay received by the employee in the previous 6 months, or where the employee has be [sic] employed for less than 6 months, for the duration of their employment.

(d) An employee shall not be required by an employer to take personal leave because of a COVID-19 diagnosis prior to exhausting their entitlement to special leave under this clause.

6. We note that the Applications in respect of the Aged Care Award and the SCHCDS Award contain additional provisions at X.2.1(g) and X.2.3(d) that provide a mechanism for calculating the amount payable to a part-time employee. In each case, the clause reads as follows:

(x) For a part-time employee, pay will be for either:

(i) their agreed ordinary hours of work under [insert clause number]; or

(ii) the average of their weekly ordinary hours of work for the previous twelve months; whichever is greater.

7. The Proposed Clauses would replace the recently introduced unpaid pandemic leave provisions in the Relevant Awards.

8. The Applicants' case is advanced by reference to the following primary contentions:

(a) Employees covered by the Relevant Awards are at increased risk of transmission of COVID-19 vis-à-vis other employees;

(b) Employees covered by the Relevant Awards face a higher economic risk vis-à-vis other employees;

(c) The Proposed Clauses allocate the economic risk more fairly between an employer and employee;

(d) Employees covered by the Relevant Awards are performing 'essential' work that has been permitted to continue despite social distancing requirements and restrictions imposed on certain businesses;

(e) The grant of the Applications will render it less likely that employees covered by the Relevant Awards will violate self isolation requirements; and

(f) The Proposed Variations will contribute to the resilience of the workforce and ensure the maintenance of a functioning health and care sector.

3. AI GROUP'S CASE

9. Ai Group opposes the Applications for numerous reasons, as set out in our submissions. Without demurring from the detail of what is later advanced, our key contentions can be distilled as follows.

10. *First*, the Proposed Clauses are unfair to employers in numerous respects. For instance:

    (a) The Proposed Clauses would entitle employees to an additional form of paid leave in a broad range of circumstances, many of which may not be characterised by any connection to the employee's employment or the purportedly higher risk faced by employees covered by the Relevant Awards.

    (b) The Proposed Clauses entitle casual employees to paid leave in circumstances where the employee might not have been required to work during the period of leave in any event.

11. *Second*, the Applicants' assertion that employees covered by the Relevant Awards are at an elevated risk of contracting COVID-19 is not made out and cannot be sustained. This proposition sits at the very core of the Applications. Importantly:

    (a) There is no evidence about the nature of work performed by various classes or classifications of employees covered by the Relevant Awards. The Commission cannot reach the conclusion sought by the Applicants about such employees or awards.

    (b) The proposition that all employees covered by the Relevant Awards are at an elevated risk defies logic in any event. There are various obvious examples of employees whose working arrangements would not appear to place them at such risk. Some work performed under the Relevant Awards can and is being performed remotely, without face-to-face contact with potentially infected clients / patients or potentially infectious workplaces.

(c) Employers and employees are required by work health and safety legislation, public health orders and public health directions to take various steps to minimise the risk to employees at the workplace. There is no evidence of systematic non-compliance or deficiencies in the requirements mandated by those schemes to protect employees covered by the Relevant Awards from COVID-19. Any such issues are more appropriately dealt with through health and safety systems in any event.

(d) The general rate of infection in Australia, the extent to which persons with COVID-19 have been admitted to hospitals or receiving residential or home aged care services is low and has fallen in recent times. There is no evidence of any expert expectation of this trend being reversed.

12. *Third*, it is not appropriate or *necessary* in the relevant sense for an award to contain clauses that are designed to induce employees to conduct themselves lawfully or responsibly. That is not the role of the minimum safety net. The proposition that the Proposed Clauses are necessary to ensure that employees do not breach requirements to self-isolate should not be accepted.

13. *Fourth,* the proposition that the Proposed Clauses would more fairly allocate the economic risk of employees being required to self-isolate or absent themselves from work should not be accepted. Many employers have experienced significant hardship as a result of COVID-19 and have needed to devote significant resources to manage their operations and workforce in a manner that is different to the ordinary course, including for the purposes of protecting the health and safety of its employees and other persons.

14. *Fifth*, the Proposed Clauses would have an adverse impact on business. They would increase employment costs and the regulatory burden. They will not, as asserted by the Applicants, have the effect of ensuring that businesses are able to continue operating.

15. *Sixth*, the Proposed Clauses are not *necessary* to ensure that the Relevant Awards achieve the modern awards objective, nor are the variations proposed by the Applicants.

4. THE STATUTORY FRAMEWORK

16. The Applications are made pursuant to s157 of the *Fair Work Act 2009* (**Act**).

17. Section 157 of the Act empowers the Commission to make a determination varying an award if it is satisfied that making the determination is necessary to achieve the modern awards objective.

18. The power afforded by s.157 of the Act is enlivened only if the Commission is satisfied that the making of the determination is *necessary* to achieve the modern awards objective, as defined by s.134(1) of the Act.

19. In *Shop, Distributive and Allied Employees Association v National Retail Association (No.2)*[1] (***SDA v NRA***) Tracey J considered the proper construction of s.157(1) of the Act. His Honour said: (our emphasis)

> 35. The statutory foundation for the exercise of FWA's power to vary modern awards is to be found in s 157(1) of the Act. The power is discretionary in nature. Its exercise is conditioned upon FWA being satisfied that the variation is "necessary" in order "to achieve the modern awards objective." That objective is very broadly expressed: FWA must "provide a fair and relevant minimum safety net of terms and conditions" which govern employment in various industries. In determining appropriate terms and conditions regard must be had to matters such as the promotion of social inclusion through increased workforce participation and the need to promote flexible working practices.
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> 36. The sub-section also introduced a temporal requirement. FWA must be satisfied that it is necessary to vary the award at a time falling between the prescribed periodic reviews.
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> …
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> 46. In reaching my conclusion on this ground I have not overlooked the SDA's subsidiary contention that a distinction must be drawn between that which is necessary and that which is desirable. <u>That which is necessary must be done. That which is desirable does not carry the same imperative for action.</u> Whilst this distinction may be accepted it must also be acknowledged that reasonable minds may differ as to whether particular action is necessary or merely desirable. It was open to the Vice President to form the opinion that a variation was necessary.[2]

[1] *Shop, Distributive and Allied Employees Associates v National Retail Association (No.2)* [2012] FCA 480.

[2] *Shop, Distributive and Allied Employees Associates v National Retail Association (No.2)* [2012] FCA 480 at [35] – [36] and [46].

20. The modern awards objective is contained in s.134(1) of the Act:

> (1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:
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> (a) relative living standards and the needs of the low paid; and
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> (b) the need to encourage collective bargaining; and
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> (c) the need to promote social inclusion through increased workforce participation; and
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> (d) the need to promote flexible modern work practices and the efficient and productive performance of work; and
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> (da) the need to provide additional remuneration for:
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> (i) employees working overtime; or
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> (ii) employees working unsocial, irregular or unpredictable hours; or
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> (iii) employees working on weekends or public holidays; or
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> (iv) employees working shifts; and
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> (e) the principle of equal remuneration for work of equal or comparable value; and
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> (f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and
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> (g) the need to ensure a simple, easy to understand, stable and sustainable modern awards system for Australia that avoids unnecessary overlap of modern awards; and
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> (h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.
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> This is the ***modern awards objective.***

21. The modern awards objective applies to the performance or exercise of the Commission's functions of powers under Part 2-3 of the Act.[3] This includes the Commission's powers to vary an award pursuant to s.157 of the Act.

[3] Section 134(2)(a) of the Act.

22. In its decision[4] concerning a number of claims to reduce penalty rates in a range of modern awards (***Penalty Rates Decision***), the Commission said as follows about s.134(1) of the Act: (footnotes removed)

> **[115]** The modern awards objective is to 'ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions', taking into account the particular considerations identified in sections 134(1)(a) to (h) (the s.134 considerations). The objective is very broadly expressed. The obligation to take into account the s.134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision making process. No particular primacy is attached to any of the s.134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award.
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> **[116]** While the Commission must take into account the s.134 considerations, the relevant question is whether the modern award, together with the NES, provides a fair and relevant minimum safety net of terms and conditions. As to the proper construction of the expression 'a fair and relevant minimum safety net of terms and conditions' we would make three observations.
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> **[117]** First, fairness in this context is to be assessed from the perspective of the employees and employers covered by the modern award in question. So much is clear from the s.134 considerations, a number of which focus on the perspective of the employees (e.g. s.134(1)(a) and (da)) and others on the interests of the employers (e.g. s.134(1)(d) and (f)). Such a construction is also consistent with authority. In *Shop Distributive and Allied Employees Association v $2 and Under (No. 2)* Giudice J considered the meaning of the expression 'a safety net of fair minimum wages and conditions of employment' in s.88B(2) of the *Workplace Relations Act 1996* (Cth) (the WR Act). …
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> …
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> **[120]** Second, the word 'relevant' is defined in the Macquarie Dictionary (6th Edition) to mean 'bearing upon or connected with the matter in hand; to the purpose; pertinent'. In the context of s.134(1) we think the word 'relevant' is intended to convey that a modern award should be suited to contemporary circumstances. As stated in the Explanatory Memorandum to what is now s.138:
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> > '527 … the scope and effect of permitted and mandatory terms of a modern award must be directed at achieving the modern awards objective of a fair and relevant safety net *that accords with community standards and expectations*.' (emphasis added)
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> **[121]** Finally, as to the expression 'minimum safety net of terms and conditions', the conception of awards as 'safety net' instruments was introduced by the *Industrial Relations Reform Act 1993* (Cth) (the 1993 Reform Act). The *August 1994 Review of Wage Fixing Principles decision* summarised the changes made to the legislative framework by the 1993 Reform Act. In particular, the Commission noted that:

[4] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001.

'The Act now clearly distinguishes between the arbitrated award safety net and the bargaining stream. It intends that the actual wages and conditions of employment of employees will be increasingly determined through bargaining at the workplace or enterprise.

Under the Act the Commission, while having proper regard to the interests of the parties and the wider community, is now required to ensure, so far as possible, that the award system provides for 'secure, relevant and consistent wages and conditions of employment' (s 90AA(2)) so that it is an effective safety net 'underpinning direct bargaining' (s 88A(b)).'

…

[125] The objects of the FW Act are set out in s.3 (see [108]), relevantly s.3(b) speaks of:

'ensuring a guaranteed safety net of fair, relevant and enforceable minimum terms and conditions through the National Employment Standards, modern awards and minimum wage orders.'

[126] It is apparent from the scheme of the FW Act that modern awards and the NES 'underpin' enterprise agreements, through the operation of s.55 and the 'better off overall test' (s.186(2)(d) and s.193). Under s.57 a modern award does not apply to the extent that an enterprise agreement applies to a particular employment relationship, even where the award deals with matters not covered in the agreement.[5]

23. It then went on to consider the various considerations listed at s.134(1): (footnotes removed)

[162] In order for the Commission to be satisfied that a modern award is *not* achieving the modern awards objective it is not necessary to make a finding that the award fails to satisfy one or more of the s.134 considerations. Generally speaking, the s.134 considerations do not set a particular standard against which a modern award can be evaluated; many of them may be characterised as broad social objectives. As the Full Court of the Federal Court said in *National Retail Association v Fair Work Commission*:

> 'It is apparent from the terms of s.134(1) that the factors listed in (a)–(h) are broad considerations which the FWC must take into account in considering whether a modern award meets the objective set by s.134(1), that is to say, whether it provides a fair and relevant minimum safety net of terms and conditions. The listed factors do not, in themselves, however, pose any questions or set any standard against which a modern award could be evaluated. Many of them are broad social objectives. What, for example, was the finding called for in relation to the first factor ("relative living standards and the needs of the low paid")? Furthermore, it was common ground that some of the factors were inapplicable to the SDA's claim.'

[163] There is a degree of tension between some of the s.134 considerations. The Commission's task is to balance the various considerations and ensure that modern awards provide a fair and relevant minimum safety net of terms and conditions. This balancing exercise and the diverse circumstances pertaining to particular modern

[5] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [115] – [126].

awards may result in different outcomes in different modern awards. As the Full Bench observed in the *Preliminary Jurisdictional Issues decision*:

'The need to balance the competing considerations in s.134(1) and the diversity in the characteristics of the employers and employees covered by different modern awards means that the application of the modern awards objective may result in different outcomes between different modern awards.

Given the broadly expressed nature of the modern awards objective and the range of considerations which the Commission must take into account there may be *no one set* of provisions in a particular award which can be said to provide a fair and relevant safety net of terms and conditions. Different combinations or permutations of provisions may meet the modern awards objective.'

…

[165] Section 134(1)(a) requires that we take into account 'relative living standards and the needs of the low paid'. This consideration incorporates two related, but different, concepts. As explained in the *2012–13 Annual Wage Review* decision:

> 'The former, relative living standards, requires a comparison of the living standards of award-reliant workers with those of other groups that are deemed to be relevant. The latter, the needs of the low paid, requires an examination of the extent to which low-paid workers are able to purchase the essentials for a "decent standard of living" and to engage in community life. The assessment of what constitutes a decent standard of living is in turn influenced by contemporary norms.'

[166] In successive Annual Wage Reviews the Expert Panel has concluded that a threshold of two-thirds of median full-time wages provides 'a suitable and operational benchmark for identifying who is low paid', within the meaning of s.134(1)(a). There is, however, no single accepted measure of two-thirds of median (adult) ordinary time earnings. The surveys that provide the information about the distribution of earnings from which a median is derived vary in their sources, coverage and definitions in ways that affect the absolute values of average and median wages (and, accordingly, what constitutes two-thirds of those values). The two main Australian Bureau of Statistics (ABS) surveys of the distribution of earnings are the '*Employee Earnings, Benefits and Trade Unions Membership* (the 'EEBTUM') and the survey of *Employee Earnings and Hours* (the 'EEH'). We note that the EEBTUM is no longer published and the relevant data is now produced as part of the *Characteristics of Employment Survey* (the 'CoE'). Some data is also available from the HILDA survey.

[167] In the *2015–16 Annual Wage Review* decision the Expert Panel noted that the submissions provided different estimates of the 'two-thirds of median (adult) ordinary time earnings' threshold. The relevant extract from that decision, and the Expert Panel's conclusion, are set out below:

> 'In its submission, the Australian Government provided two estimates to identify low-paid workers:
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> - $18.67 per hour (or about $710.00 per week over a 38-hour week), using the May 2014 EEH data; and
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> - $18.42 per hour (or about $700.00 per week over a 38-hour week) using the 2014 HILDA survey data.

> The Australian Government contended that there were about 1.3 million low-paid employees in 2014 (or 13.3 per cent of all employees), with around one-third of award-reliant workers being low paid in the EEH data. Their analysis took explicit account of the number and the level of pay of junior workers.
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> The ACTU used unpublished ABS EEH data on the distribution of award only workers by hourly earnings to estimate the number of employees at each award classification level. On the basis of the May 2014 data, the ACTU estimated that 43 per cent of award only employees had hourly earnings at or below the C10 rate of pay in May 2014 ($724.50).
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> Research Report 6/2013 found that around 75 per cent of adult award-reliant employees in the non-public sector were earning below the C10 rate of $18.60 per hour.
>
> Whilst no specific conclusion is available, the information as a whole suggests that a sizeable proportion—probably a majority—of employees who are award reliant are also low paid by reference to the two-thirds of median weekly earnings benchmark.' (footnotes omitted)

[168] The most recent data for the 'low paid' threshold is set out below:

Two-thirds of median full-time earnings	*$/week*
Characteristics of Employment survey (Aug. 2015)	818.67
Employee Earnings and Hours survey (May 2016)	917.33

[169] The assessment of relative living standards focuses on the comparison between award-reliant workers and other employed workers, especially non-managerial workers. As noted in the 2015–16 Annual Wage Review decision:

> 'There is no doubt that the low paid and award reliant have fallen behind wage earners and employee households generally over the past two decades, whether on the basis of wage income or household income.'

[170] Award reliance is a measure of the proportion of employees whose pay rate is set according to the relevant award rate specified for the classification of the employee and not above that rate. Table 4.8 from the *2015–16 Annual Wage Review* decision sets out the extent of award reliance by industry. Relevantly for present purposes, the most recent data identify the Accommodation and food services and Retail trade industries as among the most award reliant in that they are the industries in which the highest proportion of employees are award reliant (42.7 per cent and 34.5 per cent, respectively).

[171] The relative living standard of employees is affected by the level of wages they earn, the hours they work, tax-transfer payments and the circumstances of the households in which they live. As a general proposition, around two-thirds of low-paid employees are found in low income households (i.e. in the bottom half of the distribution of employee households) and have lower living standards than other employees. Many low-paid employees live in households with low or very low disposable incomes.

[172] In taking into account 'relative living standards' in the context of Annual Wage Reviews, the Expert Panel has paid particular attention to changes in the earnings of all award-reliant employees compared to changes in measures of average and median earnings more generally.

[173] In the *2015–16 Annual Wage Review* decision the Expert Panel also observed that increases in modern award minimum wages have a *positive* impact on the relative living standards of the low paid and on their capacity to meet their needs. It seems to us that the converse also applies, that is, the variation of a modern award which has the effect of reducing the earnings of low-paid employees will have a *negative* impact on their relative living standards and on their capacity to meet their needs.

[174] Section 134(1)(b) requires that we take into account 'the need to encourage collective bargaining'.

…

[178] It seems to us that the observations made by the Expert Panel in the context of Annual Wage Reviews are also apposite to the present context. A reduction in penalty rates is likely to increase the incentive for employees to bargain, but may also create a disincentive for employers to bargain. It is also likely that employee and employer decision-making about whether or not to bargain is influenced by a complex mix of factors, not just the level of penalty rates in the relevant modern award.

[179] Section 134(1)(c) requires that we take into account 'the need to promote social inclusion through increased workforce participation'. The use of the conjunctive 'through' makes it clear that in the context of s.134(1)(c), social inclusion is a concept to be promoted exclusively '*through* increased workforce participation', that is obtaining employment is the focus of s.134(1)(c).

[180] However, we also accept that the level of penalty rates in a modern award may impact upon an employee's remuneration and hence their capacity to engage in community life and the extent of their social participation. The broader notion of promoting social inclusion is a matter that can be appropriately taken into account in our consideration of the legislative requirement to 'provide a fair and relevant minimum safety net of terms and conditions' and to take into account 'the needs of the low paid' (s.134(1)(a)). Further, one of the objects of the FW Act is to promote 'social inclusion for all Australians by' (among other things) 'ensuring a guaranteed safety net of fair, relevant and enforceable minimum terms and conditions through … modern awards and national minimum wage orders' (s.3(b)).

[181] The likely impact of any exercise of modern award powers on 'employment growth' is also one of the considerations we are required to take into account, by s.134(1)(h). It is these considerations (i.e. ss.134(1)(c) and (h)) which have led us to assess the likely impact of any proposed change to penalty rates on employment growth, that is the creation of new jobs or an increase in hours worked.

[182] Section 134(1)(d) requires that we take into account 'the need to promote flexible modern work practices and the efficient and productive performance of work'.

[183] We deal further with this consideration later in our decision when addressing the review of the particular modern awards before us.

[184] Section 134(1)(da) requires that we take into account the 'need to provide additional remuneration' for:

> '(i) employees working overtime; or
> (ii) employees working unsocial, irregular or unpredictable hours; or
> (iii) employees working on weekends or public holidays; or
> (iv) employees working shifts.'

…

[188] Five observations may be made about s.134(1)(da).

[189] First, s.134(1)(da) speaks of the 'need to provide additional remuneration' for employees performing work in the circumstances mentioned in s.134(1)(da)(i), (ii), (iii) and (iv).

[190] An assessment of 'the need to provide additional remuneration' to employees working in the circumstances identified in paragraphs 134(1)(da)(i) to (iv) requires a consideration of a range of matters, including:

> (i) the impact of working at such times or on such days on the employees concerned (i.e. the extent of the disutility);
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> (ii) the terms of the relevant modern award, in particular whether it already compensates employees for working at such times or on such days (e.g. through 'loaded' minimum rates or the payment of an industry allowance which is intended to compensate employees for the requirement to work at such times or on such days); and
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> (iii) the extent to which working at such times or on such days is a feature of the industry regulated by the particular modern award.

[191] Assessing the extent of the disutility of working at such times or on such days (issue (i) above) includes an assessment of the impact of such work on employee health and work-life balance, taking into account the preferences of the employees for working at those times.

[192] The expression 'additional remuneration' in the context of s.134(1)(da) means remuneration in addition to what employees would receive for working what are normally characterised as 'ordinary hours', that is reasonably predictable hours worked Monday to Friday within the 'spread of hours' prescribed in the relevant modern award. Such 'additional remuneration' could be provided by means of a penalty rate or loading paid in respect of, for example, work performed on weekends or public holidays. Alternatively, additional remuneration could be provided by other means such as a 'loaded hourly rate'.

[193] As mentioned, s.134(1)(da) speaks of the 'need' to provide additional remuneration. We note that the minority in *Re Restaurant and Catering Association of Victoria* (the *Restaurants 2014 Penalty Rates decision*) made the following observation about s.134(1)(da):

> 'This factor must be considered against the profile of the restaurant industry workforce and the other circumstances of the industry. It is relevant to note that the peak trading time for the restaurant industry is weekends and that employees in the industry frequently work in this industry because they have other educational or family commitments. These circumstances distinguish industries and employees who expect to operate and work principally on a 9am-5pm Monday to Friday basis. Nevertheless the objective requires additional remuneration for working on weekends. As the current provisions do so, they meet this element of the objective.' (emphasis added)

[194] To the extent that the above passage suggests that s.134(1)(da) '*requires* additional remuneration for working on weekends', we respectfully disagree. We acknowledge that the provision speaks of 'the *need* for additional remuneration' and that such language suggests that additional remuneration is required for employees working in the circumstances identified in paragraphs 134(1)(da)(i) to (iv). But the expression 'the need for additional remuneration' must be construed in context, and the context tells against the proposition that s.134(1)(da) *requires* additional remuneration be provided for working in the identified circumstances.

[195] Section s.134(1)(da) is a relevant consideration, it is *not* a statutory directive that additional remuneration must be paid to employees working in the circumstances mentioned in paragraphs 134(1)(da)(i), (ii), (iii) or (iv). Section 134(1)(da) is a consideration which we are required to take into account. To take a matter into account means that the matter is a 'relevant consideration' in the *Peko-Wallsend* sense of matters which the decision maker is bound to take into account. As Wilcox J said in *Nestle Australia Ltd v Federal Commissioner of Taxation*:

> 'To take a matter into account means to evaluate it and give it due weight, having regard to all other relevant factors. A matter is not taken into account by being noticed and erroneously disregarded as irrelevant'.

[196] Importantly, the requirement to take a matter into account does not mean that the matter is necessarily a determinative consideration. This is particularly so in the context of s.134 because s.134(1)(da) is one of a number of considerations which we are required to take into account. No particular primacy is attached to any of the s.134 considerations. The Commission's task is to take into account the various considerations and ensure that the modern award provides a 'fair and relevant minimum safety net'.

[197] A further contextual consideration is that 'overtime rates' and 'penalty rates' (including penalty rates for employees working on weekends or public holidays) are terms that *may* be included in a modern award (s.139(1)(d) and (e)); they are not terms that *must* be included in a modern award. As the Full Bench observed in the *4 yearly review of modern awards – Common issue – Award Flexibility* decision:

> '… s.134(1)(da) does not amount to a statutory directive that modern awards must provide additional remuneration for employees working overtime and may be distinguished from the terms in Subdivision C of Division 3 of Part 2-3 which *must* be included in modern awards…'

[198] Further, if s.134(1)(da) was construed such as to *require* additional remuneration for employees working, for example, on weekends, it would have significant consequences for the modern award system, given that about half of all modern awards currently make no provision for weekend penalty rates. If the legislative intention had been to mandate weekend penalty rates in all modern awards then one would have

expected that some reference to the consequences of such a provision would have been made in the extrinsic materials.

[199] Third, s.134(da) does not prescribe or mandate a fixed relationship between the remuneration of those employees who, for example, work on weekends or public holidays, and those who do not. The additional remuneration paid to the employees whose working arrangements fall within the scope of the descriptors in s.134(1)(da)(i)–(v) will depend on, among other things, the circumstances and context pertaining to work under the particular modern award.

[200] Fourth, s.134(1)(da)(ii) is not to be read as a composite expression, rather the use of the disjunctive 'or' makes it clear that the provision is dealing with separate circumstances: 'unsocial, irregular or unpredictable hours' (emphasis added).

[201] Section 134(1)(da)(ii) requires that we take into account the need to provide additional remuneration for employees working in each of these circumstances. The expression 'unsocial … hours' would include working late at night and or early in the morning, given the extent of employee disutility associated with working at these times. 'Irregular or unpredictable hours' is apt to describe casual employment.

[202] Fifth, s.134(1)(da) identifies a number of circumstances in which we are required to take into account the need to provide additional remuneration (i.e. those in paragraphs 134(1)(da)(i) to (iv)). Working 'unsocial … hours' is one such circumstance (s.134(1)(da)(i)) and working 'on weekends or public holidays' (s.134(1)(da)(iii)) is another. The inclusion of these two, separate, circumstances leads us to conclude that it is not necessary to establish that the hours worked on weekends or public holidays are 'unsocial … hours'. Rather, we are required to take into account the need to provide additional remuneration for working on weekends or public holidays, irrespective of whether working at such times can be characterised as working 'unsocial … hours'. Ultimately, however, the issue is whether an award which prescribes a particular penalty rate provides 'a fair and relevant minimum safety net.' A central consideration in this regard is whether a particular penalty rate provides employees with 'fair and relevant' compensation for the disutility associated with working at the particular time(s) to which the penalty attaches.

…

[204] Section 134(1)(e) requires that we take into account 'the principle of equal remuneration for work of equal or comparable value'.

[205] The 'Dictionary' in s.12 of the FW Act states, relevantly:

> 'In this Act:
>
> ***equal remuneration for work of equal of comparable value:*** see subsection 302(2).'

[206] The expression 'equal remuneration for work of equal or comparable value' is defined in s.302(2) to mean 'equal remuneration for men and women workers for work of equal or comparable value'.

[207] The appropriate approach to the construction of s.134(1)(e) is to read the words of the definition into the substantive provision such that in giving effect to the modern awards objective the Commission must take into account the principle of 'equal remuneration for men and women workers for work of equal or comparable value'.

…

[215] Further, even if it was shown that a reduction in Sunday penalty rates disproportionately impacted on women workers that fact would not necessarily enliven s.134(1)(e). Section 134(1)(e) requires that we take into account the principle of equal remuneration for men and women workers 'for work of equal or comparable value'. Any reduction in Sunday penalty rates in these awards would apply equally to men and women workers.

[216] However, if it was shown that a reduction in penalty rates did disproportionately affect female workers then it is likely to have an adverse impact on the gender pay gap. Such an outcome may well be relevant to an assessment of whether such a change would provide a '*fair* and relevant minimum safety net', but it does not necessarily enliven s.134(1)(e).

[217] Section 134(1)(f) requires that we take into account 'the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden'.

[218] We note at the outset that s.134(1)(f) is expressed in very broad terms. We are required to take into account the likely impact of any exercise of modern award powers 'on business, <u>including</u>' (but not confined to) the specific matters mentioned, that is, 'productivity, employment costs and the regulatory burden'.

[219] It is axiomatic that the exercise of modern award powers to vary a modern award to reduce penalty rates is likely to have a positive impact on business, by reducing employment costs for those businesses that require employees to work at times, or on days, which are subject to a penalty rate. The impact of a reduction in penalty rates upon productivity is less clear.

…

[221] 'Productivity' is not defined in the FW Act but given the context in which the word appears it is clear that it is used to signify an economic concept.

…

[224] The conventional economic meaning of productivity is the number of units of output per unit of input. It is a measure of the volumes or quantities of inputs and outputs, not the cost of purchasing those inputs or the value of the outputs generated. As the Full Bench observed in the *Schweppes Australia Pty Ltd v United Voice – Victoria Branch*:

> '… we find that 'productivity' as used in s.275 of the Act, and more generally within the Act, is directed at the conventional economic concept of the quantity of output relative to the quantity of inputs. Considerations of the price of inputs, including the cost of labour, raise separate considerations which relate to business competitiveness and employment costs.

> Financial gains achieved by having the same labour input – the number of hours worked – produce the same output at less cost because of a reduced wage per hour is not productivity in this conventional sense.'

[225] While the above observation is directed at the use of the word 'productivity' in s.275, it is apposite to our consideration of this issue in the context of s.134(1)(f).

[226] Section 134(1)(g) requires that we take into account 'the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards'.

[227] We deal further with this consideration later in our decision when addressing the review of the particular modern awards before us.

[228] Section 134(1)(h) requires that we take into account 'the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy'.

[229] We note that the requirement to take into account the likely impact of any exercise of modern award powers on 'the sustainability, performance and competitiveness *of the national economy*' (emphasis added) focuses on the aggregate (as opposed to sectorial) impact of an exercise of modern award powers. We deal further with this consideration later in our decision when addressing the review of the particular modern awards before us.[6]

24. Though the *Penalty Rates Decision* was issued in the context of the 4 yearly review of modern awards, the observations made by the Commission about s.134(1) of the Act are equally apposite to a matter advanced outside the scope of the award review.

25. Finally, s.138 of the Act requires that a modern award can contain provisions only to the extent that they are necessary to achieve the modern awards objective:

> A modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective.

[6] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [162] – [229].

26. Section 138 imposes an additional requirement to those considered above and effectively limits the scope of the provisions that may be included in a modern award. Ultimately, a modern award cannot include a term if it is not *necessary* to achieve the modern awards objective.

27. In the *Penalty Rates Decision*, the Commission cited the aforementioned passage from *NRA v SDA* and said as follows:

> **[136]** The above observation – in particular the distinction between that which is 'necessary' and that which is merely desirable – is apposite to our consideration of s.138. Further, we agree with the observation that reasonable minds may differ as to whether a particular award term or proposed variation is necessary (within the meaning of s.138), as opposed to merely desirable. It seems to us that what is 'necessary' to achieve the modern awards objective in a particular case is a value judgment, taking into account the s.134 considerations to the extent that they are relevant having regard to the context, including the circumstances pertaining to the particular modern award, the terms of any proposed variation and the submissions and evidence.[7]

28. Although the Applications have been advanced jointly, each award must be considered in its own right. The Commission has power to vary each Relevant Award only if it is satisfied of the requirements of ss.157 and 138 in respect of that award.

[7] *4 yearly review of modern awards – Penalty Rates* [2017] FWCFB 1001 at [134] – [136].

5. THE COMMISSION'S DECISION TO INTRODUCE UNPAID PANDEMIC LEAVE

29. In a decision of 8 April 2020[8] (***Unpaid Pandemic Leave Decision***), the Commission varied 99 modern awards, including the awards that are the subject of the current proceedings, to provide for two weeks of unpaid pandemic leave in circumstances which would give rise to an entitlement to paid leave under the clause X.2.1 proposed by the Applicants, save that there is no right to leave under the existing provision where an employer directs an employee to self-isolate.

30. The Applicants seek to rely on the reasoning of the Full Bench in the *Unpaid Pandemic Leave Decision* in support if the current claim:

> 15. The merit of two weeks pandemic leave was established in the decision. Accordingly, the findings by the Full Bench in the Decision at [112] to [131] are applicable. The principle additional issues before the Commission is whether pandemic leave should be paid leave or not."[9]

31. Central to the reasoning of the Full Bench was that the grant of an entitlement to unpaid pandemic leave would address a regulatory gap:

> **[68]** Employees who have contracted COVID-19 may have an entitlement to paid personal/carer's leave under the National Employment Standards (NES) (see ss 95–101 of the Act). But the number of employees able to utilise paid personal/carer's leave to cover a period of self-isolation is likely to be limited. And so, while some employees required to self-isolate may be able to access paid or unpaid leave; for most award-covered employees this will depend upon the agreement of their employer. If the employer does not consent then an employee required to self-isolate may be placed in the invidious position of either contravening public health directions or guidelines, or placing their employment in jeopardy.
>
> **[69]** Nor do the statutory protections against dismissal provide a complete solution to this problem. Unfair dismissal protections do not extend to all employees. A wider range of employees may be protected from dismissal under the general protections provisions in the Act, in particular s.352. But, as with paid personal leave, the protection against dismissal under s 352 may not apply to an employee required to self-isolate because they have been exposed to someone infected with COVID-19, if the employee has not tested positive to COVID-19; is not displaying any symptoms; and is not unfit for work because of personal illness.

[8] *Variation of awards at the initiative of the Commission* [2020] FWCFB 1837.

[9] Applicants submission dated 11 May 2020 at paragraph 16.

> **[70]** The gaps in leave entitlements and protections against dismissal can be addressed, for employees to whom awards apply, by providing an entitlement to unpaid 'pandemic leave' to employees who are required to self-isolate or are otherwise prevented from working by measures taken by government or medical authorities in response to the COVID-19 pandemic. As well as providing an entitlement to unpaid leave to employees who have no existing leave entitlements available to them in these circumstances, such a new leave entitlement would supplement existing leave entitlements and constitute a 'workplace right' for the purposes of the general protections under the Act.[10]

32. The variation of awards to include unpaid pandemic leave fills the regulatory gap identified by the Full Bench. Consequently, this element of the Full Bench's reasoning in the *Unpaid Pandemic Leave Decision* provides no support for the grant of paid leave.

33. Paragraphs [112] – [133] of the *Unpaid Pandemic Leave Decision* address the considerations arising from s.134(1) of the Act and the Full Bench's conclusion that unpaid pandemic leave in necessary to ensure the awards meet the modern awards objective. We later address matters arising from s.134(1) in the context of the current claim. It is sufficient to here observe that this aspect of the *Unpaid Pandemic Leave Decision* is of limited assistance to the Applicants given that:

    (a) The current claim is fundamentally different to what was previously considered. The current claim seeks *paid* rather than *unpaid* leave, would apply to a considerably smaller group of awards (and employees) rather than to the vast majority of awards and would extend for several months beyond what was provided for in the *Unpaid Pandemic Leave Decision*.

    (b) The *Unpaid Pandemic Leave Decision* was issued in the context of a complete absence of any special leave entitlements designed to address the context of COVID-19.

    (c) The *Unpaid Pandemic Leave Decision* was issued at a time when it was far less clear how successful Australia would be in managing the spread of the virus.

[10] *Variation of awards at the initiative of the Commission* [2020] FWCFB 1837 AT [68] – [70].

34. The Applicants' submission that the "findings of the Full Bench in the Decision at [112] to [131] are applicable" [11] is unduly simplistic and cannot be sustained in light of the distinguishable context of the nature of the current claims and circumstances in which they are is advanced from that dealt with by the Commission.

[11] Applicants submissions dated 11 May 2020 at paragraph 15.

6. THE TERMS OF THE PROPOSED CLAUSES

35. Before dealing with the key tenants of the Applicants' case, we raise the following 16 propositions about the terms of the Proposed Variations and various issues that arise on the face of the Proposed Clauses.

36. *First*, the Proposed Clauses would apply in circumstances where there is no connection between the reason for the employee seeking to take leave and the employee's employment. For instance:

    (a) If an employee was required by a government or medical authorities to self-isolate because the employee had returned from overseas travel that was undertaken for personal reasons, the employee would be entitled to paid leave under clause X.2.1.

    (b) If that same employee was diagnosed with COVID-19 whilst in self isolation, in circumstances where the employee has not had any contact with their workplace, colleagues, patients or clients for several weeks or months due to their overseas trip; the employee would nonetheless be entitled to paid leave until they receive medical clearance to return to work under clause X.2.3.

    (c) If an employee attended a sporting event in circumstances entirely unrelated to work and was subsequently required by a government or medical authorities to self isolate because other attendees were diagnosed with COVID-19, the employee would be entitled to paid leave under clause X.2.1.

    (d) If an employee's child had close contact with another child at school who had tested positive with COVID-19 and the employee was required by a government or medical authorities to self isolate, the employee would be entitled to paid leave under clause X.2.1.

(e) If a flatmate of an employee is diagnosed with COVID-19 and the employee is required by a government or medical authority to self isolate, not because of the nature of the work performed by the employee but because the requirement applies to all such persons, the employee would be entitled to paid leave under clause X.2.1.[12]

(f) If an employee was required on the advice of a medical practitioner (noting the lack of clarity regarding this element of the clause, which we later return to) to self isolate because the employee's partner suffers from a medical condition that renders them particularly vulnerable to the virus, irrespective of the extent to which the employee is in fact potentially exposed to COVID-19, the employee would be entitled to paid leave under clause X.2.1.

(g) An employee would be entitled to leave where they are diagnosed with COVID-19 without regard for how the virus was contracted. Accordingly, if the employee was infected outside the course of their employment, the employee would nonetheless be entitled to paid leave under clause X.2.3.

37. These are but a few examples of the many and varied ways in which the Proposed Clauses would apply where the reason for the leave is not connected with the employee's employment. There is no reasonable justification for such an entitlement. It would operate in a way that is plainly unfair to employers, who would incur additional employment costs arising from circumstances that sit well beyond the scope of the employment relationship.

38. We also note that the above circumstances could arise for any number of employees covered by virtually any modern award. Although in some cases the impact may be limited where an employee is able to self isolate and continue to work from home, this will not be feasible in the context of work performed under a large number of modern awards. Additionally, an employee covered by any award may be diagnosed with COVID-19 and unable to work, even from home, due to their condition.

[12] See for example Section 7 of the *Diagnosed Persons and Close Contacts Directions (No 2)*.

39. Examples of modern awards covering employees who are likely unable to perform their work remotely include:

(a) *Aircraft Cabin Crew Award 2010*;

(b) *Airline Operations – Ground Staff Award 2020*;

(c) *Airport Employees Award 2020*;

(d) *Air Pilots Award 2020*;

(e) *Black Coal Mining Industry Award 2010*;

(f) *Building and Construction General On-Site Award 2010*;

(g) *Business Equipment Award 2010;*

(h) *Children's Services Award 2010;*

(i) *Cleaning Services Award 2020;*

(j) *Electrical, Electronic and Communications Contracting Award 2010;*

(k) *Electrical Power Award 2020;*

(l) *Fast Food Industry Award 2010;*

(m) *Food, Beverage and Tobacco Manufacturing Award 2010;*

(n) *General Retail Industry Award 2010;*

(o) *Hair and Beauty Industry Award 2010;*

(p) *Horticulture Award 2010;*

(q) *Hospitality Industry (General) Award 2020;*

(r) *Manufacturing and Associated Industries and Occupations Award 2020;*

(s) *Meat Industry Award 2020;*

(t) *Mining Industry Award 2010;*

(u) *Plumbing and Fire Sprinklers Award 2010;*

(v) *Restaurant Industry Award 2020;*

(w) *Road Transport and Distribution Award 2020;*

(x) *Road Transport (Long Distance Operations Award) 2020;*

(y) *Security Services Industry Award 2010;*

(z) *Stevedoring Industry Award 2020;*

(aa) *Storage Services and Wholesale Award 2020;*

(bb) *Vehicle Repair, Services and Retail Award 2020;*

(cc) *Waste Management Award 2020;*

(dd) *Water Industry Award 2010;* and

(ee) *Wine Industry Award 2010*.

40. The proposition that the circumstances of the employees covered by the Relevant Awards is unique because of the work they perform cannot be sustained in this context. As can be seen from the above list (which is not exhaustive), many employees may be unable to perform work while self isolating or while infected with COVID-19.

41. *Second,* clause X.2.1 applies where an *employer* requires an employee to self isolate (clause X.2.1(a)(ii)).

42. In the context of permanent employees, it is our view that an employer will commonly be required to pay an employee for a period of self isolation required by the employer in circumstances where the employee is otherwise ready, willing and able to work. In such circumstances, the proposed provision cannot be said to form a *necessary* part of the minimum safety net.

43. *Third*, clause X.2.1 applies where an employee is required on the advice of a medical practitioner to self isolate.

44. The circumstances in which this element of the clause is likely to apply are somewhat unclear. A medical practitioner may *recommend* that a person self isolate due to, for instance, their increased susceptibility to the virus on account of pre-existing medical conditions. However, it is not clear that a medical practitioner would or could *require* a person to self isolate or provide 'advice' to that effect. It would appear therefore that the proposed clause would potentially have very little work to do.

45. However, if the proposed clause is interpreted to apply wherever an employee decides to follow *advice* provided by a medical practitioner to self isolate, the entitlement may apply in ways that are particularly unfair to employers and may impose significant additional employment costs, particularly given that the clause does not limit the amount of leave that may be taken by an employee pursuant to it.

46. The evidence of Margery Zillmann relevantly illustrates the potential application of the clause. Ms Zillmann states:

> 8. I do not have any particular medical conditions that would make me vulnerable. …
>
> …
>
> 21. Following advice from the Federal Government and my doctor, I have been on leave from work since 24 March 2020.
>
> 22. I felt like I had no choice but to take leave from work. I am over 70 years old. I cannot be working in an aged care facility during a health pandemic. I felt very vulnerable and I became very fearful. My job requires me to handle soiled plates and food scraps and I felt like I was putting my self at an unacceptable risk of contracting the virus.
>
> …
>
> 26. … It is not fair that I cannot work and earn money to support myself because I am responsible and I don't want to get sick. … I want to go

> back to work and the work still needs to be done by someone. But it's too dangerous. I'm not going back until this is over.[13]

47. We do not dispute that some employees performing work covered by the Relevant Awards may be genuinely concerned or anxious about their potential exposure to COVID-19. However, if the Proposed Clauses afford an employee an entitlement to potentially extended periods of paid leave wherever a medical practitioner advises them that they ought to self isolate in order to assist with managing their purported fear or concerns about the virus, the proposed entitlement potentially has far reaching application in a manner that is unfair to employers.

48. A major deficiency in the clause appears to be that it does not provide any objective basis or criteria that needs to be satisfied before advice from a medical practitioner to self isolate would constitute a valid justification for an employee accessing the leave. Instead, it appears to merely leave the decision as to whether an employee should self isolate to the medical practitioner. This situation varies markedly from the approach adopted by the safety net in relation to personal leave. In this context the legislation provides clear criteria that must be satisfied for an absence to be justified and an assessment of a medical practitioner merely evidences the existence of the relevant pre-requisite to the taking of the leave. Relevantly, the employee must be accessing the leave "because the employee is not fit for work because of a personal illness, or personal injury, affecting the employee".[14] Clause X.2.1 fails to provide any comparable relevant guidance as to when or why a medical practitioner may validly advise an individual to self isolate.

49. In making this submission we note that the clause requires the provision of evidence that would satisfy a reasonable person that the leave is taken for a reason given in clause X.2.1(a) (i.e. that the leave is taken because a medical practitioner has advised that the person self isolate). Nonetheless, an employer would appear to be left without recourse under the Relevant Awards if an

[13] Statement of Margery Zillmann, undated, at paragraphs 8, 21 – 22 and 26.

[14] Section 97 of the Act.

employee sought to unreasonably or unjustifiably access the leave on account of their medical advice. This is obviously unfair.

50. *Fourth*, the proposed clause X.2.1 would entitle an employee to a day of leave on each occasion the employee is tested for COVID-19, subject to one exception relating to the testing constituting time worked. It is not clear that the proposed leave applies only where an employee is absent from work to be tested. For instance, if a part-time employee is tested on a Monday in circumstances where the employee was not required to work on that day, it appears that the employee would nevertheless be entitled to a paid day of leave. It is also not clear which day would then be treated as the day of leave. Notwithstanding that such a reading of the clause is potentially available, we note that it appears to be inconsistent with the Applicants' submissions about this element of the clause: (our emphasis)

> 9. It is part of our claim that employees should be entitled to take paid time off <u>to undergo a test</u> for COVID-19. That would include the time waiting for the test to be performed and all precautionary waiting time for the test result.

51. The clause is not simple or easy to understand in this respect. If the clause is interpreted to apply in the manner described above, it is also unfair and unjustifiable.

52. *Fifth,* while clause X.2.1 requires that an employee provide evidence in accordance with clause X.2.1(c), the proposed provision does not disentitle an employee to leave if an employee fails to provide such evidence (i.e. if the employee fails to provide evidence or fails to provide evidence that would satisfy a reasonable person that the leave is taken for a reason in clause X.2.1(a)). An employee would therefore be entitled to paid leave irrespective of their failure to substantiate the reason for the leave.

53. In this respect the operation of the proposed provision is out of step with other forms of leave afforded by the safety net.[15] It is plainly unfair that an employee is entitled to a form of paid leave even if they do not satisfy the evidentiary requirement and that an employer's only recourse in such circumstances is to institute a dispute under the award's dispute settlement procedure or to prosecute the employee for breaching a term of the award.

54. *Sixth*, it is unclear how or when an entitlement to paid leave will apply in the context of casual employment that is unpredictable in nature.

55. Although the proposal includes a mechanism for calculating payment for casual employees in a manner that accounts for variances in their engagement, it does not provide any practical basis for determining (let alone limiting) the circumstances in which a casual employee who has been engaged by an employer on an 'ad hoc' or 'as needs basis' would be able to access the entitlement. The clause does not, for example, limit eligibility to casuals that have been given an advanced commitment as to the hours that they will work or even to casual who has been engaged on a regular and systematic basis and who has a reasonable expectation of ongoing work. This raises the obviously unfair prospect that an employee may be able to access 'paid leave' in circumstances where they would not have otherwise been engaged by the employer to work during the period of the 'leave'.

56. If, despite our submissions, the Award is to provide casual employees an entitlement to paid leave, it must be clear that it would only apply in circumstances where the employee would otherwise have been required to work.

57. *Seventh*, it is unclear how the pay for a single day of leave (as opposed to a week) would be calculated under proposed X.2.1(f) clause for a casual employee or clause X.2.1(g) for a part-time employee under the Aged Care Award and SCHCDS Award. The clause appears to assume absences will be of a week's duration. Read literally, the clause would appear to provide such employees with

[15] See for example s.107(4) of the Act in relation to paid personal / carer's leave, unpaid carer's leave, compassionate leave and unpaid family and domestic violence leave.

a weekly rate of pay for any absence. The clause is not simple or easy to understand in this regard.

58. *Eighth,* the amount payable to a casual employee for a period of leave taken pursuant to clause X.2.1 would not be limited to the base rate of pay, unlike the entitlement of permanent employees. It appears that the entitlement of a casual employee would include additional amounts such as the casual loading, other loadings, penalties and overtime rates. The Applicants' submissions do not offer any justification for this nor is one apparent from the remainder of the material filed. This aspect of the clause would compound its unfairness to employers.

59. *Ninth*, the amounts payable pursuant to clause X.2.1 do not appear to be limited to amounts prescribed by the Relevant Awards and instead appear to require the payment of over-award amounts. It is not appropriate for an award to require the payment of over-award amounts, nor can such a term be said to form a *necessary* part of a minimum safety net.

60. *Tenth*, the absence of any requirement that the employee has worked for an employer for any minimum period before they accrue or access the leave further renders it unfair for an employer. For example, the clause would unreasonably require an employer of a permanent employee that has been newly engaged (and potentially not even actually undertaken any work for the employer) to provide paid leave to that employee. This is clearly out of step with entitlements to paid personal/carers leave.

61. The possibility of the clause operating unfairly for employers of newly employed employees is magnified in the context of casual employment given there is no obligation on the casual employee to perform any work after the conclusion of the leave.

62. *Eleventh*, it appears that the proposed clause would enable employees who maintain employment with multiple employers to simultaneously access leave from each employer in a manner that may deliver to then an unfair and unjustifiable windfall gain. This is particularly likely to arise in the context of casual or part-time employees engaged under the Aged Care Award and the

SCHCDS Award, given the variability in the number of ordinary hours that may be worked by such employees under the terms of the instruments and the proposition that the payment for leave is to be calculated by reference to the "average weekly pay" or "average weekly ordinary hours", absent any mechanism to prevent employees from 'double dipping' by claiming such leave from multiple employers simultaneously. We doubt that it will be disputed that some employees in the sectors covered by the aforementioned awards do simultaneously maintain employment with multiple employers.

63. *Twelfth,* the form of leave proposed at clause X.2.3 does not require an employee to provide any evidentiary basis for the proposition that they have been diagnosed with COVID-19. This is clearly problematic. An employee would not have an award-derived obligation nor would an employer have an award-derived right to require an employee to provide any evidence. As a result, the Relevant Awards would not provide any mechanism that enables an employer to verify whether the employee has been diagnosed with COVID-19. This is self-evidently unfair.

64. *Thirteenth*, clause X.2.3(b) states that once an employer is advised of an employee's diagnosis, the employer *must* allow the employee to be absent from work and not perform work. It appears that the proposed provision would prohibit an employee from working from home. Alternatively, at the very least, it appears that clause would permit an employee to elect not work from home, even if they can do so safely.

65. Whilst we accept that of some work performed by employees covered by the Relevant Awards is not able to be performed from home, this will not always be the case. Some work can and is being performed remotely, without contact with others in the workplace. There is in our submission no justification for disturbing such arrangements.

66. The evidence reveals the following examples of employees performing work from home: speech pathologists[16], pharmacists[17], social workers[18], family therapists[19] and youth workers[20]. In our submission, various other types of work performed by employees covered by the Relevant Awards may also be performed from home. Obvious examples include clerical / administrative work performed by employees covered by the SCHCDS Award.

67. We also note that the Commonwealth Government has introduced a range of 'telehealth services' to the Medicare Benefits Scheme that may be provided by telephone or video. As can be seen from the Department of Health publication at **Attachment A** to this submission, a number of services provided by employees covered by the Relevant Awards have been identified as being eligible for telehealth services, thereby enabling them to be bulk billed and provided remotely. The list at pages 5 – 16 is reflective of the relevant services being able to be provided remotely. Examples of the relevant classes of employees include medical practitioners covered by the MP Award, psychologists covered by the HPSS Award, occupational therapists covered by the HPSS Award, social workers covered by the HPSS Award, speech pathologists covered by the HPSS Award, audiologists covered by the HPSS Award, orthoptists covered by the HPSS Award, physiotherapists covered by the HPSS Award, dieticians covered by the HPSS Award and midwives covered by the Nurses Award.

68. We also note in this regard that the symptoms of COVID-19 may be mild (or indeed non-existent) and thus a diagnosis of COVID-19 will not necessarily render a person unfit to perform work from their own home.

[16] Statement of Alex Leszczynski dated 8 May 2020 at paragraph 21.

[17] Statement of Jennifer Madden dated 7 May 2020 on page 2.

[18] Statemen of unidentified employee (undated) at paragraph 11.

[19] Statement of Tiresi Paterson dated 7 May 2020 at paragraph 13.

[20] Statement of Rachel Humphrys dated 6 May 2020 at paragraph 10.

69. *Fourteenth*, clause X.2.3(b) requires that an employee must not suffer a loss of pay during the period of leave. As we understand it, the proposed clause thereby requires the payment of all amounts that would have been paid to the employee had the employee worked (including over award payments). The Applicants' submissions do not offer any justification for this. The resulting cost impost on an employer is unfair and unwarranted.

70. *Fifteenth*, clause X.2.3(b) is expressed to apply until the employee has had medical clearance to return to work. The operation of this element of the clause is unclear. For instance; does 'medical clearance' mean certification from a medical practitioner? Must such certification require that the employee is no longer infectious? Is the employee required to provide evidence of that certification to the employer? The proposed clause is not simple or easy to understand.

71. *Finally*, clause X.2.3(d) is in the following terms:

> (d) An employee shall not be required by an employe[r] to take personal leave because of a COVID-19 diagnosis prior to exhausting their entitlement to special leave under this clause.

72. The clause is not simple or easy to understand. The leave afforded by clause X.2.3 cannot, as such, be 'exhausted'. It is a form of leave that applies each time an employee is diagnosed with the virus and continues in each instance until the employee has had medical clearance to return to work.

73. Further, an employee cannot be *required* by an employer to take personal leave in any event. Section 97 of the Act is permissive. It permits an employee to take personal / carer's leave in the prescribed circumstances. Neither the Act nor the Relevant Awards enable an employer to require an employee to take the leave.

74. In addition, the clause does not clearly demarcate the interaction between it and the entitlement to personal / carer's leave under the NES. For instance, it is not clear whether personal / carer's leave is not to be accessed by an employee where they are entitled to leave under clause X.2.3.

75. Ai Group contends that it is unfair to employers to grant employees an ability to access paid leave under clause X.2.3 in circumstances where they could otherwise access paid personal carers leave. That is, where a permanent employee is unfit for work because the employee has contracted COVID-19, the employee would be entitled to access personal / carer's leave which is intended for the very purpose of ensuring that such employees can take paid leave in the relevant circumstances. Such a clause is also not *necessary* in the relevant sense.

7. HEALTH AND SAFETY CONSIDERATIONS

77. The Applicants' case appears to turn in large part on the proposition that employees covered by the Relevant Awards are at a higher risk of contracting COVID-19 than other employees performing other types of work. Further, some of the evidence relied upon goes to employee perceptions about having been provided with insufficient personal protective equipment (**PPE**).

78. The Applications and the material advanced in support of them should in our submission be considered in the context of the obligations created by workplace health and safety legislation on employers and employees, which serve to protect the health and safety of employees and others in the workplace. In addition, governments and regulators have imposed requirements and introduced guidelines concerning COVID-19 that are also designed to achieve the same outcome, including in the specific context of the industries and occupations covered by the Relevant Awards. Collectively, these various rights, obligations and mechanisms provide important protections to employees covered by the Relevant Awards.

79. We return to the relevance of these matters to the Applications in the submissions that follow.

7.1 Obligations under Work Health and Safety Legislation

80. The *Model Work Health and Safety Act* has been adopted through legislation by all Australian jurisdictions other than Victoria and Western Australia. The obligations of employers under the *Model Work Health and Safety Act* are outlined below. Though the obligations in Victorian and Western Australian legislation are cast differently, their practical application is substantially the same.

81. Employers have obligations under workplace health and safety laws to ensure the health and safety of employees and other persons, to the extent that is reasonably practicable[21]. This includes (without limitation):

(a) The provision and maintenance of a work environment without risks to health and safety;

(b) The provision and maintenance of safe plants and structures;

(c) The provision and maintenance of safe systems of work;

(d) The safe use, handling and storage of plant, structures and substances;

(e) The provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities;

(f) The provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking; and

(g) That the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.[22]

82. When managing risks, employers are required to minimise or eliminate the risk so far as is reasonably practicable, taking into account:

(a) The likelihood of the hazard or the risk concerned occurring;

(b) The degree of harm that might result from the hazard or the risk;

[21] Section 19 of the *Model Work Health and Safety Laws*.

[22] Section 19(3) of the *Model Work Health and Safety Act.*

(c) What the person concerned knows, or ought reasonably to know, about:

(i) The hazard or the risk; and

(ii) Ways of eliminating or minimising the risk;

(d) The availability and suitability of ways to eliminate or minimise the risk; and

(e) After assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk. [23]

83. In addition, employers must, so far as it reasonably practicable, consult with employees who are likely to be directly affected by a matter relating to work health and safety. [24] Such consultation is required in relation to a range of health and safety matters including:

(a) When identifying hazards and assessing risks to health and safety arising from the work carried out or to be carried out by the business or undertaking;

(b) When making decisions about ways to eliminate or minimise those risks;

(c) When making decisions about the adequacy of facilities for the welfare of employees; and

(d) When proposing changes that may affect the health or safety of employees.[25]

[23] Section 17 of the *Model Work Health and Safety Act*.

[24] Section 47 of the *Model Work Health and Safety Act*.

[25] Section 49 of the *Model Work Health and Safety Act*

84. Consultation under the legislation requires:

(a) That relevant information about the matter is shared with employees;

(b) That employees be given a reasonable opportunity:

(i) To express their views and to raise work health or safety issues in relation to the matter; and

(ii) To contribute to the decision-making process relating to the matter;

(c) That the views of employees are taken into account;

(d) That the employees consulted are advised of the outcome of the consultation in a timely manner; and

(e) That if the employees are represented by a health and safety representative, the consultation must involve that representative. [26]

85. The legislation also establishes obligations on employees. While at work, an employee must:

(a) Take reasonable care for his or her own health and safety;

(b) Take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons;

(c) Comply, so far as the employee is reasonably able, with any reasonable instruction that is given by the person conducting the business or undertaking to allow the person to comply with the legislation; and

(d) Co-operate with any reasonable policy or procedure of the person conducting the business or undertaking relating to health or safety at the workplace that has been notified to workers. [27]

[26] Section 48 of the *Model Work Health and Safety Act*

[27] Section 28 of the *Model Work Health and Safety Act.*

86. Work health and safety laws impose a carefully constructed set of obligations on employers and reciprocal requirements on employees to consider, discuss, implement and comply with measures that are intended by design to ensure the health and safety of employees and other persons. They provide a sophisticated regime for consulting, cooperating and coordinating with other duty holders (suppliers, customers, labour hire companies, contractors), identifying hazards, assessing risks, implementing control measures and ensuring that control measures remain relevant and appropriate. They emphasise the importance of ensuring that the health and safety of employees and other persons are at front-of-mind. Significant penalties apply for non-compliance with the various obligations outlined above.

87. The evidence does not establish nor suggest that there is widespread non-compliance with the relevant obligations in the context of COVID-19 or that the relevant obligations are inadequate to deal with the circumstances posed by the virus.

88. To the extent that the Applicants seek to argue that the relevant obligations are not being met by some employers (for example, due to the provision of insufficient PPE – a matter that is not expressly dealt with in their submissions but has been referenced in certain elements of the evidence filed), a paid leave entitlement that is said to apply where the consequences of such non-compliance are experienced by an employee is a blunt instrument for dealing with what is a complex health and safety issue. Such matters are more appropriately dealt with through the workplace health and safety system at the enterprise level in a manner that is directed towards minimising if not eradicating the spread of the virus – an objective that the Applicants claim sits at the core of their case.

7.2 Public Health Orders and Directions Issued in relation to COVID-19

89. State and territory governments and / or health authorities have issued a range of public health orders and directions that apply to the population generally and in some cases, more specifically to workplaces covered by the Relevant Awards. In each case, the requirements imposed are directed towards containing the spread of the virus.

90. For instance,

(a) In New South Wales:

(i) The *Public Health (COVID-19 Self-Isolation) Order 2020* requires a person diagnosed with COVID-19 to self isolate until medically cleared.[28]

(ii) The *Public Health (COVID-19 Restrictions on Gathering and Movement) Order (No 3) 2020* requires that an employer must allow an employee (including employees covered by the Relevant Awards) to work at the employee's place of residence if it is reasonably practicable to do so.[29]

(iii) The *Public Health (COVID-19 Restrictions on Gathering and Movement) Order (No 3) 2020* also requires that an occupier or operator of a premises comprised predominantly of an indoor space must not permit more than 100 persons to be in the premises at the same time or allow persons to be on the premises if the size of the premises is insufficient to ensure that there is four square metres of space for each person on the premises. These requirements do not, however, apply to:

- A gathering at a hospital or other medical or health service facility if that gathering is necessary for the normal business of the facility; and
- A gathering at a disability or aged care facility if that gathering is necessary for the normal business of the facility.[30]

[28] Section 5 of the *Public Health (COVID-19 Self-Isolation) Order 2020*.

[29] Section 9 of the *Public Health (COVID-19 Restrictions on Gathering and Movement) Order (No 3) 2020.*

[30] Section 8 of the *Public Health (COVID-19 Restrictions on Gathering and Movement) Order (No 3) 2020.*

(iv) The *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020* places limitations on who may enter the premises of a residential aged care facility. Specifically, the operator of a residential aged care facility is required to take all reasonable steps to ensure that a person (including an employee) does not enter or remain on the premises of a facility if, for instance:

- In the 14 days preceding the proposed entry, the person arrived from overseas or had known contact with a person diagnosed with COVID-19;
- If the person has a temperature higher than 37.5 degrees or symptoms of acute respiratory infection;
- The person does not have an up-to-date vaccination against influenza, if the vaccination is available to the person.[31]

(b) In Victoria:

(i) The *Diagnosed Persons and Close Contacts Directions (No 2)* requires that a person diagnosed with COVID-19 must self isolate until they receive clearance from self isolation (as defined[32]).[33]

(ii) The *Diagnosed Persons and Close Contacts Directions (No 2)* requires that a person diagnosed with COVID-19 must self isolate if they reside with a person who is required to self isolate because they have been diagnosed with COVID-19.[34]

[31] Sections 4 – 6 and 7 of the *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020*.

[32] Section 5 of the *Diagnosed Persons and Close Contacts Directions (No 2).*

[33] Section 4 of the *Diagnosed Persons and Close Contacts Directions (No 2).*

[34] Section 7 of the *Diagnosed Persons and Close Contacts Directions (No 2)*.

(iii) The *Restricted Activities Directions (No 9)* requires that an employer must not permit an employee to perform work at the employer's premises where it is reasonably practicable for the employee to work at the employee's place of residence or another suitable premises which is not the employer's premises.[35]

(iv) The *Hospital Visitor Directions (No 4)* places limitations on who may enter a hospital. Relevantly, a person (including an employee) must not be allowed to enter or remain in a hospital if they have been diagnosed with COVID-19, a temperature of over 37.5 degrees or symptoms of acute respiratory infection, returned from overseas during the preceding 14 days or had known contact with a person diagnosed with COVID-19 in the preceding 14 days.[36] The operator of the hospital is required to take all reasonable steps to ensure that such an employee does not enter or remain in a hospital.[37]

(v) The *Care Facilities Directions (No 4)* places similar limitations on entry to residential aged care facilities, disability residential services and other care facilities to those contained in the *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020* of NSW.

91. As can be seen, in addition to the obligations on employers and employees under workplace health and safety legislation, various strict requirements are also in force pursuant to the public health orders and directions issued to date. They further serve to protect the health and safety of employees covered by the Relevant Awards (as well as their patients / clients).

[35] Section 16 of the *Restricted Activities Directions (No 9)*.

[36] Section 4 of the *Hospital Visitor Directions (No 4).*

[37] Section 8 of the *Hospital Visitor Directions (No 4)*.

92. Similar public health orders are in force in the ACT[38], Queensland[39], Northern Territory[40], South Australia[41], Tasmania[42] and Western Australia[43].

93. As can be seen, in addition to the obligations on employers and employees under workplace health and safety legislation, various strict requirements are also in force pursuant to the public health orders and directions issued to date. They further serve to protect the health and safety of employees covered by the Relevant Awards (as well as their patients / clients).

94. We also note that significant penalties apply if a person or body corporate is found to have breached such orders. For instance:

    (a) A refusal or failure to comply with the Victorian directions referenced above carries a penalty of 120 penalty units for an individual (i.e. $19,826) and 600 penalty units in the case of a body corporate (i.e. $99,132).

    (b) A failure to comply with the NSW public health orders mentioned above carries the following maximum penalties, with additional penalties that may be ordered of the offence continues:

        (i) In the case of an individual: 100 penalty units (i.e. $11,000) or imprisonment for 6 months, or both.

        (ii) In the case of a corporation: 500 penalty units ($55,000).

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[38] The *Public Health (Self-Isolation) Emergency Direction 202* and the *Public Health (Residential Aged Care Facilities) Emergency Direction 2020 (No 2)*.

[39] The *Aged Care Direction (No. 6)*, the *Hospital Visitors Direction (No. 4)*, the *Movement and Gathering Direction* and the *Self-isolation for Diagnosed Cases of COVID-19 Direction (No. 3)*.

[40] The *COVID-19 Directions (No. 24) 2020 Directions for Aged Care Facilities*, the *COVID-19 Directions (No. 21) 2020 Directions for Potentially Infected Persons* and the *COVID-19 Directions (No. 7) 2020*.

[41] The *Emergency Management (Residential Aged Care Facilities No 4) (COVID-19) Direction 2020*, the *Emergency Management (COVID-19) (Isolation Following Diagnosis or Close Contact) Direction 2020* and the *Emergency Management (Public Activities) (COVID-19) Direction 2020*.

[42] The *Direction under section 16 – Gatherings – No 12*, the *Direction under section 16 – Quarantine – No 1*, the *Direction under section 16 – Isolation – No 2* and the *Direction under section 16 – Residential Aged Care Facilities – No 7*.

[43] The *Visitors to Residential Aged Care Facilities Directions (No 2)*, the *Isolation (Diagnosed) Directions* and the *Quarantine and Isolation (Undiagnosed) Directions*.

95. In addition, employers covered by the Relevant Awards are required in Queensland[44], Northern Territory[45] and Tasmania[46] to develop and implement a 'safety plan' that deals with the application of public health orders to their workplace, identification of risks and implementation of controls to mitigate those risks.

96. The Applicants contend that the grant of the Applications would render it less likely that employees would "violate self isolation requirements". We later return to other reasons why that is not is an appropriate basis for varying the safety net. For present purposes though, we note that there are clear requirements imposed by the various public health orders / directions to self isolate in the prescribed circumstances. A failure to do so could result in the imposition of a hefty penalty; a matter which of itself creates an important incentive to comply or, put another way, a disincentive to breach the relevant requirements. It is neither appropriate nor *necessary* in the relevant sense that the minimum safety net be varied to introduce a significant additional cost for employers for the purposes of achieving this same outcome. Employers should not be exposed to the employment costs and regulatory burden associated with the proposed leave entitlements in order to entice employees to conduct themselves lawfully and responsibly.

7.3 Other Health and Safety Measures in the Context of COVID-19

97. The nature of the work undertaken in a number of industries has required employers to put in place measures that are designed to mitigate the risks associated with the spread of COVID-19, often in accordance with guidance or recommendations from governments, government agencies and / or regulators.

[44] *Restrictions on Businesses, Activities and Undertakings Direction (No.2)*.

[45] *Directions for Safety Measures at Reopened Places, Businesses, Activities, Services and Premises*.

[46] *Direction under section 16 – Workplace COVID Plan – No 1*.

98. Recommended measures include:

(a) The rescheduling work, and patients/clients, to minimise contact between them;

(b) Providing additional personal hygiene requirements, including provision of hand sanitiser;

(c) Additional cleaning practices, including high frequency cleaning of high touch surfaces such as door handles, chairs, tables and desks – often between each consultation with a patient/client;

(d) Providing for the appropriate use of PPE, including gloves and masks;

(e) Installation of barriers between staff and patients/clients where physical distancing cannot be achieved, e.g. at reception desks;

(f) Providing instruction and training to employees on personal hygiene and social distancing requirements;

(g) Providing instruction and training to employees on other risk controls such as the appropriate use of masks and gloves in the COVID-19 environment;

(h) Directing employees and others not to attend the workplace if they have any symptoms associated with COVID-19; and

(i) Identifying and managing other risks that may arise due to the presence of COVID-19 in the community, such as anxious or aggressive clients, fatigue, and other mental health risks associated with the COVID-19 pandemic.

99. On 24 April 2020, the Prime Minister announced that the National Cabinet had agreed to develop "nationally-consistent, industry specific work health and safety guidance on COVID-19, accessible via a central hub provided by Safe Work Australia".[47] To support the development of that guidance material, the National Cabinet agreed on 'National COVID-19 Safe Workplace Principles'. A copy of the principles is at **Attachment B** to this submission. The principles are centred around the responsibilities of employers and employees to maintain a safe and healthy workplace and controlling risks associated with COVID-19.

100. Governments, government agencies and regulators have published a wealth of information, guidelines and recommended procedures available to employers covered by the Relevant Awards that focusses on strategies such as physical distancing, hygiene protocols, cleaning protocols and training employees in the aforementioned. We identify three examples for illustrative purposes below.

101. *First*, the Commonwealth Department of Health website contains extensive advice available to employers in the health and aged care sectors. It describes an employer's responsibilities in broad terms as follows: (hyperlinks removed)

> **Employer responsibilities**
>
> As an employer, you should brief all staff on how to prevent the spread of COVID-19. This includes your contract staff and domestic and cleaning staff.
>
> If one of your staff members has tested positive for COVID-19, you need to follow the health advice from the National Coronavirus Helpline on 1800 020 080 or state or territory helpline.
>
> You also need to:
>
> - support employee personal hygiene
> - make sure the workplace is thoroughly cleaned
> - promote physical distancing, where this does not prevent care
> - adhere to the limits on public gatherings, noting that this does not apply to staff meetings
> - support your employees' mental health

[47] Prime Minister of Australia, *Media Statement* (24 April 2020).

- provide information to workers in residential age care facilities

When other responsibilities may apply

Additional responsibilities may apply when your organisation:

- supports patients face to face
- supports patients remotely
- provides aged care[48]

102. The information also includes advice about personal hygiene, cleaning, physical distancing and further information regarding residential aged care facilities.

103. *Second*, the Department of Health website contains various detailed publications such as:

(i) A *Guide for Home Care Providers*[49] (**Attachment C**), which includes guidance about a range of matters such as accessing and using PPE, organisation planning, communication with and training of staff, infection control, cleaning and laundry.

(ii) *Guidance on the Use of [PPE] In Non-inpatient Healthcare Settings, during the COVID-19 Outbreak*[50] (**Attachment D**), which is endorsed by the Australian Health Protection Principal Committee and contains various recommendations regarding the use of PPE in settings such as general practice, specialist, outpatient, allied health, respiratory/COVID-19 clinics, hospital-in-the-home and pathology collection centres.

(iii) Similar information is available regarding *Environmental cleaning and disinfection principles for health and residential care facilities*[51]*.*

[48] Department of Health, *Working arrangements for the health and aged care workforce during COVID-19* (accessed 17 June 2020).

[49] Department of Health, *Guide for Home Care Providers* (21 May 2020).

[50] Department of Health, *Guidance on the use of personal protective equipment (PPE) in non-inpatient healthcare settings, during the COVID-19 outbreak* (11 May 2020).

[51] Department of Health, *Environmental cleaning and disinfection principles for health and residential care facilities* (15 May 2020).

104. *Third*, the National Disability Insurance Scheme Quality and Safeguards Commission has made available a raft of materials about steps that should be taken to protect employees and their clients in the context of providing disability support, including online training modules for employees. The *COVID-19 Information Pack, Information for NDIS Providers and Workers*[52] appears to be the most comprehensive (**Attachment E**) of the various available publications.

105. Significant resources have been devoted by the relevant institutions to educating, advising and guiding employers as to the steps they should take to ensure the health and wellbeing of their employees and patients / clients. In addition to assisting employers with ensuring compliance with their obligations under health and safety legislation, the material promotes measures that might be characterised as 'best practice' approaches that extend beyond the mandatory requirements imposed on employers and promote enhanced safeguards and protections.

[52] NDIS Quality and Safeguards Commission, *COVID-19 Information Pack, Information for NDIS Providers and Workers* (June 2020).

8. THE RISK PROFILE OF EMPLOYEES COVERED BY THE RELEVANT AWARDS

106. As we have previously highlighted, the Applicants argue that employees covered by the Relevant Awards are at a heightened risk of infection as a product of the nature of their duties. In our submission, this proposition requires careful consideration having regard to:

(a) The extent to which COVID-19 is prevalent in Australia and the health and care systems;

(b) The existing obligations on employers to protect the health and safety of their employees and others as well as other guidance and recommendations being issued to employers;

(c) The existing obligations on employees to protect their own health and safety at work as well as that of others; and

(d) The nature of the work performed by employees covered by the Relevant Awards.

107. We also observe that to the extent that the Applicants submit that employees covered by the Relevant Awards are at an elevated risk of contracting the virus when compared to other employees, the evidence does not establish the risk profile of such other employees. As a result, a meaningful comparison cannot be drawn.

108. For instance, there is no evidence of the extent to which cabin crew and / or ground staff are potentially exposed to the virus and how that compares to the risk of employees covered by the Relevant Awards. Similarly, there is no evidence of the risk of exposure amongst employees covered by the *General Retail Industry Award 2010* and how that compares to employees covered by the *Pharmacy Industry Award 2010*. There is certainly no evidence to explain why, by way of a further example, the risk to clerical employees working from home under the SCHCDS Award is any higher than the risk to clerical employees working from home under the *Clerks – Private Sector Award 2010*.

8.1 The Prevalence of COVID-19 in Australia and the Health and Care Systems

109. The infographic at **Attachment F** published by the Department of Health provides a snapshot of the number of COVID-19 cases diagnosed as at 3pm on 15 June 2020. As can be seen from that summary:

    (a) There were 382 'active' cases of COVID-19.

    (b) 0.4% of all tests administered had resulted in a positive diagnosis of COVID-19.

    (c) There were only 17 cases admitted to hospitals. These cases were located in NSW, Victoria and Queensland.

    (d) There were only four cases admitted to an intensive care unit (**ICU**). These cases were located in Queensland and Victoria.

    (e) There has been a total of 68 residential aged care service recipients[53] who have been diagnosed with COVID-19. None of those cases were 'active' cases as at the time of the information being published.

    (f) There has been a total of 31 in home aged care recipients[54] who have been diagnosed with COVID-19. None of those cases were 'active' cases as at the time of the information being published.

110. As at 9pm on 15 June 2020, 15 new cases of COVID-19 had been diagnosed in the preceding 24 hours.[55]

[53] Defined as care recipients in Australian Government subsidised Residential and In Home Care settings in each state and territory.

[54] Defined as care recipients in Australian Government subsidised Residential and In Home Care settings in each state and territory.

[55] Department of Health, *Coronavirus (COVID-19) current situation and case numbers* (accessed on 16 June 2020 at 3.15pm).

111. This can be compared to the same dataset published by the Department of Health on 11 May 2020 (**Attachment G**), the date on which the Applicants filed submissions in support of the Proposed Clauses:

(a) There were 672 'active' cases of COVID-19.

(b) 0.8% of all tests administered had resulted in a positive diagnosis of COVID-19.

(c) There were 49 cases admitted to hospitals. These cases were located in all states and territories except the ACT.

(d) There were 16 cases admitted to an ICU. These cases were located in NSW, Queensland, Victoria and WA.

(e) There had been a total of 63 residential aged care service recipients[56] who had been diagnosed with COVID-19. Twenty-one of those cases were 'active' cases as at the time of the information being published.

(f) There had been a total of 31 in home aged care recipients[57] who had been diagnosed with COVID-19. Six of those cases were 'active' cases as at the time of the information being published.

112. Though we recognise that the situation remains fluid and that the precise number of cases will likely vary day to day, a comparison between the two data sets reveals that:

(a) The number of active cases had fallen by 290;

(b) The proportion of positive test results had fallen by 0.4 percentage points;

(c) The number of persons admitted to hospital had fallen by 32;

[56] Defined as care recipients in Australian Government subsidised Residential and In Home Care settings in each state and territory.

[57] Defined as care recipients in Australian Government subsidised Residential and In Home Care settings in each state and territory.

(d) The number of persons admitted to an ICU had fallen by 12;

(e) The number of active cases amongst residential aged care recipients had fallen from 21 to nil; and

(f) The number of active cases amongst home aged care recipients had gone from six to nil.

113. Whilst the virus remains present in the community, the data above paints a promising picture and is reflective of the significant progress made in considerably lowering the rate of transmission of the virus in Australia and by extension, a lowering of the overall risk to all persons including employees covered by the Relevant Awards.

114. The position in Australia stands in stark contrast to the circumstances facing most other countries, as can be seen from the World Health Organisation publication of 15 June 2020 at **Attachment H**. Further we note that as at 15 June 2020, when compared to the United Kingdom and the United States of America, Australia had experienced a considerably lower number of cases and deaths in total and per population of 1 million:[58]

	Total Cases	**Total Deaths**	**Total Cases per 1 million**	**Total Deaths per 1 million**
Australia	7320	102	287	4
United Kingdom	295,893	41,698	4348	613
United States of America	2,057,838	115,112	6217	348

115. The Applications and the Applicants' submissions must be seen in this context. That is:

(a) The number of persons diagnosed with COVID-19, the proportion of tests undertaken resulting in a positive diagnosis and the number of cases admitted to hospitals and ICUs are low. In each case they reflect a fraction of a percentage of the overall population.

[58] World Health Organisation, *WHO Coronavirus Disease (COVID-19 Dashboard)* (Accessed 16 June at 3.45pm).

(b) There is as at the time of filing this submission one active case amongst residential aged care service recipients (as defined).[59]

(c) There are at the time of filing this submission no active cases amongst home aged care recipients (as defined).[60]

(d) The Applicants have not called evidence about the extent to which persons who come into contact with employees covered by the Relevant Awards in the course of their employment (e.g. clients and patients of the relevant services) have been diagnosed with COVID-19. The Department of Health data cited above, however, suggests that the exposure to such persons in hospitals, residential aged care and home aged care is very limited.

(e) There is no evidence of the extent to which employees covered by the Relevant Awards have contracted COVID-19 much less the likelihood of such persons having contracted COVID-19 in the course of their employment.

(f) The risk of transmission to employees covered by the Relevant Awards would appear to be lower as at the time of preparing these submissions than it was over a month ago when the Applicants' file their materials in support of the claims.

(g) There is no evidence of any expert expectation that that trend will be reversed and by extension, the extent of any such expected reversal.

(h) The risk of transmission to employees covered by the Relevant Awards would appear to be lower than the risk faced by employees performing comparable work in the United Kingdom, the United States and elsewhere around the world. Evidence relied upon by the Applicants regarding the rate of infection amongst health care workers in such places must be considered in that context.[61] Given the very different circumstances facing the health

[59] Department of Health, *Coronavirus (COVID-19) at a Glance* (accessed 18 June at 7.40am).

[60] Department of Health, *Coronavirus (COVID-19) at a Glance* (accessed 18 June at 7.40am

[61] See for example the evidence of Professor MacIntyre on the third page of her report.

care sector in Australia (amongst any other relevant factors), it does not necessarily follow that health care workers in Australia will be infected at the same rate as that which has been experienced overseas.

116. Whilst we accept that the evidence establishes that the work performed by some employees covered by the Relevant Awards requires direct contact with patients or clients at less than 1.5 metres (that being the distance that we are recommended to maintain between persons) and / or with food scraps, bodily fluids or with potentially contagious surfaces, the evidence does not establish that the overall incidence or rate of infection of COVID-19 or the likelihood of the circumstances described by the Proposed Clauses arising amongst employees covered by the Relevant Awards warrants the introduction of an entitlement to paid leave.

117. Even if the evidence established that the risk of employees covered by the Relevant Awards is greater than other employees, the evidence does not establish that the risk of the relevant group of employees in the current circumstances is so high that the proposed entitlements might be justifiable. Indeed this appears to have been implicitly accepted by the Applicants, who submit that the "maintenance of a functioning health and social assistance sector is an overarching justification for paid pandemic leave" however they go on to cite a passage of Professor MacIntyre's evidence in which she states that the Proposed Clauses will "improve the resilience of the health system in the event of a second wave"[62] (our emphasis). The proposition that there may be a second wave is, of course, entirely speculative and without any proper basis having been made out in these proceedings.

8.2 The Health and Safety Obligations on Employers and Employees and Other Recommended Measures

118. In section 7 of this submission we have dealt in detail with various obligations on employers and employees to ensure the health and safety of employees and others (including patients / clients). These obligations are primarily contained in

[62] Applicants' submission dated 11 May 2020 at paragraph 13.

work health and safety legislation and recently issued public health orders / directions. As we there noted, the evidence in these proceedings does not establish any widespread non-compliance of those obligations by employers and to the extent that any isolated instances of that arise, the relevant systems provide mechanisms for dealing with those issues in a more appropriate and targeted way than the Proposed Clauses.

119. The various requirements on employers and employees, coupled with the abundance of other measures recommended to employers by governments, regulators and government agencies operate in conjunction with one another to collectively reduce the risk that the virus might otherwise have posed for employees covered by the Relevant Awards as well as patients / clients accessing the relevant services.

8.3 The Nature of the Work Required to be Performed by Employees Covered by the Relevant Awards

120. The Relevant Awards cover employees who perform a very broad range of work. Despite this, the Applicants have not presented evidence about the nature of the work performed by numerous classes of employees covered by those awards. The material advanced does not establish whether a range of employees covered by the Relevant Awards are in fact particularly exposed to the potential transmission of COVID-19, as claimed by the Applicants.

121. For instance, while there is some evidence of certain health professionals covered by the HPSS Award, there is no evidence about the vast majority of such employees covered by the award. Similarly, there is no evidence about certain types of work performed under the SCHCDS Award that does not require physical or face-to-face engagement with clients.

122. In our submission, the risk profile of employees will logically vary, depending on the nature of work they perform. It is trite to observe that employees engaged under the Nurses Award at a hospital treating patients who have been diagnosed with COVID-19 will necessarily be more at risk than:

(a) Clerical employees covered by the Aged Care Award.[63]

(b) A gardener covered by the Aged Care Award.[64]

(c) Support services employees covered by the HPSS Award which could include gardeners, car park assistants, seamspersons and clerical employees.[65]

(d) A number of the 'common health professionals' listed at Schedule C to the HPSS Award such as biomedical engineers, counsellors, dieticians, genetics counsellors, music therapists and naturopathists.

(e) Occupational health nurses.[66]

(f) Clerical employees and managers covered by the SCHCDS Award.

123. Indeed, some employees covered by the Relevant Awards may not have any direct contact with patients or clients; or in the circumstances of the pandemic, may be able to perform their work remotely without such contact. We refer to submissions we have previously made about employees covered by the Relevant Awards being able to perform work remotely, at section 6 of this submission.

124. The Commission should not proceed on the basis that the likelihood of employees covered by the Relevant Awards being exposed to the virus is synonymous across awards or classifications, or that the risk profile of those classes of employees about whom there is no evidence advanced will be comparable to the risks that the various witnesses claim to be exposed to. A clerical employee covered by the HPSS Award working at a practice of ophthalmologists is not necessarily at any greater risk than a receptionist at a manufacturing plant.

[63] Aged care employee – level 1 to Aged care employee – level 5 and Aged care employee – level 7.

[64] Aged care employee – level 1, Aged care employee – level 2, Aged care employee – level 4, Aged care employee level 6 and Aged care employee level 7.

[65] Schedule B to the HPSS Award.

[66] Schedule B.6 of the Nurses Award.

125. In circumstances where one of the central tenants of the Applicants' case is that employees covered by the Relevant Awards should be afforded the leave entitlements proposed because they are at greater risk of contracting COVID-19, the absence of material that establishes that that is so in relation to countless types of work performed by employees covered by the Relevant Awards is particularly glaring.

126. What follows is that the Applications effectively seek the introduction of substantial new entitlements in relation to a potentially significant number and / or proportion of employees covered by the Relevant Awards about whom the Applicants have not so much as attempted to ground a key proposition advanced in support of their case, nor has any other proper basis for the grant of the entitlement to such employees been established.

9. THE MEDICAL PRACTITIONERS AWARD 2020

127. In this part of our submission, we deal specifically with the MP Award, including the nature of the occupations engaged under the award and the broad range of workplaces where such employees may be engaged. In addition to the various other submissions we have made, we contend that the matters raised in this part of our submission further the proposition that the Applications should not be granted in relation to the MP Award.

128. The Applicants' submissions pay little attention to patterns of engagement under the MP Award and ignore existing protections and the extensive training undertaken by employees covered by the award. The Applicants assert that employees covered by the Relevant Awards are exposed to certain vulnerabilities and disabilities. Whilst we do not accept that this proposition has been made out in relation to the Relevant Awards, we submit that the propositions advanced are particularly ill-founded in the context of medical practitioners given their extensive medical knowledge and training.

129. Specifically, introducing the proposed entitlements would impose an unfair additional cost burden on labour hire businesses who deploy medical professionals covered by the MP Award. The imposition of a requirement to provide paid pandemic leave to such employees would be ill suited to such arrangements. The extensive use of such arrangements in the health sector would be disrupted by the grant of the claim.

9.1 Common Patterns of Engagement under the MP Award

130. Locum arrangements are common in the health sector and many such medical professionals are employed by labour hire providers. Medical professionals employed by a public or private hospital are, in some cases, separately engaged for short periods of time by labour hire or consulting firms for deployment elsewhere.

131. In addition to the submissions we have previously made about the unfairness of the Proposed Clauses to employers where they entitle employees to paid leave where the relevant eligibility criteria is satisfied by an employee for reasons that are not connected with their employment, a further unfairness emerges in the context of labour hire employers covered by the MP Award (and indeed labour hire employers more generally).

132. Where labour hire is utilised for a locum arrangement, the contract for medical officer engagements over a period of time will often be put out to tender. The rate paid for a locum arrangement will be set by the contract arrived at with the successful tenderer. The rates which are set pursuant to the successful tender will typically last for a number of years. If paid pandemic leave is introduced into the MP Award, the cost of such an entitlement will not have been factored into rates already agreed to by a health provider under existing contracts. As such, for the duration of any ongoing labour hire contracts, there will be no capacity for a labour hire employer to pass any proportion of the cost of the leave onto the health provider or recipient of the medical care.

133. Some Government health departments set maximum rates which apply to locum arrangements with little scope for labour hire entities to vary this.[67] Moreover, third parties supplying labour to a hospital will, in some cases be liable for a penalty where a doctor fails to attend. It would be a significant burden upon an employer to be required to provide paid pandemic leave as well as meeting further obligations to pay the recipient of the labour hire service for such cancellations under the circumstances covered by the Proposed Clauses.

134. Finally, locum arrangements involving medical professionals are typically short term, with such employees commonly engaged as casual employees. Labour hire operators covered by the MP Award may deploy workers to multiple workplaces.

[67] See for example, Queensland Health, 'Locum Arrangements and Conditions – Medical Officers' (Human Resources Policy) Effective October 2011, Attachment 1.

135. The Proposed Clauses would introduce an entitlement to paid leave on each relevant occasion regardless of the duration of employment or the projected length of a specific engagement. It would be iniquitous for an employee deployed to a hospital for a small number of days to be entitled to two weeks of paid leave where required to self-isolate.

136. At paragraph [29] of the Applicants' submission, reference is made to paid leave granted in the public sector during the pandemic. It should be noted by the Commission that such entitlements are not generally granted to casual employees. For example, the Queensland Office of Industrial Relations issued Directive 01/20: Employment Arrangements in the Event of a Health Pandemic, effective 16 March 2020. Importantly, with the exception of long-term casual employees, the Special Pandemic Leave granted under this instrument was only granted to casual employees at the discretion of a Chief Executive.[68]

137. The Commission should not in our submission vary the MP Award in the manner proposed. Such a variation may interfere with the types of arrangements described above, render them unviable and ultimately limit the extent to which medical professionals in such circumstances are deployed to provide crucial medical care.

9.2 The Risk Setting for Employees Covered by the MP Award

138. At paragraph [8] of the Applicants' submission, reference is made to the 'special risk setting' which is claimed to characterise the working environment of health care workers.

[68] Minister for Industrial Relations and Commission Chief Executive, *Employment Arrangements in the Event of a Health Pandemic (Directive 01/20)* at clauses 13.2, and 14.2.

139. The coverage provision of the MP Award is expressed in the following terms:

> **4.1** This occupational award covers employers of medical practitioners throughout Australia in the classifications listed in clause 12—Classification Definitions to the exclusion of any other modern award.
>
> **4.2** Medical practitioner means a person who is employed as a medical practitioner in hospitals, hospices, benevolent homes, day procedure centres, Aboriginal health services, community health centres, the Red Cross Blood Service, the South Australian Institute of Medical and Veterinary Science, the Victorian Cytology Service or the Victorian Institute of Forensic Medicine.

140. A medical practitioner covered by the MP Award will not necessarily be in close contact with virus sufferers in all of the workplaces listed in clause 4.2. An employee may not be considered at significantly greater risk if they spend time working in benevolent homes, day procedure centres or community health centres, particularly if these are located outside the major cities. For those medical professionals working in hospitals, many of these will be confined to departments which do not deal specifically with virus sufferers. It is unclear why an orthopaedic surgeon or cardiologist primarily occupying separate rooms within a complex would be considered at increased risk of contracting COVID-19.

141. Attention should also be paid to the diverse range of medical professionals that are covered by the MP Award. The classification definitions in clause 12 of the Award do not confine its operation to general practitioners. Classification definitions range from orderlies to specialists and Director of Medical Services. Many of the employee classifications may rarely see patients in person. For example, a radiologist interpreting x-rays will commonly interact with a patient via their own physician. Similarly, for providers of telehealth services which involve specialist video consultations, no contact with a patient is necessary. We refer to the submissions made about such matters at section 6.

142. Medical practitioners are highly trained and understand the importance of precautionary measures as well as the manner in which they should be implemented. Even in those workplaces where there is a greater likelihood of exposure to COVID-19, it is inappropriate to consider the level of risk without taking into account medical professionals' highly developed understanding of the fundamentals of infection prevention.

143. In assessing the degree to which additional risks in the health sector warrant access to paid pandemic leave, it is necessary to consider the stringent standards of hygiene which apply in health care organisations. For example, in NSW an Environmental Cleaning Policy has been prepared by the Clinical Excellence Commission.[69] The policy outlines key indicators for measuring performance and standard operating procedures in respect of environmental cleaning with a view to achieving a uniform approach to hygiene in health facilities. The policy is listed as applying to a significant number of the workplaces to which employees engaged under the Medical Practitioners Award 2020 may be deployed, such as:

    (a) Local Health Districts

    (b) Affiliated Health Organisations

    (c) Community Health Centres

    (d) Dental Schools and Clinics

    (e) Public Health Units

    (f) Public Hospitals

144. NSW Health has also developed environmental cleaning audit templates to support internal audits of cleaning services.

[69] NSW Government Health, *Environmental Cleaning Policy* (16 November 2012)

145. Ai Group understands that many hospitals have divided their emergency departments into respiratory and non-respiratory sections to contain COVID-19 patients in one place.

146. The considerable standards of hygiene and the standardisation of cleaning practices in the health sector may mitigate to some extent the risk to which employees are exposed. Also relevant are the matters we have raised at sections 7 and 8 of this submission.

9.3 Section 134(1)(a): The relative living standards and needs of the low paid

147. The Applicants argue that the Proposed Clauses are supported by the consideration mandated under s.134(1)(a) of the Act. They claim that lack of access to the proposed form of leave would expose employees to a risk of poverty. We deal with this submission at section 10 of this submission. However, for present purposes we note that this argument should be given little weight when considering whether the proposed amendments to the MP Award are necessary to achieve the modern awards objective.

148. Many employees engaged under this Award are highly paid in comparison to most employees covered by the modern award system and, indeed, much of the Australian population. In the 2018/19 Annual Wage Review decision, based on a definition of low paid meaning two-thirds of median average earnings, this was equal to $886.67 per week or $23.33 per hour in 2018.[70] None of the minimum rates of pay listed in clause 16 of the award fall below the minimum amount to be considered 'low paid' under this definition. The minimum weekly rates prescribed by the award range from $984.52 - $2469.73. In our submission, such employees cannot be considered 'low paid' and accordingly, s.134(1)(a) is, at best, a neutral consideration in the context of the MP Award.

[70] *Annual Wage Review* [2019] FWCFB 3500 at [205].

149. Considering the high rates of pay provided for under the MP Award and the fact that many employees likely earn amounts in excess of the minima provided for under the award, the introduction of paid pandemic leave would constitute a significant cost for employers. For labour hire entities providing staff for locum arrangements and those who engage employees on a casual basis for short-term engagements, paid leave for a highly paid employee may result in an entitlement that constitutes a significant proportion of the value of the employee's service for a particular engagement.

10. THE MODERN AWARDS OBJECTIVE

150. Before addressing the relevant statutory considerations mandated by s.134(1), it is important to acknowledge that COVID-19 has undoubtedly visited significant hardship upon various elements of the Australian community. The development of COVID-19 has commonly been described as a catalyst for both a health crisis and an economic crisis. Neither description is exaggerated, although it is important to appreciate that a raft of regulatory responses and initiatives flowing from government and public institutions (including the Commission), coupled with the sustained efforts of the community, appear to have resulted in Australia weathering the storm so far in a manner that has limited the degree of hardship and suffering that could otherwise have flowed from the pandemic.

151. Vast numbers of Australians have lost their employment or seen their livelihoods significantly diminished. This includes many award reliant employees across a range of sectors. Similarly, many employers are facing unprecedent challenges. Many businesses have been forced to close or limit their operations by virtue of relevant restrictions intended to prevent the transmission of the virus and in many instances either have or will close permanently because of the adverse economic conditions.

152. Neither employees nor employers covered by the Relevant Awards are immune from the current crises; however, it must be acknowledged that in certain respects the most challenging effects and risks of the pandemic for these sectors appear to have been significantly moderated, at this stage. Perhaps most relevantly in the context of the Applications, rates COVID-19 infections have continued on a sustained downward trend and have never reached the levels experienced in many countries. Our health system has not been overwhelmed in the manner experienced elsewhere.

153. Similarly, the sectors covered by these awards are not likely to have experienced the levels of job losses visited upon workers in many sectors.

154. In these proceedings, the Full Bench must consider whether the proposed variation is a *necessary* part of a fair safety net in contemporary circumstances. This of course includes the context of the COVID-19 pandemic.

155. More specifically, the Full Bench must consider whether the introduction of the proposed new entitlement for a discrete portion of the Australian workforce covered by the Relevant Awards is *necessary* to ensure that such instruments meet the modern awards objective.

156. Ultimately, Ai Group contends that a case for such a profound expansion of entitlements has not been made out and indeed that such a variation would not strike a fair balance between the interests of employers and employees covered by the Relevant Awards. We have highlighted various aspects of the Proposed Clauses that are particularly unfair to employers in section 6 of this submission.

157. In advancing this submission we do not seek to detract from the importance of the work undertaken by the various employees covered by the Relevant Awards. Nor do we seek to downplay the challenges they face. There are however limitations on the extent to which the awards system can address many of the difficulties flowing from the current global pandemic. Importantly, there are also limitations on the extent to which employers can fairly be expected to meet the costs of maintaining employee incomes in circumstances where they cannot work because of the pandemic or government initiatives to limit its spread. The proposed variations would create a burden for employers in a manner that is unfair and potentially unsustainable.

10.1 The Nature of the Workforce covered by the Relevant Awards

158. The Applicants argue, in effect, that it is fair for employees covered by the Relevant Awards to receive paid pandemic leave in circumstances where others do not due distinguishing factors such as the essential nature of their work, the elevated risk that workers covered by the Relevant Awards are exposed to the

virus and the "broad social objective of the maintenance of the health care workforce"[71].

159. While it cannot be contested that some work performed by employees covered by the Relevant Awards is essential in nature, it would be inaccurate to suggest that only employees covered by these Awards perform essential work. Throughout the pandemic, employees across a broad range of sectors have been required to, and have in fact, continued to perform their roles notwithstanding the unavoidable close interaction that their work has caused them to have with the general public or work in public spaces. This has been essential to the continued functioning of our society and economy.

160. It is similarly inaccurate to suggest that all workers covered by the Relevant Awards currently face an elevated risk relative to all other workers. The recent progressive lifting throughout Australia of various restrictions implemented by governments to prevent the spread of the virus means that the elevated risk to some workers covered by the Relevant Awards relative to other workers has undoubtedly dissipated. Though it was previously the case that some employees were not subject to potential exposure to the virus in the course of their employment because their employers' businesses were prohibited from operating (for instance, restaurants, cafes, fast food operations, gyms, beauty services and so on), such services are generally now permitted to operate subject to certain social distancing principles.[72] It is no longer the case that the work performed by such employees is not permitted or that the work covered by the Relevant Awards is amongst a limited category of work that is being performed.

161. Section 8 of these submissions dealt with whether employees covered by the Relevant Awards face an elevated risk of infection such that a variation to Relevant Awards is justified. In support of our contention that they do not, we here simply emphasise the need to take into account the success that Australia

[71] Applicants' submission dated 11 May 2020 at paragraph 16.

[72] Fair Work Commission, *Information note – Government responses to COVID-19 pandemic* (16 June 2020).

has had in managing the spread of COVID-19, the raft of regularly protections afforded to employees and the various measures implemented by employers covered by the Relevant Award to protect employees.

162. We also submit that given the dynamic nature of the COVID-19 pandemic, its impact on the nature of work in all sectors has been unprecedented and variable over time. It is therefore crucial that the Commission make any assessment of the need for the proposed new entitlements based on current circumstances, without giving undue weight to employee experiences of working during the early stages of the pandemic. The rate of infection, government and regulatory responses and extent of employer education as to how they should respond to the virus have markedly improved over the course of the crisis. It cannot be concluded that such earlier experiences are necessarily reflective of extant experiences.

163. In response to the Applicants' appeal to the broad social objective of maintaining the health care workforce, we submit that the current circumstances do not necessitate the variation of modern awards in order to support such an outcome. Further, whilst such considerations are not irrelevant to the Commission's deliberations, they must be viewed through the prism of the Commission's task of ensuring that awards achieve the modern awards objective and that this is achieved only through the inclusion of terms that are necessary to meet the modern awards objective. It is not sufficient to identify that particular proposed terms further a broader policy objective in order to justify their inclusion in the minimum safety net of terms and conditions constituted by awards.

10.2 The Allocation of 'Economic Risk'

164. A key argument advanced by the Applicants as to why paid pandemic leave is a necessary part of a fair and relevant safety is that it allocates economic risk more fairly between employers and employees. The Applicants argue that employers are "more able to manage the risk when an employee is required to self isolate,

and better able to bear the cost of their absence. They also identify that some employees covered by some of the Relevant Awards are low paid"[73].

165. The blanket proposition that all employers are better placed to bear the relevant economic risk cannot be accepted. Firstly, it cannot simply be assumed that this is the case absent evidence of the financial position of employers covered by the Relevant Awards or at least of the current trading environment relevant to the sectors covered by those awards. Regardless, there are obvious reasons to be cautious about assuming that employers can meet any substantial additional costs flowing from an award in at least some of the sectors covered by the relevant awards. For example, many employers covered by the SCHCDS Award performing services in the context of the National Disability Insurance Scheme operate with perilously tight margins and will face significant difficulties recovering additional cost increases flowing from the proposed variations as there is no allowance for such matters in the relevant funding arrangements.

166. The cumulative impact upon employers of potential multiple staff absences must also be considered; as must the fact that employers must not only bear the cost of absences contemplated by the claim, but also resource the kinds of necessary initiatives that are necessary to comply with the various regulatory obligations discussed in section 7 and must in many instances meet such costs at a time when their revenue sources have declined for reasons associated with the pandemic.

167. The merit of the argument that there is a need to shift the cost of employees' absences from work, due to reasons related to COVID-19, from employees to employers is undermined by the extent to which employees faced with such circumstances can potentially obtain income by applying for or seeking access to:

[73] Applicants' submission dated 11 May 2020 at paragraph 17.

(a) Paid personal/carers leave (if the employee is unfit for work due to COVID-19);

(b) Paid annual leave;

(c) Paid long service leave;

(d) Workers compensation; and

(e) Welfare support (including the enhanced forms of support introduced by the government in response to COVID-19).

168. In relation to the above reference to workers compensation, we observe that in circumstances where an employee's infection with COVID-19 arises from the course of their employment, they will potentially have an entitlement to receive payment by virtue of the various workers compensation systems in place throughout Australia. Ai Group is not aware of health care workers in any jurisdiction who have acquired COVID-19 experiencing any difficulty in establishing their eligibility to such payments.

169. In NSW, an amendment to the *Workers Compensation Act (1987)* has introduced presumptive liability provisions that make it easier for certain employees to establish that they have acquired COVID-19 in circumstances that would give rise to an entitlement to compensation.[74] The legislation provides that this includes employees working in the following (emphasis added):

(a) the retail industry (other than businesses providing only on-line retail),

(b) the health care sector, including ambulance officers and public health employees,

(c) disability and aged care facilities,

(d) educational institutions, including pre-schools, schools and tertiary institutions (other than establishments providing only on-line teaching services),

(e) police and emergency services (including fire brigades and rural fire services),

(f) refuges, halfway houses and homeless shelters,

[74] Section 19(b) of the *Workers Compensation Act (1987)* (NSW).

(g) passenger transport services,

(h) libraries,

(i) courts and tribunals,

(j) correctional centres and detention centres,

(k) restaurants, clubs and hotels,

(l) the construction industry,

(m) places of public entertainment or instruction (including cinemas, museums, galleries, cultural institutions and casinos),

(n) the cleaning industry,

(o) any other type of employment prescribed by the regulations for the purposes of this definition.

170. The availability of workers compensation to employees who have acquired COVID-19 (or would be taken to have acquired COVID-19 under relevant workers compensation legislation) in the course of their employment significantly undermines any argument that employees should receive additional paid leave as proposed in circumstances where they have been infected with the illness. If they have been infected in the course of their employment, the matter is appropriately dealt with under special legislation dealing with workers compensation and if they have acquired it outside of their employment, it is not fair to expect an employer to cover costs beyond an employee's entitlement to personal/carer's leave.

171. The potential eligibility of employees to workers compensation also raises complex questions as to whether an employee who is eligible for workers compensation might nonetheless also be eligible to access paid leave under the proposed clause X.2.3. The clause fails to address this issue. There can be no valid justification for an employee receiving both payments but the clause does not make it clear that such an outcome might not arise.

10.3 The Witness' Perceptions as to Fairness and Relevance

172. The Applicants assert that a number of witnesses have identified the proposed entitlement as "fair and relevant". It is of course trite to observe that it does not follow that the Proposed Clauses are fair or relevant simply because this is asserted by the relevant witnesses. The employees' evidence is reflective of their perceptions only. It is hardly surprising that an employee would be supportive of a proposed entitlement to additional leave and consider that such an entitlement would be fair.

173. We also note that several witnesses cite extended waiting times for their test results and / or that they were required to self-isolate for an extended period of time because they were experiencing relevant symptoms but were not eligible to be tested. These matters appear to have coloured the witness' perceptions of the impact that the virus has had on their ability to attend work and, where relevant, on their earnings.

174. We note that the Applicants' witness statements were filed on or before 11 May 2020. Since then, the eligibility criteria for testing has been expanded in many if not all states and territories and the waiting times for test results also appear to be have been reduced. These are material developments that would necessarily reduce the extent to which an employee may be required to absent themselves from work in circumstances where they are suspected of being infected by COVID-19. At **Attachment I** we set out the most recent publicly available information regarding testing eligibility criteria and expected waiting times.

10.4 Section 134(1)(a) – the relative living standards and needs of the low paid

175. Ai Group accepts that some employees covered by the Relevant Awards are low paid, in the relevant sense. However, it cannot be said that all employees covered by all of the Relevant Awards would fit this description. Indeed, it is not clear that any employees covered by some of the Relevant Awards would.[75]

[75] See for example the MP Award.

176. Nonetheless, by the Applicants' design, eligibility to the proposed new entitlement is not differentiated based on whether particular workers would meet this definition. This significantly tempers the extent to which s.134(1)(a) could be said to weigh in favour of the claim.

177. In their submissions pertaining to ss134(1)(a), the Applicants point to the existence of entitlements to paid COVID-19 leave for some public sector employees and submit that a fair and relevant safety net for employees covered by the Relevant Awards necessitates that their leave entitlements during the pandemic are not considerably inferior to health and social and community services employees performing the same or similar work in the public sector. Such a contention is deeply flawed.

178. There is no justifiable reason for modern award entitlements applicable in the private sector to be aligned to public sector terms and conditions. Nor is it necessary to vary modern awards so that they reflect terms contained in State awards made under different legislative regimes.

179. We also note that the approach of the Applicants appears to be to simply cherry-pick one type of entitlement applicable in the public sector without seeking to compare or align conditions between the sectors more broadly. This is obviously not a sound basis for setting minimum conditions contained within the safety net.

180. The Applicants address the "needs of the low paid consideration" arising under s.134(1)(a) at paragraph 32 of their submissions. The crux of their contention appears to be that where employees are low paid and award reliant in the sectors covered by the Relevant Awards, they are more likely to be at risk of poverty due to their lack of access to paid leave coupled with the greater likelihood that they will need to self-isolate or contract COVID-19 given their work as compared to other persons.

181. The force of this argument is reduced by the availability various forms of paid leave to many such employees and, where such employees are unable to work due to COVID-19 or needing to self-isolate, workers compensation or welfare payments.

182. Further, any proposition that all employees covered by the Relevant Awards and working during the pandemic will face a greater risk of exposure to COVID-19 or the need to self-isolate than either the general public or other groups of low paid award reliant employees should not be accepted for the reasons articulated in particular at section 8 of this submission.

10.5 Section 134(1)(b) - the need to encourage collective bargaining

183. Ai Group accepts that the short-term nature of the proposed variations limits the extent to which they would encourage or discourage parties from engaging in collective bargaining.

184. To the extent that the claim increases the threshold against which proposed new agreements will be assessed for the purposes of the better off overall test, it may logically be expected to serve as factor discouraging employers that operate under existing enterprise agreements that do not contain such provisions from seeking to enter into new agreements or to pursue any form of variation to their current agreement. Such a submission arguably applies with greater force in the context of the SCHCDS Award, given what we assume to be an uncontentious proposition that the practice of bargaining in this industry often does not result in enterprise agreements proving significant over-award payments or entitlements, the cost of which could not be recovered through relevant funding arrangements.

185. Notwithstanding the above submissions we acknowledge that the factors that influence a party's preparedness to engaging in bargaining are typically multifaceted and we accept that the Commission cannot, on the material before it, draw any firm conclusions as to the extent to which the Proposed Clauses would tangibly serve to encourage or discourage collective bargaining.

10.6 Section 134(1)(c) – the need to promote social inclusion through increased workforce participation

186. It cannot be accepted on the material advanced that the Proposed Clauses will result in increased workforce participation as asserted by the Applicants, and as such this should be a neutral consideration.

10.7 Section 134(1)(d) – the need to promote flexible modern work practices and the efficient and productive performance of work.

187. The Applicants' submissions in relation to this point fail to provide any cogent articulation as to how the consideration mandated by s.134(1)(d) is to be treated.

188. To the extent that the Proposed Clauses may result in employees accessing leave in circumstances where they may be able to have safely attended work or worked remotely, they would undermine the implementation of flexible work practices and the efficient and productive performance of work.

10.8 Section 134(1)(da) – the need to provide additional remuneration for employees working in various circumstances

189. This is a neutral consideration.

10.9 Section 134(1)(e) – equal remuneration for work of equal or comparable value

190. This is a neutral consideration.

10.10 Section 134(1)(f) – the impact on business including on productivity, employment costs and the regulatory burden

191. The grant of the application will expose employers to whom the Relevant Awards apply to additional costs and increase the regulatory burden. This will be a direct product of such employers needing to both pay the relevant amounts and facilitate the implementation of the entitlement. Section 134(1)(f) clearly weighs against the grant of the claim.

192. The imposition of any additional cost impact or regularly burden on employers covered by the Relevant Awards should be approached particularly cautiously given the challenges that employers in the relevant sectors are currently facing as a consequence of COVID-19. This includes managing the various regulatory and operational challenges flowing from the pandemic as well as, for many employers, a significant decline in their trading environment.

193. The grant of the Applications risks redirecting the limited resources of such organisations away from measures that may more squarely assist in addressing the health issues requiring immediate attention, protecting the safety of employees or from their usual and often essential operations.

194. We nonetheless here acknowledge the finding in the *Unpaid Pandemic Leave Decision* that the entitlement to unpaid pandemic leave would support the public policy objective of encouraging those who should self-isolate to do so and thereby limit the spread of COVID-19 in workplaces, allowing businesses to continue to operate.[76] The Applicants refer to the Full Bench's reasoning and further assert that paid pandemic leave is a measure in aid of infection control and that:

> Paid Pandemic Leave is a measure in aide of infection control and it is appropriate to consider the worst case scenarios where a failure in infection control results in system failure, catastrophic loss of productivity and significant monetary and reputational costs for employer. Further, the prospect of greater numbers of death in the community is not exaggerated consequence of health and care systems lacking the necessary resilience...[77]

195. The importance of infection control and maintenance of a properly functioning health care system cannot be disputed, particularly in the context of COVID-19. However, it does not follow that a paid leave entitlement is the panacea to the various challenges flowing from COVID-19 or indeed that it will have such a significant role, in current circumstances, so as to justify a conclusion that it will have a positive impact on business or productivity (either at the enterprise level or across the economy). It would certainly be an exaggeration to assert that the entitlement would allow businesses to continue to operate or that the proper functioning of the health system depends upon or is in some way reliant upon the grant of a new entitlement to paid pandemic leave.

196. The lack necessity for, and utility of, the proposed variations as a mechanism for dealing with the health crisis has to some extent already been canvassed in these submissions. In response to the Applicants' contentions outlined above we below emphasise the following 6 key considerations that undermine any

[76] *Variation of awards at the initiative of the Commission* [2020] FWCFB 183 at [124].

[77] Applicants' submissions dated 11 May 2020 at paragraph 40.

contention that variation will be instrumental in limiting the spread in workplaces or indeed the broader society so as to ground an argument that is in the interests of business.

197. *First*, the grant of unpaid pandemic leave in most awards (including the Relevant Awards) has filled the regulatory gap identified by the Full Bench in the *Unpaid Pandemic Leave Decision* and as such already largely serves to facilitate necessary absences of the type contemplated by the current application.

198. *Second*, the evidence does not establish that an award-derived entitlement to payment would be necessary to motivate employees in the sectors covered by the Relevant Awards to be absent from work in the circumstances contemplated by the Proposed Clauses. That is, it does not suggest that employees have been (or would) inappropriately attend work in such circumstances. Indeed, the largely evidence depicts a cohort of employees who are very conscious to not expose others to infection and anxious to ensure that they act appropriately.

199. *Third*, the extent to which payment may already be accessible in circumstances of absence contemplated by the claim as a product of the availability of paid personal carer's leave, annual leave, long services leave, paid leave voluntarily granted by some employers, workers compensation or welfare payments further undermines the justification for the Applications.

200. *Fourth*, as earlier articulated, employees are already subject to various legal obligations to not attend work where doing so will spread the virus. The provision of payment to incentivise employees to not contravene such requirements is not warranted. We refer to our submissions at section 7 of this submission in this regard.

201. *Fifth*, given Australia has had in controlling the transmission of the virus, the prospects of widespread failure of our health system does not appear to be an imminent risk.

202. *Sixth*, given the narrower scope of the application of the Relevant Awards in comparison to the coverage of the 99 awards that were varied to include unpaid pandemic leave, it cannot be concluded that the Proposed Clauses would likely

play a comparable role to the variation flowing from the earlier proceedings in limiting the spread of the virus broadly throughout society.

10.11 Section 134(1)(g) – the need to ensure a simple, easy to understand, stable and sustainable modern award system that avoids unnecessary overlap

203. At section 6 of this submission, we have identified various deficiencies in the drafting of the Proposed Clauses that would render them far from simple and easy to understand.

204. The mere fact that certain elements of the Proposed Clauses are in similar terms to the provisions dealing with unpaid pandemic leave does not mean that there should not be a careful assessment of the manner in which the Proposed Clauses have been framed. Moreover, it is arguably more important that provisions providing for significant entitlements to paid leave are robustly and clearly drafted. Readers of the awards should be able to easily identify the circumstances when a payment is required to be made and the precise quantum of any such payment so as to avoid underpayment or disputation.

10.12 Section 134(1)(h) – the likely impact on employment growth, inflation and sustainability, performance and competitiveness of the national economy

205. The Commission cannot be satisfied on the material before it that the Proposed Clauses would have any discernible positive impact on the sustainability or performance of the Australian economy. The Commission should not find that this consideration weighs in favour of the granting of the claim.

Attachment A

COVID-19 Temporary MBS Telehealth Services

Last updated: 27 May 2020

- Commencing 13 March 2020, new temporary MBS telehealth items have been made available to help reduce the risk of community transmission of COVID-19 and provide protection for patients and health care providers.
- The list of telehealth services has continued to expand since 13 March. This is the latest factsheet and provides details on all current telehealth items.
- The new temporary MBS telehealth items are available to GPs, medical practitioners, nurse practitioners, participating midwives, allied health providers and dental practitioners in the practice of oral and maxillofacial surgery.
- A service may only be provided by telehealth where it is safe and clinically appropriate to do so.
- The new temporary MBS telehealth items are for out-of-hospital patients.
- It is a legislative requirement that the GPs and Other Medical Practitioner (OMP) new telehealth services, must be bulk billed for Commonwealth concession card holders, children under 16 years old and patients who are more vulnerable to COVID-19.
- As of 20 April 2020, specialist and allied health service providers are no longer required to bulk bill these new telehealth items.
- Providers are expected to obtain informed financial consent from patients prior to providing the service; providing details regarding their fees, including any out-of-pocket costs.
- The bulk-billing incentive Medicare fees have temporarily doubled (until 30 September) for items relating to GP and OMP services, diagnostic imaging services (items 64990 and 64991) and pathology services (items 74990 and 74990). These items can be claimed with the telehealth items where appropriate. The fees are provided later in the factsheet. As of 20 April, two new bulk-billing incentive items have been introduced for services provided to patients who are more vulnerable to COVID-19.

What are the changes?

As part of the Australian Government's response to COVID-19, new temporary MBS telehealth items have been introduced to ensure continued access to essential Medicare rebated consultation services. As of 30 March 2020 these items have become general in nature and have no relation to diagnosing, treating or suspecting COVID-19.

A list of the new telehealth items is provided later in this fact sheet.

Why are the changes being made?

The new temporary MBS telehealth items will allow people to access essential Medicare funded health services in their homes and reduce their risk of exposure to COVID-19 within the community.

Who is eligible?

The new temporary MBS telehealth items are available to providers of telehealth services for a wide range of consultations. All Medicare eligible Australians can now receive these services.

GP and OMP services provided using the MBS telehealth items must be bulk billed for Commonwealth concession card holders, children under 16 years of age, and patients who are more vulnerable to COVID-19. For specialist and allied health services, bulk billing is at the discretion of the provider, so long as informed financial consent is obtained prior to the provision of the service.

Vulnerable means a patient at risk of COVID-19, so a person who:

- is required to self-isolate or self-quarantine in accordance with guidance issued by the Australian Health Protection Principal Committee in relation to COVID-19; or
- is at least 70 years old; or
- if the person identifies as being of Aboriginal or Torres Strait Islander descent—is at least 50 years old; or
- is pregnant; or
- is the parent of a child aged under 12 months; or
- is being treated for a chronic health condition; or
- is immune compromised; or
- meets the current national triage protocol criteria for suspected COVID-19 infection.

A chronic health condition is medical condition that has been present (or is likely to be present) for at least six months or is terminal. The Department of Health website provides additional detail online: https://www.health.gov.au/health-topics/chronic-conditions/about-chronic-conditions. The diagnosis of immune compromised is a clinical decision made by the patient's treating doctor. Please note this is guidance only, and does not constitute MBS claiming advice.

What telehealth options are available?

Videoconference services are the preferred approach for substituting a face-to-face consultation. However, in response to the COVID-19 pandemic, providers will also be able to offer audio-only services via telephone if video is not available. There are separate items available for the audio-only services.

No specific equipment is required to provide Medicare-compliant telehealth services. Practitioners must ensure that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws. To assist providers with their privacy obligations, a privacy checklist for telehealth services has been made available on MBSOnline: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TelehealthPrivChecklist. Further information can be found on the Australian Cyber Security Centre website

What does this mean for providers?

The new temporary MBS telehealth items will allow providers to continue to deliver essential health care services to patients within their care.

Providers do not need to be in their regular practice to provide telehealth services. Providers should use their provider number for their primary location, and must provide safe services in accordance with normal professional standards.

The telehealth MBS items can substitute for current face-to-face consultations that available under the MBS when the service/s cannot be provided due to COVID-19 considerations. The telehealth items will have similar requirements to normal timed consultation items.

GP and OMP telehealth items must be bulk billed for vulnerable patients, concession card holders and children under 16 years at the time the service is being provided, meaning MBS rebates are paid to the provider. Rebates for services provided by GPs and non-vocationally registered medical practitioners will be paid at 85% of the new item fees - these fee amounts have been increased so that the Medicare rebates paid for the new GP and medical practitioner telehealth services are at the same level as the rebates paid for the equivalent face-to-face services. (Due to the urgency of the new telehealth arrangements, the Department of Health has not been able to amend the legislation that establishes 100% rebates for GP/medical practitioner services.)

For additional information on the use of telehealth items, please refer to the Provider Frequently Asked Questions document available on MBSOnline.

How will these changes affect patients?

The new temporary MBS telehealth items will require GPs and OMPs to bulk-bill only for vulnerable patients, concession card holders and children under 16 years, so there will be no additional charge for these patients. Patients are required to consent to their service being bulk-billed. Eligible patients should ask their service providers about their telehealth options, where clinically appropriate.

Specialist and allied health telehealth items do not need to be bulk billed, however the provider must ensure informed financial consent is obtained prior to the provision of the service.

A consumer factsheet is available on MBSOnline which provides further information on how these changes will affect patients.

Who was consulted on the changes?

Targeted consultation with stakeholders has informed the new temporary MBS telehealth items. Due to the nature of the COVID-19 emergency, it was not reasonably possible to undertake normal, broad consultations prior to implementation.

How will the changes be monitored and reviewed?

The Department of Health will monitor the use of the new temporary MBS telehealth items. Use of the items that does not seem to be in accordance with the relevant Medicare guidelines and legislation will be actioned appropriately.

Where can I find more information?

COVID-19 National Health Plan resources for the general public, health professionals and industry are available from the Australian Government Department of Health website.

The full item descriptors and information on other changes to the MBS can be found on the MBS Online website at www.mbsonline.gov.au. You can also subscribe to future MBS updates by visiting MBS Online and clicking 'Subscribe'.

The Department of Health provides an email advice service for providers seeking advice on interpretation of the MBS items and rules and the Health Insurance Act and associated regulations. If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

Subscribe to 'News for Health Professionals' on the Services Australia website and you will receive regular news highlights.

If you are seeking advice in relation to Medicare billing, claiming, payments, or obtaining a provider number, please go to the Health Professionals page on the Services Australia website or contact Services Australia on the Provider Enquiry Line – 13 21 50.

Please note that the information provided is a general guide only. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation.

This sheet is current as of the Last updated date shown above, and does not account for MBS changes since that date.

COVID-19 – TEMPORARY MBS TELEHEALTH ITEMS

GENERAL PRACTITIONER ATTENDANCES

These services need to be bulk-billed for vulnerable patients, concession card holders and children under 16 years, and are for out-of-hospital patients

Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items** – *for when video-conferencing is not available*
Standard GP Attendance Items introduced 13 March 2020			
Attendance for an obvious problem	3	91790	91795
Attendance less than 20 minutes	23	91800	91809
Attendance at least 20 minutes	36	91801	91810
Attendance at least 40 minutes	44	91802	91811
Health assessment for people of Aboriginal or Torres Strait Islander descent Items introduced 30 March 2020			
Health assessment	715	92004	92016
Chronic Disease Management Items introduced 30 March 2020			
Preparation of a GP management plan (GPMP)	721	92024	92068
Coordination of Team Care Arrangements (TCAs)	723	92025	92069
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	92026	92070
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	92027	92071
Review of a GPMP or Coordination of a Review of TCAs	732	92028	92072
Autism, Pervasive Developmental Disorder and Disability Services Items introduced 30 March 2020			
Assessment, diagnosis and preparation of a treatment and management plan for patient under 13 years with an eligible disability, at least 45 minutes.	139	92142	92145
Pregnancy Support Counselling program Items introduced 30 March 2020			
Non-directive pregnancy support counselling, at least 20 minutes	4001	92136	92138
Eating Disorder Management Items introduced 30 March 2020			
GP without mental health skills training, preparation of an eating disorder treatment and	90250	92146	92154

management plan, lasting at least 20 minutes, but less than 40 minutes			
GP without mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90251	92147	92155
GP with mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90252	92148	92156
GP with mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90253	92149	92157
Review of an eating disorder treatment and management plan	90264	92170	92176
Eating disorder psychological treatment (EDPT) service, lasting at least 30 minutes, but less than 40 minutes	90271	92182	92194
EDPT service, at least 40 minutes	90273	92184	92196
Mental Health Services Items introduced 30 March 2020			
GP without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2700	92112	92124
GP without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2701	92113	92125
Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan	2712	92114	92126
Mental health treatment consultation, at least 20 minutes	2713	92115	92127
GP with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	2715	92116	92128
GP with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	2717	92117	92129
Items introduced 13 March 2020			
Focussed Psychological Strategies (FPS) treatment, lasting at least 30 minutes, but less than 40 minutes	2721 and 2729	91818	91842
FPS treatment, at least 40 minutes	2725 and 2731	91819	91843
Urgent After Hours Attendance Items introduced 30 March 2020			
Urgent attendance, unsociable after hours	599	92210	92216

OTHER MEDICAL PRACTITIONER ATTENDANCES These services need to be bulk-billed for vulnerable patients, concession card holders and children under 16 years, and are for out-of-hospital patients			
Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items** – *for when video-conferencing is not available*
Standard Attendance Items introduced 13 March 2020			
Attendance of not more than 5 minutes	52	91792	91797
Attendance of more than 5 minutes but not more than 25 minutes	53	91803	91812
Attendance of more than 25 minutes but not more than 45 minutes	54	91804	91813
Attendance of more than 45 minutes	57	91805	91814
Attendance of not more than 5 minutes	179	91794	91799
Attendance of more than 5 minutes but not more than 25 minutes. Modified Monash 2-7 area	185	91806	91815
Attendance of more than 25 minutes but not more than 45 minutes. Modified Monash 2-7 area	189	91807	91816
Attendance of more than 45 minutes. Modified Monash 2-7 area	203	91808	91817
Health assessment for people of Aboriginal or Torres Strait Islander descent Items introduced 30 March 2020			
Health assessment	228	92011	92023
Chronic Disease Management Items introduced 30 March 2020			
Preparation of a GP management plan (GPMP)	229	92055	92099
Coordination of Team Care Arrangements (TCAs)	230	92056	92100
Contribution to a Multidisciplinary Care Plan, or to a review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	231	92057	92101
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	232	92058	92102
Review of a GPMP or Coordination of a Review of TCAs	233	92059	92103
Pregnancy support Counselling program Items introduced 30 March 2020			
Non-directive pregnancy support counselling of at least 20 minutes	792	92137	92139

Eating Disorder Management Items introduced 30 March 2020			
Medical Practitioner without mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90254	92150	92158
Medical Practitioner without mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90255	92151	92159
Medical Practitioner with mental health skills training, preparation of an eating disorder treatment and management plan, lasting at least 20 minutes, but less than 40 minutes	90256	92152	92160
Medical Practitioner with mental health skills training, preparation of an eating disorder treatment and management plan, at least 40 minutes	90257	92153	92161
Review of an eating disorder treatment and management plan	90265	92171	92177
Eating disorders psychological treatment (EDPT) service, lasting at least 30 minutes, but less than 40 minutes	90275	92186	92198
EDPT service, at least 40 minutes	90277	92188	92200
Urgent After Hours Attendance Items introduced 30 March 2020			
Urgent attendance, unsociable after hours	600	92211	92217
Mental Health Items introduced 30 March 2020			
Medical Practitioner without mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	272	92118	92130
Medical Practitioner without mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	276	92119	92131
Review of a GP mental health treatment plan or Psychiatrist Assessment and Management Plan	277	92120	92132
Medical Practitioner mental health treatment consultation, at least 20 minutes	279	92121	92133
Medical Practitioner with mental health skills training, preparation of a GP mental health treatment plan, lasting at least 20 minutes, but less than 40 minutes	281	92122	92134
Medical Practitioner with mental health skills training, preparation of a GP mental health treatment plan, at least 40 minutes	282	92123	92135

Items introduced 13 March 2020			
Focussed Psychological Strategies (FPS) treatment, lasting at least 30 minutes, but less than 40 minutes	283 and 371	91820	91844
FPS treatment, at least 40 minutes	286 and 372	91821	91845

SPECIALIST, CONSULTANT PHYSICIAN, PSYCHIATRIST, PAEDIATRICIAN, GERIATRICIAN, PUBLIC HEALTH PHYSICIAN, NEUROSURGEON AND ANAESTHETIST ATTENDANCES These services are for out-of-hospital patients			
Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items –** *for when video-conferencing is not available*
Specialist Services Items introduced 13 March 2020			
Specialist. Initial attendance	104	91822*	91832*
Specialist. Subsequent attendance	105	91823*	91833*
Consultant Physician Services Items introduced 13 March 2020			
Consultant physician. Initial attendance	110	91824 **	91834 **
Consultant physician. Subsequent attendance	116	91825**	91835**
Consultant physician. Minor attendance	119	91826**	91836**
Items introduced 6 April 2020			
Consultant physician. Initial assessment, patient with at least 2 morbidities, prepare a treatment and management plan, at least 45 minutes	132	92422**	92431**
Consultant physician, Subsequent assessment, patient with at least 2 morbidities, review a treatment and management plan, at least 20 minutes	133	92423**	92432**
Specialist and Consultant Physician Services Items introduced 30 March 2020			
Specialist or consultant physician early intervention services for children with autism, pervasive developmental disorder or disability	137	92141	92144
Geriatrician Services Items introduced 6 April 2020			
Geriatrician, prepare an assessment and management plan, patient at least 65 years, more than 60 minutes	141	92623	92628
Geriatrician, review a management plan, more than 30 minutes	143	92624	92629

Consultant Psychiatrist services			
Items introduced 6 April 2020			
Consultant psychiatrist, prepare a treatment and management plan, patient under 13 years with autism or another pervasive developmental disorder, at least 45 minutes	289	92434	92474
Consultant psychiatrist, prepare a management plan, more than 45 minutes	291	92435	92475
Consultant psychiatrist, review management plan, 30 to 45 minutes	293	92436	92476
Consultant psychiatrist, attendance, new patient (or has not received attendance in preceding 24 mths), more than 45 minutes	296	92437	92477
Items introduced 13 March 2020			
Consultant psychiatrist. Consultation, not more than 15 minutes	300	91827	91837
Consultant psychiatrist. Consultation, 15 to 30 minutes	302	91828	91838
Consultant psychiatrist. Consultation, 30 to 45 minutes	304	91829	91839
Consultant psychiatrist. Consultation, 45 to 75 minutes	306	91830	91840
Consultant psychiatrist. Consultation, more than 75 minutes	308	91831	91841
Items introduced 20 April 2020			
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving group of 2 to 9 unrelated patients or a family group of more than 3 patients, each referred to consultant psychiatrist	342	92455	92495
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving family group of 3 patients, each referred to consultant psychiatrist	344	92456	92496
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving family group of 2 patients, each referred to consultant psychiatrist	346	92457	92497
Items introduced 6 April 2020			
Consultant psychiatrist, interview of a person other than patient, in the course of initial diagnostic evaluation of patient, 20 to 45 minutes	348	92458	92498
Consultant psychiatrist, interview of a person other than patient, in the course of initial diagnostic evaluation of patient, 45 minutes or more	350	92459	92499
Consultant psychiatrist, interview of a person other than patient, in the course of continuing management of patient, not less than 20 minutes, not exceeding 4 attendances per calendar year	352	92460	92500

Items introduced 30 March 2020			
Consultant psychiatrist, prepare an eating disorder treatment and management plan, more than 45 minutes	90260	92162	92166
Consultant psychiatrist, to review an eating disorder plan, more than 30 minutes	90266	92172	92178
Paediatrician Services Items introduced 30 March 2020			
Paediatrician early intervention services for children with autism, pervasive developmental disorder or disability	135	92140	92143
Paediatrician, prepare an eating disorder treatment and management plan, more than 45 minutes	90261	92163	92167
Paediatrician, to review an eating disorder plan, more than 20 minutes	90267	92173	92179
Public Health Physician Services Items introduced 20 April 2020			
Public health physician, level A attendance	410	92513	92521
Public health physician, level B attendance, less than 20 minutes	411	92514	92522
Public health physician, level C attendance, at least 20 minutes	412	92515	92523
Public health physician, level D attendance, at least 40 minutes	413	92516	92524
Neurosurgery attendances Items introduced 20 April 2020			
Neurosurgeon, initial attendance	6007	92610	92617
Neurosurgeon, minor attendance	6009	92611	92618
Neurosurgeon, subsequent attendance, 15 to 30 minutes	6011	92612	92619
Neurosurgeon, subsequent attendance, 30 to 45 minutes	6013	92613	92620
Neurosurgeon, subsequent attendance, more than 45 minutes	6015	92614	92621
Anaesthesia Attendances Items introduced 22 May 2020			
Anaesthetist, professional attendance, advanced or complex	17615	92701	92712

*For all specialties that have an existing arrangement to access consultations at the specialist rate.

**For all specialties that have an existing arrangement to access consultations at the consultant physician rate.

OBSTETRICIANS, GPs, MIDWIVES, NURSES OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONERS ATTENDANCES

These services for out-of-hospital patients

Items introduced 13 March 2020

Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items** – *for when video-conferencing is not available*
Antenatal Service provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner	16400	91850	91855
Postnatal attendance by an obstetrician or GP	16407	91851	91856
Postnatal attendance by: (i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner	16408	91852	91857
Antenatal attendance	16500	91853	91858

DENTAL PRACTITIONER IN THE PRACTICE OF ORAL AND MAXILLOFACIAL SURGERY ATTENDANCES

These services are for out-of-hospital patients

Items introduced 22 May 2020

Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items** – *for when video-conferencing is not available*
Dental practitioner (oral and maxillofacial surgery only), initial attendance	51700	54001	54003
Dental practitioner (oral and maxillofacial surgery only), subsequent attendance	51703	54002	54004

PARTICIPATING NURSE PRACTITIONER ATTENDANCES These services are for out-of-hospital patients Items introduced 13 March 2020			
Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items** – *for when video-conferencing is not available*
Attendance for an obvious problem	82200	91192	91193
Attendance less than 20 minutes	82205	91178	91189
Attendance at least 20 minutes	82210	91179	91190
Attendance at least 40 minutes	82215	91180	91191

MENTAL HEALTH ATTENDANCES GP mental health attendances and OMP mental health attendances are included under the GP and OMP tables above. These services are for out-of-hospital patients			
Service	**Existing Items** *current video-conference items* *Current geographic restrictions apply*	**Telehealth items** *via video-conference* *Geographic restrictions do not apply*	**Telephone items** – *for when video-conferencing is not available* *Geographic restrictions do not apply*
Clinical Psychologists Items introduced 13 March 2020			
Attendance lasting more than 30 minutes but less than 50 minutes	80001	91166	91181
Attendance lasting at least 50 minutes	80011	91167	91182
Psychologists Items introduced 13 March 2020			
Attendance lasting more than 20 minutes but less than 50 minutes	80101	91169	91183
Attendance lasting at least 50 minutes	80111	91170	91184
Occupational Therapists Items introduced 13 March 2020			
Attendance lasting more than 20 minutes but less than 50 minutes	80126	91172	91185
Attendance lasting at least 50 minutes	80136	91173	91186
Social Workers Items introduced 13 March 2020			
Attendance lasting more than 20 minutes but less than 50 minutes	80151	91175	91187
Attendance lasting at least 50 minutes	80161	91176	91188

ALLIED HEALTH ATTENDANCES These services are for out-of-hospital patients			
Service	**Existing Items** *face to face*	**Telehealth items** *video-conference*	**Telephone items** – *for when video-conferencing is not available*
Chronic disease management Items introduced 30 March 2020			
Allied health CDM services (all 13 items)	10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970	93000	93013
Items introduced 20 April 2020			
CDM service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner	10997	93201	93203
Follow-up Allied Health Services for people of Aboriginal or Torres Strait Islander descent Items introduced 30 March 2020			
Allied health Follow-up services (all 13 items)	81300, 81305, 81310, 81315, 81320, 81325, 81330, 81335, 81340, 81345, 81350, 81355, 81360	93048	93061
Items introduced 20 April 2020			
Follow up services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner	10987	93200	93202
Pregnancy Support Counselling program Items introduced 30 March 2020			
Non-directive pregnancy support counselling by eligible psychologist, social worker or mental health nurse, at least 30 minutes	81000, 81005, 81010	93026	93029
Autism, Pervasive Developmental Disorder and Disability Services Items introduced 30 March 2020			
Psychologist. Autism, pervasive developmental disorder and disability assessment service for children under 13 years, at least 50 minutes	82000	93032	93040
Speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist. Autism, pervasive developmental	82005, 82010, 82030	93033	93041

disorder and disability assessment service for children under 13 years, at least 50 minutes			
Psychologist. Treatment of a pervasive developmental disorder or eligible disability for children under 15 years, at least 30 minutes	82015	93035	93043
Speech pathologist, occupational therapist, audiologist, optometrist, orthoptist or physiotherapist. Treatment of a pervasive developmental disorder or eligible disability for children under 15 years, at least 30 minutes	82020, 82025, 82035	93036	93044
Eating Disorder Services Items introduced 30 March 2020			
Dietitian, eating disorders service, at least 20 minutes	82350	93074	93108
Clinical psychologist, eating disorders service lasting more than 30 minutes, but less than 50 minutes	82352	93076	93110
Clinical psychologist, eating disorders service, at least 50 minutes	82355	93079	93113
Psychologist, eating disorders service, lasting more than 20 minutes, but less than 50 minutes	82360	93084	93118
Psychologist, eating disorders service, at least 50 minutes	82363	93087	93121
Occupational therapist, eating disorders service, lasting more than 20 minutes, but less than 50 minutes	82368	93092	93126
Occupational therapist, eating disorders service, at least 50 minutes	82371	93095	93129
Social worker, eating disorders service, lasting more than 20 minutes, but less than 50 minutes	82376	93100	93134
Social worker, eating disorders service, at least 50 minutes	82379	93103	93137
Group Dietetics Services Items introduced 22 May 2020			
Dietitian, eligible, assessment for a group service	81120	93284	93286
Dietitian, eligible, group service	81125	93285	Not Available

PARTICIPATING MIDWIFE ATTENDANCES These services for out-of-hospital patients Items introduced 13 March 2020			
Service	**Existing Items** *face to face*	**Telehealth items** *via video-conference*	**Telephone items** – *for when video-conferencing is not available*
Short antenatal attendance lasting up to 40 minutes	82105	91211	91218
Long antenatal attendance lasting at least 40 minutes	82110	91212	91219
Short postnatal attendance lasting up to 40 minutes	82130	91214	91221
Long postnatal attendance lasting at least 40 minutes	82135	91215	91222

Bulk Billing Incentives*		
Item	**Temporary Fee (30 March – 30 September 2020)**	**Temporary Benefit (30 March – 30 September 2020)**
10990	$15.00	$12.75
10991	$22.70	$19.30
10992	$22.70	$19.30
64990	$14.10	$12.00
64991	$21.30	$18.15
74990	$14.10	$12.00
74991	$21.30	$18.15
New Item	**Temporary Fee (14 April – 30 September 2020)**	**Temporary Benefit (14 April – 30 September 2020)**
10981	$15.00	$12.75
10982	$22.70	$19.30

***** Note: bulk billing incentives are paid at the 85% MBS rate. While the fee for an incentive for a service provided by a metropolitan practice is $15.00, the MBS rebate – which is paid to the practitioner rather than the patient – is $12.75. For non-metropolitan practices, the fee is $22.70 and the actual payment received by the practitioner is $19.30. These arrangements have applied to the MBS bulk billing incentive payments since their introduction.

National COVID-19 safe workplace principles

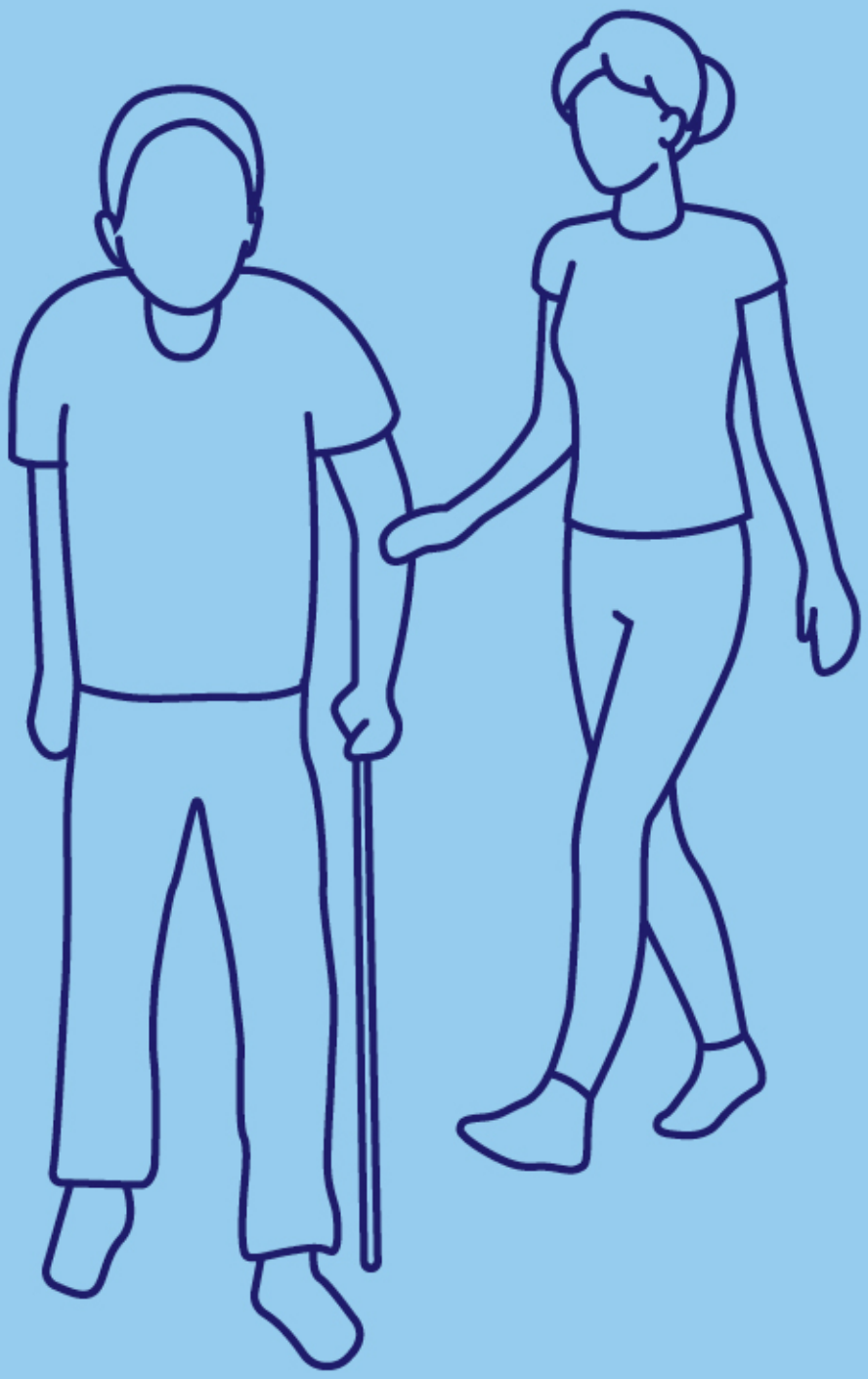
Recognising that the COVID-19 pandemic is a public health emergency, that all actions in respect of COVID-19 should be founded in expert health advice and that the following principles operate subject to the measures agreed and implemented by governments through the National Cabinet process

1. All workers, regardless of their occupation or how they are engaged, have the right to a healthy and safe working environment.
2. The COVID-19 pandemic requires a uniquely focused approach to work health and safety (WHS) as it applies to businesses, workers and others in the workplace.
3. To keep our workplaces healthy and safe, businesses must, in consultation with workers, and their representatives, assess the way they work to identify, understand and quantify risks and to implement and review control measures to address those risks.
4. As COVID-19 restrictions are gradually relaxed, businesses, workers and other duty holders must work together to adapt and promote safe work practices, consistent with advice from health authorities, to ensure their workplaces are ready for the social distancing and exemplary hygiene measures that will be an important part of the transition.
5. Businesses and workers must actively control against the transmission of COVID-19 while at work, consistent with the latest advice from the Australian Health Protection Principal Committee (AHPPC), including considering the application of a hierarchy of appropriate controls where relevant.
6. Businesses and workers must prepare for the possibility that there will be cases of COVID-19 in the workplace and be ready to respond immediately, appropriately, effectively and efficiently, and consistent with advice from health authorities.
7. Existing state and territory jurisdiction of WHS compliance and enforcement remains critical. While acknowledging that individual variations across WHS laws mean approaches in different parts of the country may vary, to ensure business and worker confidence, a commitment to a consistent national approach is key. This includes a commitment to communicating what constitutes best practice in prevention, mitigation and response to the risks presented by COVID-19.
8. Safe Work Australia (SWA), through its tripartite membership, will provide a central hub of WHS guidance and tools that Australian workplaces can use to successfully form the basis of their management of health and safety risks posed by COVID-19.
9. States and Territories ultimately have the role of providing advice, education, compliance and enforcement of WHS and will leverage the use of the SWA central hub in fulfilling their statutory functions.
10. The work of the National COVID-19 Coordination Commission will complement the work of SWA, jurisdictions and health authorities to support industries more broadly to respond to the COVID-19 pandemic appropriately, effectively and safely.

Australian Government
Department of Health

COVIDSAFE

GUIDE FOR HOME CARE PROVIDERS



Contents

Overview and purpose

This document provides guidance for providers to manage during the COVID-19 Pandemic. It is aimed at providers of supports and services that assist people living at home. This includes:

- Home Care providers,
- Commonwealth Home Support Program providers, and
- those providing support to people with disability.

The direct care workforce includes disability support workers, aged care workers, personal care workers, nurses, administration and support staff and allied health professionals. This document refers to 'staff' or 'care workers' to recognise the range of workers employed in care services. The person receiving care is referred to as a 'consumer'.

Preparation guide for in-home care providers

ORGANISATION PLANNING

- Review clinical governance processes and how they apply to the current situation, which may change rapidly. Develop plans with local GPs and other primary care professionals to agree on processes and communications if consumers' care needs change.

- Review business continuity plans and consider how the service will respond if staff are unwell or unable to work, this may include deploying an alternative workforce.

- If parts of your organisation have closed (e.g. community based activities, day activity centres or day respite) consider how staff can be redeployed according to their skills and personal circumstances.

- Consider whether your organisation can implement flexible work hours in order to maintain services.

- Consider which teams need to extend operational hours, or link to other services (such as out of hours general practice) to provide the best possible care for consumers in the community.

- Consider how to contact consumers who are temporarily not receiving services to monitor their safety and wellbeing. The organisation might explore alternative models of care, including tele-care, to provide advice and guidance to consumers their families and support networks.

- Identify the contact details for your local Population/Public Health Unit so that you can seek specific advice about the impact of any COVID-19 cases occurring in your workforce or amongst your consumers;

- Be aware of COVID-19 incident state or territory notification and Safe Work Australia requirements that apply in your jurisdiction.

ACCESSING PERSONAL PROTECTIVE EQUIPMENT (PPE) & OTHER RESOURCES

- Everyone seeking access to masks and other PPE from the National Medical Stockpile should continue attempts to purchase through commercial channels.

- Aged care providers that require PPE from the National Medical Stockpile should email agedcarecovidppe@health.gov.au for all requests.

- NDIS providers and NDIS self-managing participants who require Personal Protective Equipment (PPE) and cannot obtain these through usual means should email NDIScovidppe@health.gov.au for all requests.

- The following information must be provided in your email request:
    - the facility, program or service requiring PPE
    - if you have had a confirmed case of COVID-19 at your facility, program or service
    - types and quantities of PPE required – please note, only masks are available at this stage and other PPE will be provided when available
    - details of other suppliers you have attempted to source PPE stock from.
- In addition, confirm that hand sanitiser and/or liquid soap is available for staff delivering face to face care.
- Monitor stock levels of PPE, and implement measures to reduce opportunities for theft.
- Review cleaning practices, and implement regular, scheduled cleaning of frequently touched objects and services (several times a day, or when visibly soiled).
- Ensure there is adequate stock of soaps, hand sanitiser and disinfectants.

STAFF

- Clearly communicate to staff that **monitoring their own health will help ensure that the people they care for are protected and safe.**

  It is very difficult to distinguish between the symptoms of COVID-19, influenza and a cold. If staff have any symptoms of illness, including cold or flu-like symptoms, they should not go to work, even if their symptoms are mild. Symptoms may include:

    - fever
    - cough
    - shortness of breath
    - sore throat
    - Headache
    - loss of smell
    - loss of taste
    - runny nose,
    - muscle pain
    - joint pain
    - diarrhoea
    - nausea/vomiting
    - loss of appetite.

  If they have any symptoms they:
    - must self-isolate
    - should be assessed by a medical professional, and
    - may need testing for COVID-19.

  Staff must not return to work until cleared by a medical professional.
- Review and update all staff contact details, and emergency contact details.
- Provide regular updates to staff as new information is released. Also notify staff when there is any change to processes and priorities. Identify how you will communicate regularly with staff and who is responsible for contacting staff.
- Identify any staff members in at risk groups. Also identify staff who are unwilling to deliver face to face care, and in what circumstances.

- Identify whether these staff can be redeployed to alternative roles, such as:

    - making phone calls to consumers who are unwell at home
    - monitoring daily staffing and updating supervisors
    - contacting families of any concerns or emergencies
    - completing paperwork etc.

- Identify who staff should contact if they are unwell or are unable to come to work. Provide that person's contact details to all staff.

- Keep records of training, particularly training relating to infection prevention and control.

- Identify the moments of hand hygiene, when delivering care to consumers in the community. The moments are:
    - immediately before entering the home
    - before touching the consumer
    - after touching the consumer or surfaces within their home
    - immediately after exiting the home.

- Confirm all staff have access to of liquid soap and hand sanitiser.

- Confirm whether the organisation has developed procedures to address unforeseen circumstances. Identify who will be responsible for managing and coordinating the response.

- Identify who is responsible for providing information to consumers and families as situations change.

- Keep a record of staff members who have recovered from COVID-19.

- Encourage and promote flu vaccination. Keep records of staff immunisation.

CONSUMERS

- Update consumers' records, including their contact details, emergency contact details, and current GP.

- Make a record of any consumers who may only be contacted by a face to face visit. For example, the consumer may not have a phone, or may be unable to use the phone independently.

- Consider the implications for each consumer, if the delivery of a service is interrupted. For example:

    - the risk to the consumer might be low if the provider is unable to mow the consumer's lawn.
    - For other essential services (such as cooking) the provider may need to consider alternative delivery models. This could include delivering premade meals to mitigate the high risk to the consumer.

- Make contact with the consumer's family members and friends, to discuss alternative delivery models if required. Identify whether the consumer has family or friends who can provide assistance in the short-term if the delivery of services is interrupted. For example they may be able to cook meals for the consumer.

- Identify whether the consumer has the support of family or friends to do online shopping for groceries, and/or delivery of medications.

- Identify any consumers who are considered to be at high risk of serious illness from COVID-19. This includes:
    - people aged 70 years and over
    - people aged 65 years and over with chronic medical conditions
    - Aboriginal and Torres Strait Islander people aged 50 years and over with chronic medical conditions, and
    - people with compromised (weakened) immune systems

- Provide consumers and their family members with a phone number to call if there is any change to their health condition or circumstances. The number must be monitored by a staff member with the capacity to provide advice, assess risk, and notify relevant parties. Changes to condition or circumstance might include:
    - if they are in self-isolation
    - have been in contact with a confirmed COVID-19 case, or
    - develop symptoms suggestive of COVID-19.
- Identify any consumers at risk of harm due to their non-compliance with public health requirements, for example. hand hygiene, or self-isolation. Document their risks on their consumer record.
- Identify consumers who have advance care plans, healthcare or support plans, and keep a copy if possible.
- Encourage advance care, healthcare or support planning, and discussion between consumers, their doctors and families to clarify wishes and intentions.
- Encourage and promote flu vaccination.
- Encourage pneumococcal pneumonia vaccination where appropriate.
- If other organisations or volunteers are involved in the care of consumers, maintain contact and assist in times of need.
- Consider how volunteer groups can stay in touch with consumers to provide psychosocial support, especially consumers who have become socially isolated. See 'Resources' for more information.

CONSUMERS' EMERGENCY PLANS AND READINESS

- Develop an emergency plan for use by consumers, their carers and staff.
- The emergency plan should contain:
    - details of the name, address and other contact details of the consumer;
    - emergency contacts, such as their friends, family, legal representative, or others;
    - details of any medications they take, including dose and frequency;
    - details of current GP and any other relevant professionals;
    - details of any ongoing treatment; and
    - details of the advanced care plan (if the consumer has one).
- Encourage the consumer to ask their GP for a shared health summary on their MyHealthRecord (if the consumer has not opted out). Update the shared health summary as applicable.
- Consumers who are at risk should have a hospital bag prepared. Include in the bag a copy of their emergency plan, details of any planned care appointments and things for an overnight stay (snacks, pyjamas, toothbrush, medication, etc.) Remember to pack phone and charger.

MEDICAL CONSIDERATIONS

- Make a list of any services which the consumer's GP can deliver to keep them safe. These could include telehealth consultations, flu vaccination, testing for COVID-19 (where required), and advice on local testing arrangements etc.
- Keep up to date with the current protocols and logistics for admission to local hospital services.

How to protect staff and consumers

INFECTION CONTROL AND THE USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

Staff should complete the online training module at https://covid-19training.gov.au/ to understand how COVID-19 is transmitted.

When caring for consumers with undiagnosed respiratory infections and other symptoms that could be COVID-19 (a fever, cough, shortness of breath, sore throat, headache, loss of smell, loss of taste, runny nose, muscle pain, joint pain, diarrhoea , nausea/ vomiting, loss of appetite), staff should use standard, contact and droplet based precautions.

Standard precautions are infection prevention practices always used in health and care settings. The precautions are to:

- Perform hand hygiene, before and after every episode of contact with another resident/client;
- Safely use and dispose of sharps;
- Routinely clean the environment as well as clean and sanitise re-suable equipment;
- Conduct and encourage respiratory hygiene and cough etiquette
- Avoid touching where possible when there is a risk of spreading disease ;
- Managing waste and linen appropriately
- Use personal protective equipment (PPE) when in contact with blood and body fluids (secretions and excretions excluding sweat) or if the staff member has a break in their skin. Skin is a natural barrier to the spread of infection.

Contact and droplet precautions are additional precautions required when caring for consumers with suspected or confirmed COVID-19, with any respiratory illness or with other symptoms that could be COVID-19. Contact and droplet precautions include donning (putting on) gloves, surgical masks, and gown and may include protective eyewear.

If PPE is required, then staff must use new PPE for each episode of personal care:

- Do not re-use the same gown, surgical mask, eye protection*, or gloves for the same client at a later time
- Do not re-use any PPE for different clients (even if these clients are in the same house).

* Eye protection may be re-used if appropriately cleaned between uses.

All staff must perform hand hygiene before and after every contact with a consumer. Staff are strongly advised to view the PPE training videos at health.gov.au.

PUTTING ON AND REMOVING PPE

Staff should don (put on) the PPE before they enter the home. Hand hygiene should always be performed before donning PPE.

PPE should be removed (doffed) in a way that prevents contamination of the staff member's clothing, hands and the environment. The staff member should hygiene their hands between removal (doffing) of each item of PPE, and after all PPE is removed.

Information, including videos, on using PPE is available at www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-aged-care-sector/providing-aged-care-services-during-covid-19#how-to-stop-the-spread

These tools are suitable for disability care providers to utilise as well. More tools for disability services are being developed.

DISPOSE OF PPE SAFELY

Gloves, gowns and masks must be disposed of in an infectious (biohazard) waste bag.
Alternatively, used PPE may be 'double bagged' - placed in a disposable rubbish bags, which is then placed in another bag, tied securely and disposed of with other waste. Hands should be hygiened (washed or sanitised) between touching each bag.

REDUCE RISK RELATED TO AEROSOLS

Some medical treatments, which consumers may use at home, increase the risk of virus being spread into the air within parts of the client's home. The two that might be most commonly used in the community are nebulisers and CPAP machines.

Nebulisers should not be used during the COVID-19 outbreak. A nebuliser is used to transfer medicine into mist for a person to breathe in. It creates aerosols which could potentially spread virus into the air. A spacer that holds inhalant material such as Ventolin is a suitable alternative. The consumer may need to speak to their treating doctor about this.

If a client uses CPAP:

- Try to ensure that any visit occurs at least one hour after the CPAP was switched off to allow some aerosols to dissipate.
- If this is not possible then try to see the client in another room, with the door of the room where CPAP is used staying closed while the worker is in the client's home.

If you cannot avoid visiting the client while they are actively using CPAP staff should use personal protective equipment (PPE) which includes a face fit tested P2 mask (N95 in the USA).

CLEANING

If staff undertake cleaning duties, they should use usual household products. Frequently touched surfaces should be cleaned with detergent or a detergent/disinfectant wipe several times a day, and also if visibly dirty or soiled.

Cleaning is an essential part of disinfection. Cleaning reduces the soil load, allowing the disinfectant to work. Removal of germs such as the virus that causes COVID-19 requires thorough cleaning followed by disinfection. This can be done by a 2-in-1 clean - a physical clean using a combined detergent and TGA-listed hospital-grade disinfectant with activity against viruses (according to label/product information) i.e. a combined detergent/disinfectant wipe or solution.

A 2-step clean requires physical cleaning with detergent, followed by disinfection with a chlorine based product such as bleach. The bleach will not kill the virus if the surface as not been cleaned with a detergent first.

Further information is able in the fact sheet '**Coronavirus (COVID-19) Environmental cleaning and disinfection principles for health and residential care facilities**'.

Personal waste (for example, used tissues, continence pads, other items soiled with bodily fluids and used PPE) and disposable cleaning cloths should be disposed of in an infectious (biohazard) waste bag.

Alternatively, they may be stored in disposable rubbish bags. These bags should be placed into another bag, tied securely and disposed of with other waste. Hands should be hygiene between touching each bag.

LAUNDRY

If staff support a person with laundry, they should not shake dirty laundry before washing. This minimises the possibility of dispersing the virus through the air.

Wash items using hot water in accordance with the manufacturer's instructions.

Dirty laundry that has been in contact with an ill person can be washed with other laundry.

If laundry is heavily soiled (for example, with vomit or diarrhoea), or cannot be washed, dispose of the items after getting permission from the consumer.

Clean and disinfect clothes hampers or baskets which held dirty clothes. Staff must:

- Perform hand hygiene after handling contaminated clothing or linen.
- Avoid touching eyes, nose or mouth whilst doing laundry.

Scenarios

STAFF MEMBERS

A STAFF MEMBER IS CONCERNED THEY HAVE COVID-19

If any staff member has symptoms of illness, including cold or flu-like symptoms, (such as a fever, cough, shortness of breath, sore throat, headache, loss of smell, loss of taste, runny nose, muscle pain, joint pain, diarrhoea , nausea/ vomiting, loss of appetite) they should not go to work, even if their symptoms are mild.

They need to self-isolate and seek medical advice from their GP or call the National Coronavirus Helpline on 1800 020 080. The member of staff should tell their doctor or the helpline they are a care worker or work in a care service, such as an aged care or disability support service. They are eligible for COVID-19 testing.

They must not return to work until cleared by a medical professional. They should not visit or care for people (consumers) until told it is safe to do so. Staff should notify their employer immediately.

To self-isolate they should follow the isolation guidance on the Department's website.

A STAFF MEMBER HAS PROVIDED CLOSE PERSONAL CARE TO A PERSON WHO IS DIAGNOSED WITH COVID-19

It is OK for a care worker to provide necessary care involving close contact to a confirmed COVID-19 case, as long as the recommended PPE is used properly.

If staff in close contact with a confirmed COVID-19 case did not don (put on) recommended PPE correctly, or they are concerned there was a breach or failure in PPE (for example – glove breaks, mask comes away from face, gown becomes soaked, care worker gets body fluid on the skin), they must notify their employer. The employer must then notify the local public health unit in the relevant territory/state. The staff member will be required to quarantine for 14 days and be alert for symptoms of COVID-19.

If you are uncertain, the Public Health Unit can provide advice regarding whether PPE was used correctly. As long as PPE was used correctly, it is safe for staff to continue to provide care.

IN HOME CARE STAFF WHO ALSO WORK IN A RESIDENTIAL CARE FACILITY WHERE THERE IS A CONFIRMED COVID-19 CASE

The staff member should notify their employer who should check with their state or territory Public Health Unit about the safety of the staff member continuing to provide care.

CONSUMER

NOTE: If staff are unsure of the COVID-19 status of a person they are caring for or unsure about PPE usage, they should contact their employer to seek advice on individual cases and use of PPE before entering a home.

THE PERSON BEING CARED FOR IS IN QUARANTINE, IS AWAITING TEST RESULTS, OR HAS SUSPECTED OR CONFIRMED COVID-19

Staff should use standard, contact and droplet precautions when entering the home or room of a person in quarantine or under investigation or with suspected or confirmed COVID-19 infection. Staff should notify their employer of any quarantined, suspected or confirmed COVID-19 cases

Organisations should minimise the number of staff who come into contact with the consumer, and consider which services are critical to keep the consumer safe.

With the consumer's consent staff should also notify the consumer's family and friends, and request their assistance to monitor the consumer's health condition. If the consumer's condition deteriorates, staff should escalate to the consumer's GP or call an ambulance.

THE CONSUMER DOES NOT HAVE SYMPTOMS BUT IS PART OF A HOUSEHOLD WHERE SOMEONE IS ISOLATING

The staff member should contact their employer who should check with their state or territory public health unit about the safety of the staff member providing care.

THE CONSUMER IS FOUND TO BE UNWELL OR HAVE NEW SYMPTOMS

At times care workers may arrive at the home of a consumer and find they are unwell and have not sought medical advice. Care workers should:

- Maintain a distance of 1.5m from the consumer
- Talk to their supervisor about the functions they are there to perform, and, unless essential, should not provide care that requires close contact until the COVID-19 status of the consumer has been determined, and it is clear what PPE may be needed to safely provide the care
- Advise the consumer to isolate until they have been assessed by their GP. An assessment may be possible via telehealth
- Perform hand hygiene before and after any contact with the consumer.

If the person is very unwell then the care worker should call an ambulance.

Further guidance is available through the **online training module**.

THE CONSUMER HAS SOME SYMPTOMS OF COVID-19 BUT THEY ARE NOT A CONFIRMED CASE AND NOT CONSIDERED A SUSPECTED CASE BY HEALTH AUTHORITIES

This scenario may occur if the consumer has a chronic cough caused by a diagnosed pre-existing health condition.

Care workers should implement standard precautions, and general interventions such as increased cleaning and keeping the property well ventilated by opening windows.

Care workers should be alert for any change in the health condition of a consumer. If any change (e.g. worsening of a chronic cough, worsening of pre-existing breathlessness, increased confusion, loss of appetite, any cold or flu-like symptoms) is noticed by care workers, they should:

- Ensure that the client is reviewed by their GP. This may be possible via telehealth
- Advise the consumer to isolate until they have been assessed by their GP
- Maintain a distance of 1.5m from the consumer
- Talk to their supervisor about the functions they are there to perform, and, unless essential, should not provide care that requires close contact until the COVID-19 status of the consumer has been determined, and it is clear what PPE may be needed to safely provide the care
- Perform hand hygiene before and after any contact with the consumer.

Further guidance is available through the **online training module**.

THE CONSUMER DOES NOT HAVE SYMPTOMS OF COVID-19

If the person receiving care is not symptomatic, then personal protective equipment is not required. However, care workers should still implement standard precautions to minimise the risk of infection.

Care workers should strictly follow advice on hand hygiene at all times.

DEFINITIONS

SYMPTOMS OF COVID-19

- The most common symptoms of COVID-19 are: fever, cough, sore throat, and shortness of breath.
- Other reported symptoms of COVID-19 include: headache, fatigue, loss of smell, loss of taste, runny nose, muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite.

WHAT IS CLOSE CONTACT?

A 'close contact' is defined as requiring:

- face-to-face contact in any setting with a confirmed or probable case of COVID-19, for greater than 15 minutes cumulative over the course of a week, in the period extending from 48 hours before onset of symptoms in the confirmed or probable case, or
- sharing of a closed space with a confirmed or probable case of COVID-19 for a prolonged period (e.g. more than 2 hours) in the period extending from 48 hours before onset of symptoms in the confirmed or probable case.

Resources

ONLINE TRAINING

The Australian Government has launched a new **COVID-19 training program** at https://covid-19training.gov.au/ . This training is for care workers across all settings, including:

- hospitals
- primary care
- aged care (both in residential aged care facilities or with visiting carers at home, including cleaners and cooks)
- disability (both in residential/shared care facilities or part-time carers in people's homes, including cleaners and cooks)
- allied health
- Aboriginal Community Controlled Health Services
- pharmacies
- dental practices, including dentists, nurses, cleaners and receptionists

To access these go to the website and register as a care worker. The program includes:

- Module One: Personal Safety
- Module Two: Families and Visitors
- Module Three: COVID-19 and aged care
- Module Four: Outbreak management procedures
- Module Five: Personal Protective Equipment
- Module Six: Laundry
- Module Seven: Catering
- Module Eight: If you suspect a case
- Module Nine: COVID-19 in-home care settings

USEFUL INFORMATION

Updates on the COVID-19 pandemic: www.health.gov.au

Coronavirus (COVID-19) advice for the health and aged care sector https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-aged-care-sector including :

- Attending the workplace
- Protection in the workplace
- Providing health care and supporting patients
- Managing COVID-19 in aged care
- Resources and training
- Staying informed

'It's ok to have home care' information flyer for in-home care recipients https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-aged-care-sector

Translated versions of 'It's ok to have home care' are available at: https://www.health.gov.au/resources/translated/its-ok-to-have-home-care-other-languages

Mental health and social support for consumers

- Community Visitors Scheme (CVS) The CVS arranges volunteer visits to older people to provide friendship and companionship. Visits are available to anyone receiving government-subsidised residential aged care or Home Care Packages. www.health.gov.au/initiatives-and-programs/community-visitors-scheme-cvs
- COVID-19 support line for Senior Australians 1800 171 866
- Beyond Blue www.beyondblue.org.au

The National Disability Insurance Agency (NDIA) has also published information and supports for National Disability Insurance Scheme (NDIS) participants and providers. Go to www.ndis.gov.au/coronavirus. Dementia Australia – Coronavirus COVID19 information for Home Care Providers www.dementia.org.au/resources/coronavirus-covid-19-helpsheets/tips-for-home-care-providers

Attachment D

Guidance on use of personal protective equipment (PPE) in non-inpatient healthcare settings, during the COVID-19 outbreak

Date published: May 11, 2020

Background

This guidance was developed by the Infection Control Expert Group and endorsed by the Australian Health Protection Principal Committee (AHPPC).

The recommendations are based on current status of COVID-19 in Australia, risk assessment expert advice and current evidence. They will be updated as new evidence becomes available[1].

This guidance is intended for healthcare workers in non-inpatient healthcare settings, including general practice, specialist, outpatient, allied health, respiratory/COVID-19 clinics, hospital-in-the-home and pathology collection centres.

Guidance on the use of personal protective equipment (PPE) in hospitals during the COVID-19 outbreak is available at: https://www.health.gov.au/resources/publications/guidance-on-the-use-of-personal-protective-equipment-ppe-in-hospitals-during-the-covid-19-outbreak

For current case definitions and testing criteria see the *Communicable Diseases Network Australia (CDNA) National guidelines for public health units*

Current status of COVID-19 in Australia

- By international standards, Australia has a high (and increasing) rate of testing and a very low percentage of positive results.
- More than 60% of total cases in Australia have been acquired overseas.
- The number of cases and deaths from COVID-19 in Australia are in marked contrast to that in many parts of Europe, the United Kingdom and North America.
- Since the introduction of travel restrictions and social distancing measures the daily number of new infections in Australia has fallen dramatically.
- Community transmission is low and limited to a few localised sites.
- The case fatality rate in Australia, overall, is <2% and the median age of death is 79-80 years.
- Limited data are available about workplace acquisition of COVID-19 by healthcare workers. Of those for which information is available, a significant proportion were acquired overseas or in community/non-clinical settings.

These data indicate that current containment measures in community and health care settings in Australia are effective if consistently observed.

[1] Note: this document supersedes previous advice: Revised advice on non-inpatient care of persons with suspected or confirmed COVID-19, including use of personal protective equipment (PPE)

General guidance for patients presenting for non-inpatient healthcare

If a person, who is in quarantine or under investigation for COVID-19, has been in close contact with someone who has COVID-19 and/or has respiratory symptoms, needs medical attention for any reason (e.g. for possible COVID-19 or any other illness, injury or therapy) they are requested:

- to telephone the doctor or clinic before presenting.

Patients with symptoms suggestive of pneumonia (e.g. fever, difficulty breathing, frequent, productive coughing and/or tachypnoea etc.) should be referred to and managed in hospital.

- If symptoms are severe, call 000 and advise the operator of a potential COVID-19 risk.

When other patients phone for an appointment or present to the clinic, they should be asked about clinical and epidemiological evidence of COVID-19 (acute respiratory symptoms, fever, recent overseas travel or contact with a suspected/confirmed COVID-19 case).

- Note: In general, the use of nebulisers should be avoided and alternative medication administration devices (e.g. spacers) used.

COVID-19 **is not** suspected

For a patient in whom there is no clinical or epidemiological evidence of COVID-19, who has no respiratory symptoms and is not in quarantine:

- **Standard precautions** apply as for all patients, including hand hygiene (5 Moments).
- Whether personal protective equipment (PPE) is required. should be determined by risk assessment, based on the patient's presenting complaint or condition.
- PPE should be used according to the *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*[2].

In the context of the low rate of community transmission of COVID-19, in Australia, routine use of masks is not recommended.

- **Cough etiquette and respiratory hygiene** must be observed at all times.
- **Staff and patients should observe physical distancing:** stay at least 1.5 m away from other people including:
  - patients, except when physical distancing is impossible, e.g. during physical examination or clinical care,
  - members of the public, hospital visitors, AND
  - other staff e.g. in clinics and nonclinical areas during meetings, tea breaks etc.

COVID-19 **is** suspected

Upon presentation of a person who is under quarantine or investigation, is a suspected or confirmed case of COVID-19 or has respiratory symptoms:

- Apply **standard precautions**, **cough etiquette/respiratory hygiene** and **physical distancing**, as above.
- Immediately give the patient a surgical mask and ensure they put it on correctly.
- Direct them to a single room, whether or not respiratory symptoms are present.

[2] https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019#block-views-block-file-attachments-content-block-1

    - If a single room is unavailable, an area separate from other patient areas should be designated for assessment of suspected COVID-19 patients.
- The patient should be tested for COVID-19 (if this has not been done already).

General guidance on the use of transmission-based precautions in patients with suspected or confirmed COVID-19

Transmission-based precautions should be used, in addition to standard precautions as follows:

- **Contact and droplet precautions** for clinical consultation and physical examination of patients in quarantine or with plausible evidence or risk of COVID-19.
- **Contact, droplet and airborne precautions** should be observed if an aerosol generating procedure (AGP) is required for a patient with plausible evidence or risk of COVID-19.
- AGPs are unlikely to be required in non-inpatients settings, except in an emergency. See Appendix 1 for examples of emergency AGPs.

NOTE: Previous advice to use airborne precautions for care of patients with severe cough has been withdrawn because:

- viral load does not necessarily correlate with clinical condition
- coughing predominantly generates droplets
- a surgical mask worn by the healthcare worker, in conjunction with other recommended precautions, provides adequate protection.
- the patient wearing a mask, if tolerated, provides additional protection for others

Clinical consultation in the context of suspected or confirmed COVID-19

These recommendations apply in non-inpatient settings in which consultation and physical examination are required for patients in whom there is a plausible suspicion or risk of COVID-19.

- Patients with acute respiratory symptoms should be asked to wear a surgical mask upon presentation to health care setting (or when a healthcare worker enters their home).
- The consultation should take place in a single room with the door closed or in a physically separate closed area designated for suspected COVID-19 cases.
- If a patient is in respiratory distress or has hypoxaemia or shock, immediately give supplemental oxygen and empirical antibiotics (and arrange urgent transfer to hospital).
- Perform hand hygiene before donning gown, gloves, eye protection (safety glasses or face shield) and surgical mask (in that order).
- After the physical examination is complete, specimen(s) for diagnosis of COVID-19 or other indications can be collected by the clinician, during the same consultation, or the patient referred to a pathology collection centre, as appropriate.
    - The patient will need to remove the mask during respiratory specimen collection. This should be done carefully, without touching the front of the mask or other objects or surfaces; the patient should hold the mask while specimen is collected, then replace it and perform hand hygiene before touching any surfaces or objects in the room.

    - The patient should continue to wear the mask until s/he has left the premises and observe cough etiquette/respiratory hygiene.
- After consultation, remove gown and gloves, perform hand hygiene, remove eye protection perform hand hygiene, remove surgical mask and perform hand hygiene.
    - Do not touch the front of any item of PPE during removal,
    - Perform hand hygiene at any stage if contamination is thought to have occurred
- The room surfaces should be wiped clean with detergent/disinfectant by a person wearing gloves, gown and surgical mask.

Specimen collection in the context of suspected or confirmed COVID-19

The following precautions apply to specimen collection in a clinic or pathology collection centre, when it is the only procedure required.

If clinical examination is required, full contact and droplet precautions should be observed as described above.

Infection prevention and control precautions

- Perform hand hygiene
- Use gloves, surgical mask and eye protection (safety glasses or face shield)
    - gloves must be removed, and hand hygiene performed after each patient, and new gloves put on before the next one
    - safety glasses and face shields can be worn during consecutive patients' specimen collections in the same location
        - if it is labelled as reusable, the face shield can be cleaned with a detergent/disinfectant wipe in between uses.
    - if surgical masks are in short supply, they can be used for periods up to 4 hours during consecutive patients' specimen collections in the same location
        - the mask should be discarded if it becomes wet or contaminated and on leaving the room
        - take care not to touch the mask while it is on; if the front of the mask is touched, remove and discard it, perform hand hygiene and put on a new one.
- The need for a gown or apron is based on risk assessment
    - A gown or apron is needed for specimen collection, only if close physical contact with a symptomatic patient or splash/spray of body substances is anticipated.
    - if worn, a gown or apron can be worn for specimen collections from consecutive patients in the same location.
        - It must be changed if it becomes visibly contaminated
        - It must be removed when leaving the immediate area to avoid contaminating other environments

Note: For collection of upper respiratory samples from asymptomatic members of the public for surveillance purposes, standard precautions apply; perform hand hygiene between individual subjects.

Specimen collection

Simple precautions to reduce the risk of exposure to respiratory droplets when physical distancing cannot be maintained:

- To collect upper respiratory swabs, stand slightly to the side of the patient to avoid exposure to respiratory secretions, should the patient cough or sneeze.
- Encourage the patient to maintain a slow breathing pattern and not hold the breath as this reduces the likelihood of gagging.
- Self-collection of a nasal swab is acceptable, with appropriate supervision.
- To collect a sputum sample from a patient with a productive cough:
    - Ask the patient to stand approximately 2 metres away and turn aside before coughing into the specimen container. OR
    - ask the patient to go outside or into another room to produce the specimen.

For a detailed description of methods of specimen collection for diagnosis of COVID-19 see:
PHLN guidance on laboratory testing for SARS-CoV-2 (the virus that causes COVID-19)
https://www1.health.gov.au/internet/main/publishing.nsf/content/Publications-13

Removal of PPE

- At the end of a specimen collection session:
    - remove gloves; perform hand hygiene
    - remove gown or apron (if worn), perform hand hygiene
    - remove face shield or safety glasses without touching the front, perform hand hygiene
    - remove mask, without touching the front, perform hand hygiene.

Environmental hygiene

- In addition to routine cleaning, frequently touched surfaces should be wiped, after every patient, with detergent/disinfectant wipes or a detergent product, using a disposable cloth
- any contaminated or visibly soiled surface should be cleaned/disinfected, immediately

Environmental cleaning and disinfection for health and residential care facilities is available at:
https://www.health.gov.au/resources/publications/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities

Appendix

Aerosol-generating procedures

AGPs during the care of patients with COVID-19 are associated with an increased risk of transmission. AGPs are only likely to be required in primary care or community practice in an emergency. The following *examples* are illustrative of emergency AGPs.

Instrumentation or surgical procedures involving the respiratory tract including:

- Insertion or removal of endotracheal tube
- Open oropharyngeal or tracheal suctioning
- Intercostal catheter insertion for relief of pneumothorax

Other procedures that can generate respiratory aerosols

- Manual or non-invasive ventilation (NIV);
    - Bi-level positive airway pressure ventilation (BiPAP)
    - Continuous positive airway pressure ventilation (CPAP)

Note: Cardiopulmonary resuscitation (CPR) is a special circumstance:

- Chest compression and defibrillation during resuscitation are not considered AGPs
- First responders can commence resuscitation without the need for airborne precautions while awaiting the arrival of clinicians to undertake airway manoeuvres

For a more extensive list of AGPs see: *Guidance on the use of personal protective equipment (PPE) in hospitals during the COVID-19 outbreak*: https://www.health.gov.au/resources/publications/guidance-on-the-use-of-personal-protective-equipment-ppe-in-hospitals-during-the-covid-19-outbreak

Where can I get more information?

For the latest advice, information and resources, go to the Australian Government Department of Health website at www.health.gov.au.

Call the National Coronavirus Health Information Line on 1800 020 080. The line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

The telephone number of your state or territory public health agency is available on the coronavirus page at www.health.gov.au/state-territory-contacts.

NDIS Quality and Safeguards Commission

COVID-19 Information Pack

Information for NDIS providers and workers

Issue 1, June 2020

NDIS Quality and Safeguards Commission

Contents

1. Introduction

The coronavirus (COVID-19) pandemic is presenting us all with unprecedented challenges in our daily lives and in how we do our work.

First and foremost, **our focus should be on ensuring the health, wellbeing and safety of people with disability**, and the workforce that delivers the supports and services that are critical to NDIS participants' personal support, nutrition and hygiene.

The NDIS Commission has issued regular updates about important issues to support NDIS providers to continue to provide the safe and quality supports NDIS participants rely on. There is a dedicated COVID-19 webpage for NDIS providers, which contains links to all our resources, and others from trusted sources.

We have also developed resources to support NDIS participants, including a dedicated page that contains information in a range of formats.

As states and territories start to lift restrictions put in place during the pandemic, the risk of COVID-19 infection remains, so we strongly encourage you to read this resource and share its guidance with your workers. This will ensure you continue to meet your obligations while protecting the health, safety and wellbeing of the NDIS participants you support.

Subscribing to NDIS Commission updates

Registered providers receive our provider newsletters and provider alerts at the email address registered providers have provided in the NDIS Commission Portal.

In addition, anyone can receive NDIS Commission communications by completing the subscription form.

2. Provider obligations

The COVID-19 pandemic does not change the obligations of all NDIS providers – registered and unregistered. These obligations are to protect and prevent people with disability from experiencing harm arising from poor quality or unsafe supports, abuse, neglect and exploitation, or poorly managed changes to supports.

As a registered NDIS provider, you have obligations under the NDIS Code of Conduct and the NDIS Practice Standards, as well as your conditions of registration, that relate to the delivery of safe, quality supports and services, and the management of risks associated with the supports you provide to NDIS participants.

These risks include the possible COVID-19 infection of yourself, your workers and people you otherwise engage to deliver NDIS supports, as well as the risk of infection of NDIS participants.

NDIS Code of Conduct

The NDIS Code of Conduct requires workers and providers who deliver NDIS supports to NDIS participants to, among other things:

- provide supports and services in a safe and competent manner with care and skill

- promptly take steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability.

NDIS Practice Standards

The NDIS Practice Standards provide guidance for registered providers, including standards for governance and operational management, as well as the provision of supports environment.

Governance and operational management, includes:

- having robust governance and operational management systems
- considering organisational risks, other requirements related to operating under the NDIS, participants' and workers' needs and the wider organisational environment in your strategic and business planning
- identifying and managing risks, both to participants and workers
- analysing, prioritising and treating risks to the organisation, including participants, work health and safety risks, and risks associated with providing supports
- ensuring continuity of support so that participants access timely and appropriate support without interruption, including that disaster preparedness and planning measures are in place to enable continuation of critical supports before, during or after a disaster.

Provision of supports environment, includes:

- each participant accessing supports in a safe environment that is appropriate to their needs. This includes, where relevant, you working with other providers and services to identify and treat risks, ensure safe environments, and prevent and manage injuries
- verification standards include a requirement for risk management, including managing work health and safety, which requires protecting the health, safety and wellbeing of workers and others who may be affected by work activities – including NDIS participants.

Notifying the NDIS Commission of certain events

On 24 March 2020, the NDIS Quality and Safeguards Commissioner wrote to all registered providers to remind you that it is a condition of registration with the NDIS Commission that you notify us of changes or events that adversely affect your ability to deliver supports and services to NDIS participants.

This includes any change or event that:

- significantly affects your ability to comply with your conditions of registration and the NDIS Practice Standards
- seriously impairs your ability to effectively conduct your operations and deliver ongoing supports or services to NDIS participants
- adversely affects a person with disability's access to the supports or services you are registered to provide.

In the context of the COVID-19 pandemic, these may include you becoming aware:

- that the COVID-19 pandemic has, or is likely, to significantly impact your organisation's ability to provide supports and services to NDIS participants

- that a significant shortfall in available workers to provide the supports or services your organisation is registered to provide
- of the cessation, on a temporary or permanent basis, of the provision of supports or services that your organisation is registered to provide.

Recommencing services to NDIS participants

Many states and territories are starting to ease restrictions put in place during the COVID-19 pandemic. Please note you **do not need to submit a notification form to advise us when you recommence services** in line with the lifting of state and territory health directions.

Our regulatory approach during COVID-19

We are taking a proportionate regulatory approach, concentrating on supporting providers to be agile and resourceful in meeting their obligations, and adjusting in these complex and challenging times.

During the pandemic, our compliance and provider engagement activities are concentrating on matters that present the **most critical level of risk** to participants' health and safety and wellbeing, and we have adjusted routine regulatory activities (e.g. registration processes) to avoid putting untimely demands on providers.

Registration renewals and advice to approved quality auditors

We have advised approved auditors to:

- ensure audit practices are provided in a way that minimises the risk of exposure to COVID-19 for participants, providers and auditors
- where audits are scheduled to occur, engage with providers to confirm their availability to continue where practicable to do so
- delay or reschedule audit dates where providers are not in a position to proceed with these.

We have written directly to registered NDIS providers who have already started, or are due to start, the registration renewal process. We have advised them about variations we have made to their registration that give them additional time to complete the registration renewal process, including audits.

We will continue to monitor the impact of COVID-19 and will make further adjustments to providers' registration where necessary.

If you have a query about your registration renewal, contact the Provider Registration team at registration@ndiscommission.gov.au or on 1800 035 544.

3. Business continuity planning

You are expected to have plans that set out how your organisation will manage in the event of a crisis or disaster situation. Many providers have detailed plans that set out how they will respond in general situations.

We recommend that you:

- **test your plans** to the specific impacts of this pandemic on your business, the people you support and your workforce, and refine as required
- **set regular review points** for the plan, so that you can respond to this rapidly changing situation, and adapt to additional advice from the Australian Government and state and territory public health orders, as required.

When testing the plan, ensure any third parties included in it are able to fulfil their responsibilities to your organisation. You should also:

- identify options for managing temporary changes in support, should this be required
- identify the staff in your organisation who have capabilities in contingency planning, infection control, or other specialisations who can be deployed to provide support
- know your staff availability to support potential gaps in service provision, which may be created by workers impacted by COVID-19
- identify the need to engage an alternative workforce, ensuring that inductions appropriately set the expectations for working with people with disability. These might include:
    - undertaking the NDIS Commission Worker Orientation Module
    - ensuring they have the appropriate competencies to deliver the appropriate services and supports in accordance with the expectations of the NDIS Practice Standards.

Know the NDIS participants you support

- Undertake a risk assessment of the supports and services that your organisation provides. This should include the degree to which NDIS participants rely on those supports and services to meet their daily living needs, and the extent to which their health and safety would be affected, should those services be disrupted.
- Understand the specific needs of each of the participants you support and how they would like to receive information. Understand how this would be impacted if changes were made to existing service and support arrangements. See also 'Communicating with participants'
- Make sure participant records are up-to-date and accessible, so that their support needs and preferences are clear, documented and available should new or temporary staff be required to support them. This might include their preferred means of communication, specific needs and preferences, health care plans, behaviour support plans, other providers, and their representatives.
- If possible, understand any informal supports and services that may be available to the person with disability.

Communicate effectively

- Familiarise your workforce and any third parties with the business continuity arrangements and triage points within your organisation.
- Familiarise your workforce with policies, procedures and responsibilities regarding infection control.
- Make sure clear communication channels are in place with all of the NDIS participants that your organisation supports. This will enable the effective communication of any changes that might be required to a participant's supports and services.

Due to the current limitations on public gatherings and closure of certain facilities and businesses, you may need to explore alternatives for activities or supports that must be ceased or adjusted. Refer to the Adjusting services and supports section for ideas on ways to do this while adhering to social distancing and other requirements.

Outbreak management plan

As part of business continuity planning you should prepare an outbreak management plan that is proportionate to the risk of supports you deliver, and the size of your organisation. This plan may include the following components:

- Identify which supports are **critical for the health, wellbeing and safety of a person with disability**. Decisions on which services are continued, altered, or suspended are based on the assessed risk to the person with disability and in conjunction with relevant state/territory public health orders. Read more about making alterations to services.
- Identify and **assess risks** to people you support and to the organisation (such as financial, operational, workplace health and safety obligations), and implement controls to mitigate these where possible. This may include:
    - reviewing behaviour support strategies for people who are isolated and may display behaviours of concern
    - encouraging workers and people you support to have flu vaccinations, and maintain up-to-date records of vaccination status
- Outline **workforce contingency plans** in the event of an outbreak, or that workers are unwell and need to self-isolate, or are not able to work because of caring responsibilities or their own health vulnerabilities.

  This may include:
    - changing leave entitlements to ensure that all workers, regardless of their employment status, can access leave to allow them to self-isolate if required. Temporary changes have been made to awards (including to the Social, Community, Home Care and Disability Services Industry Award 2010) to include a minimum entitlement to 2 weeks unpaid pandemic leave
    - maintaining an up-to-date contact list of all staff, including casual or agency staff. The National Disability Insurance Agency (NDIA) has links for platforms who match providers with new or backup support workers
    - streamlining the on boarding of new staff to maintain health, wellbeing and safety, and avoid risk of harm and having new workers undertake the training for workers modules.

- Establish a **COVID-19 incident reporting process** as part of your organisation's incident management system, and understand your reporting obligations to the NDIS Commission
- Set up an **outbreak management team** – commensurate to the scale of your organisation or the facility. This team will be responsible for planning, coordinating, and managing logistics if an outbreak occurs, and communicating with state/territory health departments, the NDIS Quality and Safeguards Commission (NDIS Commission) and the NDIA (if required).
- **Update staff training** in infection control procedures, including standard precautions (hand hygiene, correct use of appropriate PPE where needed (and disposal procedures), and cough and sneeze etiquette) and transmission-based precautions (contact and droplet precautions).
- Implement **standard infection control precautions** throughout all work places.
- Establish communication channels to **keep your workforce informed** of any updates or changes to your business processes as a result of the outbreak. This includes contracted or agency staff, such as cleaners.
- Document a **strategy for communicating with the people you support, their families or guardians/advocates.** This should include the different communication formats depending on communication preferences, and outline how people will be supported to understand changes to services and supports.
- Undertake a **stocktake of consumables and source additional supplies** if necessary. This could include compiling an 'outbreak kit' with items such as:
    - personal protective equipment
    - hand hygiene products (hand sanitiser, liquid soap)
    - cleaning supplies
    - other essential supplies such as toilet paper and food.
- Plan for increased **environmental cleaning**, including where additional cleaners and oversight is required.
- Identify any participants who have **advance care or healthcare or support plans**, and keep a copy if possible.
- Develop an **emergency plan** for the people with disability you support. This should contain details of:
    - their emergency contacts (e.g. family, guardian or advocate)
    - any medical conditions as well as ongoing treatment and current medications, including dose and frequency
    - current GP and any other health professionals
    - the advanced care or support plan (if they have one).
- If any participants are at higher risk, **prepare a hospital bag** with things they might need for an overnight stay.
- Document a **visitor management policy** in the event that there is a suspected/confirmed case or an outbreak
- Arrange for **appropriate isolation** of people who are unwell and have a suspected or confirmed case of COVID-19 and must be isolated, or for your workers to stay in to limit transmission risk. This may include arranging alternative accommodation for a resident who has contracted COVID-19 at their request, or where other residents are at serious risk of adverse effects from a COVID-19 infection. Alternative arrangements for accommodation

should always be made in consultation with the person and ensuring that adequate supports are maintained for that person should they need to temporarily relocate.

In-home support settings

An addition to the points above, if you provide **in-home supports** to people with disability, you should also:

- work with them to agree on **escalation processes** and communication plans if their needs change. The upcoming *National Individual Health Plans for COVID-19* will assist people with preparing this information
- consider **how you would monitor their safety** and wellbeing if they could not receive services temporarily
- make a record of participants who can **only be contacted by a face-to-face visit** (that is, if they cannot use the phone independently)
- give the participant and their family, guardian or advocate contact details of someone they can call if there is a **change to their health condition or circumstances** (such as, if they develop symptoms, are in self-isolation or have been in contact with a confirmed COVID-19 case)

4. Accessing and using personal protective equipment (PPE)

If you use PPE as a usual part of your support arrangements, you should continue to access it through your usual means. Where this is no longer possible, you should email the National Medical Stockpile (NMS) at NDISCOVIDPPE@health.gov.au.

Access to PPE is being prioritised for those NDIS providers who deliver personal care and other activities that require close physical contact where there is an immediate threat to continuity of safe quality care due to lack of access to PPE, or where the participant has a confirmed or suspected case of COVID-19.

When should disability support workers use PPE?

Refer to the Australian Government Department of Health's fact sheet 'Guide to personal protective equipment (PPE) for disability care providers' for guidance on:

- using PPE when providing support to a confirmed or suspected case
- how to remove PPE
- what type of PPE to wear in different scenarios
- using PPE when providing care to people with disability
- access to PPE

Outside of usual clinical care requirements, workers supporting NDIS participants are not required to wear surgical masks or other items of PPE unless they are working with people who have suspected or confirmed COVID-19, and:

- supports being provided are essential to the participant's life, health or safety

- contact between people exceeds Australian Government Department of Health guidelines for social distancing or isolation.

It is recommended that NDIS and disability support providers delivering supports to people in residential settings follow the interim advice from the Australian Government Department of Health on the care of people with suspected or confirmed COVID-19.

Where a worker is suspected of having been exposed to COVID-19 or is displaying symptoms of COVID-19, they should not be providing direct support to NDIS participants. PPE is not an appropriate solution to workers in this situation.

Accessing PPE to support a person with suspected or confirmed COVID-19

The NMS will consider applications for access to PPE from disability providers, prioritising access to providers that have a confirmed or suspected COVID-19 case and are delivering accommodation support in a shared or group setting, and where providers can demonstrate:

- they have been unable to source PPE through the open market
- existing stocks have been depleted
- who the requested masks are intended for
- how the masks will be prioritised and distributed in order to minimise transmission to greatest effect
- how any previous NMS stocks have been used efficiently and effectively.

Information about risk of infection in your location

Some state and territory departments of health are issuing information on the distribution of confirmed cases in local areas across their states. You can find information about case levels in the ACT, NSW, the NT, Queensland, South Australia, Tasmania, Victoria and Western Australia.

5. Managing your workforce through COVID-19

Criteria for when staff should not come to work or have contact with participants

All workers should take reasonable precautions to continue to provide supports and services in a safe and competent manner with care and skill and to keep themselves and others safe.

Workers **must not go to work** if they have:

- returned from overseas or interstate in the last 14 days, consistent with their state or territory's public health directions, or
- been in contact with someone diagnosed with COVID-19, or
- a fever, or any symptoms of respiratory illness (e.g. cough, shortness of breath, sore throat, runny nose or nasal congestion).

If a worker experiences fever or acute systems of respiratory illness (such as those outlined above), they must **report those symptoms to their place of work**. If they experience any of

these symptoms for the first time during a shift, **they should leave work immediately**, report their symptoms as identified above, and seek medical advice from their doctor or call the National Coronavirus Hotline on 1800 020 080..

If COVID-19 is excluded, the worker may be able to return to work once well (and as guided by the infections period for their condition). **If they are diagnosed with COVID-19**, they must be isolated at home or hospital (depending on the severity of illness) until they are cleared to return to work by a medical practitioner.

If the worker attended work in the 24 hours before the onset of symptoms, close contacts should be informed. Once the test results are obtained (whether positive or negative), the same close contacts should be informed and given advice on whether they need to self-isolate.

Close contact is defined as:

- More than 15 minutes face-to-face contact in any setting with a confirmed (or probable) case in the period from 24 hours before onset of symptoms in the confirmed (or probable) case, **or**
- Sharing a closed space with a confirmed (or probable) case for a prolonged period (e.g. more than 2 hours) in the period extending from 24 hours before onset of symptoms in the confirmed (or probable) case.

Training for NDIS workers

Worker Orientation Module: 'Quality, Safety and You'

It is important that workers in the NDIS understand their obligations under the NDIS Code of Conduct and, specifically, how these relate to the rights, health and safety of the NDIS participants you support.

The NDIS Code of Conduct applies to all NDIS providers and workers.

The Worker Orientation Module, 'Quality, Safety and You' is an interactive online course that explains worker obligations under the NDIS Code of Conduct – from the perspective of NDIS participants.

The module takes approximately 90 minutes to complete, and helps workers understand:

- what the NDIS is and why we need it
- the role of the NDIS Quality and Safeguards Commission
- responsibilities under the NDIS Code of Conduct
- their role in achieving the vision of the NDIS.

Infection prevention and control

The Australian Government Department of Health has developed a free online training module: Infection prevention and control for COVID-19.

It covers the fundamentals of infection prevention and control for COVID-19, including:

- COVID-19 – what is it?
- Signs and symptoms

- Keeping safe – protecting yourself and others
- Myth busting.

At the end of this training module, you should be able to:

- understand the basics about the COVID-19 virus, including how it is spread
- describe what you can do to protect the people you support and your workforce
- know what to do if the person you are supporting develops symptoms
- know what to do if you develop symptoms
- tell the difference between myths and facts of COVID-19.

Email any technical questions about the training portal to support@covid-19training.gov.au

Worker screening

Worker screening is a way to check that the people who are working, or wish to work, with NDIS participants don't present an unacceptable risk to them.

All NDIS workers must be screened in accordance with the state and territory arrangements. Find more on our Worker Screening webpage.

Minimising the risk of COVID-19 transmission

In any support, whether continuing or being adjusted, consideration must be given to reducing the risk of COVID-19 infection. Factors that can increase that risk, and the impact of a COVID-19 infection include:

- the likelihood of underlying medical conditions placing individuals at risk for severe disease from COVID-19
- people with complex support needs who may have difficulty meeting the requirements for social distancing and personal hygiene
- centre-based supports, and the management of a centre-based environment may facilitate the spread of COVID-19.

Strategies to control infection transmission

- Provide adequate training and refreshers to all staff on respiratory etiquette and hand hygiene practices. This includes:
    - Washing hands frequently with soap and water, before and after eating, and after going to the toilet (see more information about hand washing published by the Department of Health
    - Covering the mouth when coughing and sneezing, disposing of tissues, and using alcohol-based hand sanitiser
    - If unwell, avoiding contact with others (i.e. touching, kissing, hugging, and other intimate contact)
- Ensure support workers who have travelled overseas or interstate self-isolate for 14 days before returning to work.
- Conduct routine environmental cleaning, particularly for frequently-touched surfaces and proper waste management.

- Where possible, continue in-home supports and shared care planning to minimise the risk of a participant being admitted to health or quarantined facilities.
- Where a case of COVID-19 is suspected, clear communication on preventive health measures should be given to staff and updated as circumstances change.
- Make sure that participants are kept informed and support them to understand how they can stay safe. There are accessible resources on our Coronavirus information for people with a disability page, including an Easy Read factsheet.

Staff flu vaccinations

Although COVID-19 is not the flu, flu vaccinations are critical to reducing the risk of serious health issues for many people with disability.

It is strongly recommended that all providers carers, workers, NDIS participants and their family members to receive the annual flu vaccination from mid-April 2020.

6. Dealing with suspected or confirmed cases of COVID-19

In-home support settings

If your workers provide supports to a person living in their own home, they should monitor for symptoms of COVID-19 in the person with disability whom they support or any other family members. While a participant or other family members showing symptoms is not sufficient reason to cease providing supports to them, you and your workers should implement your outbreak management plan.

Depending on the types of supports provided, this may include:

- assisting the participant to **seek medical advice** from their doctor or call the National Coronavirus Hotline on 1800 020 080 and assisting them to undergo COVID-19 testing, if that is advised. Refer to the Australian Government Department of Health's fact sheet 'Information for support workers and carers on COVID-19 testing for people with disability' for advice about the testing process
- identifying **which supports are essential** for the participant's health, wellbeing and safety, and whether any of these supports can be provided in a different way. For example, telephone welfare checks, or purchasing medication and food and leaving it in a safe place
- ensuring good **communication with the participant** and/or their family members and support workers so that everyone understands any disruption or alteration to supports and services
- **sourcing PPE** through usual means, and using it when:
  - a participant has or is suspected to have COVID-19
  - the supports being provided are essential to their life, health or safety
  - contact between people exceeds the Australian Government Department of Health Guidelines for social distancing and isolation.

Workers should not enter the home of a person who is unwell until either:

- their COVID-19 status is confirmed, or
- appropriate PPE is used correctly to provide any supports necessary to maintain the person's health, safety and wellbeing.

Disability accommodation settings

We encourage providers to review *National guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential settings* (Communicable Diseases Network Australia (CDNA)).

All workers and people with disability in the accommodation setting should actively monitor for symptoms of COVID-19.

If a participant shows symptoms of COVID-19:

- **seek medical advice** from their doctor or call the National Coronavirus Hotline on 1800 020 080. If recommended by a medical practitioner, assist the participant to undergo COVID-19 testing. Refer to the Australian Government Department of Health's fact sheet 'Information for support workers and carers on COVID-19 testing for people with disability' for advice about the testing process
- while awaiting the test results, **isolate the participant** and ensure they wear a face mask when in common areas. Increase routine environmental cleaning, and implement droplet precautions
- inform any person who **may have had close contact** with the participant from 24 hours before the onset of symptoms that there is a suspected case of COVID-19, including co-residents, families, and workers.
- **keep the participant informed** and support all residents to understand any changes to supports and services that may affect them.
- **source PPE** through usual means and use it when:
    - a participant has or is suspected to have COVID-19
    - the supports being provided are essential to the participant's life, health or safety
    - contact between people exceeds the Australian Government Department of Health Guidelines for social distancing and isolation.
- complete an internal **incident report** for the suspected case of COVID-19 (or other reports as required according to your organisation's outbreak management plan).

If a case of COVID-19 is confirmed by a positive test, you should take the following steps consistent with advice from your state or territory's public health unit:

- Inform people who have been in **close contact**, who must then self-quarantine for 14 days.
- Update **internal incident report** of a confirmed case (or other applicable internal reporting).
- **Notify the NDIS Commission** by completing and submitting the COVID-19 Notification of event form.

- Isolate the participant until they have recovered and been cleared by a medical professional. Ideally, this would be in a single room with ensuite, if available. This may involve assisting the participant to **relocate to alternative, temporary accommodation** for this period, if they agree to do so.
- Take precautions to **limit risk of spread** such as
  - suspending non-essential visitors for 14 days
  - arranging for professional cleaning of the residence and increased frequency of cleaning and disinfection
  - where your workers work across multiple outlets, or providers, work with those workers to determine if you can provide the level of work they require within your organisation to limit them working across multiple outlets. You may be able to collaborate with other providers to achieve this outcome.

Visitor management

Regularly review your organisation's visitor management policies to ensure they are consistent with the current public health orders in your state or territory, and reflect whether there are suspected or confirmed cases of COVID-19 within the provider setting. When doing so, seek guidance from the public health officials who are assisting with the confirmed or suspected outbreak.

This will include:

- informing all visitors about social distancing and hand hygiene
- preventing visitors who are not necessary to provide support to people in the residence from attending the facility if there is a suspected or confirmed case, and suspending all group activities (if this has not already been done)

You should communicate often with the people you support, their families and guardians/advocates about the steps you are taking to prevent infection, including any changes to the visitor management policies. Where it is possible in the context of the local health authorities' advice, and public health orders, visits by family members should be supported.

7. Managing an outbreak of COVID-19

Your outbreak management plan will help your workforce identify, respond to and manage a potential COVID-19 outbreak; protect the health of all workers and residents, and reduce the severity and duration of outbreaks if they occur.

An outbreak is considered by the Australian Government Department of Heath to have started when **two people in three days become sick** with the symptoms AND **at least one of these has a positive test** for COVID-19.

Your state or territory's public health unit will help you decide whether to declare an outbreak and in conjunction with medical practitioners caring for staff and residents will provide guidance on how to manage the outbreak.

If an outbreak is suspected or confirmed, you should:

- confirm standard infection control precautions are in place and implement transmission-based precautions (contact and droplet precautions)
- bring your outbreak management team together
- isolate any suspected or confirmed cases and assign dedicated support workers to them
- liaise with medical practitioners to closely monitor symptoms
- schedule regular environmental cleaning and disinfection of all areas
- put up signage at entrances to inform essential visitors
- put up droplet precaution signage outside symptomatic person's rooms
- suspend all non-essential services and supports
- suspend all non-essential visitors.

For more detailed information on outbreak management, see the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities.

8. Supporting participants through COVID-19

Adjusting services and supports

Below are some ideas received from NDIS providers about how to continue to support NDIS participants while adhering to current advice from the Australian Government, Commonwealth Chief Medical Officer, and state and territory governments about self-isolation and social distancing.

Provide telephone or online supports

- Where possible, consider moving services to be phone-based or interactive online services rather than face-to-face.

Provide activities in an alternative way

- Where supports are usually provided in groups that are not exempt from state and territory requirements, consider moving to individual one-on-one support (where a participant's plan/budget allows, and in line with current health advice).
- If participants are unable to access group recreational activities, consider activities that can be provided in the home, such as dance sessions (e.g. "silent disco"), sing-alongs, cooking activities or craft.

Establish COVID-19 communication channels

- Set up dedicated helplines or email addresses to handle enquiries about COVID-19 and changes to services from participants, their families, support worker and others.

Move to drop-in or contactless services

- Where appropriate, consider changing domestic assistance support to welfare checks, with only essential domestic assistance (such as shopping for food, medication delivery or changing bedding) continuing as usual.
- Arrange for support workers to go grocery shopping without participants. They can leave groceries at the doorstep for high-risk groups.

Arrange alternative ways for participants to communicate with friends and family

- Organise telephone/video calls for participants with friends and family, instead of face-to-face visits. This may include establishing a new team to coordinate and initiate connections for participants and their friends and family to stay in touch.
- Encourage participants to send (or send on their behalf, with their consent) regular emails to friends and family about the participant's daily activities.

Organise a contingency workforce

- Investigate the availability of staff in your local area whose working hours may have been reduced (e.g. staff who may have been providing group and centred-based activities).
- Explore other potential workforce sources who have the necessary skills to assist with the services and supports you deliver.
- If your workforce includes international students, consider increasing their working hours beyond 40 hours per fortnight, in line with the temporary lifting of work restrictions announced by the Australian Government.
- Consider using a matching platform to search for suitable new or backup workers.

Arrange back-up accommodation for isolation

- Identify spare rooms for participants to self-isolate if necessary.
- To reduce risk of infection, identify accommodation for staff to stay on-site or nearby, rather than travelling to and from home.

Variations to registered support categories

If, because of the COVID-19 pandemic, you want to make changes to the supports and services you deliver and these supports are outside the support categories that you are already registered to provide, you can contact us about a variation to your registration.

Where the additional or new supports you wish to provide are at the same level of risk and complexity as your existing supports, we can consider an urgent registration variation. For example, if you are no longer able to provide supports under *Participate in the Community, Social and Civic Activities* (Registration Group 0125) but would like to provide in-home supports such as *Development of daily living and life skills* (Registration Group 0117).

Communicating with participants

It is important to allow the person to **exercise choice and control** over decisions that affect them. Ways to do this include:

- Speaking to them about COVID-19 and seeking their input about sudden changes to their activities due to the measures being implemented.

- Providing them with the right information and seeking their views, as this will help you develop different strategies and approaches.
- Sharing information about adjustments and changes that may happen because of medical isolation and/or due to the closure of services.

See also 'Know the NDIS participants you support'.

Flu vaccinations

Some NDIS providers have responsibility to assist people they support in accessing their community and mainstream services, such as health care services. This includes helping people to get a flu vaccination.

If this is part of your responsibility, you should:

- make arrangements to assist a person to obtain a vaccination
- be aware of the population groups and chronic conditions associated with increased risk of flu-related complications
- strongly encourage carers, workers, NDIS participants and their family members to receive the annual flu vaccination
- support a person to get medical advice where appropriate, for example if a participant is unable to receive a vaccination
- reinforce staff hygiene practices especially hand hygiene and respiratory/cough etiquette in addition to vaccination
- implement and reinforce policies addressing good hygienic practices and infection control to reduce disease transmission
- role model and encourage regular handwashing.

Supporting NDIS participants with behaviour support needs

Below is some practical guidance to assist you to support your NDIS participants with behaviour support needs during COVID-19.

- In the case of a medically directed need for isolation, **review the person's behaviour support plan** (if they have one) for any recommendations for managing their behaviours of concern as well as the common triggers for their behaviour.
- As many community access services have been affected by the measures limiting public gatherings, **activate a business continuity plan**, such as providing alternative community access that complies with state or territory requirements, or at-home activities.
- Identify the **person's preferred modes of communication**, as effective communication can help to reduce their anxiety about any changes that need to happen.
- If the person you support wishes to attend public gatherings that they typically participate in, and those gatherings are limited, it is critical that you **gently explain to them why they cannot** participate during this period. Refer to their behaviour support plan (if they have one) for any recommendations before doing so.

- If the person does not have a behaviour support plan, draw on your existing **understanding of their interaction and communication preferences**. Or ask someone who knows them well, what those preferences are.
- Consider known **triggers for the person's behaviour of concern** and put in place strategies to mitigate these. Some common triggers are boredom, sudden changes to routines, missing friends or families, and communication difficulties.
- Take into account the **person's preferences** when preparing activities or indoor recreational activities that may be used for time in isolation at home. Ask what they wish to do or offer alternatives that are not inconsistent with the Commonwealth Chief Medical Officer's advice. For example, cooking or baking together at home, fun recreational activities that adhere to social distancing requirements at the home, or going for walks.
- **Explain the need for and importance of social distancing** and ask them what activities they wish to do. For example, some may prefer to do activities on their own or where they do not need to be in close proximity with others. These activities may include a social story-telling activity, individual art or craft, spending time in one's own room to play computer games, read a book or write a journal, individual dance (e.g. "silent disco") or sing-along sessions.
- Maintain the **person's social and family network** through telephone, social media or videoconferencing facilities to help ensure connectedness to friends and families during this period. Some activity ideas include sharing news or stories using video-phone links or sending photos of themselves doing an activity or sharing news via the telephone.
- Consider rostering **support staff with whom the person is familiar** or gets along well.

Behaviours of concern after risk mitigation strategies are implemented

- Any requirements to self-isolate or quarantine (as set out in state or territory Public Health Orders) may, at times, lead to the subsequent use of restrictive practices. For example, if the health order to self-isolate leads to a person being confused or angry about being in 'isolation', which then leads to behaviours of concern (such as leaving their home unsupported placing the person at risk), you may need to apply an environmental restraint, such as locking the doors for this period**. It is not a reportable incident if it is within the required period for self-isolation** as directed by the Commonwealth Chief Medical Officer to the whole community.
- However, if a physical restraint is used to prevent a person leaving the home, **then it is a regulated restrictive practice and its use is reportable**. If the physical restraint is not part of the person's existing behaviour support plan then it is a reportable incident.
- To prevent resorting to the use of physical restraint, it is important to speak to the person about why self-isolation and social distancing are needed. During this difficult time, it is more important to focus on **comforting and reassuring** the person, and providing them with a level of safe choice and control. The use of physical restraint should be the last resort of intervention.
- Staff supporting a person who is in isolation need to follow appropriate universal **infection control precautions**.
- Contact the person's **specialist behaviour support practitioner** or any other behaviour support practitioner in your organisation that may be able to assist.

Implementing a new regulated restrictive practice to support an NDIS participant

The following NDIS provider requirements apply when using regulated restrictive practices.

If a new restrictive practice for an NDIS participant is identified as needed, you must facilitate steps to engage an NDIS Behaviour Support practitioner to obtain an **interim behaviour support plan and a comprehensive behaviour support plan** for that person. This may require an NDIS plan review or locating an appropriate service providers. The list of service providers can be found on the NDIS 'myplace provider portal' under the service provider finder. Search for providers by their name, profession or support category. Where appropriate and available behaviour support plans can be done over the phone.

If this restrictive practice is not in accordance with a behaviour support plan and does not have current authorisation from your state or territory, it is a reportable incident to the NDIS Commission as an unauthorised restrictive practice.

Using restrictive practices as a 'precaution'

If you isolate an NDIS participant because you are concerned about their health but there is no directive from a medical practitioner that is in line with the Commonwealth Chief Medical Officer's advice, then this could be a regulated restrictive practice. You should follow the Australian Government's advice on COVID-19 symptoms and always seek medical advice where a person's health presents a concern.

Your workers should never make assumptions about the nature of the person's health issue, or disregard symptoms that may relate to COVID-19.

It is **not a regulated restrictive practice** if there is a self-isolation order or any other direction to the community as a whole that is issued by the Australian Government Chief Medical Officer or as directed by state and territory Chief Health Officers.

If your decision causes an NDIS participant to have more restricted access to the community than they would normally have, within the current limits on public gatherings, then it may be an **environmental restraint or seclusion**. For example, a person normally visits their friend over the weekend. The friend is not sick. It is a regulated restrictive practice if you prevent the person from visiting the friend who is not sick.

The NDIS Commission recognises that this advice needs to be considered in the context of community movement restrictions, which may be progressively put in place across Australia.

9. Information for participants

Fact sheets

We have written two fact sheets participants.

1. There is a COVID-19 NDIS participant information fact sheet explains:
    - what to expect from your NDIS providers
    - your rights, how to make a complaint about a provider
    - what resources are available from the NDIA
    - where to find more information and resources about COVID-19.

    This fact sheet is available in Easy Read and Auslan formats.

2. We have also produced a fact sheet to explain what participants can expect from their providers and workers during COVID-19. This includes some changes that a person with disability might experience in the way their supports and services are delivered during this time.

    This fact sheet is available in Easy Read and Auslan formats.

Both fact sheets are also available in in 11 community languages.

COVID-19 information pack

We have also developed an information pack about COVID-19 for NDIS participants. The pack explains how COVID-19 may affect some services and supports they receive, and what they can expect from you and their support workers. It also addresses several frequently asked questions, and contains links to a number of trusted sources of COVID-19 information and support.

We encourage you to share the resource with the NDIS participants you support, to help minimise any anxiety or confusion they may be experiencing.

10. COVID-19 links and resources

NDIS Commission

FAQs about COVID-19

We have developed a webpage of frequently asked questions about COVID-19 and how it affects the services and supports you provide to NDIS participants. We will continue to update these over time.

We have also produced the following updates, tools and resources during the COVID-19 pandemic:

Provider alerts

- Guidance from the Australian Government Department of Health (27 May 2020)

- Guidance on preventing, preparing for and dealing with a COVID-19 outbreak (13 May 2020)
- Advice for people with disability (7 May 2020)
- Changes to student visa work conditions for workers of registered NDIS providers (30 April 2020)
- FAQs for all stakeholders and information for NDIS participants (28 April 2020)
- Management and Operational Plan for People with Disability (20 April 2020)
- Further assistance for organisations, people and households (9 April 2020)
- Adjusting supports and reducing infection risk (3 April 2020)
- Practice Alert: Influenza (flu) vaccine from mid-April 2020 (2 April 2020)
- Information for providers on the use of Personal Protective Equipment (31 March 2020)
- Behaviour support and restrictive practices (31 March 2020)
- Supporting providers to respond (31 March 2020)
- Assistance for organisations (26 March 2020)
- Information for support workers and access to PPE (24 March 2020)
- Business continuity planning (19 March 2020)
- Online training module for support workers (17 March 2020)
- Provider obligations and COVID-19 health information (9 March 2020)
- Information about the novel coronavirus outbreak (7 February 2020)

Fact sheets

- Coronavirus (COVID-19): What the NDIS Commission is doing
- Coronavirus (COVID-19): NDIS participant information
- Coronavirus (COVID-19): NDIS participant information – Easy Read
- Coronavirus (COVID-19): Behaviour support and restrictive practices
- Coronavirus (COVID-19): Information for providers on the use of Personal Protective Equipment (PPE)
- Coronavirus (COVID-19): What NDIS participants can expect from their providers and support workers
- Coronavirus (COVID-19): What NDIS participants can expect from their providers and support workers – Easy Read
- Coronavirus (COVID-19): What NDIS participants can expect from their providers and support workers - Auslan
- Coronavirus (COVID-19): Relaxation of student visa work (letter from Department of Home Affairs)
- Coronavirus (COVID-19): Outbreak preparedness, prevention and management

Australian Government resources

- COVID-19 webpage: Webpage of the Australian Government containing essential COVID-19 information, key updates, advice and links to state and territory governments.
- COVIDSafe app**:** This app can help health officials quickly contact people exposed to COVID-19. You can download it from on the Apple App Store or Google Play.

- Coronavirus Australia app**:** Download the official government 'Coronavirus Australia' app in the Apple App Store or Google Play. Or join the Australian Government's WhatsApp channel on iOS or Android.
- Department of Health Coronavirus FAQs: The Department of Health has issued an information sheet that answers common questions about COVID-19.
- Guide to personal protective equipment (PPE) for disability care providers: The Australian Government Department of Health has produced guidance on using guidance on using PPE to prevent the spread of COVID-19.
- COVID-19 testing for people with disability**:** The Department of Health has released a fact sheet for support workers and carers of people with disability. The fact sheet covers who should be tested, where testing can be done, and how to explain the testing process to a person with disability.
- Residential care facilities: National guidelines for the prevention, control and public health management of COVID-19 outbreaks (Communicable Diseases Network Australia). These guidelines provide some useful information for disability providers to apply in the context of the settings where they deliver support to people with disability.
- COVID-19 preparedness webinar for in-home and community aged care (Australian Government Department of Health).
- Department of Health videos and campaign resources: The Australian Government Department of Health has released a series of short videos, posters and audio about COVID-19 and the steps we can all take to protect ourselves and those most at risk, and help stop the spread.
- Health care and residential care workers: An information sheet issued by the Department of Health for health care and residential care workers about COVID-19.
- Management and Operational Plan for People with Disability: Supports the objectives of the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19).

Other languages

- The Department of Home Affairs has translated COVID-19 information into 36 other languages

Australian Government
Department of Health

Attachment F

BE COVIDSAFE

CURRENT STATUS OF CONFIRMED CASES

7,335	102	6,851
Total cases	Total deaths	Cases recovered

4

CURRENT CASES INTENSIVE CARE UNITS (ICU)

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
0	0	0	1	0	0	3	0

17

CURRENT CASES ADMITTED TO HOSPITALS

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
0	9	0	1	0	0	7	0

1,828,149

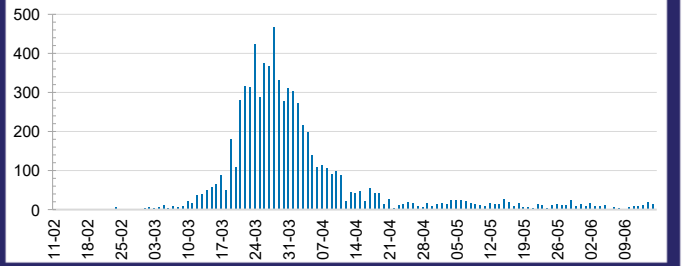
TOTAL TESTS CONDUCTED

0.4% POSITIVE

ACT	NSW	NT	QLD
23,571	641,442	10,488	251,322
POSITIVE	POSITIVE	POSITIVE	POSITIVE
0.5%	0.5%	0.3%	0.4%

SA	TAS	VIC	WA
126,572	36,471	594,865	143,418
POSITIVE	POSITIVE	POSITIVE	POSITIVE
0.3%	0.6%	0.3%	0.4%

DAILY NUMBER OF REPORTED CASES

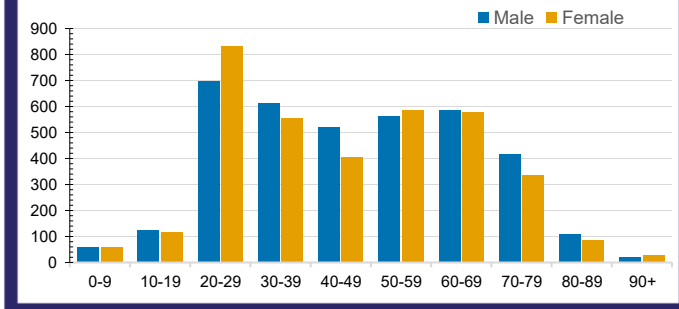


CASES IN AGED CARE SERVICES

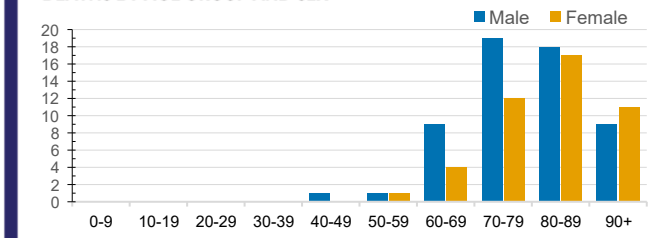
Confirmed Cases	Australia	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Residential Care Recipients	68 [39] (29)	0	61 [34] (27)	0	1 (1)	0	1 (1)	5 [5]	0
In Home Care Recipients	31 [28] (3)	0	13 [13]	0	8 [8]	1 [1]	5 [3] (2)	3 [3]	1 (1)

Cases in care recipients [recovered] (deaths)

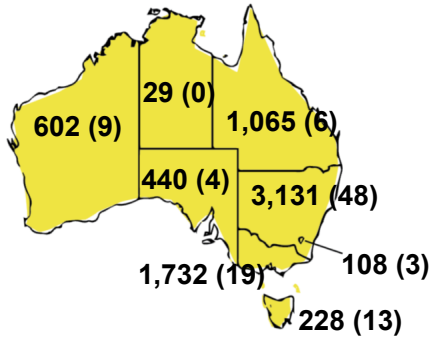
CASES BY AGE GROUP AND SEX



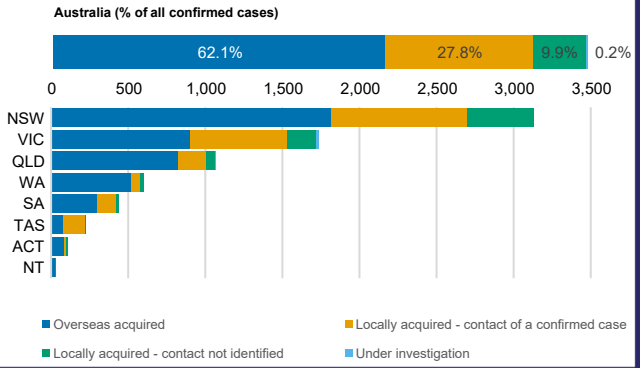
DEATHS BY AGE GROUP AND SEX



CASES (DEATHS) BY STATE AND TERRITORIES

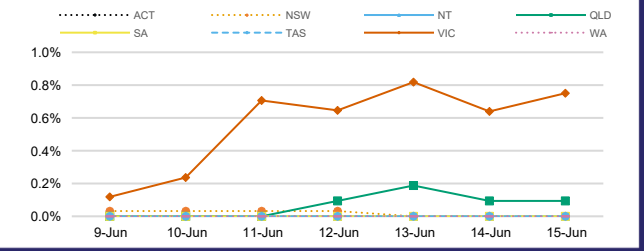


CASES BY SOURCE OF INFECTION



PUBLIC HEALTH RESPONSE MEASURE

Proportion of total cases under investigation



Last updated 15 June 2020

This infographic is updated every afternoon based on the data we receive by 3.00pm from states and territories

Australian Government
Department of Health

Attachment G

Coronavirus (COVID-19)

CURRENT STATUS OF CONFIRMED CASES

6,948	97	6,179
Total cases	Total deaths	Cases recovered

16

CURRENT CASES INTENSIVE CARE UNITS (ICU)

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
0	7	0	3	0	0	5	1

49

CURRENT CASES ADMITTED TO HOSPITALS

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
0	20	2	7	1	8	7	4

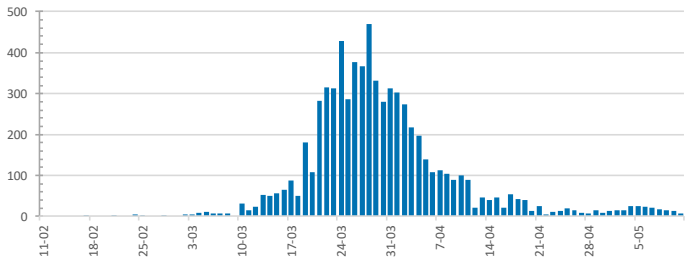
855,119

TOTAL TESTS CONDUCTED

0.8% POSITIVE

ACT	NSW	NT	QLD
11,939	309,722	5,527	137,009
POSITIVE	POSITIVE	POSITIVE	POSITIVE
0.9%	1.0%	0.5%	0.8%
SA	**TAS**	**VIC**	**WA**
70,147	19,351	245,326	56,098
POSITIVE	POSITIVE	POSITIVE	POSITIVE
0.6%	1.2%	0.6%	1.0%

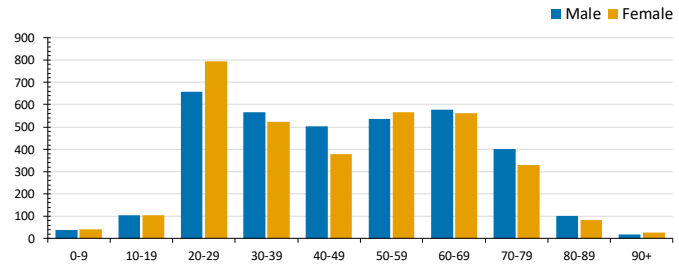
DAILY NUMBER OF REPORTED CASES



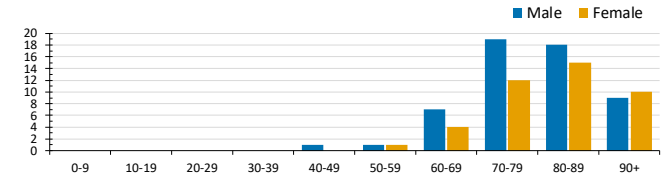
CASES IN AGED CARE SERVICES

Confirmed Cases	Australia	ACT	NSW	NT	Qld	SA	Tas	Vic	WA
Residential Care Recipients	63 [16] (26)	0	61 [16] (24)	0	1 (1)	0	1 (1)	0	0
In Home Care Recipients	31 [22] (3)	0	13 [11]	0	8 [7]	1 [1]	5 (2)	3 [3]	1 (1)
Cases in care recipients [recovered] (deaths)									

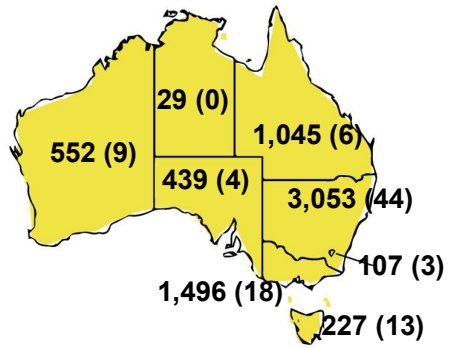
CASES BY AGE GROUP AND SEX



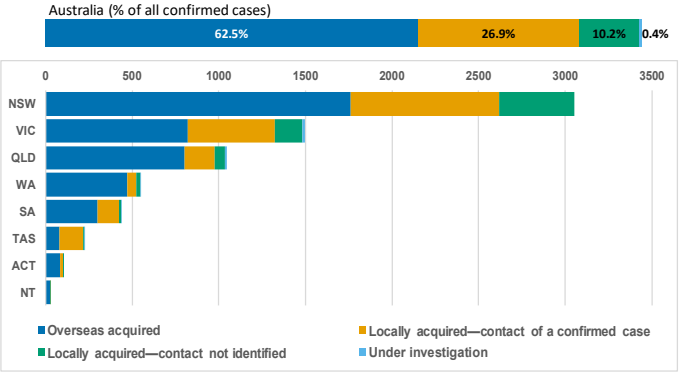
DEATHS BY AGE GROUP AND SEX



CASES (DEATHS) BY STATE AND TERRITORIES

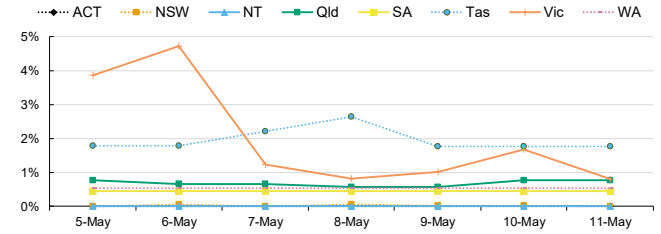


CASES BY SOURCE OF INFECTION



PUBLIC HEALTH RESPONSE MEASURE

Proportion of total cases under investigation



Last updated 11 May 2020

This infographic is updated every afternoon based on the data we receive by 3.00pm from states and territories

Coronavirus disease (COVID-19)

Situation Report – 147

Data as received by WHO from national authorities by 10:00 CEST, 15 June 2020

Highlights

As the pandemic accelerates in low- and middle-income countries, WHO is especially concerned about its impact on people who already struggle to access health services – often women, children and adolescents. WHO has developed guidance on maintaining essential services.

WHO has also carefully investigated the risks of women transmitting COVID-19 to their babies during breastfeeding. Based on the available evidence, WHO's advice is that the benefits of breastfeeding outweigh any potential risks of transmission of COVID-19. A Q and A on breastfeeding and COVID-19 is also available.

WHO has recently released a photo story outlining ten actions you can take to protect and improve your sexual and reproductive health during the COVID-19 pandemic. At present, there is no evidence of sexual transmission of the virus responsible for COVID-19. The virus can be passed however, through direct contact with saliva, for instance, kissing.

There are also many things people can do to take care of their own health, like staying active, eating a nutritious diet and limiting their alcohol intake.

In today's Subject in Focus, we look at the Solidarity Trials, which are being used to accelerate research on a COVID-19 Vaccine.

Situation in numbers (by WHO Region)

Total (new cases in last 24 hours)

Globally	7 823 289 cases (132 581)	431 541 deaths (3 911)
Africa	175 503 cases (7 937)	4 111 deaths (113)
Americas	3 781 538 cases (69 770)	201 848 deaths (2 596)
Eastern Mediterranean	778 200 cases (19 649)	17 077 deaths (437)
Europe	2 416 920 cases (18 141)	188 350 deaths (349)
South-East Asia	471 392 cases (15 953)	12 927 deaths (401)
Western Pacific	198 995 cases (1 131)	7 215 deaths (15)

Subject in Focus: Accelerating research on a COVID-19 Vaccine

Since the start of the pandemic, there has been an urgent need to accelerate the research and development of a safe and effective vaccine.

To facilitate research and vaccine development, WHO's R&D Blueprint team convened:

1. A process to develop a core clinical trial study protocol for a global, and globally coordinated, clinical trial for vaccines. The idea is to accelerate research on COVID-19 vaccines through a large, international, randomized controlled clinical trial using a standardized study protocol that enables the agile, simultaneous evaluation of the benefits and risks of multiple candidate vaccines in sites with sufficient COVID-19 attack rates.

   To date, more than 120 different candidate vaccines are under development and could be available or suitable to enter the trial at different times. The aim of the Solidarity Trial, is to quickly enrol and individually randomize very large numbers of adult participants in many different populations and settings across the world. By using a shared placebo/control group and a common core study protocol to evaluate multiple candidate vaccines in the trial, resources allocated to the evaluation of each candidate vaccine can be saved while ensuring a high standard of scientific rigor and efficiency.

   Following an in-depth review by experts and various consultations, a revised version of the WHO core protocol was recently published. In addition, WHO has also launched a call for expressions of interest from vaccine trial sites around the world to identify those that would participate in a vaccine Solidarity Trial using this core protocol.

2. A multi-disciplinary group of experts from across the world to discuss, from different perspectives, to develop the concept of Human Challenge Studies. The WHO Advisory Group for "Human Challenges" was tasked with considering the feasibility, potential value and limitations of establishing a closely monitored human challenge model of experimental COVID-19 infection and illness in healthy young adult volunteers.

   This Advisory Group included experts with experience in:

   - design and performance of many types of volunteer challenge studies,
   - SARS-CoV-2 virology,
   - measurement of human immune responses to SARS-CoV-2 and to other microbial pathogens,
   - clinical management of COVID-19 clinical disease in different geographic settings,
   - regulatory considerations associated with testing and emergency pre-licensure use of vaccines and with larger-scale post-licensure deployment,
   - and GMP manufacture of virulent viruses under BSL-3 containment.

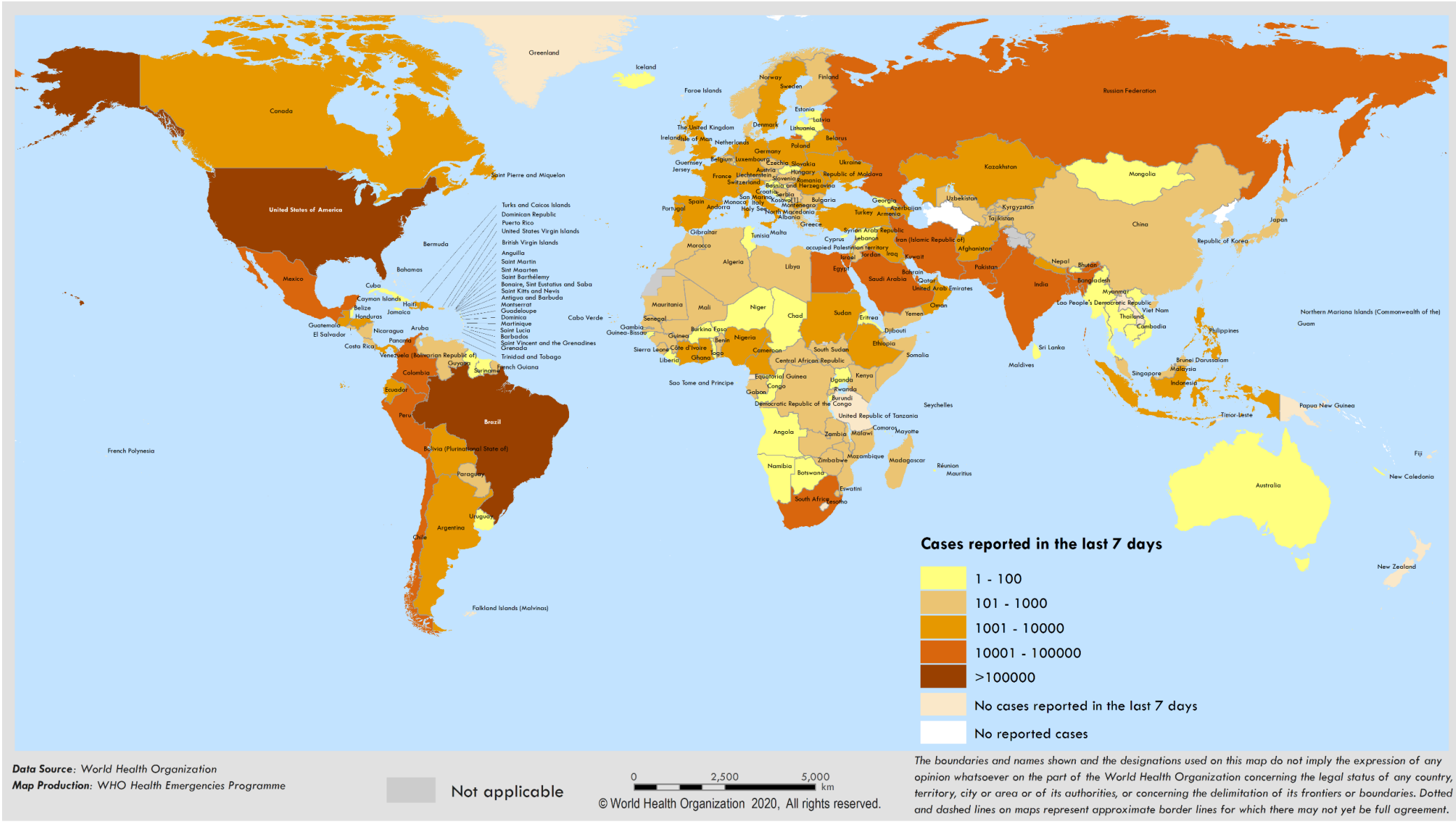
The Working Group was sub-divided into four subgroups to address: Clinical Trials Issues, Challenge Virus Strain Issues, Measurement of Immune Responses Pre- and Post-Challenge, and Detection of SARS-CoV-2 in Clinical Specimens Post-challenge.

Since its constitution, the Advisory Group has convened several times to deliberate on this question and to make recommendations. A full report of this Advisory Group will be available shortly on the R&D Blueprint and COVID-19 webpage. This complements the 6 May 2020 document outlining the key criteria for the ethical acceptability of Covid-19 human challenge studies.

Further information on WHO's work relating to vaccine research can be found on the R&D Blueprint and COVID-19 webpage.

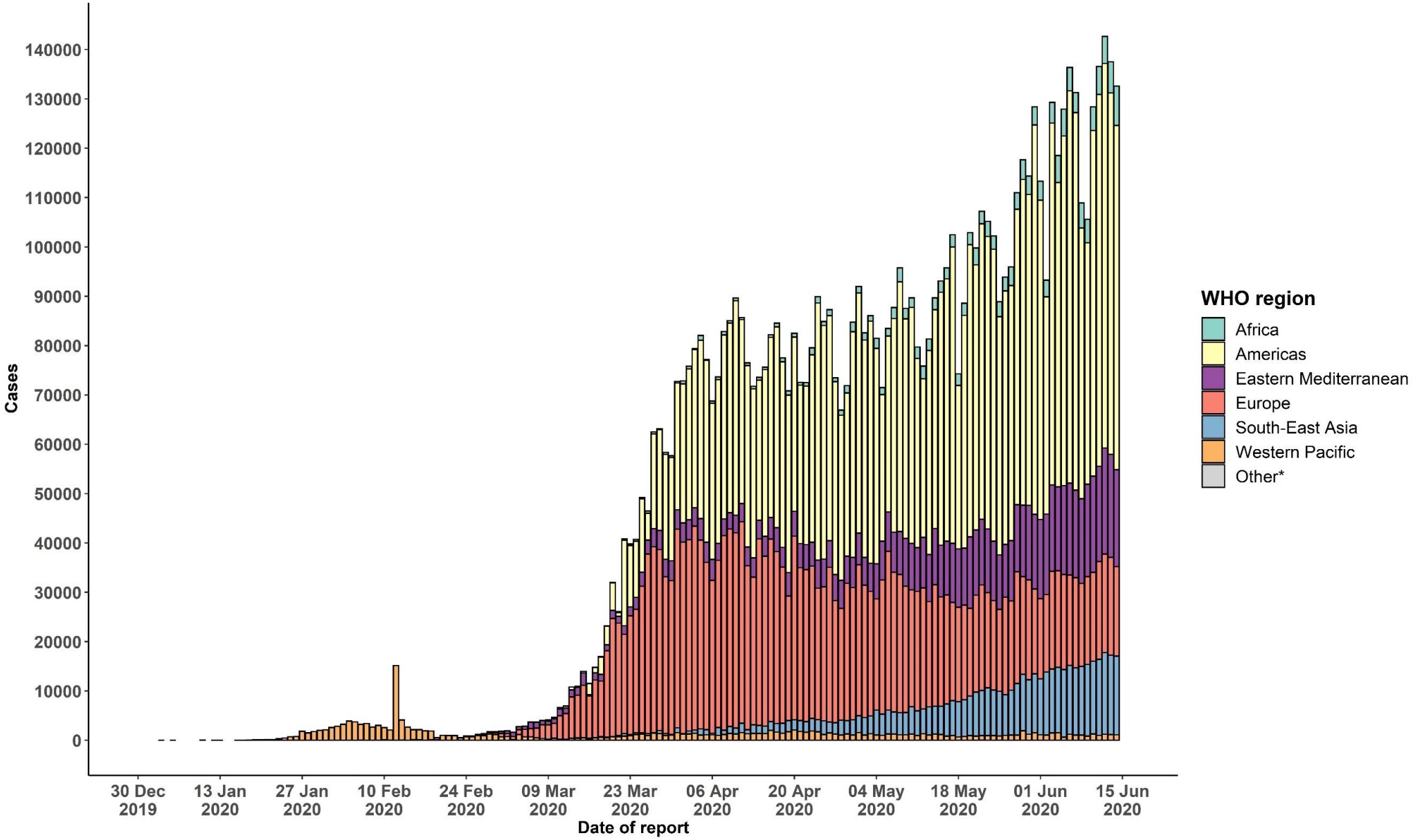
Surveillance

Figure 1. Number of confirmed COVID-19 cases reported in the last seven days by country, territory or area, 09 June to 15 June**



**See Annex 1 for data, table and figure notes.

Figure 2. Number of confirmed COVID-19 cases, by date of report and WHO region, 30 December through 15 June**



***See Annex 1 for data, table and figure notes.*

Table 1. Countries, territories or areas with reported laboratory-confirmed COVID-19 cases and deaths, by WHO region. Data as of 10 AM CEST, 15 June 2020**

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Africa						
South Africa	70 038	4 302	1 480	57	Community transmission	0
Nigeria	16 085	904	420	21	Community transmission	0
Ghana	11 422	304	51	3	Community transmission	0
Algeria	10 919	109	767	7	Community transmission	0
Cameroon	9 572	829	275	5	Community transmission	0
Senegal	5 090	94	60	0	Community transmission	0
Côte d'Ivoire	5 084	236	45	0	Community transmission	0
Democratic Republic of the Congo	4 777	54	106	1	Community transmission	0
Guinea	4 534	50	25	0	Community transmission	0
Kenya	3 594	137	103	3	Community transmission	0
Gabon	3 463	0	23	0	Community transmission	3
Ethiopia	3 345	179	57	2	Community transmission	0
Central African Republic	2 222	165	7	0	Community transmission	0
Mali	1 809	33	104	0	Community transmission	0
Mauritania	1 783	210	87	6	Clusters of cases	0
South Sudan	1 693	9	27	2	Clusters of cases	0
Guinea-Bissau	1 460	0	15	0	Community transmission	1
Zambia	1 358	1	11	1	Community transmission	0
Madagascar	1 272	20	10	0	Clusters of cases	0
Sierra Leone	1 169	37	51	0	Community transmission	0
Equatorial Guinea	1 043	0	12	0	Community transmission	22

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Niger	980	2	66	1	Community transmission	0
Burkina Faso	894	2	53	0	Community transmission	0
Chad	850	2	73	1	Community transmission	0
Uganda	823	0	0	0	Sporadic cases	1
Congo	779	0	25	0	Community transmission	1
Cabo Verde	750	24	6	0	Clusters of cases	0
Mozambique	583	30	2	0	Clusters of cases	0
Rwanda	582	41	2	0	Sporadic cases	0
Malawi	547	18	6	1	Clusters of cases	0
Togo	530	5	13	0	Community transmission	0
United Republic of Tanzania	509	0	21	0	Community transmission	38
Eswatini	490	4	4	1	Clusters of cases	0
Benin	470	58	7	1	Community transmission	0
Liberia	458	12	32	0	Community transmission	0
Sao Tome and Principe	388	0	10	0	Clusters of cases	4
Zimbabwe	383	27	4	0	Sporadic cases	0
Mauritius	337	0	10	0	Clusters of cases	9
Comoros	176	0	2	0	Community transmission	1
Angola	140	2	6	0	Clusters of cases	0
Eritrea	96	31	0	0	Sporadic cases	0
Burundi	94	0	1	0	Clusters of cases	3
Botswana	60	0	1	0	Clusters of cases	2
Namibia	32	0	0	0	Sporadic cases	1

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Gambia	28	0	1	0	Sporadic cases	6
Seychelles	11	0	0	0	Clusters of cases	69
Lesotho	4	0	0	0	Sporadic cases	11
Territories[ii]						
Mayotte	2 282	0	29	0	Clusters of cases	1
Réunion	495	6	1	0	Clusters of cases	0
Americas						
United States of America	2 057 838	25 314	115 112	646	Community transmission	0
Brazil	850 514	21 704	42 720	892	Community transmission	0
Peru	225 132	4 383	6 498	190	Community transmission	0
Chile	174 293	6 938	3 323	222	Community transmission	0
Mexico	142 690	3 494	16 872	424	Community transmission	0
Canada	98 410	467	8 107	58	Community transmission	0
Colombia	48 746	1 888	1 592	47	Community transmission	0
Ecuador	46 751	395	3 896	22	Community transmission	0
Argentina	30 295	1 531	819	17	Community transmission	0
Dominican Republic	22 962	390	592	15	Community transmission	0
Panama	20 059	848	429	8	Community transmission	0
Bolivia (Plurinational State of)	17 842	913	585	26	Community transmission	0
Guatemala	9 491	509	367	16	Community transmission	0
Honduras	8 455	323	310	4	Community transmission	0
Haiti	4 165	224	70	6	Community transmission	0
El Salvador	3 720	117	72	0	Community transmission	0
Venezuela (Bolivarian Republic of)	2 904	25	24	1	Community transmission	0

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Cuba	2 248	10	84	0	Clusters of cases	0
Costa Rica	1 662	50	12	0	Clusters of cases	0
Nicaragua	1 655	0	55	0	Community transmission	4
Paraguay	1 289	28	11	0	Community transmission	0
Uruguay	847	0	23	0	Clusters of cases	3
Jamaica	615	1	10	0	Clusters of cases	0
Suriname	187	0	3	0	Clusters of cases	1
Guyana	159	0	12	0	Clusters of cases	1
Trinidad and Tobago	117	0	8	0	Sporadic cases	14
Bahamas	103	0	11	0	Clusters of cases	8
Barbados	96	0	7	0	Clusters of cases	4
Saint Vincent and the Grenadines	27	0	0	0	Sporadic cases	6
Antigua and Barbuda	26	0	3	0	Clusters of cases	1
Grenada	23	0	0	0	Clusters of cases	19
Belize	21	1	2	0	Sporadic cases	0
Saint Lucia	19	0	0	0	Sporadic cases	9
Dominica	18	0	0	0	Clusters of cases	2
Saint Kitts and Nevis	15	0	0	0	Sporadic cases	55
Territories[ii]						
Puerto Rico	5 811	121	147	1	Community transmission	0
French Guiana	1 255	94	3	1	Clusters of cases	0
Martinique	202	0	14	0	Clusters of cases	8
Cayman Islands	187	0	1	0	Clusters of cases	1
Guadeloupe	171	0	14	0	Clusters of cases	2

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Bermuda	144	2	9	0	Clusters of cases	0
Aruba	101	0	3	0	No cases	40
Sint Maarten	77	0	15	0	Sporadic cases	9
United States Virgin Islands	72	0	6	0	Clusters of cases	4
Saint Martin	41	0	3	0	Sporadic cases	15
Curaçao	22	0	1	0	Sporadic cases	4
Falkland Islands (Malvinas)	13	0	0	0	Clusters of cases	50
Turks and Caicos Islands	12	0	1	0	Sporadic cases	48
Montserrat	11	0	1	0	Sporadic cases	62
British Virgin Islands	8	0	1	0	Sporadic cases	30
Bonaire, Sint Eustatius and Saba	7	0	0	0	No cases	20
Saint Barthélemy	6	0	0	0	Sporadic cases	76
Anguilla	3	0	0	0	Sporadic cases	72
Saint Pierre and Miquelon	1	0	0	0	Sporadic cases	68
Eastern Mediterranean						
Iran (Islamic Republic of)	187 427	2 472	8 837	107	Community transmission	0
Pakistan	144 478	5 248	2 729	97	Clusters of cases	0
Saudi Arabia	127 541	4 233	972	40	Clusters of cases	0
Qatar	79 602	1 186	73	3	Community transmission	0
Egypt	44 598	1 618	1 575	91	Clusters of cases	0
United Arab Emirates	42 294	304	289	1	Pending	0
Kuwait	35 920	454	296	7	Clusters of cases	0
Afghanistan	25 527	761	476	5	Clusters of cases	0
Oman	23 481	1 404	104	5	Clusters of cases	0

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Iraq	20 209	1 259	607	58	Clusters of cases	0
Bahrain	18 544	317	43	4	Clusters of cases	0
Morocco	8 793	101	212	0	Clusters of cases	0
Sudan	7 220	213	459	12	Community transmission	0
Djibouti	4 465	16	43	2	Clusters of cases	0
Somalia	2 595	16	88	1	Sporadic cases	0
Lebanon	1 446	4	32	0	Clusters of cases	0
Tunisia	1 096	2	49	0	Community transmission	0
Jordan	961	8	9	0	Clusters of cases	0
Yemen	732	23	165	4	Pending	0
Libya	418	0	8	0	Clusters of cases	1
Syrian Arab Republic	177	7	6	0	Community transmission	0
Territories[ii]						
occupied Palestinian territory	676	3	5	0	Clusters of cases	0
Europe						
Russian Federation	537 210	8 246	7 091	143	Clusters of cases	0
The United Kingdom	295 893	1 514	41 698	36	Community transmission	0
Spain	243 928	323	27 136	0	Community transmission	0
Italy	236 989	338	34 345	44	Community transmission	0
Germany	186 461	192	8 791	4	Community transmission	0
Turkey	178 239	1 562	4 807	15	Community transmission	0
France	152 767	307	29 343	8	Community transmission	0
Belgium	60 029	111	9 655	5	Community transmission	0
Belarus	53 973	732	308	5	Community transmission	0

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Sweden	51 614	683	4 874	0	Community transmission	0
Netherlands	48 783	143	6 059	2	Community transmission	0
Portugal	36 690	227	1 517	5	Community transmission	0
Ukraine	31 810	656	901	12	Community transmission	0
Switzerland	31 034	23	1 676	0	Community transmission	0
Poland	29 392	375	1 247	10	Community transmission	0
Ireland	25 303	8	1 706	1	Community transmission	0
Romania	21 999	320	1 410	19	Community transmission	0
Israel	19 008	132	300	0	Pending	0
Armenia	17 064	397	285	16	Community transmission	0
Austria	17 038	24	677	0	Community transmission	0
Kazakhstan	14 809	313	77	4	Clusters of cases	0
Serbia	12 310	59	254	1	Pending	0
Denmark	12 193	54	597	0	Community transmission	0
Republic of Moldova	11 740	281	406	7	Community transmission	0
Czechia	10 024	33	329	0	Clusters of cases	0
Azerbaijan	9 957	387	119	4	Clusters of cases	0
Norway	8 606	0	242	0	Clusters of cases	2
Finland	7 104	17	326	1	Pending	0
Uzbekistan	5 103	109	19	0	Clusters of cases	0
Tajikistan	5 035	64	50	0	Pending	0
Hungary	4 076	12	563	4	Community transmission	0
Luxembourg	4 070	7	110	0	Clusters of cases	0
North Macedonia	4 057	155	188	9	Clusters of cases	0

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Bulgaria	3 290	24	174	2	Clusters of cases	0
Greece	3 121	9	183	0	Clusters of cases	0
Bosnia and Herzegovina	3 001	109	163	1	Community transmission	0
Kyrgyzstan	2 372	87	27	0	Clusters of cases	0
Croatia	2 252	1	107	0	Sporadic cases	0
Estonia	1 973	0	69	0	Sporadic cases	1
Iceland	1 810	2	10	0	Community transmission	0
Lithuania	1 768	5	75	0	Community transmission	0
Albania	1 590	69	36	0	Clusters of cases	0
Slovakia	1 548	3	28	0	Clusters of cases	0
Slovenia	1 495	3	109	0	Clusters of cases	0
Latvia	1 097	0	28	0	Clusters of cases	1
Cyprus	983	3	18	0	Clusters of cases	0
Georgia	879	15	14	0	Community transmission	0
Andorra	853	0	51	0	Community transmission	2
San Marino	695	0	42	0	Community transmission	10
Malta	646	0	9	0	Sporadic cases	1
Montenegro	325	1	9	0	Clusters of cases	0
Monaco	99	0	1	0	Sporadic cases	8
Liechtenstein	83	0	1	0	Pending	50
Holy See	12	0	0	0	Sporadic cases	39
Territories[ii]						
Kosovo[1]	1 443	6	23	- 9	Community transmission	0
Isle of Man	336	0	24	0	Pending	24

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Jersey	313	0	30	0	Community transmission	5
Guernsey	252	0	13	0	Community transmission	43
Faroe Islands	187	0	0	0	Pending	52
Gibraltar	176	0	0	0	Clusters of cases	6
Greenland	13	0	0	0	Pending	17
South-East Asia						
India	332 424	11 502	9 520	325	Clusters of cases	0
Bangladesh	87 520	3 141	1 171	32	Community transmission	0
Indonesia	38 277	857	2 134	43	Community transmission	0
Nepal	5 760	425	19	1	Sporadic cases	0
Thailand	3 135	0	58	0	Clusters of cases	1
Maldives	2 035	22	8	0	Clusters of cases	0
Sri Lanka	1 889	5	11	0	Clusters of cases	0
Myanmar	262	1	6	0	Clusters of cases	0
Bhutan	66	0	0	0	Sporadic cases	1
Timor-Leste	24	0	0	0	Clusters of cases	52
Western Pacific						
China	84 778	49	4 645	0	Clusters of cases	0
Singapore	40 604	407	26	0	Clusters of cases	0
Philippines	25 930	538	1 088	14	Community transmission	0
Japan	17 502	73	925	0	Clusters of cases	0
Republic of Korea	12 121	36	277	0	Clusters of cases	0
Malaysia	8 453	8	121	1	Clusters of cases	0

Reporting Country/Territory/Area	Total confirmed cases	Total confirmed new cases	Total deaths	Total new deaths	Transmission classification[i]	Days since last reported case
Australia	7 320	18	102	0	Clusters of cases	0
New Zealand	1 154	0	22	0	Clusters of cases	24
Viet Nam	334	0	0	0	Clusters of cases	1
Mongolia	197	0	0	0	Sporadic cases	2
Brunei Darussalam	141	0	2	0	Clusters of cases	38
Cambodia	128	2	0	0	Sporadic cases	0
Lao People's Democratic Republic	19	0	0	0	Sporadic cases	63
Fiji	18	0	0	0	Sporadic cases	55
Papua New Guinea	8	0	0	0	Sporadic cases	53
Territories[ii]						
Guam	177	0	5	0	Clusters of cases	1
French Polynesia	60	0	0	0	Sporadic cases	40
Northern Mariana Islands (Commonwealth of the)	30	0	2	0	Pending	5
New Caledonia	21	0	0	0	Sporadic cases	5
Subtotal for all regions	**7 822 548**	**132 581**	**431 528**	**3 911**		
Other*	741	0	13	0	Not applicable	-
Grand total	**7 823 289**	**132 581**	**431 541**	**3 911**		

***See Annex 1 for data, table and figure notes.*

Technical guidance and other resources

- To view all technical guidance documents regarding COVID-19, please go to this webpage.
- Updates from WHO regional offices
  - WHO AFRO
  - WHO EMRO
  - WHO EURO
  - WHO PAHO
  - WHO SEARO
  - WHO WPRO
- Research and Development
- Online courses on COVID-19 and in additional national languages
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- WHO Coronavirus Disease (COVID-19) Dashboard
- Weekly COVID-19 Operations Updates

Recommendations and advice for the public

- Protect yourself
- Questions and answers
- Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities

Case definitions

WHO periodically updates the Global Surveillance for human infection with coronavirus disease (COVID-19) document which includes surveillance definitions.

Definition of COVID-19 death

A COVID-19 death is defined for surveillance purposes as a death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g. trauma). There should be no period of complete recovery between the illness and death.

Further guidance for certification and classification (coding) of COVID-19 as cause of death is available here and here.

Annex 1: Data, table and figure notes

Caution must be taken when interpreting all data presented. Differences are to be expected between information products published by WHO, national public health authorities, and other sources using different inclusion criteria and different data cut-off times. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change. Case detection, definitions, testing strategies, reporting practice, and lag times differ between countries/territories/areas. These factors, amongst others, influence the counts presented, with variable underestimation of true case and death counts, and variable delays to reflecting these data at global level.

The designations employed, and the presentation of these materials do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Countries, territories and areas are arranged under the administering WHO region.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). In the map, number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes.

Counts reflect laboratory-confirmed cases and deaths, based on WHO case definitions, unless stated otherwise (see Country, territory, or area-specific updates and errata), and include both domestic and repatriated cases.

Other*: includes cases reported from international conveyances.

Due to the recent trend of countries conducting data reconciliation exercises which remove large numbers of cases or deaths from their total counts, WHO will now display such data as negative numbers in the "new cases" / "new deaths" columns as appropriate. This will aid readers in identifying when such adjustments occur. When additional details become available that allow the subtractions to be suitably apportioned to previous days, graphics will be updated accordingly. Prior situation reports will not be edited; see covid19.who.int for the most up-to-date data.

Additional table notes

[i] Transmission classification is based on a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be revised as new information becomes available. and. Differing degrees of transmission may be present within countries/territories/areas; classification is based on the highest category reported within a country/territory/area. Categories:

- No cases: with no confirmed cases
- Sporadic cases: with one or more cases, imported or locally detected
- Clusters of cases: experiencing cases, clustered in time, geographic location and/or by common exposures

- Community transmission: experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to: large numbers of cases not linkable to transmission chains; large numbers of cases from sentinel lab surveillance; and/or multiple unrelated clusters in several areas of the country/territory/area
- Pending: transmission classification has not been reported to WHO

ii "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status.

Country, territory, or area-specific updates and errata

- Erratum 15 June 2020, Kosovo[1]: The Situation Report from 14th June 2020 included an additional 9 deaths. To align with the national authorities, counts have been corrected.
- Note: 15 June 2020, Beijing, China: The investigation of a cluster of COVID-19 cases in Beijing associated with a wholesale market continues. As of 15 June, 12PM CEST, Chinese authorities have reported a total of 105 cases since 11 June, including 2 linked cases in Liaoning Province. WHO is closely monitoring the situation and is in close contact with national authorities in China.

Attachment I

	COVID-19 Testing Eligibility Criteria and Waiting Times	
	Eligibility Criteria	**Waiting Times**
VIC	Testing is currently available to persons with the following symptoms, however mild: • Fever • chills or sweats • cough • sore throat • shortness of breath • runny nose, and • loss of sense of smell. Source: Victorian State Government Department of Health and Human Services - Getting tested for coronavirus (Covid-19)	Test results are usually returned in 1 – 3 days. Source: Victorian State Government Department of Health and Human Services - Getting tested for coronavirus (Covid-19)
NSW	The criteria have recently been expanded to recommend that anyone with symptoms should be tested for COVID-19. This is said to be especially important for: • anyone who lives or works in a high risk setting, including healthcare facilities, aged care and other residential facilities, schools, prisons, and other closed settings • Aboriginal and Torres Strait Islander people • people who are close contacts of a confirmed case or who have returned from overseas in the last 14 days • anyone admitted to hospital • people who reside in areas for increased testing and surveillance (Note: these areas are updated weekly). Source: NSW Government: COVID-19 (Coronavirus) – How to protect clinics – COVID-19 testing clinics	Results will typically be available 24 to 72 hours after testing. Source: NSW Government: COVID-19 (Coronavirus) – Symptoms and testing

Attachment I

QLD	Anyone with any COVID-19 symptoms is eligible for testing**, no matter** how mild. It is recommended that testing is undertaken immediately after experiencing such symptoms. Source: Queensland Government - Testing and fever clinics — coronavirus (COVID-19)	Results should be available from 36-48 hours after the test has occurred. Source: Queensland Health - COVID-19 testing results

SA	A person is eligible for testing if they are experiencing:
	
	• fever OR chills with no alternative illness that explains these symptoms
	• an acute respiratory infection, for example:
	  ○ cough
	  ○ sore throat
	  ○ runny nose
	  ○ shortness of breath
	• loss of taste and smell.
	
	Source: SA Health - Testing for Coronavirus
		Test results should usually be received within 2 days from when the test occurred.
		
		Source: SA Health - Testing for Coronavirus

WA	Any person will be eligible for testing if they meet any of the following criteria: • presenting with a fever (≥37.5°C); • a recent history of a fever (e.g. night sweats, chills); or • an acute respiratory infection e.g. shortness of breath, cough, sore throat. Source: Government of Western Australia Department of Health - COVID clinics	Test results should be made available from 2-3 days from when the test occurred. Source: Government of Western Australia Department of Health - Frequently asked questions

TAS	It is recommended that persons with the any of the following symptoms are tested: • fever • runny nose • cough • sore/itchy throat • shortness of breath. Testing is also being encouraged for people who fall into the following criteria: • All persons presenting with respiratory symptoms, or with history of recent respiratory symptoms (within the last 7 days) • Hospital patients being discharged to residential aged care facilities • Healthcare workers displaying symptoms or healthcare workers without symptoms. Household members of healthcare and aged care workers who are displaying symptoms are also encouraged to be tested • Close contacts of confirmed cases between days 10-12 of quarantine period • Non-essential travellers between days 10-12 of quarantine period. Source: Tasmanian Government - Testing for COVID-19	Results are usually provided within 48 hours. Source: Tasmanian Government - Testing for COVID-19
NT	Criteria for testing includes anyone with the following symptoms: • a recent, acute respiratory infection (e.g. cough, shortness of breath, sore throat) • a fever or history of fever (e.g. night sweats, chills). Source: Northern Territory Government - Coronavirus (COVID-19)	It may take a few days for the test results to come back. Source: Northern Territory Government - Coronavirus (COVID-19)

ACT	Criteria for testing includes anyone with the following symptoms: • Fever of 37.5 degrees or greater (or recent history of fever such as chills or night sweats); or • Respiratory infection (such as shortness of breath, cough, or sore throat). In addition, people who have sudden onset of loss of smell, loss of taste, runny nose, muscle pain, joint pain, diarrhoea, nausea, vomiting or loss of appetite may be eligible for COVID-19 testing, after assessment by a health professional. Source: ACT Government - COVID-19	If the swab result is positive for COVID-19, it will usually be returned within 1–2 days. Source: ACT Government - COVID-19