Department of Health and Human Services
CHIEF HEALTH OFFICER

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Office of the Chief Health Officer Pandemic (H1N1) 2009 and Seasonal Influenza Response Plan

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Table of Contents

Purpose of Plan 4

Overarching Planning and Operational Construct 5

OCHO Response Arrangements 6

Annexe A - Situational Background Pandemic (H1N1) 2009 9

Annexe B - Key Elements of the PROTECT Phase in Tasmania 10

Annexe C - Response Planning Considerations 11

Annexe D - Communications 13

Document Acceptance and Version Notification

This Plan outlines the role and responsibilities of the Office of the Chief Health Officer in response to Pandemic (H1N1) 2009 and the current influenza season. This Plan is a managed document and changes will only be issued as a complete replacement. Recipients should remove superseded versions from circulation. This Plan is authorised for release once approved by the Chief Health Officer.

Prepared for acceptance by:	OCHO Emergency Management Advisory Officer	Date: 29 July 2009
Approved for release by:	Chief Health Officer	Date: 29 July 2009

Purpose of Plan

This plan guides the actions of the Office of the Chief Health Officer (OCHO) in response to Pandemic (H1N1) 2009 and the current influenza season. The OCHO will plan, manage and coordinate the strategic aspects of the health and human services sector response to this major health event. The Plan specifically acknowledges that the Departmental response to the current situation must be timely, scalable and aligned wherever possible to existing service delivery arrangements. As such, response operations will be delivered on an Area Health Service basis. Should the situation deteriorate to the extent that a declaration under the *Public Health Act* 1997 or the *Emergency Services Act 2006* is required, the Plan will be reviewed accordingly,

This plan replaces previous versions of the Emergency Coordination Centre and Public Health Emergency Operations Centre Incident Action Plans and outlines new joint roles and responsibilities following a review of the strategic and operational direction of the OCHO response. This plans aligns with the current PROTECT Phase of pandemic alert and is adaptable to future phases, objectives and actions.

To assist understand the context of current response operations, background information - specifically related to Pandemic (H1N1) 2009 - is detailed at Annexe A. Key elements of the PROTECT phase as applied in Tasmania are detailed at Annexe B and response planning considerations are detailed at Annexe C.

Overarching Planning and Operational Construct

The OCHO response to Pandemic (H1N1) 2009 and the current seasonal influenza is guided by the *Australian Health Management Plan for Pandemic Influenza 2008* (AHMPPI). The AHMPPI construct has proven to be a useful tool for planning, coordinating and managing the response and was confirmed by the Australian Health Protection Committee (AHPC) as the enduring framework within which the health sector would consider future planning and operational responses. The AHMPPI outlines four key operational objectives that guide actions; these objectives are detailed below:

1. Communicate the best available information to decision makers, health professionals and to the public in a timely manner:
   - information collection and analysis.
   - information distribution.
2. Minimise transmission of the pandemic virus to reduce the number of people who become infected:
   - slow the spread in the community.
   - protecting the population using vaccination.
3. Ensure health services are optimised to reduce overall morbidity and mortality:
   - protecting and ensuring appropriate health workforce.
   - establish and maintain influenza services.
   - sustain life-saving non-influenza services and support services.
   - reduce avoidable demand on the health system.
4. Working across government:
   - support decision making across government.
   - identify and monitor interdependencies from other sectors on health infrastructure and services essential for health system function.

Under the current PROTECT Phase; actions of the OCHO will be based on these four operational objectives. The following section details the new OCHO response arrangements under OCHO and includes a matrix aligning each AHMPPI objective with a discrete operational unit.

OCHO Response Arrangements

While acknowledging the importance of the Incident Control System and the emergency management framework (which will continue to provide the operational basis for OCHO actions concerning any future emergency), a recent review of OCHO response arrangements acknowledged a number of functions into which existing efforts could be consolidated. Consequent discussion identified the need for a new and integrated strategic response structure built on current OCHO, Public and Environmental Health Unit, Care Reform and other Departmental business functions. Managers of business functions external to OCHO will be consulted on the best approach to obtaining the necessary services, information or personnel required as part of these new response arrangements.

These arrangements capitalise on existing systems, personnel, procedures and content knowledge, and highlight a shift toward normal business for strategic and operational units of the Agency. However, it is important to note that relevant business functions will be operating in an enhanced capacity. The new arrangements recognise that the level of response required will vary over time and that OCHO activities will need to remain flexible with the capacity to expand and contract as appropriate. The new response arrangements are detailed below:

Influenza Coordination Team

The Influenza Coordination Team (ICT) will manage the strategic direction and operation of the OCHO actions in response to Pandemic (H1N1) 2009 and the current influenza season. The OCHO will continue to act as a conduit with the Australian Government on issues related to Pandemic (H1N1) 2009 and seasonal influenza, provide representation on the AHPC and provide advice and information to jurisdictional members of the National Pandemic Emergency Committee. The OCHO will also provide advice and information, at a whole of Government level, to the State Emergency Management Committee (SEMC) and the Security and Emergency Management Advisory Group.

The ICT will be led by the Chief Health Officer and the Director of Public Health, and include the Deputy Chief Health Officer, the Director OCHO Projects, the Coordinator Emergency Preparedness, the OCHO Human Resource Relationship Manager and the leaders of the Planning and intelligence, Communications, and System Monitoring and Advice units. The OCHO's Emergency Management Advisory Officer and Policy Officer Medical Workforce will support the ICT.

Coordination Meetings

The ICT will convene regularly and at least weekly to discuss response issues and make decisions as appropriate.

The State Health and Human Services Emergency Committee (SHHSEC) will continue to meet regularly and act as a conduit with the health and human service sector. The SHHSEC will maintain its primary role as an advisory body to the SEMC and as a source of information to the health and human service sector.

Regional Medical Coordinators are members of the SHHSEC though separate meetings with them may be necessary to address operational issues.

Planning and Intelligence

The Planning and Intelligence Unit will gather, analyse and interpret real-time data/information from a range of sources to support response planning and situation forecasting. The information generated will assist decision makers (e.g. ICT), and inform communication functions and advice to health professionals and to the public.

The Planning and Intelligence Unit will be led by a Specialist Medical Advisor Population Health, and include the Public Health Operational Information Manager and selected specialist staff TBA

Communications

The Communications Unit will adopt an expanded role to develop and distribute information and messages to decision makers, health professionals (public and private) and to the community in a timely manner. This function will include communications internal to government, across the health sector, to and from the public (including at risk groups), the media, the business community, and the education sector. The Communications Unit will also manage telephone-based public and health professional information and advice services.

The Communications Unit will be led by a Director, and include the Project Manager (Review of THAPPI) and selected specialist staff drawn from a number of Agencies. The organisational structure of the Communication unit is outlined in Annexe D.

System Monitoring and Advice

The System Monitoring and Advice Unit will develop response standards, set and monitor performance expectations and outcomes, identify *triggers* and decision-making points, and provide advice to the ICT in partnership with the Planning and Intelligence unit.

The System Monitoring and Advice Unit will be led by the Medical Advisor Safety and Quality, and include the Coordinator Safety and Quality, the Director Medical Integration Primary and Rural Health and selected specialist staff TBA.

Administration and Support

The Administration and Support Unit will perform the administrative and support functions required to supplement OCHO and Public Health response arrangements. The Administration and Support Unit will be led by the OCHO Executive Support Officer and, if required, include selected staff co-opted from within the Department.

Other Functions

In addition to the functions detailed above a number of micro-level functions will complement OCHO response arrangements. These functions include but are not limited to:

- National Medical Stockpile logistical coordination – delivered through the Royal Hobart Hospital Supply Department;
- human resource management – delivered through the Department's Human Resource unit; and
- outbreak management – delivered through the Public Health Communicable Disease Prevention Unit.

The matrix below aligns each functional unit with response objectives. The means by which functional units will achieve their operational objectives is detailed in the relevant functional unit plan.

OCHO Response Matrix

Objective	Influenza Coordination Team	Planning and Intelligence	Communications	System Monitoring and Advice
1.1 Information collection and analysis		✓		✓
1.2 Information distribution	✓		✓	
2.1 Slow the spread in the community			✓	
2.2 Protecting the population using vaccination	✓			
3.1 protecting and ensuring appropriate health workforce			✓	✓
3.2 establish and maintain influenza services				
3.3 sustain life-saving non-influenza services and support services	✓			
3.4 reduce avoidable demand on the health system	✓			✓
4.1 support decision making across government	✓	✓	✓	✓
4.2 identify and monitor interdependencies from other sectors on health infrastructure and services essential for health system function	✓	✓		✓

The OCHO will plan, manage and coordinate the strategic aspects of the health and human services sector response to Pandemic (H1N1) 2009 during the current influenza season and consequences, e.g. mass vaccination planning.

Listed below are key elements of the operational clinical response to be coordinated by Area Health Services and supported by regional data collection, analysis, planning and forecasting, and communications:

1. clinical management;
2. coordination of flu services;
3. measures to protect frontline health care workers;
4. continuity of essential services; and
5. media management.

Annexe A - Situational Background Pandemic (H1N1) 2009

Pandemic (H1N1) 2009 has been confirmed in the majority of countries worldwide. On 11 June 2009, the World Health Organisation (WHO) raised their pandemic alert from Phase 5 (human-to-human spread in at least two countries in one WHO region) to Phase 6 (community level outbreaks in at least two countries in one WHO region and one other country in a different WHO region).

On 17 June 2009, the Australian Government changed their pandemic alert from CONTAIN to PROTECT. This reflects evidence indicating that overall, the disease is not as severe as originally envisaged. The PROTECT phase requires a measured, reasonable and proportionate response to the risk posed by the virus and recognises that in most cases, the disease is mild and the overwhelming majority of patients are making a rapid and full recovery. Importantly, PROTECT focuses on the provision of a clear medical response (based on the best available medical and scientific evidence) to those most likely to have poor outcomes.

Tasmania has been operating under the PROTECT phase since Monday 22 June 2009. Transitional preparations were implemented to ensure that the PROTECT phase was fully operational from that date.

Annexe B - Key Elements of the PROTECT Phase in Tasmania

The key changes from the previous phase of pandemic alert, CONTAIN, to the current PROTECT phase include:

- the identification and early treatment of the virus in those who are vulnerable or at high risk;
- the early identification of the virus in high risk closed settings (e.g. schools, childcare centres, aged care facilities, group homes etc);
- the identification of the virus and early treatment of those with moderate to severe symptoms;
- the voluntary isolation of those with mild disease and the provision of supportive treatment only, without the need for antiviral therapy;
- the restricted provision of antiviral therapy (on a case-by-case basis) to those at high risk or in high risk closed settings;
- contacts will not be isolated;
- increased identification and monitoring of hospital admissions, ICU admissions and deaths and the monitoring of clinical outcomes throughout the influenza season; and
- increased testing for influenza at sentinel sites in the community to identify levels of community transmission.

Under the PROTECT Phase, the overall coordination of the clinical response will be managed by Area Health Services. General Practitioners will be at the forefront of the response in conjunction with the major Regional Hospitals. Regionally coordinated flu services will appropriately support these operational response elements.

Annexe C - Response Planning Considerations

- Public health experts in Australia have predicted a greater impact on the community this winter associated with the seasonally circulating strains of Influenza.
- At this stage, Pandemic (H1N1) 2009, is currently showing over 99 per cent homology in Australia with the index strains characterised by the US Centre for Disease Control and Prevention, and is in the majority of people affected thus far a relatively mild clinical illness showing typical flu symptoms with perhaps a slightly greater incidence of gastrointestinal symptoms. It has however shown a more severe impact in some, particularly but not exclusively those with underlying health problems (including morbid obesity) and in pregnant women (2nd and 3rd trimesters).
- To date the predominant age group affected are the under 20s, and the disease (in keeping with other pandemics and outbreaks of respiratory illness) has shown a propensity for more rapid transmission in settings where children and teenagers mix for several hours at a time (e.g. schools, social and sporting events). These foci of rapid transmission have then seeded the neighbouring communities as the children effectively introduce the illness into households.
- There has been no significant immunity demonstrated to Pandemic (H1N1) 2009 although the relative lack of penetration into the over sixty age group is thought in part to relate to that cohort's previous exposure to strains of H1N1 Influenza A in the previous century.
- The Pandemic (H1N1) 2009 virus continues to exhibit sensitivity to neuraminidase inhibitors, but already carries the genes, which confer resistance to the adamantanes. The strains of seasonal influenza currently circulating are resistant to neuraminidase inhibitors.
- Reflecting the high transmissibility of, and lack of immunity to, the Pandemic (H1N1) 2009 virus without any attempt at mitigating its spread, modelling demonstrates a rapid escalation of the number of cases in our community in a period of 3-4 weeks, with a tailing off in numbers over the ensuing 3-4 weeks. The precise point at which Tasmania will enter the phase of rapid escalation is uncertain, however, evidence indicates this point to be imminent.
- Data presented to Chief Health Officers on 11 June 2009 suggested a reasonable estimate of the clinical attack rate (i.e. symptomatic cases) as being 20 per cent of the population over an eight week period, distributed in a bell shaped curve in that time frame. Experience in the US and Canada, and more recently parts of Victoria, suggest hospitalisation rates of up to 2 per cent of those with symptoms, and of those, 10 per cent may require ICU care (11per cent in the US).
- With fortunately relatively few deaths thus far in Australia and with some doubt about the denominator of case numbers in the northern hemisphere data, a case fatality rate of 0.14 per cent of seasonal flu has been used in the latest modelling.
- For Tasmania, such modelling foreshadowed for the Pandemic (H1N1) 2009 virus alone indicates:
    - 100 000 cases with noticeable symptoms over an eight week period;
    - Up to 1 000 hospitalisations (peaking at 150 in the seventh week and if the US experience of hospitalisation is mirrored in other first world communities, 43 per cent of those hospitalised could be under the age of 19 (20 per cent aged under five);
    - Up to 100 additional admissions to ICU; and
    - Up to 140 additional deaths.

- The following population strategies may to some extent reduce the rate and extent of development of the influenza epidemic in the Tasmanian community:
  - People with influenza like illness staying away from work (or school as appropriate).).
  - People pursuing good respiratory and hand hygiene if they develop influenza or are in contact with those experiencing the illness, particularly in households.
  - Active management of outbreaks in vulnerable settings such as residential aged care facilities, indigenous communities and special schools (although the primary focus of this intervention is to reduce the number of vulnerable people affected).
- In the short term, with relatively little influenza illness circulating in the Tasmanian community, the issues that are most likely to require attention are:
  - early admissions to ICU, particularly in children;
  - the first deaths in Tasmania attributable to influenza, particularly Pandemic (H1N1) 2009;
  - outbreaks of influenza in vulnerable settings such as residential aged care facilities, indigenous communities and special school; and
  - the level of 'alert', maintaining community compliance with respiratory hygiene measures, and use of resources, particularly in dedicated Flu Services.
- In the medium term (weeks to months), the major issues that will require attention are:
  - managing the pressure on the health system in general and specific pressure points such as general practice, emergency departments, and intensive care units;
  - the effective and consistent handling of challenging clinical and service level decisions (such as deferral of elective surgery);
  - ensuring that 'load balancing' strategies (e.g. Flu Services) are responsive and effective;
  - the potential impact on business continuity in the wider community if levels of absenteeism increase associated with increasing levels of influenza;
  - having contingencies in place to detect and respond to changes in the behaviour of the virus due to genetic reassortment or mutation (including the development of drug resistance);
  - having in place a flexible and responsive community vaccination program; and
  - determining the mode and timing of a return to normal operations, and having in place a maintenance regime of monitoring, communication and planning for subsequent waves of pandemic activity.

Annexe D - Communications