Exercise *Talune 2016*

Exercise Plan

1 June 2016

Department of Health and Human Services

Tasmanian Government

This document contains information that is for exercise-use only and not for public distribution or distribution to exercise participants before or during Exercise *Talune 2016*.

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Summary

Title: Exercise *Talune 2016*

Lead Agency: Department of Health and Human Services (DHHS)

Sponsor: Secretary, DHHS

Date: 2 June 2016, 10.00 – 3.30 pm (time to be confirmed)

Venue: Hobart Function and Conference Centre, 1 Elizabeth St, Hobart

Executive Summary

Exercise *Talune 2016* will be a single-day facilitated multi-agency discussion exercise. It will focus on Tasmania's planned response to pandemic influenza within the broad emergency management framework, as outlined in the *Tasmanian Health Action Plan for Pandemic Influenza* and the *Australian Health Management Plan for Pandemic Influenza*. The draft *Health Emergency Communication Guidelines* will also be considered.

Budget: $5,000

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This document was developed using the draft 'Managing Exercises: a handbook for Tasmanian Government agencies 2016'.

Contents

1. Introduction

Through a grant from the Natural Disaster Resilience Program, the Department of Health and Human Services (DHHS) is undertaking the Building Community Emergency Capacity and Capability Project. Exercise *Talune 2016* will be a major output of this project along with the *Tasmanian Health Action Plan for Pandemic Influenza* 2016 (THAPPI 2016) and Tasmania's Health Emergency Communication Guidelines.

The **Building Community Emergency Capability project steering committee** provided initial direction and endorsement of the project's aim, objectives and scope.

1.1. Exercise Need

Exercise *Talune 2016* is required because:

1. Pandemic exercises and staff training were identified as treatment options through the 2016 Tasmanian State Natural Disaster Risk Assessment project.
2. Health and human services across Tasmania have been restructured since the 2009 H1N1 pandemic, the most recent pandemic event.
3. The arrangements described in THAPPI 2016 are significantly different to those used in 2009.
4. DHHS, the Response Management Authority (RMA) for pandemic influenza, gets few opportunities to activate emergency plans for incidents for which it is the RMA.
5. Pandemic planning and preparedness is complex in that:
    - it involves many stakeholders and is based on many assumptions
    - the response differs from the response to other hazards because a pandemic generally has far more widespread impact and the response is generally of a longer duration.

1.2. Exercise overview

Exercise *Talune 2016* will be a single-day, multi-agency facilitated discussion exercise held on Thursday 2 June 2016, from 10:00 am – 4:00 pm, at the Hobart Function Centre. It will have no impact on the public or non-participating stakeholders.

It will focus on the planned response to pandemic influenza within the emergency management framework, as outlined in THAPPI 2016 and the *Australian Health Management Plan for Pandemic Influenza*. The health emergency communication arrangements will also be considered.

1.3. Exercise Aim and Objectives

The aim of Exercise *Talune 2016* is to practise, explore and validate the pandemic response arrangements described in THAPPI 2016.

The objectives and sub-objectives of Exercise *Talune 2016* are listed in Table 1.

Table 1: Exercise *Talune 2016* Objectives and sub-objectives

Objective	Sub-objectives
1. To explore the control command and coordination arrangements outlined in THAPPI 2016.	a) (*Control*) Validate the arrangements for the overall direction of response activities, as described in *THAPPI 2016*.
	b) (*Command*) Explore the command arrangements to be activated by DHHS, the THS and Primary Health Tasmania to enable these organisations to undertake roles allocated to them, as described in *THAPPI 2016*.
	c) (*Coordination*) Explore the arrangements for accessing additional resources during a pandemic response, including the stakeholder engagement and liaison arrangements outlined in *THAPPI 2016*.
	d) (*Coordination*) Review the functions of and interface between the DHHS Emergency Coordination Centre (ECC), the Public Health Emergency Operations Centre (PHEOC), the THS Emergency Operations Centre and the Ambulance Tasmania Emergency Operations Centre.
2. To explore pandemic response strategic decision-making processes.	a) Explore the likely triggers for activating public health emergency Level 1, 2 and 3 responses, and the likely consequences across sectors
	b) Explore the decision-making processes for activating and deactivating response activities including public health measures and flu services.
3. To explore the response roles and responsibilities outlined in THAPPI 2016.	a) Validate the roles and responsibilities assigned to participating organisations in *THAPPI 2016*. (*Have the right roles and responsibilities been assigned to the right organisations?*)
	b) Identify potential gaps in response planning.
	c) Identify potential barriers to stakeholders undertaking allocated roles, as outlined in *THAPPI 2016*.
	d) Identify potential unintended consequences from implementing the response activities outlined in *THAPPI 2016*.
4. To explore the draft Health Emergency Communications Guidelines.	a) Identify inconsistencies between health sector and whole-of-government emergency communications plans.
	b) Identify potential gaps in communications planning and preparedness.

1.4. Scope

Discussion of the following issues is **within the scope** of Exercise *Talune 2016*:

- pandemic response command, control and coordination arrangements, including the PHEOC and the DHHS ECC
- response arrangements for a Level 1 and 2 emergency, including activation arrangements, likely response strategies and the roles and responsibilities of participating organisations
- potential triggers for a Level 3 response and implications / considerations for stakeholders
- methods to engage stakeholders, in a coordinated response
- the communications strategy, including staffing arrangements
- the use of and processes for accessing state stockpiles
- national commitments and liaison arrangements
- staffing arrangements for potential response strategies.

The following activities are **outside the scope** of Exercise *Talune* 2016:

- activation of response arrangements
- discussion of recovery arrangements
- discussion of antiviral distribution and dispensing strategies
- discussion of the mass vaccination strategy
- liaison with stakeholders not participating in the exercise, including interstate and national agencies/committees
- subsequent discussion exercises undertaken by stakeholders to review pandemic response arrangements specific to individual organisations.

1.5. Participating Organisations

PHS will coordinate and facilitate exercise planning and preparedness.

Participating agencies are:

- the Department of Health and Human Services: PHS, Ambulance Tasmania, Policy, Purchasing and Performance, Communications Services, and Corporate, Policy and Regulatory Services
- the Tasmanian Health Service
- Primary Health Tasmania
- the Department of Police, Fire and Emergency Management
- the Department of Premier and Cabinet
- the Local Government Association of Tasmania
- Red Cross Australia
- Tas Networks
- Tas Water
- Hobart City Council
- Council of Churches.

1.6. Participants

Participants will include Players and Advisers (active observers).

Players will be mid- to senior-level staff members who are able to effectively represent their agency's interests in a multi-agency emergency response and use the exercise experience to support pandemic preparedness within their agency. Players will be expected to have a basic understanding of the reference documents listed below.

Advisers will be staff with specialist expertise or knowledge who will support players within their syndicate group during the exercise. Advisers will not participate in whole-group discussion (other than providing advice as requested by Players) but will participate in syndicate discussions.

There will be observers present at the exercise. Observers will be instructed not to provide input to the exercise.

1.7. References

	Document	Location
1	THAPPI 2016	Link will be provided to all participants. Hard copy will be available in the Situation Manual on each table at the Exercise
2	Australian Health Management Plan for Pandemic Influenza 2014	Hard copy will be available in the Situation Manual on each table at the Exercise
3	Draft Health Emergency Communications Guidelines (DHHS, 2016)	Hard copy will be available in the Situation Manual on the Communications and EXCON tables at the exercise. Draft provided to communications staff, and available from belinda.fenneywalch@dhhs.tas.gov.au
4	*Plan for the Delivery of Integrated Emergency Management within the DHHS and Tasmanian Health Organisations, 2013*	Hard copy will be available in the EXCON Situation Manual at the Exercise Document also available on the DHHS Intranet
5	Tasmanian State Special Emergency Management Plan: *Tasmanian Public Health Emergencies Management Plan 2014*	Hard copy will be available in the EXCON Situation Manual at the Exercise Document also available from leanne.cleaver@dhhs.tas.gov.au
6	The Tasmanian Emergency Management Plan	Hard copy will be available in the EXCON Situation Manual at the Exercise

1.8. Budget

A budget of $5,000 has been allocated to Exercise *Talune 2016*, through the Building Community Emergency Capacity project (Natural Disaster Resilience Program).

2. Governance and Exercise Control

2.1. Governance

The **Exercise Sponsor** is the DHHS Secretary.

The **Exercise Director** is Dr Scott McKeown, Public Health Physician, DHHS

The **Exercise Facilitator** is Senior Sergeant Andrew Bennett, DPFEM

The **Project Coordinator** is Belinda Fenney-Walch, PHS, DHHS

The **Exercise Planning Team** is

- Leanne Cleaver, Senior Public Health Advisor, PHS, DHHS (Exercise Planning Team Leader)
- Belinda Fenney-Walch, Project Coordinator, PHS, DHHS
- Dr Peter Renshaw, Director of Clinical Services, THS
- Sergeant Heath Collidge, Counter Terrorism Unit, DPFEM

The **Exercise Evaluation Team** is:

- the Exercise Planning Team plus David Coleman, Scientific Officer, Communicable Diseases, PHS, DHHS.

2.2. The Exercise Control (EXCON) Team

Exercise Role	Name
Exercise Director	Scott McKeown
Facilitator	Andrew Bennett
Exercise Controller and 'Red Team' (providing 'at the time' guidance to the facilitator)	Leanne Cleaver
Deputy Exercise Controller and 'Red Team'	Belinda Fenney-Walch
Runner/General support	
Evaluators	David Coleman
	Peter Renshaw
	Heath Collidge

2.3. Exercise Briefings

Brief	Person Responsible for briefing	Time / Date
Evaluation Assistants	Leanne and Belinda	31 May 2016
EXCON and Red Team	Leanne and Belinda	1 June 2016
Exercise Players, Advisers and Observers	Andrew Bennett	2 June (at Exercise)

2.4. Exercise Documentation

Type of document	Distributed to	Prepared by
Exercise Plan (this document)	Planning Team, Exercise Director, EXCON staff	Project Coordinator
Facilitators Guide	Facilitator	Project Coordinator
Participant Handbook	Participants (Players, Advisors and Observers). Distributed at least one week before the exercise.	Project Coordinator
Situation Manual	One copy on all syndicate tables	Project Coordinator
Evaluation Tools	Evaluators and Evaluation Assistants	Project Coordinator
Participant Feedback Form	All participants	Project Coordinator

2.5. Risk Management/Safety and Security

Risk	Mitigation
Illness affecting the availability of participants	Invite at least one active observer from each organisation, capable of filling in as a participant if necessary.
Illness affecting facilitator	Identify a second person from the EXCON team who has the skills to facilitate the Exercise if necessary.
Unrealistic responses provided during the exercise and insufficient exploration of issues	Belinda, Leanne and a representative from the THS to advise the facilitator throughout the Exercise using a single email address.
'No duff' emergency incident affecting the availability of participants and/or control, evaluation or planning team members.	Given Tasmania's small emergency management sector, it is accepted that a significant, multi-agency no-duff emergency may cause the Exercise to be postponed and there is no mitigating action.
Illness or injury from the Exercise	Standard health and safety information will be provided to participants at commencement of the Exercise.

3. Exercise Evaluation

3.1. Purpose of the Evaluation

The purpose of the evaluation will be to:

- ascertain strengths and weaknesses of pandemic preparedness, within the scope of the exercise
- identify any exercise activities that should be improved before subsequent internal discussion exercises undertaken by stakeholders.

3.2. Management of the Evaluation

The **Exercise Director** is responsible for approving the activity being evaluated and will be the final recipient of the Evaluation Report.

The **Project Coordinator** will plan the evaluation with the Exercise Evaluators and manage it on a day to day basis.

The **Director of Public Health** is responsible for ensuring issues and evaluation findings relating to the health response are responded to as appropriate.

The **Secretary Department of Premier and Cabinet** is responsible for ensuring issues and evaluation findings relating to the broader (non-health) response are actioned. (The Department of Premier and Cabinet is the Preparedness Management Authority for pandemic influenza.

3.3. Process of the Evaluation

Exercise *Talune 2016* will be evaluated using the draft Tasmanian Exercise Framework Evaluation Methodology as a guide, by the identified exercise evaluators.

The evaluation team is responsible for planning, conducting and reporting the evaluation, with support from the project coordinator.

3.3.1. Evaluators and Evaluation Assistants

The evaluators are Sergeant Heath Collidge, Dr Peter Renshaw and David Coleman.

The evaluators are the primary data collectors and analysers of the collected evidence, and will contribute their findings to the exercise reports. Evaluators are responsible for:

- observing participants' responses, collecting information and recording their observations
- assessing strengths and weaknesses of pandemic preparedness against the exercise objectives
- evaluating and reporting on the achievement of Exercise objectives.

Evaluators will be responsible for observing and recording their observations and points of discussion from whole-group and syndicate group discussions. They will also provide support and guidance to the evaluation assistants. To facilitate this, each evaluator has been assigned particular syndicate groups to focus on. Evaluators will move freely around the room, and may provide input to the facilitator through the Red Team (see section 5.6.3) if there are particular questions they would like asked or areas they would like explored further.

An **Evaluation Assistant** will be assigned to each syndicate group and will be responsible for observing and recording their observations of and points of discussion from syndicate groups, in liaison with the relevant evaluator.

Evaluators and Evaluation Assistants will not provide input to the exercise other than to clarify points raised to enable accurate recording and evaluation.

3.3.2. Main Themes

The main themes to be considered through the evaluation process are:

1. Would the command, control and coordination arrangements described in THAPPI work and are they understood by agency representatives?
2. Are pandemic response strategic decision-making processes clear and workable?
3. Do agencies understand their roles and responsibilities? Are they comfortable with them?
4. Are there any significant response roles that have not been allocated to an agency?
5. Are there barriers to agencies/units performing their allocated roles?

3.3.3. Evaluation Tools

Evaluators and Evaluation Assistants will have evaluation forms to facilitate recording of information.

3.3.4. The P2OST2E Model

The P2OST2E Model will help evaluators categorise and group issues and identify causal factors when analysing information after the exercise.

The P2OST2E Model

Category	Scope / description of category
People	roles, responsibilities and accountabilities, skills
Process	includes plans, policies, procedure, processes
Organisation	structure and jurisdiction
Support	infrastructure, facilities, maintenance
Technology	equipment, systems, standards, interoperability, security
Training	capability qualifications/skill levels, identify courses required
Exercise Management	exercise development, structure, management, conduct

3.3.5. Exercise Outcomes

The insights from this exercise will be identified through

- evaluators and evaluation assistants capturing outcomes from discussions and the exercise debrief
- a participant questionnaire, to be completed by players, advisers and observers before the end of the exercise
- notes recorded by each syndicate group on butchers' paper throughout the exercise.

The Exercise Planning and Evaluation and Control Team will meet soon after the Exercise to discuss their findings.

Evaluators will report against the exercise objectives, and may identify additional issues that merit reporting.

The project coordinator will work with the exercise evaluators to produce a post exercise report that will include a summary of any key issues, gaps or insights. The report will be subjected to a validation/resolution process at an agency level. The final report will be submitted to the Exercise Director, the DHHS representative on the Interagency Exercise Coordination Group, the Director of Public Health and the Secretary Department of Premier and Cabinet.

Follow-up action will be taken as appropriate in line with the draft Tasmanian Exercise Framework's Evaluation Findings Resolution Process.

4. Milestones / Program of Activities

Event	Due by
Initial Planning and Concept Development Meeting	1 April 2016
Mid Planning Meeting	22 April 2016
Pre-exercise Environmental Health Unit presentation	2 May 2016
Planning team meeting	10 May 2016
Evaluation team meeting	13 May 2016
Final exercise plan to Exercise Director for endorsement	16 May 2016
Facilitators Guide to Exercise Planning Team for input	16 May 2016
Formal invitations issued to participants	19 May 2016
Participant Handbook and Facilitators Guide to EXCON for input	19 May 2016
Final planning and evaluation meeting (if required)	23 May 2016
Participant handbook distributed to participants	26 May 2016
Pre-exercise meeting with the Department of Premier and Cabinet	27 May 2016
EXCON briefing/meeting	30 May 2016
Exercise documents finalised	30 May 2016
Evaluation Assistants' briefing	31 May 2016
Exercise Practise Run	1 June 2016
Exercise	**2 June 2016**
Exercise Debrief	6 June 2016
Evaluation Report to Exercise Director	14 June 2016
Finalisation of Exercise Report	24 June 2016

5. On the Day

5.1. Agenda

	Time	Activity	Who	Time
1	**9:30 am**	Registration, **morning tea**		30 mins
2	**10:00 am**	Welcome	Dr Scott McKeown	5 mins
3	**10:05 am**	Introductions and briefing	Andrew Bennett	10 mins
4		Icebreaker		
5	**10:15 am**	Influenza, pandemic influenza and avian influenza (General Idea)	Belinda Fenney-Walch	15 mins
6	**10:30 am**	Discussion Exercise – Special Idea 1 – introduction	Belinda Fenney-Walch	5 mins
7	**10.35 am**	Discussion Exercise – Special Idea 1 – Dr Mark Veitch	Andrew Bennett	5 mins
8	**10:40 am**	Discussion Exercise – Special Idea 1 – syndicate activity	Andrew Bennett	20 mins
9	**11:00 am**	Discussion Exercise – Special Idea 1 – syndicates report back – 1 minute each	Andrew Bennett	10 mins
10	**11:10 am**	Discussion Exercise – Special Idea 2 – introduction	Belinda Fenney-Walch	3 mins
11	**11:13 am**	Discussion Exercise – Special Idea 2 – Dr Mark Veitch	Andrew Bennett	7 mins
12	**11.20 am**	Discussion Exercise – Special Idea 2 – whole group	Andrew Bennett	15 mins
13	**11:35 am**	**Coffee break**		5 mins
14	**11:40 am**	Discussion Exercise – Special Idea 3 – introduction	Belinda Fenney-Walch	5 mins
15	**11:45 am**	Discussion Exercise – Special Idea 3 – Dr Mark Veitch	Andrew Bennett	10 mins
16	**11.55 am**	Discussion Exercise – Special Idea 3 – syndicate activity	Andrew Bennett	20 mins
17	**12:15 pm**	Discussion Exercise – Special Idea 3 – syndicates report back		20 mins
18	**12.35 pm**	**Lunch**		40 mins
19	**1.15 pm**	Discussion Exercise – Special Idea 4 – introduction	Belinda Fenney-Walch	5 mins
20	**1:20 pm**	Discussion Exercise – Special Idea 4 – Dr Mark Veitch	Andrew Bennett	10 mins
21	**1:30 pm**	Discussion Exercise – Special Idea 4 – syndicate activity	Andrew Bennett	30 mins

		Open discussion		
22	**2.00 pm**	Syndicates report back		30 mins
23	**2:30 pm**	**Afternoon tea**		15 mins
24	**2.45 pm**	Debrief – syndicate activity	Andrew Bennett	15 mins
25	**3:00**	Debrief – syndicates report back	Andrew Bennett	20 mins
26	**3.20**	Completion of Participant Questionnaires and CLOSE	Dr Scott McKeown	10 mins
21	**3.30 pm**	CLOSE		

5.2. Resources

The following resources will be required:

- laptop, projector, screen
- nine tables, each to seat up to ten people
- exercise documents (see section 1.7 and 2.4)
- butchers' paper pre-labelled for each syndicate group and special idea
- identification badges for all participants
- microphones for each syndicate table
- PA system
- lapel microphone for facilitator.

5.3. Catering

Morning tea, lunch and afternoon tea will be provided by on-site caterers. Tea and coffee will be available continuously.

5.4. Style

Participants will be seated in syndicate groups to facilitate small-group discussion.

A PowerPoint presentation will include summaries of each special idea and will track progress of the exercise.

After introduction of each Special Idea, the Facilitator will ask the Incident Controller to provide an overview of the likely response, focus areas and how he is managing the situation.

Each syndicate group will then discuss the situation in more detail.

After syndicate group discussions the entire group will reconvene to discuss decisions made, interdependencies, multi-agency issues and conflicting opinions.

The seven syndicate groups will be:

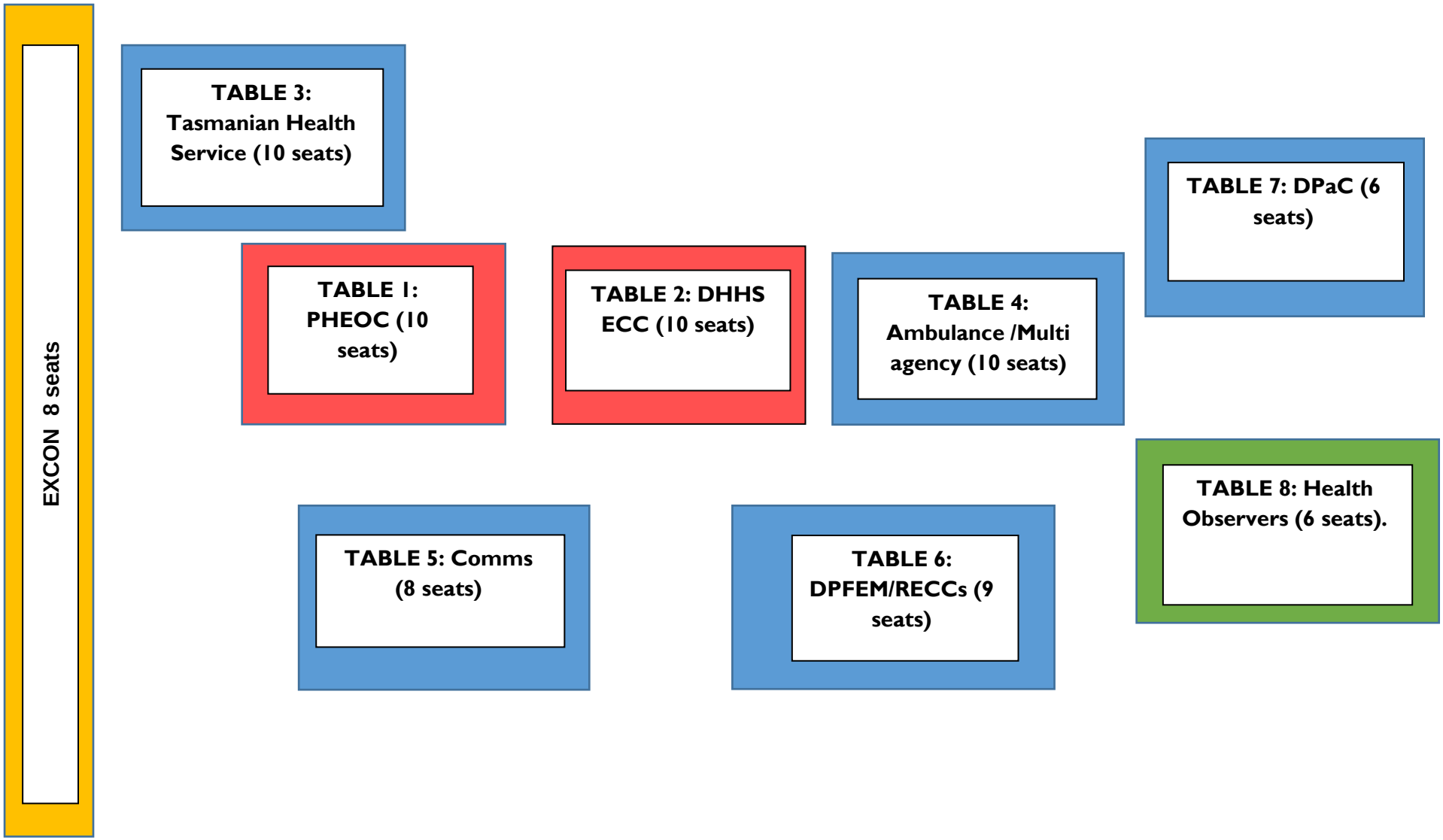
1. PHEOC
2. DHHS ECC
3. THS

4. Ambulance Tasmania / Multi-Agency
5. Communications
6. Department of Police, Fire and Emergency Management (DPFEM)/ Regional Emergency Coordination Centres (RECCs)
7. Department of Premier and Cabinet (DpaC).

5.5. Room set-up

Room set-up will comprise nine tables seating up to ten people, as shown in the figure over the page

Room set-up and exercise players in each syndicate



5.6. Roles

5.6.1. Exercise Director

The Exercise Director, Dr Scott McKeown, will welcome attendees and introduce the facilitator. The Exercise Director will also be the umpire if required, to manage any controversy and provide strategic oversight and direction.

5.6.2. Project Coordinator

The Project Coordinator, Belinda Fenney-Walch, will provide an overview of influenza and describe the scenarios.

5.6.3. Exercise Facilitator

The Exercise Facilitator, Senior Sergeant Andrew Bennett, will guide discussions, ask probing questions and lead the debrief.

5.6.4. Red Team

The 'red team' will be led by Leanne Cleaver. The role of the Red Team will be to identify points of discussion that should be explored in more detail, as the exercise unfolds. Red Team members will provide direct feedback to the Facilitator throughout the exercise, through a single email address.

5.6.5. Runner

The Runner will be Rebekah Harrison, who will be responsible for distributing and retrieving printed and written information throughout the day and liaising with the venue manager.

5.6.6. Evaluators and Evaluation Assistants

For information about the roles and responsibilities of evaluators and evaluation assistants, see section 3.3.

The evaluators, evaluation assistants and their assigned syndicate groups are shown in the table below.

Syndicate	Evaluation Assistant	Evaluator
PHEOC	*(Names deleted)*	David Coleman
DHHS ECC		
Tasmanian Health Service		Dr Peter Renshaw
Ambulance Tasmania/Multi Agency		
Communications		Sergeant Health Collidge
Department of Police, Fire and Emergency Management/RECC		
Department of Premier and Cabinet		

5.6.7. Players

Players are attendees who will be asked to respond to questions on behalf of their Agency or profession and be syndicate spokespersons. Players will be:

- *(Names deleted)*

5.6.8. Advisers

Each player will be supported by advisers seated at the same table. They will have an active role in syndicate discussions but not whole-group discussions (although players may ask advisers in their syndicate group occasional quick questions 'on the side' during whole-group discussion).

5.6.9. Scribes

Each syndicate group will be asked to nominate a scribe for their group. The scribe will be responsible for recording key points from discussions, including issues that arise and decisions that are made.

5.6.10. Observers

There will be one table of observers from Public Health Services. Additional observers will be placed on vacant seats across the syndicate tables. Unless there is a 'no duff' safety issue, observers will be instructed not to provide input to the exercise except through:

- the completion of syndicate activities
- the completion of feedback forms at the close of the exercise

6. General Idea

Human infection with avian influenza A(H5N1) is rare. It was first known to infect humans in 1997, and since 2003, there have been 850 human cases across 16 countries, with 449 deaths. The case fatality rate is 53 per cent.

The vast majority of people infected with avian influenza A(H5N1) have had recent contact with infected poultry. There have been five cases of the virus spreading from person to person within households; but none outside households. There is no epidemiological or virological evidence that H5N1 has acquired the ability to spread easily between people.

It has raised global public health concerns due to its potential to cause illness and deaths in people, and its pandemic potential if the virus changes into a form that can spread easily among humans.

There have been no reported infections with H5N1 in Australia.

The World Health Organization (WHO) monitors avian influenza, including A(H5N1) very closely, and adjusts guidelines in collaboration with its partners, include animal health agencies. The WHO revises its guidance and actions as the situation evolves and more information becomes available.

Under *International Health Regulations 2005*, WHO Member States are required to report information on every case of H5N1 human infection (or novel influenza virus infection) to the WHO.

Avian Influenza A(H5N1) Facts at a Glance

- 850 human cases across 16 countries, since 2003
- 449 human deaths
- Human case fatality rate = 53%
- Does not spread easily between humans
- 5 cases of human-to-human infection within households.

The situation in Australia

There have been no reported infections with H5N1 in Australia.

The Australian Health Management Plan for Pandemic Influenza guides the health sector's preparedness for and response to pandemic influenza.

The Australian Government coordinates national pandemic measures and supports the health response in jurisdictions if jurisdictional capacity is overwhelmed. The Australian Health Protection Principal Committee is the key national policy and coordinating body, and is supported by:

- the Communicable Diseases Network of Australia (CDNA)
- the Public Health Laboratory Network
- the National Health Emergency Management Standing Committee.

Pandemic planning is structured around the following national pandemic stages:

1. **Prevention and Mitigation, and Preparedness:** no novel strain detected (or emerging strain under investigation by the WHO
2. **Response – *Standby*:** sustained person-to-person transmission overseas; no cases detected in Australia (note, this stage may be very short)
3. **Response – *Initial Action***: the early stages of a pandemic in Australia; cases detected but information about the disease in the Australian context is scarce making it difficult to predict the level of impact and tailor the response accordingly
4. **Response – *Targeted Action***: when enough is known about the disease in the Australian context to tailor measures to specific needs; in the *Targeted Action* stage, all nationally-recommended health response activities will be reviewed by the Department of Health in liaison with expert committees; any that fail to demonstrate effectiveness and efficiency proportionate to the level of risk will cease.
5. **Response: *Stand-down***
6. **Recovery**

Different activities are recommended for each stage, and may be implemented differently and at different times across Australia according to local circumstances.

The situation in Tasmania

Under the Tasmanian Emergency Management Plan (TEMP), DHHS (through Public Health Services) is the Prevention and Mitigation Management Authority and the Response Management Authority for pandemic influenza.

The health response is guided by the Tasmanian Health Action Plan for Pandemic Influenza (DHHS, 2016) and the *Tasmanian Public Health Emergencies Management Plan (DHHS 2014)*.

The whole-of-government response is guided by the State Special Emergency Management Plan: *Human Influenza Pandemic Emergencies* (due for review).

7. Special Idea 1: (Standby stage)

On 2 June 2016, the number of confirmed human infections with avian influenza A (H5N1) increases suddenly, with confirmed cases and clusters of illness in Laos, Malaysia and Cambodia. Investigations by the WHO show most people recently infected did **not** have contact with poultry or other birds before becoming unwell and that avian influenza A (H5N1) is now able to transmit efficiently between humans.

On **4 June 2016**, the WHO:

- declares a Public Health Emergency of International Concern
- raises the global pandemic phase to Phase 4 (*'Human to human transmission of an animal or human-animal influenza reassortment virus able to sustain community-level outbreaks have been verified'*)
- reports further clusters of illness in Laos, Malaysia, Thailand and Cambodia, and new clusters in Nepal, India and the United States of America (California)
- recommends all countries intensify surveillance for unusual outbreaks of influenza-like illness and severe pneumonia
- recommends the focus be on mitigation measures, given the widespread presence of the virus in some countries indicates that containment of the outbreak is not feasible.
- reports the case fatality rate in confirmed cases is 7.2% (compared with 2.5% for the 1918 pandemic)
- reports early epidemiological analysis shows infants under the age of 2 years, pregnant women, indigenous populations and people with chronic illnesses are most at risk of severe illness and death; and previously healthy children and young adults also suffer severe illness and death.

On **6 June 2016**, the WHO

- raises the global pandemic phase to Phase 5 *('the virus has caused sustained community level outbreaks in two or more countries in one WHO region'*)
- states all countries should immediately activate their pandemic preparedness plans and remain on high alert for unusual outbreaks of influenza-like illness (ILI) and severe pneumonia
- encourages early detection and treatment of cases, and infection control in all health facilities
- states there is a lot still unknown about the outbreak and how it will pan out.

Facts at a Glance

- Human 'confirmed case' fatality rate = 7.2%
- Groups at risk of serious illness / death = infants, pregnant women, indigenous populations and people with chronic underlying illnesses.
- Antivirals = effective if dispensed within 48 hours of symptom onset
- No cases identified in Australia.

Questions to Dr Mark Veitch, Director of Public Health

1. What are you doing? What are your main priorities?
    - What are the key elements of the response?
    - Do we have an Incident Controller in Tasmania?
    - How is the response being coordinated?
    - Have you activated the Public Health Emergency Operations Centre?
    - What are you communicating, to who?

Syndicate Questions

1. What is your Agency/Unit's priorities in responding to the emerging threat?
2. What information does your Agency/Unit need and how would you expect to receive it?

Syndicate Report Back Question

3. Is there anything you are doing at this stage that is particularly significant that you'd like to report back?

8. Special Idea 2: Initial Action Stage, No Cases in Tasmania

On 13 June, a wealthy woman living in Los Angeles flies to Brisbane on her private jet to meet Federal Minister Boyce to discuss fundraising for the upcoming federal election.

On 14 June, she suddenly becomes unwell with a fever, sore throat, fatigue and body aches. She does not see a doctor, but valiantly soldiers on with the support of pain relief medication. The meeting with Minister Boyce continues as planned.

On 15 June Minister Boyce spends the day door-knocking in his electorate. The wealthy woman fliers to Safire Freycinet (Tasmania) where she meets her partner.

On 16 June Minister Boyce and two staff members become unwell. An initial influenza diagnostic test confirms influenza A. Specimens are sent for testing to determine the strain of influenza.

On **22 June**, testing confirms Minister Boyce and one staff member have Influenza A(H5N1).

Questions to Dr Mark Veitch, Director of Public Health

1. What are you doing now? What would be your priorities?
    - Do we have an Incident Controller in Tasmania?
    - What level of emergency response are we in?
    - How is the response being coordinated?
    - Have you activated the Public Health Emergency Operations Centre?
    - What are you communicating, to who?

Questions to players

1. Is anyone else doing anything different at this stage in response to the emerging threat?
    - What is the THS doing different at this stage?
        - What's happening in Pathology
    - What is Primary Health Tasmania doing?
    - Who is managing public communications? What would your priorities be?
    - What are you doing with your business continuity plans?

9. Special Idea 3: Initial Action, Cases in Tasmania

On **23 June**, a further 13 cases are confirmed: 8 in Queensland, 3 in Tasmania and 2 in NSW.

On **24 June**, Flutracking, a national community influenza surveillance program, shows the number of people with a self-reported ILI is rising very fast. A further 39 cases are confirmed in Queensland, 9 in Tasmania, 16 in NSW, 14 in Victoria, 4 in SA, 2 in the ACT, and none in the NT and WA, bringing the total number of confirmed cases in Australia to 100.

Of the confirmed cases nationally, most people report moderate illness able to be managed at home.

Nationally, seven people (7% of confirmed cases) have been admitted to hospital. Of them, four (a 13-month-old baby, a 36-year old Aboriginal male, an 81-year old male and a 32-year old pregnant women in her third trimester) are in intensive care, and 1 (a 25-year old pregnant woman in her third trimester) has died, giving a very early indicative case fatality rate of 1%.

There have been no deaths or hospitalisations in Tasmania, except the 32-year old pregnant woman who is in ICU at the Royal Hobart Hospital.

Australian Information at a Glance

- 100 confirmed cases nationally, 12 confirmed cases in Tasmania
- Case hospitalisation rate = 7%
- Case intensive care admission rate = 4%
- Case fatality rate = 1%
- Average incubation period is 2–3 days
- Those at risk of serious illness and death are infants, pregnant women, indigenous people and people with chronic illnesses.
- Antivirals appear to be effective if dispensed within 48 hours of symptom onset. *(NOTE, the complexities of antiviral distribution, prescription and dispensing are out of scope for this exercise because of work underway nationally on this.)*

Questions to Dr Mark Veitch, Director of Public Health

1. How are you spending your day? What are the main public health actions you'd be undertaking?
    - What level of emergency response are we in? How is the response being coordinated?
    - Is Tasmania participating in the national *First Few 100 study*?
    - Have you got enough staff? If not, what are you doing to get more staff?

Syndicate questions for PHEOC

1. What are your main pandemic response roles at this stage?
2. What are your expectations of the DHHS ECC and other agencies? What do you need other agencies to do and what information do you need from them?
3. Do you need additional resources from outside PHS? If so, what and how will you access them?

Syndicate questions for DHHS ECC and THS

1. What is the command structure for your agency? Who's the decision maker and who is supporting that person? (Draw a diagram.)
2. What are your main pandemic response roles at this stage?
3. What information does your organisation need from other agencies, and how do you expect to receive it?

Syndicate questions for Communications

1. How would you expect your units to be engaged in the pandemic response and kept informed of developments?
2. What are the main elements of the communications response? What activities are you undertaking?
3. How are you staffing the communications response?

Syndicate questions for Ambulance Tas/Multi-Agencies, DPaC, DPFEM/RECCs

1. What are your main pandemic response roles at this stage?
2. How would you be fulfilling those roles? Would you be activating any operational or coordination centres?
3. What information does your organisation need from other agencies, and how do you expect to receive it?

10. Special Idea 4 Targeted Action Stage

It's 23 July 2016. The pandemic has been affecting Australia for around four weeks, but it's still relatively early days.

During the past month in Australia:

- there have been 13,478 confirmed cases; but most people with ILI have not been tested; most people presenting for medical assessment have had 'moderate' illness able to be managed at home, and have needed seven–eight days at home to recover
- those who have taken antivirals within 48 hours of symptom onset have had milder illness; many people have not been able to access antivirals within 48 hours
- around 5% of people infected have had severe illness requiring hospital admission, and around 0.1% have died
- two in three people who have experienced severe illness or death have been infants, pregnant women, indigenous Australians and people with an underlying chronic medical condition; the remainder have been previously-healthy adults of working age
- the median age of death is 49 years.

It is estimated about 10% of the population have had or currently have an ILI, and the number of current cases is expected to rise over the next two weeks then start to fall until the next wave of illness arrives.

It is anticipated that 40% of the Australian population will have been affected by influenza over the duration of the pandemic.

Work is well underway to develop an H5N1 vaccine, and it is expected to be available in mid to late October 2016.

The situation in Tasmania over the past month

- A large number of people in Tasmania have experienced or are currently experiencing an ILI requiring time off normal duties. Workplace absenteeism is significantly higher than would be expected for this time of year, and this is causing some disruption.
- There have been 2,190 confirmed cases in Tasmania, however routine testing of patients with ILI is not being carried out so the actual number of cases is assumed to be much higher.
- 187 people have been admitted to hospital with confirmed influenza A(H5N1), giving Tasmania a confirmed case hospitalisation rate of 8.5%, significantly higher than the national rate of 5%. Most patients are discharged within 72 hours.
- Nine people have been admitted to intensive care or high dependency units, giving Tasmania a confirmed case intensive care admission rate of 0.4% (compared with 0.3% nationally).
- 2 confirmed cases in Tasmania have died: the 32-year old pregnant woman who had been in ICU and a 3-year old girl.
- GPs, hospitals and ambulance services are stretched to capacity. Many GPs have run out of surgical masks.

- Employers across all sectors are reporting high staff absenteeism rates that are affecting services; two schools have chosen to close for a week because of staff absenteeism.
- A '*Tassie Flu, We Can Help'* Facebook page is coordinating voluntary support for households struck down by illness. The volunteers are predominantly people who have recovered from influenza, and they are helping people in their neighbourhood who are ill and have limited social support networks, by assisting with essential household chores. Volunteers are demanding surgical facemasks for protection.

Australian Facts at a Glance

- Proportion of people tested for A(H5N1) who have a positive result = 50%
- The estimated proportion of the population that will get sick over the duration of the pandemic = 40%
- Period of infectiousness begins 24 hours before symptom onset and persists for 5–7 days in adults, and 8–21 days in children (12 years and under)
- Confirmed case hospitalisation rate = 5%
- Confirmed case intensive care admission rate = 0.3%
- Confirmed case fatality rate = 0.1%

Tasmanian Facts at a Glance

- Confirmed cases (from laboratory testing) = 2 190
- Confirmed case hospitalisation rate = 8.5%
- Confirmed case intensive care admission rate = 0.4%
- Confirmed case fatality rate = 0.18%

Questions to Dr Mark Veitch, Director of Public Health

1. What's changed with the response?
    - Is there anything you've stopped doing?
    - What level of emergency response are we in? How are you coordinating the response?
    - What are your priorities?
    - What are the key elements of your response?

Syndicate questions

1. What are your pandemic response arrangements? (What are you doing/how)
2. How are you managing the impact and preparing for anticipated impacts on your services over the next few weeks and months?

Additional question/prompt for PHEOC

- How is PHEOC being staffed?

Additional question/prompt DHHS ECC

- How are you staffing the ECC and linking in with the THS and PHEOC?

Additional questions/prompts THS

- What are your internal command and coordination arrangements?
- How do you expect/need DHHS to support you?

Additional question/prompt for Ambulance Tas / Multi-Agencies

- Is there anything extra your organisation could do to support the overall response, other than the roles listed in THAPPI 2016?

Additional question/prompt for Communications

- How are competing demands from the DHHS ECC, PHEOC, THS, Minister for Health and Regional Emergency Coordination Centres (if active) affecting your operations?

Additional question/prompt for DPaC

- What is your Agency doing to support business continuity across the Tasmanian Government?

Additional question/prompt for DPFEM/RECCs

- What is your Agency doing to prepare for a possible escalation of response?

11. Debrief Syndicate Questions

1. What are the three pandemic preparedness priorities for your agency or unit, for 2016–17
2. What lessons you will take back to your workplace/agency from today?

12. Special Idea 5 (if required)

It's 2 August 2016.

The H5N1 virus has mutated and the mutated strain is resistant to antivirals.

The case hospitalisation rate has increased to 12%.

Case intensive care admission rate has increased to 1.3%

The case fatality rate has increased to 0.8%

There is widespread public concern.

Many people have recovered from H5N1 and returned to work, but are now staying home from work because they are concerned about getting the mutated strain of the virus.

Some schools are considering temporary closure because of unsafe staffing levels.

Many non-essential workplaces have closed because of unsafe staffing levels.

The media has fuelled speculation about supply shortages affecting Tasmania.