NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

TRUST-WIDE NON-CLINICAL DOCUMENT

PLAN FOR THE MANAGEMENT OF PANDEMIC INFLUENZA

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TRUST-WIDE NON-CLINICAL DOCUMENT

2020 – Version 2

Striving of perfect care and a just culture

TRUST-WIDE NON-CLINICAL DOCUMENT

PLAN FOR THE MANAGEMENT OF PANDEMIC INFLUENZA

Further information about this document:

Document name	**Plan for the management of pandemic influenza (IRP03)**
Document summary	**This plan provides a framework for Mersey Care NHS Foundation Trust to ensure an effective response to an influenza pandemic**
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SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child /adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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FOREWORD

The threat of an Influenza Pandemic is such that it continues to direct significant amounts of emergency preparedness activity on a global basis and remains top of the United Kingdom's National Risk Register. Mersey Care NHS Foundation Trust (the Trust) has a duty to protect and promote the health of the community, including during times of emergency with various elements of this duty made explicit in the requirements of the Civil Contingencies Act 2004.

This plan forms part of the Emergency Preparedness Resilience & Response procedures for the Trust. It outlines the methods which may be used to assist Trust staff, service users and healthcare colleagues during a pandemic. This plan should be read in conjunction with the Trust's Major Incident Plan, Business Continuity Plans and the Infection Prevention and Control Policy.

Community and mental health services are provided across a spectrum of user groups including children, adolescents, adults of working age and older people. Every individual will be at risk of becoming infected with influenza during a pandemic and the Trust will work with local organisations to ensure that their physical health needs are met during a pandemic as well as their ongoing mental health requirements.

A pandemic will differ from most Trust emergencies and major incidents in that there is likely to be at least 2-4 weeks' warning of its 'arrival' and it may then continue for up to two years, coming in three or four waves with variable amounts of time in between each wave.

The plan acknowledges that the Trust will have to work differently in order to optimise the use of the restricted resources available and maximise its capability for caring for its client group and staff. This may include:

- caring for individuals who may normally be looked after by primary or general secondary care staff working in different areas to their normal place of work
- broader consideration of physical symptoms influencing admission, placement, treatment and discharge decisions

For ease of use, this plan is divided into six sections:

- **Section I** (Influenza Pandemic Plan) gives background information and details on the probable nature and impact of an influenza pandemic, and the subsequent planning implications.
- **Section II** (World Health Organisation (WHO) and UK Response to Influenza Pandemic) outlines the WHO and UK approach to Influenza Pandemic
- **Section III (**Trust Response to an Influenza Pandemic**)** outlines the actions the Trust will take to manage an Influenza Pandemic
- **Section IV** (Business Continuity Plans: Pandemic Related Issues for Managers to Consider in an Influenza Pandemic) advises of key issues that should be contained in business continuity plans to ensure an appropriate response to an Influenza Pandemic
- **Section V** (Infection Control Guidance in Trust Premises, Shared Sites and Community Setting) outlines good practice for managing infection control during an Influenza Pandemic
- **Section VI** (Human Resources Guidance for Managers) contains useful advice and information
- **Section VII** (Appendices) contains the Appendices

This document is intended to be flexible so that the Trust response can be adapted as a pandemic evolves and knowledge about the new virus, its impact and the effectiveness

of available countermeasures emerge. Improving preparedness is a continuous activity and this plan will continue to be reviewed and updated, in particular to take account of new advice and guidance.

This plan will be activated, implemented and led by a small group of senior managers (Executive Director Level) and clinicians who will be the Trust Pandemic Strategic Coordinating Group, and supported by Trust Command and Control structures.

SECTION I – INFLUENZA PANDEMIC PLAN

1.0 BACKGROUND

1.1 Most people tend to think of influenza ('flu) as an unpleasant inconvenience that occurs every winter in the United Kingdom, rather than a serious threat to public health. Although influenza in the elderly and chronically ill can be serious and even lead to death, young people are usually less seriously affected. Routine vaccination policies are designed to minimise the impact of this normal pattern of influenza activity. Periodically, however, a completely new and virulent strain of influenza emerges. Because the population has not been exposed to the strain or others like it before, immunological protection is minimal. A vaccination against a completely new form of virus will not be available for some months after its appearance. Thus, the virus can spread causing worldwide epidemics (pandemics) with many people becoming ill and significant numbers of people dying.

1.2 Influenza pandemics have occurred at irregular intervals throughout history, but it is impossible to predict the timing of the next epidemic. There were three pandemics in the last century in 1918 (Spanish Flu), 1957 (Asian Flu) and 1968 (Hong Kong' Flu). Each of these events was associated with illness, deaths and general societal disruption far in excess of that experienced in a 'normal' winter. The 1918/19 pandemic, for instance, is estimated to have caused over 20 million deaths worldwide with 200,000 in the United Kingdom.

1.3 In 2009/2010, an epidemic of Swine Flu (H1N1) occurred, affecting a large number of people, but the clinical effects were less severe than were expected. In contrast, a further epidemic in 2010/11 was more severe in its effects but less widespread.

1.4 There will be further pandemics in the future and there may be little warning. Modern air travel has removed the time lag between the development of the disease in different parts of the world. Following the recent pandemics, modelling has suggested that a 90% ban on air travel would only serve to delay the peak of the pandemic wave by one to two weeks. Advanced planning is, therefore, essential for an effective, well managed and smooth response.

1.5 It must be remembered that all sections of the population could be affected by an influenza pandemic, although historically, the younger population is more severely affected. Multi-agency plans have been developed to ensure that essential parts of the infrastructure are maintained, in line with the Civil Contingencies Act (2004).

1.6 The Trust has a legal duty to protect patients, staff and visitors from harm. The Health and Safety at Work Act (1974) states that employers and employees are accountable through this Act, together with the Management of Health & Safety at Work Regulations 1999, to ensure that the workplace is free from hazards so far as is reasonably practicable. It also imposes specific obligations to ensure the microbiological safety of the hospital environment.

1.7 The diversity of sites belonging to the Trust, which range from complex hospital campuses and simple health centres/community clinics/offices to staff working wholly in the community, makes it inappropriate to define the procedure for each site. Therefore, it will be the responsibility of local operational teams to define their own specific service continuity plans within the framework of this plan.

1.8 This document has, therefore, been developed to facilitate an appropriate and effective Trust response through all levels of escalation to ensure that essential services are maintained during any future influenza pandemic.

2.0 SCOPE

2.1 This plan applies to all staff employed and seconded within the Trust, all Non Executive Directors, patients, service users, visitors, volunteers and any organisations contracted to work on sites operated or owned by the Trust. It also applies to Trust staff working on premises not owned by the Trust.

3.0 AIMS AND OBJECTIVES

3.1 The overall aim of this plan is to provide a framework for coordinating the Trust response to a flu pandemic, including the necessary background information, details of the relevant personnel and decision-making framework to ensure that the Trust is prepared for and can continue to function during an outbreak of pandemic influenza.

3.2 It is also aims to:

- Ensure that appropriate command and control structures are in place to effectively manage the Trust's response
- Ensure that all essential services are identified and maintained by the redistribution of resources as far as possible during a pandemic
- Ensure that all staff are adequately protected
- Provide treatment and care for those who become ill in the Trust's care
- Maintain the ability to cope with large numbers of ill patients and staff
- Consider different ways of working to support service users, patients and their families and carers
- Contain and minimise the spread of the virus if any part of the Trust is affected
- Minimise where possible disruption across all Trust services
- Make arrangements for the protection and safety of patients, service users and staff relevant to the outbreak
- Work effectively with partner health and other organisations
- Ensure that return to normal working is as rapid and efficient as possible

3.3 The objectives of the plan are to:

- Summarise and collate the key policies and procedures which will be activated in the event of an outbreak of pandemic influenza
- Outline the roles and responsibilities of key responders in a pandemic 'flu situation
- Identify issues that will require prompt action when the notification of Pandemic Influenza is made by the World Health Organisation

4.0 NATURE AND SCALE OF INFLUENZA PANDEMIC

4.1 The **outbreaks** or **epidemics** of influenza which occur most in winters may affect some 5 – 10% of the population. The vast majority will have an unpleasant but self-limiting illness or even no symptoms, with less than 0.5% consulting their GP. Those most at risk of serious illness or deaths (the elderly and those with chronic underlying diseases) are offered annual vaccination. Death from 'flu is often due to complications such as secondary bacterial infections, eg pneumonia, or exacerbation of an underlying disease, as well as to the direct effects of the influenza virus itself.

4.2 An influenza **pandemic** arises when an entirely new strain of influenza virus emerges to which most people are susceptible. Thus it is able to spread widely. Some important features of influenza pandemics are that:

- They are unpredictable
- They may occur at any time of the year
- They are most likely to start outside the United Kingdom
- They spread around the globe, and within the United Kingdom spread is likely to be rapid
- Most people will be susceptible but not all will develop clinical illness
- All ages are likely to be affected but children and otherwise fit adults could be at relatively greater risk
- About 50% of the population, or even more, may be affected over a 1-2 year period, including children and normally fit adults
- A far greater proportion of people are likely to required hospitalisation or die than for seasonal 'flu

5.0 SWINE FLU AND AVIAN FLU

5.1 The Swine Flu 2009/10 pandemic was caused by the H1N1 'flu virus and, outside Mexico, predominantly caused non-severe illness. However a pandemic can occur from many different viral strains. A virus can also mutate or mix with another strain to cause serious illness and death in humans.

5.2 The H5N1 Avian Flu virus is currently in circulation but the virus has not yet demonstrated the ability to pass easily between people but has caused serious illness and death in humans in direct contact with birds.

6.0 INFECTIVITY

6.1 Influenza viruses are respiratory viruses, primarily spread by large droplets from infected respiratory secretions produced when an infected person talks, coughs or sneezes.

6.2 It is also possible to acquire influenza by direct contact with, for example, contaminated hands and by aerosol generating activities. The incubation period is between 24 hours and 4 days, and individuals can transmit infection from the time of acquiring influenza up to 4 to 7 days after the onset of illness. Children and those who are immune-compromised can continue to shed the virus for even longer. In addition, many people acquire the infection but may not have signs of clinical

illness.

6.3 The virus can persist outside the body for up to 24-48 hours on hard surfaces, 8-12 hours in cloth, paper and tissues and 5 minutes on hands. With these characteristics, it is not surprising that flu is very readily communicable within communities.

7.0 COMPLICATIONS

7.1 Influenza can affect any age group, but usually causes the most serious complications in vulnerable groups such as the elderly or the chronically ill. All ages are likely to be affected but children and otherwise fit adults could be at relatively greater risk as elderly people may have some residual immunity from previous exposure to a similar virus earlier in their lifetime.

7.2 Pandemic viruses can have serious complications in any age group. For example, in the 1918 pandemic, young adults were the most severely affected. However, Swine Flu caused serious complications in some pregnant and post-partum women as well as children under five years old.

7.3 The complications of 'flu are primarily respiratory but it can affect other organs. Bacterial pneumonia is the most common pulmonary complication but in the 1918 pandemic, many victims died rapidly of a primary viral pneumonia. A far greater proportion of people are likely to require hospitalisation or die than for seasonal influenza

8.0 PLANNING ASSUMPTIONS

8.1 The Department of Health has issued a large amount of pandemic guidance which is available on its website. The most recent Guidance for Planners is contained on the UK Influenza Pandemic Preparedness Strategy 2011.

8.2 It must be emphasised that planning assumptions are NOT planning expectations. It is prudent that plans should be made for the worst case scenario, but the extent and nature of the response will be proportionate to the threat as determined by information gathered during the evaluation phase of the response.

8.3 The most relevant assumptions are:

- It will not be possible to stop the spread of or to eradicate the pandemic influenza virus, either in the country of origin or in the UK, as it will spread too rapidly and widely
- From arrival in the UK, it will probably be a further one or two weeks until sporadic cases and clusters of disease are occurring across the country
- Initially, disease activity in the UK may last three to five months. There may be substantial activity weeks or months apart
- The incubation period will be in the range of 1-4 days. Adults may be infectious for at least 5 days from the onset of symptoms and children for 7 days
- Regardless of the nature of the virus, there will be a wide range of severity of disease. Most affected will return to normal activities within 7-10 days
- Up to 30% of symptomatic patients may require assessment within the primary

care setting

- Between 1% and 4% of symptomatic patients will require some level of hospital care
- There is likely to be an increased demand for Intensive Care services
- Up to 60% of the workforce may require some time off. This may increase if those with caring responsibilities need additional time off
- Staff absence will follow the pandemic profile meaning that, if the pandemic affects 50% of the population overall, between 15% and 20% of staff may be absent on any given day
- An increased demand for the care of physically unwell patients may be jeopardised by high levels of sickness absence

8.4 For uncomplicated influenza, the success of local arrangements will be dependent on the majority of those who are ill managing their own illness at home. Basic information on self- management is available and will be widely promulgated at the time of the pandemic. The essentials are to:

- Drink plenty of fluids
- Take pain relievers like aspirin (not for children), Paracetamol or Ibuprofen
- Rest until feeling better

9.0 MEASURES TO MITIGATE THE HEALTH EFFECTS OF INFLUENZA

9.1 The measures available to mitigate the adverse health effects of an influenza pandemic are:

- Slowing the progress of pandemic
- Reducing non-essential activity in the Trust
- Immunisation
- Anti-viral medication
- Appropriate treatment of respiratory problems and secondary infections

9.2 Slowing the progress of the pandemic

It is unlikely that the spread of influenza can be halted but, nationally, there may be an attempt to slow the initial spread as this may reduce the size of the peak of the pandemic. It will also allow time to develop a vaccine. Within the Trust, some slowing of the spread may be achieved by the implementation of a range of measures including:

- The use of face masks and hand hygiene
- A reduction in the number of people accessing the Trust. Staff not involved in essential care will be asked to stay away. Volunteer services that are not essential will cease and the volunteers will be transferred to support the community
- Home isolation of cases

- Quarantine of contacts of known cases
- The use of surgical facemasks by infected people (to reduce droplet spread), by those in contact with infected people or by the general public when visiting patients
- Other measures will be included in guidance issued by the Health Departments based on the advice of the UK National Influenza Pandemic Committee

9.3 Reducing non-essential activity in the Trust

Throughout the pandemic, it will be important to reduce the number of people moving through the Trust as much as possible. Some specific groups are:

- Non-essential staff: when non-critical activity is being reduced, staff freed up will, where possible, be re-trained to provide skills relevant to the pandemic. If this re-skilling is not possible, they will be requested to stay away from the Trust
- Visitors: there will be restrictions on visitors during the pandemic

9.4 Vaccination

It is unlikely that a vaccine will be available in the early stages of the pandemic and, therefore, cannot be stockpiled in advance. The vaccine must be produced specifically for the virus concerned so development cannot start until the virus is known. Everything will be done to produce a vaccine as quickly as possible but this will probably take at least six months. When a vaccine is available, Department of Health guidance on its administration will be issued.

Once available, the vaccine is likely to be in short supply and demand will be high worldwide. Vaccine will only be administered in the first instance to high priority groups according to nationally agreed priorities, starting with healthcare and other essential workers and groups at special risk. Beyond that, the final decisions will be based on early information about the most severely affected age groups. When vaccine supplies become more widely available vaccination will be offered to the general population.

Guidance on how and where to obtain vaccines will be provided by NHS England.

9.5 Antiviral Strategy

Antiviral treatment is by a 5-day course of tablets, which should be started when the first symptoms appear. The identification of target groups for treatment, dispensing arrangements and care of those affected will be in accordance with national guidelines. Storage and access will be agreed by the Trust Pharmacy Departments. Additional methods of prescribing antivirals may be needed and directions may be issued for approved Prescribers in the Trust.

10.0 PROTECTING THE WORKFORCE

10.1 Establishment of an effective system of protection is essential to provide staff with adequate protection against risks associated with working practice. During an outbreak, this is critical to help reduce the spread of infection and minimise associated staff absenteeism.

10.2 The following policies and arrangements have been agreed to be measures which all health organisations should adopt:

- Reduce the number of patients with 'flu attending health premises to a minimum
- Reduce open access/walk in services in favour of appointments only. This enables patients to be triaged by telephone, reducing the number of people who will attend health premises with 'flu
- Examine all processes to avoid/reduce face-to-face contact
- If possible direct 'flu patients to dedicated premises or parts of premises separate from other patients
- Promote infection control procedures intensively to staff and patients
- Increase remote working and telephone/video conferencing where possible to reduce travelling and face-to-face contact
- Identifying individual members of staff at higher risk through pre-existing conditions, make suitable working arrangements where possible and encouraging them to take measures to minimise risk e.g. pneumococcal vaccine
- Produce prioritised list for immunisation or antivirals based on risk stratification (if appropriate) and national guidance where available
- Produce guidelines for staff and managers on fitness to work and when to return to work
- Promotion of the stay at home message if you are unwell, protecting others from exposure to the virus
- Provide appropriate protective equipment for staff based on advice from the Health Protection Agency
- Provide training for staff on protective equipment. Also to provide training and education for staff using their un-used skills during a pandemic
- Provision of psychological support to minimise the impact of a stressful working environment

10.3 Once it has been determined which individual/groups of staff are to be immunised, special Occupational Health Clinics will be organised and staff informed when they should attend.

11.0 STAFFING ISSUES

11.1 Absence from Work

Normal sickness rates are around two percent but previous pandemics indicate that 10% or more of the population may lose working days. Based on the estimated clinical attack rates, up to 50% of staff could be absent from work during the pandemic (possibly five to eight working days). Workers' needs to care for others, and difficulties (or fear) of travelling to work will mean that absenteeism may be higher. Modelling suggests that absenteeism due to the pandemic peaks at 3.5% of the workforce (over and above the existing absenteeism level) by week 14.

This absenteeism equates to a two thirds increase in the public sector.

Healthcare workers are likely to have a higher sickness absence rate than other population groups because they have a higher risk of exposure. In Liverpool in 1957, 12% to 19% of nurses were absent during the first four weeks of the pandemic. In one hospital nearly a third were absent at the peak. NHS sickness rates are usually around four to six percent.

11.2 **Schools**

The Government will take the decision on whether or not to advise closures of schools on the basis of an assessment of the emerging characteristics and impact as the pandemic develops. This will affect working parents, but also has a significant impact on business continuity and maintenance of essential services as these workers may stay at home to care for children.

11.3 **Impact on other services**

In the absence of early or effective interventions, there will be a widespread effect on all services, through staff sickness, travel restrictions (if imposed), increased workload and the knock-on effects of other disrupted businesses and services.

Travel will be affected by:

- Policies to restrict travel and public gatherings to limit the spread of 'flu
- Availability of fuel and transport workers
- People afraid of or choosing not to travel

11.4 **Public, political and media concern**

Managing people's concerns and expectations will be a key part of the response. There will be high public and political concern and scrutiny at all stages of a pandemic. Media interest, a need for information and coverage will be intense.

11.5 **Trust Staff**

All staff, including doctors and administrative staff, must be prepared to work flexibly and to have their regular duties altered to take account of service priorities. It is likely that staff who would normally work fixed hours will be required to work shifts and that non-clinical staff will be required to work in clinical areas, although not directly with patients.

Staff will not be expected to undertake tasks outside their level of competence. The Pandemic Strategic Coordinating Group will communicate with all staff the very real pressures that a pandemic will bring and advise them that they may be asked to alter shift patterns and places of work at short notice.

The traditional geographical/functional boundaries within which staff would normally work are likely to be suspended, and staff may be requested to attend specific areas to carry out their duties.

12.0 WORKING WITH A DEPLETED WORKFORCE

12.1 The principles to be adopted by health organisations to adapt to working with a depleted workforce are as follows.

12.2 Non-essential work will be postponed sufficient to release the staff needed to maintain essential services for 'flu and non-flu patients. Through Business Continuity Planning, each Directorate has determined minimum staffing levels for their essential functions and identified staff working in other areas who have the appropriate qualifications and skills to support these functions if necessary.

12.3 Small specialist teams (or even individuals) are particularly vulnerable, therefore particular attention has been given to training select individuals in advance of an outbreak to ensure these services are maintained, e.g. people from the Human Resource (HR) team could be trained to back up the Communications Team.

12.4 Information sheets are held on all staff to facilitate redeployment. This information has been collated by individual teams. It is essential that this information is reviewed and updated regularly to make sure it is fit for purpose

12.5 HR policies and procedures relating to pandemic 'flu issues will be followed when redeploying staff, requesting staff to work additional hours and calling in retired people etc.

12.6 All departments across the Trust have used business continuity planning to identify and plan for increasing staffing levels to maintain essential services.

12.7 Sickness absence reporting will be redesigned to enable managers to make the appropriate decisions on redeploying staff and to enable the organisation to report the current situation to the NHS England.

13.0 VOLUNTEER INVOLVEMENT

13.1 The Trust has volunteers who have a variety of skills which may form part of the Trust's redeployment programme of staff in the event of providing support to essential services across the Trust.

13.2 The Trust has a large number of healthcare students i.e. student nurses who may be used to support frontline services at the peak of the pandemic.

14.0 IMPLICATIONS OF PANDEMIC FOR MENTAL HEALTH ACT 1983/2007

14.1 Severe staff shortages are likely to affect the availability and priorities of, amongst others, Approved Mental Health Professionals (AMHPs - formerly Approved Social Workers ASWs), Section 12 Doctors and Psychiatrists. This may reduce capacity with regard to conducting Mental Health Act hearing etc.

14.2 There may be temporary changes to the Mental Health Act 2007 should exceptional circumstances arise during pandemic flu. The key aims of the changes will be to ensure both the maintenance of levels of care as well as to protect the safety and rights of patients and the public.

15.0 SAFEGUARDING ADULTS AND CHILDREN

15.1 The Trust has a legal duty to provide services that protect the rights and support the needs of vulnerable adult and children. These services are identified as 'essential services' and robust systems are in place to protect the continuity of these services during the pandemic.

16.0 SLOWING THE PROGRESS OF INFECTION

16.1 It is unlikely that the spread of influenza can be halted, but some slowing of the spread can be achieved by the implementation of national measures such as:

- Careful attention to personal hygiene including respiratory hygiene and strict hand washing with liquid soap and water and drying hands with disposable paper towels
- Travel advice to restrict international travel to and from affected areas
- Health screening in United Kingdom ports
- Voluntary home isolation of cases
- Voluntary quarantine of contacts of known cases
- Staff rostering to minimise the impact on staffing if all contacts of a case in a work team are asked to remain in voluntary quarantine
- Local restrictions on the movement of people, e.g. in a local community or town
- Restriction of public gatherings, especially mass gatherings may be recommended
- School closures in affected areas (recognising the impact this will have on maintaining the workforce in these sectors)
- The use of surgical facemasks by infected people (to reduce droplet spread), by those in contact with infected people or by the general public when visiting patients

16.2 Clear guidance will be issued by the Department of Health based on the advice of the UK National Influenza Pandemic Committee, guidance from WHO or real time modelling as the pandemic evolves or as need arises.

17.0 SURGE CAPACITY

17.1 Preparations for dealing with a surge of patients and how services and patients are prioritised, both in terms of physical capacity and staff shortages, together with actions required, have been undertaken by all Trust Directorates and these are reflected in Departmental Pandemic Influenza Plans and Business Continuity Plans.

17.2 Critical and non-critical activities have been identified. Non critical activities will be

cancelled to increase capacity and the staffing resources.

18.0 MANAGEMENT OF EXCESS DEATHS AND CERTIFICATION

18.1 In a flu pandemic many of the deceased will not have been seen by their doctor for 14 days or attended hospital in the last 24 hours therefore the death would need to be referred to the Coroner. To reduce the number of deaths referred to the coroner there may be legislation introduced to relax this limit from 14 days to 28 days.

18.2 Changes to the current death certification legislation may be implemented for individuals dying from influenza or complications of influenza. However, deaths of service users may still need to be referred to the Coroner for investigation. There may be a delay in organising funerals and during the peak of a pandemic funerals may not be allowed, to reduce the risk of infection.

19.0 STAFF TRAINING

19.1 The Infection Prevention and Control Nurses will provide general training to all staff on the infection control implications of pandemic influenza through face-to-face meetings.

19.2 NHS Basic Standards of Infection Control training will be implemented through on-line e- learning made available for all Trust staff.

19.3 The Pandemic Influenza site on the Trust Intranet also contains useful information and advice for staff and patients.

20.0 PLAN TESTING/EXERCISING

20.1 Pandemic Influenza plans must not be considered reliable until they have been tested and found to be robust.

20.2 Exercises involve plan validation and key staff role rehearsal and are undertaken in conjunction with elements of the Trust's Major Incident Response Plan and business continuity plans. They seek to confirm that plans and systems can be operationalised in order to identify any problems before the event. They provide training opportunities for staff identifying and addressing gaps in their knowledge and skills.

20.3 Learning points from all exercises are evaluated and plans modified accordingly.

21.0 RECOVERY

21.1 Once the immediate response to the emergency nears completion, the emphasis will move to recovery and remediation. At an agreed point, the Trust GOLD Command Team (as identified in the Major Incident Plan) will take the strategic lead in co-ordinating the process of returning the Trust to a state of normality. This recovery process will be managed through a three-tier management structure directed by the GOLD Command Team (Strategic), managed by the Outbreak Control Team (Tactical) and actioned by the Directorate/Service Areas (Operational).

21.2 Restoration of normal working will include:

- Assessment of the clinical and non-clinical workforce that is available to return to work
- A phasing-in period to allow the resumption of normal services, depending on the residual skills and resources available
- Psychosocial services for staff to enable them to restore their resilience
- Recruitment: although this will be at a potentially difficult time due to the nature of the work, sensitivities around the loss of staff and a potentially competitive environment
- Ensure that buildings are adequately cleaned, sanitised and otherwise made ready for resumption of normal service

21.3 Recovery will be an integral part of the response and not left until later as it is essential that the Trust resumes its daily business activities as soon as possible. Directorates will include recovery planning in their contingency plans.

21.4 The pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisational fatigue and continuing supply difficulties. The recovery will therefore take the form of a gradual return to normality.

21.5 A full Post Incident Report will be submitted to the Trust Board at the end of the pandemic.

22.0 PSYCHOLOGICAL SUPPORT

22.1 A pandemic outbreak will be a difficult time for the whole community, creating extra pressures for service users, their carers and families and staff. Bereavement, loss and caring for people are very stressful and will take its toll on individuals.

22.2 The Trust has specialist skills that may support people through these difficulties. The Trust may be required to support other organisations where staff/clients are experiencing serious difficulties with the psychological effects of pandemic influenza.

22.3 Staff will be affected by loss and grief in the event of a pandemic, and the specialist psychology staff will be available to address these issues within the limits of their organisational roles.

22.4 The Trust Chaplaincy and Spiritual Care Team may also be able to provide support to staff and patients.

23.0 RECORD KEEPING

23.1 The immediate demands of the 'flu pandemic can easily fully occupy staff to the point where no records are kept, and people try to remember what they did 'after the event'. This is not acceptable. The Trust is required to keep detailed logs/records of all individual actions, decisions, communications and instructions which should be timed, dated and initialed by the member of staff. It is helpful to review previous actions and information during an ongoing incident and also after the event, in order to provide evidence for any subsequent review.

23.2 All information relevant to the pandemic, including hand written notes, electronic documents and message pads, must be retained.

23.3 All records must be sent to the organisation's EPRR Lead when the pandemic is declared over once appropriate reports have been compiled in each Division and Corporate Services.

24.0 DEBRIEFING

24.1 A debrief will be held after every pandemic response. The key aspects of the Trust debrief process are as follows:

- It should be held within four weeks of the incident
- It should include key players within the Trust who were involved in the response to the incident
- It should address organisational issues, not personal or psychological issues
- It should look for both strengths and weaknesses and ideas for future learning
- It should provide an opportunity to thank staff and provide positive feedback
- It may be facilitated by a range of people within the Trust

24.2 If a multi-agency debrief is convened, the key aspects in addition to those above are as follows:

- It should be held within six weeks of the incident
- It may be facilitated by partner agencies

24.3 The debrief will help to inform:

- The Trust post incident report
- Lessons identified from the incident
- An action plan for the Trust

24.4 All staff with line management responsibilities will be responsible for ensuring their staff will be able to access a debrief session during and following an outbreak, be provided with information about the outbreak, and for monitoring individuals who may require extra support following an incident such as this.

25.0 FINANCE ISSUES

25.1 There are likely to be financial implications related to the management of a pandemic. Costs may arise from additional staff, training, and stockpiling of materials and equipment to ensure continued smooth running of the organisation and maintenance of the safety of patients. Personal Protective Equipment (PPE) may be issued via a national stockpile. There will be communication and guidance on how to access the stockpile when it becomes available to organisations. Estimated and anticipated costs need to be notified to the Executive Director of Finance.

26.0 PERFORMANCE TARGETS

26.1 It is not envisaged that Commissioners will suspend any targets. Therefore, performances against targets needs to be closely monitored and any concerns that they will not be met discussed with the Clinical Commissioning Groups at an early stage.

27.0 CONSULTATION

27.1 This plan has been reviewed after consultation with the Emergency Preparedness Resilience and Response Group, the Infection Prevention and Control Committee and the Trust Seasonal Influenza Group.

28.0 SUPPORTING DOCUMENTATION

28.1 This plan should be read and implemented in conjunction with other local plans including:

- Major Incident Plan – IRP00
- Local Business Continuity Plans
- Infection Prevention & Control Policy – IC01
- Social Networking Security Standard – SS01
- Handling of Medicines Policy – SD12
- Management of Decontamination of Medical Devices – SA19
- Occupational Health Policy – HR29
- Management of Attendance Policy – HR07
- Equality & Human Rights Policy – HR10
- End of Life Policy – SD47
- Cleaning Standards – SA16Trust Winter Plan
- Multi Agency Partners - Influenza Pandemic Plans
- Local Resilience Forum Influenza Pandemic Plan

29.0 MONITORING COMPLIANCE AND EFFECTIVENESS

29.1 NHS England/ Improvement will conduct a national audit of pandemic preparedness on a regular basis.

29.2 NHS England will also audit plans at a frequency to be agreed.

30.0 REVIEW

30.1 This plan will be reviewed and updated:

- following an incident when the plan is activated and lessons learned
- following changes to the legislation

- following changes to guidance issued by Public Health England
- following changes to the structure of the organisation
- if the above do not occur, the plan will be reviewed every 3 years.

SECTION II – WORLD HEALTH ORGANISATION AND UK RESPONSE TO INFLUENZA PANDEMIC

1.0 World Health Organisation (WHO)

1.1 Although the World Health Organisation (WHO) is responsible for identifying and declaring influenza pandemics, the UK was well into the first phase of infection when WHO declared a pandemic in 2009.

1.2 The use of WHO phases as a trigger for the start of different stages of local response proved to be confusing and unhelpful, as did the categorising of UK Alert Levels which were not used. The 2011 UK influenza Pandemic Preparedness Strategy recognised that a more flexible approach for pandemic preparedness and response is required. The only link to the WHO Phases is the declaration of WHO Phase 4 (sustained human to human transmission of an animal or human to animal influenza reassortant virus able to cause community-level outbreaks) initiating the UK response.

2.0 UK Response Phases (DATER)

2.1 The overall objectives of the UK's approach to preparing for an influenza pandemic are to:

- Minimise the potential health impact of a future influenza pandemic
- Minimise the potential impact of a pandemic on society and the economy
- Instil and maintain trust and confidence

2.2 The UK has developed an approach not driven by the WHO phases but determined nationally. The approach uses a series of phases **Detection, Assessment, Treatment, Escalation** and **Recovery (DATER).** It also incorporates indicators for moving from one phase to another. The phases are not numbered as they are not linear, may not follow in strict order, and it is possible to move back and forth or jump phases.

2.3 **Detection**

This phase will commence on the basis of reliable intelligence or if an influenza-related "Public Health Emergency of International Concern" (a "PHEIC") is declared by the WHO.
The focus in this stage is:

- Intelligence gathering from countries already affected
- Enhanced surveillance within the UK
- The development of diagnostics specific to the new virus
- Information and communications to the public and professionals

The indicator for moving to the next stage would be the identification of the novel influenza virus in patients in the UK.

2.4 **Assessment**

The focus in this stage is:

- The collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK.
- Reducing the risk of transmission and infection with the virus within the local community by:

  - actively finding cases
  - self-isolation of cases and suspected cases
  - treatment of cases/suspected cases and use of antiviral prophylaxis for close or vulnerable contacts, based on a risk assessment of the possible impact of the disease.

The indicator for moving from this stage would be evidence of sustained community transmission of the virus, i.e. cases not linked to any known or previously identified cases.

These two stages – Detection and Assessment - together form the initial response.

This may be relatively short and the phases may be combined depending on the speed with which the virus spreads, or the severity with which individuals and communities are affected. It will not be possible to halt the spread of a new pandemic influenza virus, and
it would be a waste of public health resources and capacity to attempt to do so.

2.5 **Treatment**

The focus in this stage is:

- Treatment of individual cases and population treatment via the National Pandemic Flu Service (NPFS), if necessary
- Enhancement of the health response to deal with increasing numbers of cases – implementation of Surge Management Plans for Healthcare Service Providers
- Consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localised school closures based on public health risk assessment
- Depending upon the development of the pandemic, to prepare for targeted vaccinations as the vaccine becomes available.

Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases and deaths. When demands for services start to exceed the available capacity, additional measures will need to be taken. This decision is likely to be made at a sector or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity. Implementation of Surge Management Plan for healthcare services providers e.g. GPs, Acute Trust and Community Nursing Services.

2.6 **Escalation**

The focus in this stage is:

- Escalation of surge management arrangements in health and other sectors
- Prioritisation and triage of service delivery with aim to maintain essential services, resilience measures, encompassing robust contingency plans
- Consideration of de-escalation of response if the situation is judged to have improved sufficiently.

These two stages form the **Treatment phase of the pandemic**. Whilst escalation measures may not be needed in mild (LOW – MODERATE) pandemics, it would be prudent to prepare for the implementation of the Escalation phase at an early stage of the Treatment phase, if not before.

2.7 **Recovery**

The focus in this stage is:

- Normalisation of services, or to a new definition of what constitutes normal service
- Restoration of business as usual services, including an element of catching-up with activity that may have been scaled-down as part of the pandemic response eg reschedule routine service user appointments
- Post-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt
- Taking steps to address staff exhaustion
- Planning and preparation for resurgence of influenza, including activities carried out in the **Detection** phase
- NHS England will continue to consider targeted vaccination, when available
- Preparations will be put into place for post-pandemic seasonal influenza

The indicator for this phase would be when influenza activity is either significantly reduced compared to the peak or when the activity is considered to be within acceptable parameters. An overview of how services' capacities are able to meet demand will also inform this decision.

SECTION III - TRUST RESPONSE TO AN INFLUENZA PANDEMIC

1.0 DUTIES

1.1 **Board of Directors**

The Board of Directors has overall responsibility for ensuring that all staff are appropriately trained and competent to effectively fulfill their role within the organisation and maintain the safety of patients. The trust has an obligation to comply with statutory and regulatory responsibilities. The Trust Board fully accepts its accountability for preparing and managing the response to an influenza pandemic.

1.2 **Lead Executive Director**

The Lead Executive Director (Executive Director of Nursing & Operations) has strategic responsibility for ensuring that the standards with this document are monitored and reported to the Board of Directors accordingly.

1.3 **Director of Infection Prevention and Control (DIPC),**
The Director of Infection Prevention and Control (DIPC) has the lead responsibility for overseeing the preparations to ensure the Trust's ability to provide and maintain its services during this period.

1.3 **Infection Prevention and Control team**
The IPC team are responsible for ensuring that appropriate specialist guidance and contact information is available to clinical staff as appropriate, for maintaining an up to date stock list of FFP3 masks in situ and for ensuring that training on FFP3 is available to staff as required

1.4 **EPRR Lead**

The EPRR Lead will oversee the implementation and promotion of the plan and will provide strategic support, including regular situation reports and updates to the Chief Executive, Board of Directors and Executive Team of any pandemic related pressures as they arise. Exception reports will be submitted as required.

1.5 **Communications Team**
The communications team is responsible for developing and publishing information messages for the intranet, website and social media, in liaison with the EPRR team as appropriate.

1.6 **Corporate Directorates**
All corporate teams are expected to support the response to a pandemic flu related incident, by ensuring that the appropriate resources are timely available to clinical staff and by monitoring and reporting to the Incident Response team potential risks related to their areas.

1.7 **Divisional Senior Management Team**
Senior managers will report to the Director(s) with responsibility for Clinical Divisions. They also have responsibility for ensuring delivery of high standards of care, implementation of this plan within their division and support the Incident Response Team as appropriate.

1.8 **Service Care Leads, Modern Matrons and Ward Managers**

Responsible for ensuring high standards of care are maintained within their areas of accountability and adherence to the process set out in this plan. They also have responsibility for identifying training needs of staff and liaison with appropriate personnel to meet those needs.

1.9 **All Healthcare Practitioners**

All Mersey Care clinical and non clinical staff are responsible for familiarising themselves with the contents of this plan and ensure that should an incident occurs they will be able to activate the appropriate action card based on their capabilities and area of work.

2.0 COMMAND AND CONTROL DURING AN INFLUENZA PANDEMIC

2.1 Once a substantial risk of actual onset of an influenza pandemic has been identified, the Trust Pandemic Strategic Coordinating Group led by the Executive Director of Nursing and Operations will be established as Strategic Command.

2.2 At the Treat and Escalate Phase of the Pandemic, each Division will convene Tactical Divisional Influenza Pandemic Outbreak Control Teams which will be coordinated by the Trust's Pandemic Tactical Coordinating Group led by the DIPC. The key functions will be to:

- Nominate a representative to attend the Trust Influenza Pandemic Tactical Coordinating Group. This may be a virtual attendance through teleconferencing during the pandemic
- Co-ordinate staff and resources during a pandemic
- Monitor staff absence and availability
- Record the number of service users infected with influenza
- Prioritise service provision and service users
- Redeploy staff to priority and essential services
- Distribute Personal Protective Equipment (PPE)
- Submit SITREPS (situation reports) to the Trust Influenza Pandemic Tactical Coordinating Group in respect of sickness, absence, risks and any associated pressures as requested.

2.3 There will also be Operational Influenza Pandemic Outbreak Control Teams in each Division. The composition of these Teams will be task dependent e.g. one group may have to change shift patterns while another group may be procuring additional supplies.

3.0 END OF OUTBREAK

3.1 A single wave pandemic profile with a sharp peak provides the most prudent basis for planning. Second and subsequent waves have occurred in some previous pandemics weeks or months after the first.

3.2 Although the first priority after the first wave will be to develop recovery plans

and gradually restore services depleted or curtailed during the pandemic, plans must assume some regrouping in anticipation of a future wave

3.3 The Divisional silver Commanders will be responsible for ensuring that the incident is officially closed when authorised to do so by the Trust Influenza Pandemic Strategic Coordinating Group and that any control measures introduced to contain the outbreak i.e. ward closure are withdrawn except for those control measures necessary for a particular individual.

3.4 It will be necessary for all Trust Directorates and Departments to prioritise the restoration of their services and to phase the return to normality in a managed and sensible way. The pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisational fatigue together with potential continuing supply difficulties.

3.5 A pandemic will be deemed to have ceased when the epidemiological indices have returned to background levels, (expected to be after two to three years). It is expected that the Department of Health will make a formal announcement that the pandemic has ceased.

SECTION IV - BUSINESS CONTINUITY PLANS: PANDEMIC RELATED ISSUES FOR MANAGERS TO CONSIDER IN AN INFLUENZA PANDEMIC

1.0 Introduction

1.1 Responding effectively to an influenza pandemic, other than at a very low-key level outbreak which can be effectively coped with within normal service delivery, is likely to be dependent on the use of business continuity arrangements. To that end, all Directorates have prepared and tested Business Continuity Plans to meet required performance targets as far as possible.

1.2 The Trust's Business Continuity process identifies 'key services' and, consequently, 'critical activities' along with continuity requirements for each of these. During the most extreme pandemic related pressures it is possible that the existing service categorisations will be simplified even further and reduce to 'easier to manage' basic such as:

Priority 1: Essential Services: priority for business continuity – must be delivered
Priority 2: Important Services: but not essential – consider partial or temporary suspension in order to redirect resources to Priority 1 Services
Priority 3: Donor Services: first to suspend with resources to be allocated to Priority 1 and/or Priority 2 Services

1.3 The above is an extremely over simplified representation of what will actually be quite sophisticated prioritisation both between and within services and elements of services. A service may not itself be considered particularly crucial, but it (or elements of it) may be vital to the continued delivery of a service that everyone would consider to be essential ie many services are likely to contain a combination of 'critical activities' (in business continuity terms) and non-critical activities. It is also often the case that such dependencies might not be at all obvious and might only be identified as a result of comprehensive business continuity planning.

1.4 It is also important to remember that a service may not initially be classified as Essential, and this might be appropriate in the short term. It may, however, over the medium or long term need to be classed as Essential, so any such planning will need to be very dynamic and subject to frequent review once implemented.

1.5 Whilst Business Continuity Planning will have identified many of the issues to be considered during a pandemic, it is possible that other scenarios or potential disruptions might have dominated or biased such planning. The following is a checklist of various issues more specific to the type of challenges likely to be faced during a pandemic. If Managers discover their Business Continuity Plans do not adequately address the identified issues, they should use this checklist to improve these plans as a pandemic becomes more likely and imminent. It is intended to be helpful and offer various 'pointers'. Many of the specific points will not apply to various services and it is also not expected to be exhaustive or comprehensive.

2.0 General Managers, Heads of Services

Planning

- Ensure that all Contingency Plans are implemented and adhered to

- Ensure that each Directorate maintains up-to-date records of staff illness and absence and reports any issues to the Directorate Pandemic Outbreak Control Team
- Investigate the feasibility of maintaining a 'clean' unit within the Trust
- A system to inform managers of staff absences at the earliest opportunity should be set up so that workloads may be re-organised
- An information system should be set up to monitor the effect of the pandemic on the Trust

Staffing Issues

- Staff who arrive on duty ill or become unwell at work MUST GO HOME, and remain off duty for the duration of the illness
- Emergency rotas to compensate for staff absence will be required, and will require constant supervision and updating
- Annual leave and study leave may have to be postponed
- Staff will be expected to work flexibly and to have their regular duties altered to take account of service priorities throughout the emergency. They will not be expected to work beyond their level of competence and training will be provided where necessary
- Staff may be unable to work flexibly because of the need to care for their own sick children, dependent relatives or because child-care arrangements have broken down
- Ensure that staff on duty have adequate rest and refreshment periods
- Ensure that debriefing and psycho-social support is available where required
- All current Trust Human Resources policies will remain in force unless otherwise advised.

3.0 Clinical Services Managers/Modern Matrons

- All routine work should be reviewed to identify where possible those tasks which may safely be deferred to allow resources to be channelled into the support of critical activities
- Work which cannot be deferred may still have to be prioritised to facilitate the support of key services and their associated critical activities
- Consider reducing and/or cancelling of outpatient clinics and home visits where this can be done safely
- Community staff may become aware of situations where care has failed, or is about to fail, due to pandemic related pressures
- Consider what additional equipment will be needed. where it will be stored and who will require what level of training
- Ensure staff contact details are up-to-date

4.0 Wards/Residential Units/Day Care Facilities (specifically who, or what role, will do that?)

Whose responsibility will it be to report cases of patients and staff with influenza to the nurse in charge and the Divisional Control Team?

NB Infected staff must stay at home for the duration of their infectivity i.e. at

least five days from the onset of symptoms (or as advised)

Closure of a ward to new admissions may be recommended by the Infection Prevention and Control Team. Who will make the decision to close a ward to new admissions?
Who will decide to cease inter-ward transfers and discharges?

NB Staff should not be required to work and 'move between' infected and non-infected areas

- Restrict numbers of staff entering the ward to those recommended by the Infection Prevention and Control Team
- Ensure redeployed staff are properly trained and orientated before commencing duties
- Encourage patients to recover in their own rooms
- Encourage patients to bathe/shower daily
- Ensure bed linen, towels and night attire are changed as soon as soiled and at least daily to reduce the risk of re-infection
- Ensure dirty linen is managed according to policy
- Ensure bedrooms, en-suites and toilets are cleaned twice daily
- Hand hygiene is paramount - all staff must wash their hands with liquid soap and water and dry hands thoroughly with disposable paper towels or use alcohol based hand rub after every contact with patients, their linen and the collection of samples
- All Infection Control advice and instructions strictly adhered to
- All non-disposable crockery and cutlery must be washed in a dishwasher where possible
- Ensure that sick patients have their physical observations, including temperature, recorded at least twice a day (unless otherwise ordered by attendant medical staff). Use disposable equipment if feasible, if not own equipment for patients only use preferably. If this is not possible ensure thorough decontamination between uses as directed by the IPC team.
- Staff attending to patients confined to bed, when handling specimens or cleaning up body fluid spillages, must wear disposable gloves and aprons to use spillage kits if available
- Ensure that extra fluids and nourishing drinks are available to prevent dehydration.
- Ensure that there is an adequate supply of disposable sample pots, disposable gloves and aprons, bed linen, towels, liquid soap and red alginate dissolvable bags
- Identify and empty wards that could be used solely for influenza patients to reduce the risk of transmission
- Ensure adequate and continuing supplies of antibiotics/antivirals for the treatment of chest infections
- Very physically unwell patients may be transferred to a hospital if beds and sufficient escort staff are available if the patient fits the admission criteria

Barrier Nursing/Cohort Nursing

- Consider options for isolating infected patients (barrier nursing) in side rooms or co-horting of cases in groups of rooms or wards
- Separate and immunise at risk patients

Consider Nursing Staff Availability

- Utilise non-ward nursing staff
- Close departments and utilise staff
- Annual leave and study leave may have to be cancelled
- Utilise non-nursing personnel from closed departments to assist
- Do not use bank staff employed in other hospitals if they are looking after influenza patients

Visitors

- Discourage all non-essential hospital visits
- Restrictions on visitors entering Trust premises to minimise the spread of infection
- Consider the impact of banning visitors
- Infection control of allowing visitors e.g. not a ban but provide with PPE
- The impact of visitors requiring training in putting on, taking off, safe disposal of PPE and general infection control guidance
- The expectation of visitors to comply with all Trust preventative infection prevention and control measures
- When the pandemic has spread widely and limitation of visiting would no longer play a part in slowing the spread, the same principles remaining in place to reduce disruption to Trust activities
- The security implications of visitors during this period of heightened public panic as there will be a high security risk in relation to the storage and distribution of antivirals, PPE, and people trying to obtain these
- Developing a Visitors Policy where practical

Information for Relatives

- Keep relatives of sick patients informed and advise that children and elderly relatives should not visit so as to reduce the risk of infection
- Advise all relatives regarding restrictions to visiting times
- Advise relatives if/when patient is transferred to hospital

Closure of Wards

- Decision process for closure of wards to admission/transfers – who decides?

- How will this be communicated and to whom?
- Will it be possible to use the bed spaces in closed wards for patients suffering from ‘flu ie a dedicated ‘flu ward?

Cancelling Appointments/Visits and Closing Clinics

- The decision process for cancellation of appointments and closure of clinics must be clarified with the Tactical Command. Consider also redeployment of staff
- The giving of depot injections must be seen as a critical function
- Standard letters for clients/patients advising them of the cancellation of appointments, visits and /or closure of clinics should be prepared in advance
- Advice sheets should be prepared in advance for issuing to clients/patients on how to cope

Personal Protective Equipment (PPE)

- What PPE is available? Gloves, aprons, masks and gowns. Consider FFP3 masks - training will be required
- Where is it stored in each area?
- Who will authorise access and issuing?
- When it is to be worn?
- Is any information, training or education relating to its use required?
- Are staff aware of how to dispose of used items?

Equipment/Stores/Consumables

- Establish core equipment requirements and availability in a pandemic
- Ensure sufficient supplies of PPE and arrangement for stock management, ordering, distribution, training in use, security of storage, and increases levels of waste disposal
- Arrangements for keeping rechargeable equipment charged at all times and regularly serviced
- Ensure that there is an adequate supply of disposable sample pots, tissues, disposable containers, gloves, aprons, masks, alcohol hand gel shrouds, ‘no touch’ waste bins, body bags, labels etc
- Establish stock levels of cored consumables
- Ensure Trust procurement function agrees and communicates arrangements for effective access to catalogues, local ordering from national stock piles, delivery schedules and on- site movement
- Use single use equipment wherever possible

Managing Deaths

- Who will inform the next of kin?
- Is there a supply of shrouds and where are they kept? Consider purchase of these if not available routinely
- Where are labels kept for attaching to the outside of the shroud? Consider purchase of these if not available routinely
- How will cadavers be transported to the mortuary?
- Who will record where bodies have been relocated to?
- How will the area the death occurred in be 'secured' until a thorough clean has been undertaken?

Mortuary Arrangements

- Be aware of mortuary arrangements at local hospitals
- In the event of capacity being exceeded, the Merseyside multi-agency Strategic Co-ordinating Group (SCG) will identify additional mortuary space and body storage facilities
- Urgent decisions may be required within each Trust inpatient site regarding:
    - Vehicles identified for transportation of bodies to temporary mortuaries
    - Identify drivers who will cover this function over a 24 hour period
    - Identify staff who will move the bodies to the temporary mortuaries
    - Shrouds must be accessible to clinical areas
    - Depending on the pandemic virus, the use of body bags may be required

Laundry Facilities

- Will these cope with additional flat linen?
- Should disposable linen be purchased?
- Where will it be stored?
- How often will linen be changed if the patient is not ill?
- How often if the patient is ill?

Dirty Laundry

- How/where will this be stored if it can't be collected? Preferably outside in locked store but not left for more than 24 hours due to increase in bacteria especially in warm weather
- Are there enough bags available?
- If washing machines are available locally, will there be enough soap powder for increased use?
- NB All soiled linen must be sealed in plastic bags before leaving the infected area. Infected linen must be handled and transported in accordance with Trust local policy and / or laundry provider including the use of red alginate bags.
- Linen should be placed in appropriate receptacles immediately after use and

bagged at the point of use

- Linen bags must be tied and sealed before removal from the influenza patient care room/area
- Gloves and aprons must be worn for handling all contaminated linen and disposed of as infectious waste
- Strict Hand hygiene with liquid soap and water, rinsing thoroughly and using disposable towel protocols must be performed after removing gloves

Clinical Waste Management

- Where will this be stored if it can't be collected?
- If outside, will it be free from the attention of rats and vermin?
- All contaminated waste must be treated as infectious waste and disposed of in line with the agreed clinical waste processes, with all cleaning staff (including contracted cleaning staff) being formally instructed accordingly

Cleaning

- Who will remind staff not to use the vacuum cleaners in infected areas?
- Who will undertake cleaning duties in the absence of domestic staff?
- Vacuum cleaners must contain hepa filters or equivalent.
- Assuming less cleaning will be done is such circumstances, are cleaning tasks prioritised? Ensure all hard surfaces are cleaned with the appropriate products.
- What training and PPE will they be provided with?

Air Conditioning

- Seek advice on whether switching off air conditioning systems will be helpful in the specific circumstances of each system. Ideally, this should be switched off.

Receptions and Waiting Areas

- All toys, books, newspapers and magazines must be removed
- All soft furnishings should be removed and only easy to clean furniture used
- By whom and when

Reducing/Failing Food Supplies

- How will this be managed?
- Consider reduced choices and restricted service as a short term solution

Catering

- Plans for internally provided services need to be considered
- If option for 'self-catering' is to be considered, where will goods be purchased from?
- How will stock be stored?
- How will the stock be kept secure and stock managed?

Shared Premises

- This section must detail any joint working relationships developed in shared premises to ensure the continuation of service delivery

Carers

- How can they be used?
- Who will provide training in the use of PPE? Preferably by the Infection Prevention and Control Team
- Where will any training be recorded?

Volunteers

- Local managers will need to consider the appropriateness of the use of volunteers
- If so, how can they be used?
- What will they not be allowed to do?
- Who will supervise them?
- Who will train volunteers in the use of PPE? Preferably by the Infection Prevention and Control Team
- Where will any training be recorded?

Infection Prevention and Control Teams

- Organise training for staff in all aspects of hygiene and infection control methods including the fit testing of masks. A strategy for training and dissemination of information will be devised by Divisional Infection Prevention and Control Teams
- Organise training for staff in the use of Personal Protective Equipment (PPE) in conjunction with Occupational Health

Medicines Management Departments

- Ensure supplies of vaccine, antiviral agents and antibiotics are distributed following discussion with the Trust Strategic Coordinating Group

- Provide advice on pharmaceutical products
- Maintain contact with manufacturers/pharmacies to obtain supplies speedily
- Issue information on indications, contra-indications and adverse reactions to drugs to be used
- Ensure proper documentation of administration of pharmaceutical preparations

Occupational Health Department

- Provide professional occupational advice to the Trust Tactical Coordinating Group
- Support in the administration of vaccinations once available.
- Provide advice to staff and their managers on absence and when they are fit to return.
- Provide psychological support to staff if needed.
- Collect data and assist with epidemiological investigations

5.0 CORPORATE BUSINESS CONTINUITY PLANNING FOR AN INFLUENZA PANDEMIC

Each Corporate Directorate will carry on doing its day job with staff who have not been deployed (as per Pandemic Influenza Continuity Plan) elsewhere in the Trust or who are absent having identified its critical activities.

Human Resources

- To agree procedures for working practices during a pandemic
- To ensure that staff details for each ward/department are up-to-date
- To identify the route(s) to accessing extra staff resource
- Create a system whereby staff sickness absence data is collected
- Create a system for informing management about staff absence
- Consider staff transport issues if services are disrupted

Communications Team

- Distribute all prepared information (staff and public)
- Issue media messages
- Deal with press enquiries
- Produce a press statement based on the advice of the Trust Pandemic Influenza Outbreak Control Team

Procurement

- Ensure that the Trust has sufficient supplies of PPE including gloves, aprons and masks
- Ensure resilience of supplies from utilities and other suppliers.

Estates/Facilities

- Ensure service provision of a seven day a week (domestic, catering, portering switchboard) to infected wards/areas
- Ensure availability of extra cleaning supplies as required
- Ensure extra provision of bed linen and towels are available (consider using disposable sheets and pillow cases)
- Ensure daily delivery of extra bed linen and towels
- Ensure daily collection of dirty laundry
- Ensure the provision of an accessible supply of shrouds (body bags may be required)
- Ensure transportation of medicines is given priority

SECTION V - INFECTION CONTROL GUIDANCE IN TRUST PREMISES, SHARED SITES AND COMMUNITY SETTINGS

BASIC INFECTION CONTROL

1.0 Hand Hygiene

The term 'hand hygiene' includes washing with liquid soap and water and thorough drying with disposable paper towels. The use of alcohol hand rub will be advised by the IPC team.

Hand hygiene must be performed in accordance with the Trust Infection Prevention and Control Policy. If hands become contaminated with respiratory secretions they must be washed with liquid soap and water and dried with paper towels which must be disposed of as infectious clinical waste.

Hands must be decontaminated:

- Before and after **all** patient contact with an infected patient or their bed area
- After removal of protective clothing
- Following cleaning of equipment

All staff, patients and visitors entering and leaving areas where care is delivered must perform hand hygiene with liquid soap and water followed by drying on a paper towel, or alcohol hand rub.

2.0 Cough and Respiratory Etiquette

When coughing, sneezing, wiping or blowing noses, patients, staff and visitors must cover noses and mouths with a disposable single use tissue, then dispose of this in the nearest waste bin. Hands must be kept away from eyes and noses. The immobile or incapable will need assistance following which hands must be washed with liquid soap and water and thorough drying with disposable paper towels

3.0 Personal Protective Equipment (PPE)

PPE must be worn to protect staff from contamination with body fluids and thus reduce the risk of transmission of pandemic influenza between patients and staff from one patient to another.

The **minimum** PPE to be worn by all staff entering the room of a patient suffering from influenza is:

- Routine surgical mask (the use of FFP3 respirators for close patient care will be advised by PHE at the time of the outbreak)
- Disposable plastic apron
- Latex free disposable gloves

Care must be taken when donning and doffing PPE to avoid inadvertent contamination. Ideally this should be done in twos with one instructing the other through the stages. All contaminated clothing must be removed before leaving a

patient care area.

4.0 Surgical Masks

A surgical mask must be worn by staff who are within close contact ie within three feet of an infected patient. This will provide a physical barrier and minimise contamination of facial mucosa by large particle droplets, one of the principle routes of transmission.
Surgical masks should:

- Cover both the nose and the mouth and not be allowed to dangle around the neck after usage
- Not be touched once put on
- Be changed when they become moist
- Be worn once and discarded in an appropriate receptacle as clinical waste

NB. In addition to respirators, eye protection must be worn to prevent eye contact with infectious material during such procedures.

Hand hygiene must be performed after disposal is complete.

If patients with pandemic influenza are co-horted in one area and multiple patients must be visited over a short time or in rapid sequence, it may be practical to wear a single surgical mask. The mask must be put on prior to entry to the area and kept on for the duration of the activity or until the surgical mask requires replacement. Other PPE (gloves and disposable aprons) must be removed between patients and hand hygiene performed.

All contaminated PPE must be removed before leaving a patient care area. Surgical masks or respirators must be removed last, followed by thorough hand hygiene.

5.0 Respirators

A disposable respirator following the highest possible protection factor available (FFP3 disposable respirator) is recommended to be worn by healthcare workers when performing procedures which have the potential to generate aerosols.

As per PHE requirements, every user should be fit tested and trained in the use of the respirator. Fit is critically important and a fit check should be carried out each time a respirator is worn. The respirator must seal tightly to the face or air will enter from the sides. A good fit can only be achieved if the area where the respirator seals against the skin is clean-shaven. Beards, long moustaches and stubble may cause leaks around the respirator.

If breathing becomes difficult, the respirator becomes damaged or distorted or contaminated by body fluids, or if a proper face fit cannot be maintained, the wearer must leave the area, following appropriate removal of PPE and hand hygiene and change the respirator immediately.

FFP3 respirators must be replaced after each use and disposed of as clinical waste.

If an FFP3 respirator becomes soiled, this must be disposed of as clinical waste.

6.0 Gloves

Sterile or non-sterile gloves conforming to EU standards must be worn for the following:

- Invasive procedures
- Contact with sterile sites
- Contact with non-intact skin
- Contact with mucous membranes
- During activities that carry a risk of exposure to blood, body fluids, secretions (including respiratory secretions) and excretions
- When handling sharp or contaminated instruments/waste
- When a member of staff has cuts/abrasions that cannot be covered with a waterproof dressing

Gloves must be removed immediately after use, disposed of as clinical waste and hand hygiene performed.

7.0 Aprons

Disposable plastic aprons must be worn whenever there is a risk of personal clothing or uniform coming into contact with a patient's blood, body fluids, secretions (including respiratory secretions) and excretions or during procedures that involve close contact with the patient (eg examining the patient, assisting with activities of daily living).

Plastic aprons must be worn as a single use item for one procedure or episode of patient care and then discarded and disposed of as clinical waste.

Aprons must be changed between patients.

8.0 Gowns

Gowns are not required for routine care of patients with influenza. However, gowns must be worn if:

- Extensive soiling of personal clothing or uniform with respiratory secretions is expected
- There is a risk of extensive splashing of blood, body fluids, secretions and excretions onto the skin of the healthcare worker
- Procedures such as intubation and activities that involve holding the patient close

Gowns must:

- Fully cover the areas that are to be protected
- Be worn only once and then placed in a waste receptacle and hand hygiene performed immediately after removal.

9.0 Eye Protection

The use of appropriate eye protection should be considered where there is a risk of contamination of the eyes by splashes and droplets, eg. blood, body fluids, secretions and excretions, though patient care. Eye protection must always be worn during aerosol generating procedures.

10.0 Sequence for Donning and Doffing of PPE

PPE must be located outside the entrance to the patient's room/cohort area and, following a risk assessment, must include the following:

- Surgical facemasks
- Plastic aprons
- Disposable latex free gloves
- Disposable gowns (if required)
- Face visors/eye protection (if required)

11.0 Putting on PPE

1. Perform hand hygiene ie. wash and dry hands thoroughly
2. Put on surgical mask and fit carefully
3. Put on disposable apron (and gown if required)
4. Put on disposable latex free gloves
5. Enter bedroom or cohort area and carry out tasks

Remove gloves, apron (and gown) and mask before leaving the bedroom or cohort area and dispose of as clinical waste. Perform hand hygiene immediately. Remove the mask when you leave the room due to air bourn transmission and wash hands again.

ENVIRONMENTAL INFECTION CONTROL

12.0 Premises

- Tissues and no-touch waste bins should be provided where possible in waiting areas of Trust premises, for patients and visitors. Ideally, clinical waste bins should be used
- A wash-hand basin or alcohol hand rub should be available for patient use
- Simple face masks should be offered to patients who are coughing, in order to contain respiratory secretions. This should be disposed of in a clinical waste bin following use. Alternately provide tissues for the patient to cough into – again these must be disposed of as clinical waste
- Coughing patients should be segregated from others, where possible, in communal waiting areas

13.0 Patients

Patients (as well as staff and visitors) should be encouraged to minimise potential influenza transmission through good hygiene measures:

- Cover nose and mouth with disposable single use tissue when coughing, sneezing, wiping or blowing the nose
- Dispose of used tissues into a clinical waste bin
- Those who are immobile/in bed will need a receptacle ready at hand for immediate disposal of tissues and a supply of both hand wipes and tissues
- Wash hands after coughing, sneezing, using tissues, or contact with respiratory secretions or contaminated objects
- Keep hands away from eyes and nose
- Certain patients (elderly, children) may need assistance with containment of respiratory secretions

14.0 Linen and Laundry

- Linen should be placed in appropriate receptacles immediately after use and bagged at the point of use and treated as infectious
- Linen bags must be tied and sealed before removal from the influenza patient care room/area
- Gloves and aprons must be worn for handling all contaminated linen and disposed of as infectious
- Hand hygiene must be performed after removing gloves and disposed of as infectious

15.0 Environmental Cleaning and Disinfection

Patients' bedrooms and co-horted areas must be cleaned twice daily by **damp dusting** rather than dry dusting using disposable cloths to avoid generating dust particles.

- Cloths must be changed for every area cleaned
- Freshly prepared combined detergent and chloride based disinfectant at 1000 ppm or a two stage clean followed by second disinfection again using 1000 ppm available chlorine based disinfectant should be used
- Clean less contaminated areas first. Change cleaning solutions and cloths regularly
- The use of vacuum cleaners that do not have hepa filters must be avoided
- Dedicated or single use equipment must be used
- All non-disposable equipment must be washed and dried after use
- Domestic staff must work in specific areas and must not move between influenza and non- influenza wards/areas
- Domestic and other staff will receive training in the appropriate use of PPE before being allowed to work in an influenza area

16.0 Medical Devices

Effective cleaning of medical devices is an essential prerequisite to decontamination.

- Gloves should be worn when handling and transporting used medical devices
- Reusable equipment (eg stethoscopes) must be decontaminated between each patient and evidence of cleaning recorded
- Use of electric fans must be avoided

17.0 Crockery and Utensils

There is no need to use disposable plates and cutlery. However, dishes and eating utensils must be washed in a dishwasher with a hot rinse.

Do not hand wash these items.

18.0 Reception and Waiting Areas

All toys, books, newspapers and magazines must be removed. All soft furnishings should be removed and only easy to clean furniture used.

19.0 Training

The Infection Prevention and Control Team will provide general training to all staff on infection control implications of pandemic influenza through face to face meetings, team meetings and partnership workshops as appropriate.

SECTION VI HUMAN RESOURCES GUIDANCE FOR MANAGERS

1.0 Introduction

1.1 In order to inform their Business Continuity plans, managers are strongly advised to find out how their employees are likely to be affected by a pandemic, e.g. impact on childcare or transport. Other effects will be more difficult to predict, for example, how employees will react to fear, and the impact of family issues and bereavements.

1.2 Managers must ensure that all staff details are kept up to date on ESR. However completion of the Staff Details pro-forma at the end of this section may assist with local planning processes. These should be reviewed and updated regularly and retained locally.

2.0 Steps to reduce and manage staff shortages

2.1 Identifying employees at risk within their service areas

Those employees with regular contact with vulnerable members of the community, (i.e. in adult care and children's services) may be more at risk of contracting the influenza.

Within these groups, any employee who is particularly vulnerable, for example employees with a respiratory condition or heart disease may be seriously at risk if they contract influenza. Some staff may also be concerned about a family member who may be at risk from influenza.

Managers should discuss the implications of contracting influenza with these employees and agree a course of action. The employee may decide to remain in frontline services or may wish to be redeployed during a pandemic.

2.2 Multi skilling of employees to cover critical functions

Managers will need to plan what refresher training may be required to ensure sufficient employees can cover essential services.

Normal training activity will cease during a pandemic and it will be replaced by special short courses to update and reskill staff for essential services.

2.3 Home-working

Managers need to understand how their employees will be affected by schools and nursery closures or reductions in public transport. There may be employees who would be able and willing to work at home, which may enable them to continue to work when they are unable to attend a work location.

Not all jobs can be undertaken from home and home working should only be offered if effective working can continue.

2.4 Redeploying employees to those areas where they are needed

Although employees may currently work from one location, they may be required to work elsewhere to cover staff shortages. Employees with suitable

competencies may also be required to work in different service areas, either within the Trust.

In such circumstances managers should engage with employees in the normal way and redeployments should be reasonable, taking into account both work and personal circumstances. Staff side colleagues will be kept up to date in such situations.

If employees incur additional costs e.g. additional mileage this should be claimed and reimbursed under the usual travel procedures.

2.5 Additional hours, overtime and Working Time Directive

Employees may be requested to work additional hours or overtime to cover other staff shortages. This time may be taken back as time in lieu on a time for time basis, or as payment for the time worked. Payment will be according to the national arrangements.

The Trust does not anticipate employees working more than 48 hours per week but in exceptional circumstances employees will be asked to consider opting out of the Working Time Regulations.

2.6 Cancelling Annual Leave

All annual leave is subject to the manager's approval and is dependent upon the needs of the service. During a pandemic, managers may need to carefully review annual leave requests in order to be able to maintain staffing levels and ensure service delivery in critical areas.

If staffing levels become critical, managers should carefully consider new annual leave approvals and may, as a last resort, need to cancel booked annual leave. In this circumstance managers will discuss the situation with staff to ascertain what flexibility may exist for the member of staff to take to the leave at an alternative time. This will always take place before any decision is taken to cancel booked leave.

Managers will not be able to guarantee any costs that employees incur will be reimbursed, for example for cancelling holidays. In a pandemic it is likely that international travel will be severely disrupted in any case. Cases and individual losses will need to be reviewed after the event.

2.7 Contacting retired or ex-employees

Where there is a shortage of employees with specific professional qualifications, recent leavers may be contacted to enquire about their availability to carry out temporary work.

2.8 Contacting other organisations

Managers of critical services may consider contacting other organisations to discuss and plan for sharing of resources during a time of extreme need.

2.9 Special leave requests

Managers will need to consider how to deal with requests for special or compassionate leave.

The Trust policies on leave for personal and emergency reasons and sick leave will continue to apply during a pandemic. Managers should apply these policies with consistency and sensitivity and may use discretion to authorise arrangements which extend beyond the periods described in the policies. Other options to consider are:

- Use of annual leave, flexi-time or time in lieu
- Unpaid time off, or,
- Alternative working arrangements such as home working or a temporary reduction in hours

HR staff will be available to provide advice to managers on the application of policies during a pandemic.

2.10 Temporary Closure of Work Bases

If a base has to close because of employee shortages or to reduce the spread of infection, then those employees who are well should be redeployed to other work bases.

2.11 Sickness Reporting Arrangements

Initially, staff must report their absence in the normal manner, and via normal channels. Should circumstances, either locally or nationally, dictate a change in reporting arrangements this will be notified.

Manager's nominated person (plus a deputy) to collate sickness information within their designated working areas. Nominated person to email, or ring-in absence report to Trust Tactical Coordinating Group each day.

In an event of a Pandemic announcement, staff should always speak to their GP first who should be recording all information and if after seven days (self-certifying), GPs may be able to post certificates out to their home address.

Employees who show signs of illness whilst at work should be sent home to prevent the spread of infection

Once employees are fit to work they should contact their line manager in the normal way. Employees returning to work after influenza will have immunity and this may be taken into account when deciding where they should work.

2.12 Employee Support

Line managers will be expected to continue to provide the first line support and advice to employees.

For additional welfare support, employees will be informed of the facilities in place

to support them, e.g. the Occupational Health Service or Staff Support Services. The resources of these teams may be very limited at the time of the pandemic. However, ongoing support may be required after the event to help employees deal with personal issues, e.g. bereavement.

Return to work interviews should still be carried out. This will provide useful information for any subsequent wave.

2.13 Refusal to Work

It is recognised that employees will be concerned about their own health during an influenza pandemic and may view coming into the workplace as a potential risk to themselves and their families.

In the event that an employee who is fit and well but who refuses to attend work due to fears about contracting influenza, managers should arrange to discuss the matter with the employee.

If following this discussion the employee still refuses to work, the matter will be dealt with as a conduct issue.

3.0 DBS Protocol

It is possible that at the time of a pandemic the Government may choose to temporarily relax the rules on DBS checks. However, this should not be assumed. The usual rules for posts will apply unless alternative communication is given.

Employees who may have previously worked for the Trust and were DBS cleared would **not** be clear to work in a new role at a later date.

At the time of a pandemic, the operations of the DBS itself are likely to be slowed considerably because of staff shortages.

In this scenario, you should be mindful of ensuring such employees do not come into contact with vulnerable service users or children and that they are supervised until their DBS checks are finalised. Risk assessments should be in place to support this approach.

It is advisable to consider the possible redeployment of those current employees who are already DBS cleared to areas which might be in most urgent need of cover.

The registration of recruits will need to be checked in the normal way and by using the online checking service.

4.0 Flexible Working during Influenza Pandemic

World Health Organisation estimates indicate that an influenza pandemic will occur affecting the United Kingdom, with the evidence suggesting that it will be sooner rather than later.

In the event of an official announcement of an influenza pandemic, the planning assumption is that up to 50% of staff will be absent for a period of the pandemic.

This will be combined with a significant increase in the demand for hospital services. As a result, increased demand combined with potentially decreased supply presents a significant risk to the maintenance of services. Accordingly, it is imperative that the Trust has in place a robust plan to most effectively utilise available manpower.

4.1 Staff already at work

Staff attending for a planned shift/work session will initially report to their normal workplace, unless contacted in advance and asked to report elsewhere. For staff reporting as normal, it may become necessary to re-deploy them elsewhere, once on duty, to assist in supporting clinical/organisational need. In such cases, consideration will be given to the most appropriate method of re-deployment, taking into consideration available skills, experience, etc.

In such instances, and where appropriate consideration has been given to the prevailing circumstances/clinical situation/risk, it is expected that staff will re-deploy.

4.2 Staff rostered to attend work

To aid pre-planning of effective clinical/departmental cover, staff may be contacted in advance of reporting for work and asked to report elsewhere for clinical/organisational reasons. As above, it is expected that staff will re-deploy.

4.3 Shift/work patterns

Command and Control Teams may decide, after assessment of prevailing situations, that shift/work patterns require temporary alteration to meet clinical and/or organisational need.

Therefore, within reason, staff (either on, or in advance of, reporting for duty) may be asked to alter an expected shift/work pattern to accommodate optimum deployment of resources.

For example, it may be decided that shift patterns require temporary adjustment and it is a reasonable expectation that staff will commit to this temporary flexibility to the best of their capability.

4.4 Remote Working

In some instances, where relevant, consideration will be given to for staff to undertake 'remote' working, to minimise potential exposure to the pandemic. Incident management staff will consider the need and appropriateness of this as an alternative, temporary, working pattern managers will facilitate this..

5.0 Appropriate working practices during an Influenza Pandemic

5.1 Non-attendance at work

Potentially, staff may not wish to attend work due to a high level of anxiety about pandemic influenza, resulting in fear of putting themselves or their dependents at risk.

Employees will be contractually obliged to attend work during a pandemic, unless there is a clear and defined health and safety risk, consideration of long term

health conditions will be given in this regard.
It should be stressed that staff who are not dealing directly with symptomatic patients are not at high risk.

In extreme circumstances, discussion may take place between employee and line manager/supervisor to make reasonable adjustments to work area on a temporary basis.
It is the case that the professional codes that apply to many NHS staff also make clear that staff have an obligation to provide care to those in need.

NHS terms and conditions of service will remain in place and it is not intended to use powers to alter employment legislation. The operation of human resources policies may need to be reviewed in the light of the pressure on the service.

In an instance where an employee categorically refuses to attend work, when rostered to do so, then appropriate action, including possible suspension of pay, will result. On return to work, the employee will be interviewed by their line manager / supervisor and further action may be taken.

6.0 Sickness Absence during Influenza Pandemic

6.1 Staff already at work

Staff attending for a planned shift/work session who develop symptoms indicative of having contracted pandemic influenza should report this to the appropriate line manager /supervisor and should then leave work immediately and not return until their symptoms have subsided.

Adherence to the Trust sickness reporting protocols during the period of illness will be an expectation to assist in forward planning of workforce availability.

6.2 Staff rostered to attend work

Staff who develop symptoms indicative of contraction of pandemic 'flu should **not** report for work but should, at the earliest possible opportunity, report their non-attendance to their relevant line manager.

6.3 Return to work

Staff should be allowed time to recuperate and where necessary, a reasonable phased return incorporated, balancing service needs against staff availability

6.4 Trust's Supporting Attendance Procedure

It is imperative that, during the occurrences outlined above, the Trust policy is followed, especially correct reporting procedures, following clear reporting lines to aid the most effective management of the situation.

EMPLOYEE CONTACT DETAILS PRO FORMA (Or use ESR System)

Emergency Planning Pro-Forma: Personal Contact Details					
Name: (Dr/Mr/Mrs/Miss/Ms):					
Address:					
Home Phone No.:			Mobile Phone No.:		
Next of Kin Details:					
Travel and Flexibility:					
Distance to work:			Would you be available to work at short notice?		
Usual method of transport:					
	Car				
	Public Trans.				
	Medilink		Do you have Carer Commitments (If yes, please outline notice required to re-arrange)		
	Bicycle				
	Walking				
	Car Share				
	Other				
Directorate			**Department**		
Area of Work:				Campus	
Job Title:				Extension:	
Managers Name:		Managers Job Title:			Extn.:
FT/PT	Hours of Work:		Days Worked:		
Pattern of Work:			Proposed Annual Leave:		
CRB Check Y/N	Level:				
Specialist Knowledge and Skills useful in Emergency Conditions:					
Specialist Training?		Relevant or recent specialist training in specialism other than current work area:			
Speaker of language other than English, if so which?					
Any other skills, please outline, e.g. lay preacher/advanced driving skills					

Manager's Signature…….. Date…….

SECTION VII – APPENDICES

APPENDIX 1 – Mental Health & Learning Disabilities Service User Prioritisation Levels

The following criteria have been devised to prioritise service users during a pandemic and are similar to the Level 1, 2 and 3 criteria developed for use by healthcare workers during an incident	
Level 1: Highest priority	At active risk of suicide and self-harm
	Following risk assessment to have risk indicators of a serious and current concern: intimidation, aggression or disinhibition
	Self-neglect to the degree it is currently endangering physical health
	Disorientated to the degree that they are not consistently aware of Time, Person or Place
	Uncommunicative to the degree that further assessment is not possible
	Sudden change in behaviours or presentation with associated risk
	Suspected use of or appears to be under the influence of alcohol or illicit drugs
	A change in physical presentation that required regular observation monitoring – e.g. weekly BP or a newly found heart problem
	Individuals unable to attend recreational or work activities
Level 2: Moderate priority	Risk of suicide or self-harm, requiring further assessment
	Previous risk assessment identified risk indicators which are/may be active but require current monitoring and further assessment
	Self-neglect to the degree which is not endangering physical health
	Some evidence of distortion
	Communicative but not to the degree as would be expected of the individual
	Sudden change in behaviours with no apparent associated risk
	Individual attending recreational and work activities with some support
Level 3: Low priority	No current evidence of risk of suicide or self-harm
	Previous risk indicators identified but no longer considered by the MDT to be an active risk. No evidence of risk indicators
	No current evidence of self-neglect, disorientation – is communicative
	Individual attending recreational and work activities without support

APPENDIX 2: Patient Prioritisation Criteria in Community Health Services

In the initial stages of the pandemic, all services will assess their patients with a view to increasing discharges and prioritising patient who will continue to require care during a pandemic. These can be categorised using the following criteria:

Level	Criteria	Patient Examples
Level 1: Highest Priority	The patient in this priority level needs uninterrupted services. The patient's condition is highly unstable, and deterioration or inpatient admission is highly probably if the individual is not seen. In case of a pandemic, every possible effort must be made for the patient to receive care	A patient who is bed bound, paralysed, ventilator-dependent or unable to meet physiologic and safety needs
		A patient who need extensive wound care
		A infusion therapy patient who requires daily visits
		A psychiatric patient unable to self-administer medications
		A cognitively impaired patient with urgent safety issues
		A functionally impaired patient requiring daily assistance to meet physical and nutritional
		A patient who requires urgent care
Level 2: Moderate Priority	The patient in this priority level may have a recent exacerbation of a disease process. The patient requires a moderate level of skilled care, meaning that care should be provided but may be able to be delayed during the peak weeks of the pandemic or at times of severe staff shortages. The patient may have essential untrained family/ care-givers not prepared to provide the needed care	A patient who uses equipment as needed (PRN), i.e. oxygen, suctioning, nebulisation, patient-controlled analgesia pump
		A diabetic who self-administers insulin and requires skilled monitoring of blood glucose less than every 24 hours
		A patient who has extensive wound care needs with support/back-up assistance
		A patient with multiple mediation changes in the past 1-2 weeks
		A patient who requires medication prefills
		A patient who requires custodial care who could not otherwise be managed
Level 3: Low Priority	The patient in this priority level can safely forgo care or a scheduled visit without a high probability of harm or deleterious effects. The patient is able to manage alone for several days or longer, or may have significant others or available support systems in place	A patient who is mobile and independent in functioning
		A patient needing uncomplicated routine wound care
		A patient who self-manages medications/diet
		A patient who is a low safety risk

Note: In the patient classification system guide, the examples in the priority levels are not listed in any rank order. It is also suggested that a patient may be classified as Level 1 owing to specific circumstances and care needs at one point in time, and may be changed to a different classification at another time as circumstances and care needs change. Time frames for patient visits with the priority levels are purposely not recommended, recognising that numerous factors may affect each agency's ability to respond, including the time, type and location of the disaster, the available personnel and the care requirements of the patient

APPENDIX 3 DATER Action Cards:

Detection Phase: Alert of Potential Pandemic or Epidemic

KEY ACTIONS • Increase vigilance for signs and symptoms of influenza • Implement training programme for staff on basic medical care and influenza assessment criteria • Establish communications methods and circulate key methods • Implement procedures for dealing with initial cases of infected service users • Review pre-pandemic vaccination arrangements and identify eligible staff and services users • Agree Trust representation at LRF meetings and relevant forums	
In the event of human to human transmission of an influenza virus determined by the World Health Organisation to cause an influenza-related Public Health Emergency of International Concern (PHEIC), the Department of Health will alert healthcare organisation to implement the Detection Phase for a potential pandemic or epidemic. **The Strategic Coordinating Group Lead will:**	
Follow guidance issued by PHE/NHS England	
Convene the first meeting of the Trust Pandemic Influenza Strategic Coordinating Group and agree meeting frequency and communication methods	
Allocate staff to multi agency Pandemic Flu Group (if/when established)	
Check case definition and epidemiology, identify at risk service users	
Activate increased surveillance for influenza (as directed by PHE/DH)	
Alert HR/General managers to monitor sickness absence reporting	
Ensure all Directorates review business continuity plans and ensure essential services are resilient	
Review pre-pandemic vaccine availability and identify suitable recipients	
Review Personnel Protective Equipment (PPE) distribution system and deliver to community based staff where necessary	
Set up infection control measures and use of PPE where necessary, circulate latest infection control guidance	
Review antiviral storage and distribution arrangements	
Review communications methods for testing receipt of key messages to staff, service users, subcontractors, local organisations etc.	
Confirm local communication messages regarding changes to services	
Review provision of information and support for cares and vulnerable people	
Regularly brief Exec Team especially Executive Director on call of current situation	
Review admission criteria and transport for suspected influenza cases	
Implement training and exercising programme for staff	
Review volunteer and recently retired staff lists, implement training programme	

Assessment Phase: New Virus Isolated in the UK

KEY ACTIONS • Implement record keeping and surveillance for suspected and confirmed cases • Implement increased infection control procedures and distribute personal protective equipment (PPE) • Implement support procedures for staff and service users • Review surge capacity and business continuity measures • Increase awareness of pandemic influenza signs, symptoms and epidemiology	
Once the virus has been isolated in the UK, primary care services will be at the forefront of dealing with suspected case. Clear communication at all levels will be essential to minimise disruption to local services. **The Trust Strategic Coordinating Group Team will:**	
Follow guidance issued by PHE/NHS England	
Ensure the Trust is represented at LRF and Health response groups	
Set up SitReps (situation reports) including the number of infected service users and staff	
Enhance surveillance and/or data collection to reflect NHS England data requests	
Request feedback from staff regarding general service user enquiries regarding influenza and concerns about accessing care (share with NHS England and Clinical Commissioning Groups)	
Review sickness absence levels	
Review essential services and allocated seconded/volunteer staff	
Review use of infection control procedures and PPE within services. Introduce stock control if necessary	
Review current cases and accelerate discharges if appropriate	
Ensure community staff are discussing potential alternative care with regular service users	
Review admission and discharge arrangements with Acute trusts	
Review changes to primary care arrangements	
Ensure communication updates are issued regarding changes to services	
Inform carers and vulnerable groups of any special arrangements or support	
Continue training programme for staff including basic medical care	
Review provision of information and support for cares and vulnerable people	
Ensure sub-contractors and commissioned services are putting their response plans in place	
Review volunteer and recently retired staff lists and training requirements	
Review pandemic plans in light of current epidemiological information	
Agree rota for staff on Trust Pandemic Influenza Management Team	

Treatment Phase: Outbreaks in the UK

KEY ACTIONS • Communication • Staff Welfare • Surge Demand – continuous assessment of capacity • Business continuity – provision of non-influenza services • Resource for services users in the community and inpatient facilities	
In the first few weeks if the pandemic, local services may be inundated with enquiries and it is extremely likely that any outbreaks will affect Trust services very quickly. The implementation of measures such as distribution of antiviral medication and provision of PPE will require careful consideration at this stage. **The Trust Strategic Coordinating Group will:**	
Follow guidance issued by PHE/NHS England	
Review Trust attendance and LRF and Health response groups	
Review SitReps (situation reports) including number of infected services users and staff	
Review surveillance and/or data collection to reflect NHS England data requests	
Review use of infection control procedures and PPE within services. Review stock control provisions and order additional stock if required.	
Review sickness absence levels	
Monitor provision of services and review trigger points for reduction	
Review guidance on PPE and use of masks	
Review national guidelines on antivirals	
Review current cases and advise changes to admission criteria if necessary	
Review ability of service users to access primary care services (National Pandemic Flu Service, antiviral collection points) and implement alternative arrangements if necessary	
Review admission and discharge arrangements with Acute trusts	
Review changes to primary and secondary care arrangements and update staff	
Ensure communication updates are issued regarding changes to services	
Review changes to voluntary service provision which may impact on services	
Review training programme and provide additional events for staff if necessary	
Review sub-contracted and supplied services, including catering and cleaning	
Agree frequency of meetings and attendance for the next three weeks	
Review pandemic plans in light of current information and public reaction	

Escalation Phase: Widespread Activity

KEY ACTIONS • Communication • Staff Welfare and Resources • Surge Demand – continuous assessment of capacity • Business continuity and resources for non-influenza service users • Resource for secondary care services service users in the community • Mental health including bereavement services, increase in mortality rate	
The peak weeks will have the heaviest impact on services and data collection to record key indicators is essential to be able to allocate essential resources during this time. **The Trust Strategic Coordinating Group will:**	
Follow guidance issued by PHE/NHS England	
Notify the Care Quality Commission (CQC) via the National Patient Safety Agency (NPSA) via Ulysses when the operation of safe services is affected by staff absence	
Regularly report situation to Executive Leadership Team	
Establish daily briefing bulletin including number of cases and mortality rate	
Review data collection and surveillance requirements during peak period	
Review mental health professional availability and impact on treatment, admission, discharge and legal position	
Confirm arrangements for judicial hearings during peak weeks	
Review staff absence rates and ability to resource essential services	
Review the implication of changes in duties for redeployed staff	
Review use of PPE (if available) and stock control provisions (record level of use during peak weeks for use during next wave)	
Communicate latest medical and self-care information to staff for service users	
Agree admission and discharge protocols for Acute trusts during peak weeks	
Determine the level of care to be provided in the community for service users in relation to staffing and resource availability	
Ensure regular communication updates are issued	
Review any reduced service policies agreed with subcontractors	
Review policy on visitors to inpatient facilities during peak of pandemic	
Assess availability of medicines and essential resources	
Ensure deputies are appointed to all key roles in case of illness/absence	

Post Peak Pandemic Recovery Period

KEY ACTIONS • Communication • Staff Welfare and Resources • Reducing influenza specific services • Re-establish core services and assessing continuing health needs • Post pandemic vaccination strategy	
Once the numbers of cases of new influenza infections have been confirmed as reducing on a weekly basis, it will be important to manage the re-implementation of services based on the availability of staff and resources and the impact the Pandemic has had on the local population who may access these services. **The Trust Strategic Coordinating Group will:**	
Follow guidance issued by PHE/NHS England	
Prepare a debrief report for the Trust Board of Directors and Trustwide Infection Control and Prevention Committee	
Reduce the frequency of briefing bulletin as appropriate	
Review absence levels and allocate additional compassionate leave where appropriate	
Review surveillance data collection methods for use in the next wave	
Review availability of services and implement recovery strategy	
Review availability of subcontracted services and suppliers	
Reduce rotas and duties (where necessary) for seconded/volunteer staff	
Ensure PPE (if available) is used to minimise the risk of infection (virus will still be circulating although the numbers of new cases is reducing)	
Review effectiveness of local communication methods and information	
Review admission protocols for Acute Trusts and reintroduction of services	
Review the level of care provided in the community and transfer individuals to appropriate inpatient care (where available)	
Assess caseloads and redeploy staff and resources where necessary to relieve short term pressures	
Ensure regular communication updates are issued regarding changes to services post-pandemic vaccination availability etc	
Review policy on visitors to in-patient facilities during peak of pandemic	
Agree stand down of Divisional Influenza Pandemic Outbreak Control Teams	

Next Pandemic Wave Planning

KEY ACTIONS • Communication • Using lessons learned to plan an effective local response • Staff welfare and resources • Working without stockpiles of antiviral medication and PPE Preparing for a higher illness, compilation and mortality rate	
Past experience of pandemics suggests that a second, and possibly further, wave of illness caused by an influenza virus are possible after the first wave has subsided. The second wave may be as, or more, intense than the first. If the second wave occurs before more stockpiling takes place, the local response will need to be adapted to reflect this. The **Trust Strategic Coordinating Group will:**	
Prepare a report listing key issued for the Executive Management and recommendations	
Set up a formal debrief procedure for staff to reflect their experience during the pandemic and use lessons learned to develop services and training material for the next wave	
Review non-influenza essential services provided during the pandemic	
Analyse the surveillance and data collection methods, including the use of date used to plan services and resources with a view to producing an efficient method of data collection and representation for use during the next wave for use in the next wave	
Set up a system to allow staff, service users and carers to discuss their experiences during the pandemic with a view to planning for the next wave	
Review the use of seconded and volunteer staff	
Review infection control information based on experience of using PPE during the pandemic	
Review the effectiveness of local communication methods and information	
Agree changes in service provision with subcontractors in for the next wave	
Assess requirements for future stockpiling of PPE and antivirals	

APPENDIX 4: PATIENTS AT RISK

The Trust's Community Teams need to identify patients in their areas who will be 'at risk' should there be disruptions to their services. These individuals will either need a home visit or a telephone call to check on their wellbeing.

If staff are in short supply, then home visits should be limited to those patients where there is critical need.

Careful co-ordination will be required between Health and Social Care teams to ensure that the appropriate organisations are aware of individuals at risk and are, therefore, in a position to discharge their responsibilities accordingly. Where possible, health and Social Care teams should share transport arrangements to avoid unnecessary duplication.

Lists need to be drawn up by all Community Teams of those individuals who have been assessed as not in 'Critical Need' and therefore not receiving a home visit so they can be contacted by telephone.

To ensure these individuals are still monitored, a Directorate 'call centre' (either physically in a Trust Premise of via Trust mobile phones) should be set up so suitably qualified staff can phone the 'at risk' people on the list.

An example of the type of table to be used for these lists can be found below. All the data requested, including contact details for the individuals, must be provided to allow those staff in the Call Centre to contact the individuals and arrange follow up as required. It will be up to Community Teams to identify those patients who fall into the above criteria who are not going to be visited by the team if they have staff shortages

Example of Spreadsheet: 'At Risk patients not due to be visited – (Team Name)

Surname	First Name	DoB	Address	Phone

APPENDIX 5: INFLUENZA PANDEMIC SITREP: Inpatient Unit Report

Facility Name				
Main Contact details:	Tel:		Email:	
Date:			Time:	
No of Beds:			No of beds in use	
No of Flu Cases			No of recovered cases	
No of Deaths			No of non-infected	
Total service Users			No of beds available	
No and type of beds available for new admissions				

Daily Situation Report	
No of staff required (state grade/role or	
Staff available for	
Estate issues	
Resources required	
Communication Messages	
Information required	
Other	
Signed (Print Name):	

APPENDIX 6: INFLUENZA PANDEMIC SITREP: Directorate Situation Report (non-residential services)

Directorate				
Main Contact details:	Tel:		Email:	
Date:			Time:	
Changes to services:				

Daily Situation Report	
No of staff required (state grade/role or	
Staff available for	
Estate issues	
Resources required	
Communication Messages	
Information required	
Other	
Signed (Print Name):	

APPENDIX 7 GLOSSARY

A/H5N1	Highly pathogenic avian influenza virus, endemic in birds in South East Asia
Antiviral Medicines	Type of medicines used to treat viral infections such as influenza
Asymptomatic	Infected but not showing symptoms
Avian	Pertaining to birds
Clinical attack rate (Attack rate)	The cumulative proportion of people infected and showing symptoms over a specified period of time
Cohorting	Services users affected by the same illness are grouped together and cared for by nominated staff
Containment	Measures to limit the spread of infection from an affected area(s)
Countermeasures	Interventions that attempt to prevent, control or treat an illness or condition
DATER	The 5 phase model on which UK Pandemic planning is based
Epidemic	The widespread occurrence of significantly more cases of a disease in a community or population than expected over a
Epidemiological models	Mathematical simulations of the spread of a disease and the likely effectiveness of countermeasures
Epidemiology	The study of the patterns, causes and control of disease in groups of people
Hand hygiene	Thorough, regular hand washing with liquid soap and water, or the use of alcoholic based products containing an emollient that do not require the use of water to remove dirt and germs at critical times, e.g. after touching potentially infected people/objects and before touching others or eating
Incubation period	The period from entry of infection to the appearance of first symptoms
Influenza	A common acute viral infection predominantly occurring in winter. Highly contagious, the flu is passed on by breathing in droplets from the breath of infected people. Symptoms include sudden onset of fever and cough with or without sore throat or other respiratory symptoms
Isolation	Separation of individuals infected with a communicable disease from those who are not for the period they are likely to be infectious in order to prevent further spread
Green Book	The Green Book has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious
Outbreak	Sudden appearance of, or increase in, cases of a disease in a specific geographical are or population eg in a village, town or closed institution
Pandemic	Worldwide epidemic – an influenza pandemic occurs when a new strain of influenza virus emerges which causes human illness and is able to spread rapidly within and between countries because people have little or no immunity to it

Personal Protective Equipment (PPE)	When dealing with confirmed cases, if possible, this should be a correctly fitted FP3 respirator, gown, gloves and eye protection. If not available, a surgical mask, disposable apron and gloves. Eye protection may be considered if the likelihood of splash exists
Prophylaxis	Administration of a medicine to prevent disease or a process that can lead to disease – with respect to pandemic influenza this usually refers to the administration of antiviral medicines to healthy individuals to prevent influenza
Surge capacity	The ability to expand provision beyond normal capacity to meet transient increases in demand, eg to provide care or services above usual capacity, or to expand manufacturing capacity to meet increased demand
Symptomatic	Showing symptoms of disease or illness
Transmission	Any mechanism by which an infectious agent is spread from a source or reservoir (including another person) to a person
Vaccination	To protect a person or animal against a disease by putting a substance into their body that makes them produce antibodies (= proteins in the blood that fight disease)
Virus	A virus is a small infectious agent that replicates only inside the living cells of other organisms
Virulence	The degree to which a micro-organism is able to cause serious disease
Wave	The period during which an outbreak or epidemic occurs either within a community or aggregated across a larger geographical area. The disease wave includes the time during which the disease occurrence increases, peaks and declines towards baseline
WHO	World Health Organisation

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