Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Pandemic Influenza Plan

Status: Approved

Document Type: Guidance

Contents

1. Purpose

This plan provides a framework for TEWV NHS Foundation Trust to ensure they can ensure an effective response to an influenza pandemic. If a pandemic is imminent the internal emergency arrangements including the Emergency Control Room may also need to be invoked.

2. Related documents

- Internal Emergency Plan
- External Major Incident Plan
- Business Continuity Policy.
- Pandemic Influenza Operational Plan, Public Health England working draft July 2013.
- The UK Influenza Pandemic Preparedness Strategy 2011 and Health and Social Care Influenza Pandemic Preparedness and Response 2012 need hyperlink

Documents are also available on the policies and procedures section of the external website.

3. Background

Definition of an Influenza Pandemic

A pandemic of influenza results when a new influenza virus emerges which is markedly different from recently circulating strains and is able to:

- infect people (rather than, or in addition to, other mammals or birds);
- spread readily from person to person;
- cause illness in a high proportion of the people infected, and also;
- spread widely, because most people will have little or no immunity to the new virus.

A pandemic exists when the new virus has been confirmed to cause clinical illness at epidemic levels in more than one country. It is impossible to predict when this will occur; there could be varying levels of warning that a pandemic has started worldwide, there could be some outbreaks locally in the UK or none at all when a pandemic starts. Previous pandemics suggest that there will be more than one epidemic wave. Local organisations would not invoke any plans without the direct briefing from their Command and Control Lead.

World Health Organisation (WHO)

The table below shows the definitions of the phases of an Influenza Pandemic as currently defined by the World Health Organisation (WHO) Levels and definitions.

WHO International Phase	WHO Level
Inter Pandemic Period	
No new influenza virus sub-types detected in humans	1
Animal influenza sub-type poses substantial risk	2
Pandemic Alert Period	
Human infection(s) with a new subtype but no (or rare) person-to-person spread to a close contact	3
Small cluster(s) with limited person-to-person transmission but spread is highly localised, suggesting that the virus is not well adapted to humans	4
Large cluster(s) but person-to-person spread is still localised, suggesting that the virus is becoming increasingly better adapted to humans	5
Pandemic Preparedness Period	
Large cluster(s) but person-to-person spread is still localised, suggesting that the virus is becoming increasingly better adapted to humans	5
Pandemic Period	
Increased and sustained transmission in general population	6

4. UK Response Phases

The World Health Organisation (WHO) is responsible for identifying and declaring influenza pandemics. However, as one of the first affected counties in 2009, the UK was well into the first wave of infection when WHO declared Phase 6. The use of WHO phases to trigger different stages of the local response proved confusing and unhelpful and it was therefore decided that a more flexible approach was needed for the UK.

The UK *Influenza Pandemic Preparedness Strategy 2011 and Health and Social Care Influenza Pandemic Preparedness and Response 2012* details the planning, response and recovery for all severities of pandemic influenza.

The new UK 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. There will also be variation in the status of different parts of the country reflecting local attack rates, circumstances and resources.

Detection

Triggered by the declaration of WHO phase 4 or on the basis of reliable intelligence or if an influenza related Public Health Emergency of International Concern (PHEIC) is declared by the WHO. The focus in this stage, led nationally by Department of Health/Public Health England (DH/PHE), would be:

- 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 phase would be the identification of the novel influenza virus in patients in the UK.

Assessment

The focus in this phase, led by DH/PHE, would be:

- 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
    - Voluntary self-isolation of cases and suspected cases
    - Treatment of cases/suspected cases and use of antiviral prophylaxis for close/vulnerable contacts, bases 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, ie cases not linked to any known or previously identified cases.

The two phases – *Detection and Assessment* – together form the initial response. This stage 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 new pandemic, to attempt to do so would waste scarce public health resources and capacity.

Treatment

The focus in this stage would be:

- Treatment of individual cases and population treatment, if necessary using the National Pandemic Flu Service (NPFS).
- Enhancement of the health response to deal with increasing numbers of cases.
- To consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localized 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 nationally to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalized 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 regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity.

Escalation

The focus in this stage would be:

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

These two phases – *Treatment and Escalation* – form the *Treatment* component of the pandemic. Whilst escalation measures may not be needed in mild pandemics, it would be prudent to prepare for the implementation of the Escalation phase at an early stage.

Recovery

The focus in this stage would be:

- Normalisation of services, perhaps 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 operations.
- 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 a resurgence of influenza, including activities carried out in the Detection phase.
- Continuing to consider targeted vaccination, when available.
- Preparing 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 service capacities are able to meet demand will also inform this decision.

The uncertainties in any pandemic mean that the actual characteristics of the pandemic may be different from the planning assumptions, and that planned actions may need to be modified to take account of changing circumstances.

4.1. Command and Control

Command and control arrangements will be determined by the progress of the pandemic and its impact. There may be a linear progression with escalation over time from outbreak control team to NHS Strategic (Flu) Command (advised by a Health Advice Cell) to full multi-agency response, or escalation may not occur or may occur more rapidly.

4.2. Outbreak Control Team (OCT)

At some point during the detection and assessment phase, the North East PHE Centre Director/Local Director of Health Protection will call an outbreak control team. Learning from the 2009 pandemic suggests this should be at the point of the first detection of the novel virus in the UK, if not sooner. This information will be available in HPA Guidance.

4.3. NHS Command and Control

NHS 'Flu Incident Management Team (NHS England Area Teams)

Depending on the pattern of the pandemic, each area team will establish an Incident Management Team (IMT) at an early stage. This will act as NHS tactical command, establishing an incident control centre (flu room) if indicated. This may be mandated nationally.

This internal group is convened by the Incident (Flu) Manager as directed by the Incident (Flu) Director. The primary functions of an IMT as described in the Incident Response Plans are to collate information regarding the operational/tactical response across the NHS and partner agencies.

NHS Strategic (Flu) Command Group

If the pandemic progresses to a medium or high impact scenario the Area Teams may have to operate in a NHS strategic co-ordination role and co-ordinate the NHS commissioned and provided resources in the area. System level decisions may need to be made in relation to operational NHS capacity and prioritization of other NHS care.

In this situation, one Area Team will take the lead and the NHS Strategic (Flu) Command will cover the north east. At his point the OCT will hand over to NHS Strategic (Flu) Command. The scientific/technical experts from PHE will form the Health Advice Cell (HAC), the chair (and as needed other specified members) of which will attend NHS Strategic (Flu) Command Group.

Members to include:

- Director level representation from North East and Cumbria commissioning Support Unit

The **Health Advice Cell (HAC)** will be the single point of scientific advice to the NHS Strategic (Flu) Command Group. The HAC will be chaired by North East PHE Centre Director/Local Director of Health Protection/PHE pandemic influenza lead. It will include the relevant PHE staff and co-opted NHS clinical experts, likely to include consultants in infectious diseases, child health, respiratory medicine, A&E and General Practice and pharmacist advice.

The **Vaccination Cell** will be established by the OCT or the NHS Strategic (Flu) Command Group. Its role is described in the Area Teams/PHE Mass Vaccination Operational Plan.

The **Network Critical Care Control Group** is established in response to triggers outlined in the North of England Critical Care Network Adult Critical Care Escalation Plan and the North of England Critical Care Network Paediatric Critical Care Escalation Plan.

Antiviral distribution procedures will be developed by each Area Team.

4.4. Multi-agency Command and Control

The multiagency pandemic plans produced prior to the 2009 pandemic [influenza A (H1N1)pdm09] were based on high disease impact scenarios and therefore assumed the establishment of multi-agency strategic co-ordinating groups (SCGs) in the three Police areas. In the event, the disease severity was low with relatively little impact on other agencies. Full multi-agency command and control structures were therefore not established.

If multi-agency command structures are implemented then the NHS Strategic (Flu) Commander (as NHS Gold) will attend/identify member(s) of the NHS Strategic (Flu) Command Group to attend the SCGs. If a multi-agency Tactical Co-ordination Group is established then appropriate representation will be agreed by the NHS Strategic (flu) Commander.

The HAC will expand membership to become a STAC which will be the single point of scientific advice to the NHS Command Group and the SCG(s).

In the high impact pandemic situation, joint multi-agency working across the three LRF areas will be essential and consideration should be given by the Police Services to a single SCG and who should chair this. In certain pandemic scenarios, the Police/other agencies may request the NHS to chair the SCG(s).

TEWV Response to a Pandemic

The Trust will be guided by the DH and PHE and Area Team and will link with the local area team to co-ordinate a response to the pandemic. A designated Director will be responsible for the Command and Control within the organization and a Pandemic Influenza Control Team (PICT) will be established to manage operational issues. Membership of this group would be:

- Designated Director
- IPC representative
- HR representative
- Communications representative
- Administrative representative
- Pharmacy representative
- Emergency Planning representative
- Other representatives as required

It is assumed that the members of this group would be those already members of the Trust:

- Emergency Planning and Business Continuity Group

5. Pharmacy and Medicines Management

The Trust's Pharmacy Team will invoke their own business continuity plans in the event of an impending pandemic.

6. Plan for obtaining antiviral medicines for inpatients in Durham, Darlington, Tees, Scarborough and Ryedale Localities out of normal working hours – Treatment Phase

First Steps	Medication needs will be based on clinical diagnosis of flu based on clinical symptoms. Medication must be prescribed on the drug prescription and administration chart. All cases needing treatment must be notified in the first instance to the 1st On-Call by the ward. The 1st On-Call will then contact the On-Call Pharmacist and inform second on call. The second on call will inform the Director On-Call. On-call Pharmacist - 07787 105 800 The on-call Pharmacist will then arrange for the ward to access a supply from the emergency cupboard.

Alternate Resources

The following table lists the resources that will be used during continuity operation of the service

Resource	Quantity	Location	Contact
Oseltamivir 75mg	2 x 10	Mediwell, Roseberry Park Hospital	On-Call pharmacist
Oseltamivir 30mg	2 x 10	Mediwell, Roseberry Park Hospital	On-Call pharmacist
Oseltamivir 75mg	2 x 10	Emergency Cupboard West Park	On-Call pharmacist
Oseltamivir 75mg	2 x 10	Mediwell, Lanchester Road Hospital	On-Call pharmacist
Oseltamivir 75mg	2 x 10	Emergency Cupboard, Cross Lane Hospital	On-Call pharmacist
Zanamivir (Relenza®)	1 pack	Mediwell, Roseberry Park Hospital	On-Call pharmacist
Zanamivir (Relenza®)	1 pack	Emergency Cupboard West Park	On-Call pharmacist
Zanamivir (Relenza®)	1 pack	Mediwell, Lanchester Road Hospital	On-Call pharmacist
Zanamivir (Relenza®)	1 pack	Emergency Cupboard, Cross Lane Hospital	On-Call pharmacist
HPA website (www.hpa.org.uk) for up to date information			
HPA tel: 0191 221 2584			
Roseberry Park reception 01642 837300, West Park reception 01325 552000			
Lanchester Road reception 0191 441 5700			
On-call Pharmacist - 07787 105 800			

Preparing for Continuity

- Locate the action card

Continuity Procedures

- Follow the instruction on the appropriate action card

Recovery

Plan for obtaining antiviral medicines for inpatients in Hambleton, Richmond and Harrogate localities out of normal working hours – Treatment Phase

<table>
<tr><td>First Steps</td><td>Medication needs will be based on clinical diagnosis of flu based on clinical symptoms. Medication must be prescribed on the drug prescription and administration chart.

All cases needing treatment must be notified in the first instance to the 1st On-Call by the ward. The 1st On-Call will then contact the Acute Trust Emergency Duty Pharmacist and inform the second on call. The second on call will inform the Director On-Call. To contact the Emergency Duty Pharmacist call The Friarage switchboard– 01609 779911 or Harrogate District Hospital switchboard - 01423 885959 and request the Emergency Duty Pharmacist

The Emergency Duty Pharmacist will then arrange for a supply to be issued to the ward.</td></tr>
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<tr><td colspan="3">HPA website (www.hpa.org.uk) for up to date information</td></tr>
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<tr><td colspan="3">The Friarage switchboard– 01609 779911</td></tr>
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<tr><td>Continuity Procedures</td><td>• Follow the instruction on the appropriate action card</td></tr>
<tr><td>Recovery</td><td></td></tr>
</table>

7. Legislative Framework

Trust services are delivered within a number of legislative frameworks, that impact directly on the care processes delivered. These primarily include: the Mental Health Act, the Mental Capacity Act, Safeguarding Adults and Safeguarding Children.

During a pandemic outbreak the administration of all of those processes may be significantly reduced or indeed cease.

The Mental Health Act team and Services will invoke their own business continuity plans in the event of a pandemic.

8. Recovery Planning

As the impact of the pandemic wave subsides and it is considered that there is no threat of further waves occurring the UK will move into the recovery phase. Although the objective is to return to pre-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisation fatigue and continuing supply difficulties in most organisations. A gradual return to normality therefore should be anticipated and expectations shaped accordingly. Plans at all levels should recognise the potential need to prioritise the restoration of services and to phase the return to normality in a managed and sustainable way.

The reintroduction of performance targets and normal care standards also need to recognise the loss of skilled staff and their experience. Most others will have been working under acute pressure for prolonged periods and are likely to require rest and continuing support. Facilities and essential supplies may also be depleted, re-supply difficulties might persist and critical physical assets are likely to be in need of backlog maintenance, refurbishment or replacement. (North East SHA 2008)

9. Action Cards for Command and Control

Action cards for the invokation of the Business Continuity Plan are in all of the ECR rooms and the following action plans have been developed specifically for pandemic influenza. Copies of this plan and the action cards will be kept in each ECR room.

The following action cards provide easy-to-follow instructions for members of the Pandemic Influenza Command and Control Team. As the Pandemic Influenza Plan is maintained and revised, additional cards may be added to this section, as well as updates to existing cards.

Action Card
Command and Control Team Leader

WHO Level 4
Continue with implementation and testing programme.
Engage with LAT/LHRP and EP networks and processes
Monthly update with PIP Core team or deputies
Arrange ongoing training and Development of Loggists
Maintain communications plans
Review and place on standby PICT members
All LATs/LHRP/NHS contact details to be checked and updated monthly at Appendix 6.
WHO Level 5
Take Category 3 position in Gold Command Structure
Establish regular liaison with LHRP/LATs PI systems –attending communication/;liaison/planning sessions as required.
Invoke plans at appropriate levels in response to Gold Command instructions
Initiate internal and external reporting at appropriate level to alert level Author sit-rep and ops communications Author Board of Directors Papers Disseminate external briefing as required
Initiate and implement communication and awareness raising systems
Initiate and implement training plans
Initiate and implement recording and advisory contact systems
Commission ECR and alternative CR room as required.
Ensure library systems implemented of communications and briefings

Action Card Communications Lead including External Agency Communications
WHO Level 4
1. Maintain contact and engage with HPE/LATs Comms teams
2. Set up Intranet pages
3 Set up internal communication systems in readiness for use
4. Research available information and awareness materials
5. Ensure media training attended by key staff in internal Command and Control structure
WHO Level 5-6
1. Invoke communication plans appropriate to alert level
2. Ensure internal and external reporting systems in place as required
3. Deal with media inquires ands press releases
4. Disseminate press releases and briefings through Gold Command structure

Action Card IPC Lead
WHO Level 4
Development and review of all training , demonstration and coaching packages for emergency clinical procedures
WHO Level 5-6
As above
Implement plans as appropriate to alert levels
Implement routine intelligence scanning

Action Card
Human Resources Lead

WHO Level 4
Maintenance of robust ESR processes and data accuracy
Liaise with bank administrators regarding capacity of bank to support services
Develop and agree plans for validation of information held and undertake validation exercise as required.
Develop training schedules and plans for rollout of training.
Undertake assessment of staff working in non-clinical environment that may be deployed to support critical clinical services.
Regular briefings to staff side representative body.
Agree plan for capturing staff attendance and mechanism for feeding through sitrep reports.
Review/refresh all emergency HR procedures
WHO Level 5
Validation of essential staffing information if not already commenced.
Agree plan for suspending all non-essential HR related activities.
Implement emergency reporting of staff absence and sitrep reporting procedures.
Issue Occupational Health briefings
Maintenance of regular briefings to staff side representatives.
Roll out training as identified in training schedules.
Develop plan for implementation of redeployment of staff working in non-clinical areas.
WHO Level 6
Continue to track staff attendance and daily sitrep reports
Invoke emergency redeployment measures
Continue regular briefings to staff side representatives
Ensure appropriate access to Occupational Health briefings and services

Action Card
EP/EFM lead

WHO Level 4
1. Development and review of all emergency procedures and systems
2. Ensure logistics and procurement plans in place
3. Work with suppliers to ensure all BCPs are in place
4. Arrange transport systems for distribution of anti viral medication, PPE and medical devices.
5. Review all Business Continuity Plans on regular review schedule
6. Convene/chair monthly EP/BCP meeting
7. Engage with NHS England and/or the LHRP emergency planning systems and networks
WHO Level 5-6
1. Invoke appropriate PI plans
2. Stand down EP/BCP Steering Group - Command and Control systems now in place
3. Board of Directors and EMT delegation of authorities invoked

Action Card
Special Instructions
Infection Prevention and Control

If patient admitted with the agreed criteria for H1N1 Influenza ('Swine') Flu	
1.	Place in single room with appropriate hand hygiene facilities (en-suite facilities if possible). Wash hand basin, disposable paper towels and liquid soap.
2.	Contact IPCNs, 0191 333 3584. For further advice on patient management (out of hours contact Director on call).
3.	Ensure you have supply of Personal Protective Equipment (PPE) disposable apron, gloves and face masks.
4.	When in direct patient contact (within 3 feet) PPE must be worn. If possible the patient should wear a mask (this will depend on patient's mental health state).
5.	All PPE is single use only and must be discarded after use as clinical waste.
6.	Staff and patient must follow strict hand hygiene procedures after each contact and after coughing or sneezing.
7.	The patient must be encouraged to cover their nose and mouth when coughing and sneezing.
8.	Paper tissues should be disposed of immediately after use as clinical waste and hand hygiene performed.
9.	All staff and patients to be reminded of the Catch it, Bin it and Kill it Campaign.
10.	The patient's room must be cleaned daily.
11.	For more detailed information please refer to IPC Guidelines during Pandemic Influenza.
12.	Action cards for specific management of patients with H1N1 swine flu are available on the temporary intranet site and have been circulated previously with Trust Operational Instruction.

Action Card
Operational Services Lead

WHO Level 4

1. Ensure awareness of individual service BCPs
2. Monitor regular sit reps and operational instructions
3. Maintain awareness of PI plan
4. Maintain knowledge of state of PI alert
5. Include PIP/BCP objectives in all service annual plans
6. Include BCP/PIP arrangements in all new service developments
7. Regular reviews of patient contacts, family and carer scenario – CPA review/updating of community care plans and support networks
8. Support HR preparedness plans with regular HR staff monitoring
9. Implement outbreak monitoring as instructed through command and control
10. Implement PI plan activities through operational Directorate leads

WHO Level 5-6

1. Take note of regular sit rep and workforce monitoring situation.
2. Ensure awareness of individual service BCPs.
3. Arrange contact with operational Directorate leads
4. Review outbreak situation
5. Review staffing situation.
6. Review invocation thresholds with each Directorate lead
7. Agree level of continuity plan action for each Directorate
8. Agree staff redeployment as required to maintain safe service levels
9. Maintain decision log of agreed continuity planning and staffing
10. Maintain record of incidents through duty period.
11. Include in incident log any emergency legislative activity
12. Maintain duty log
13. Arrange handover briefing to next operational lead

DURING RECOVERY STATE

1. As above
2. Monitor staffing situation
3. Implement staff review and support systems
4. Implement HR procedures

Action Card - Special Instructions
Operational Services Lead

WHO Level 4
1. To ensure staff aware of usual site security procedures
2. To spot check and review usual site security arrangements
3. To maintain register of site security vulnerabilities
4. To maintain awareness of PI developments and security implications
5. Implement basic security awareness standards across sites through operational site management
6. Monitor areas of security vulnerability and implement any contingency planning through operational site management.
WHO Level 5-6
1. As in level 4
2. Implement specific security plans as agreed with operational site management
3. Monitor security incident reports – liaise with local police force

Action Card

For obtaining a supply of antiviral medication for inpatients out of normal working hours in Durham, Darlington, Scarborough, Whitby & Ryedale

The 1st On-Call to contact the On-Call Pharmacist to request a supply of antiviral treatment. 1st on-call will advise the second on call manager who will in turn advise the Director on Call. On call Pharmacist 07787 105 800.

The following details will be required: -

Patient's name

Ward

Medication prescribed and of dose

Ward contact name and telephone number

Following a request from the 1st On-Call for a supply of antiviral treatment the On-Call Pharmacist will contact the ward to confirm patient details, treatment required and check assessment procedures have been followed.

Diagnosis of H1N1 (swine) flu to be made by assessing clinical symptoms:

Fever (temperature ≥ 38ºC) or clinical history of fever **and**

Influenza like illness (TWO OR MORE of the following symptoms: cough, sore throat, rhinorrhoea, limb or joint pain, headache, vomiting or diarrhoea).

Patients at high risk of becoming seriously ill from swine flu are those with: -

Chronic lung disease

Chronic heart disease

Chronic kidney disease

Chronic liver disease

Chronic neurological disease

Immunosuppression

Diabetes mellitus

Oseltamivir should be prescribed unless the patient is pregnant or has renal failure and regularly attends a specialist renal clinic. These patients should be prescribed zanamivir.

Oseltamivir dosages:

Over 7 and under 13 years (23-40kg) 60mg (2 x 30mg capsules) twice a day for 5 days.

Over 13 years (over 40kg) 75mg twice a day for 5 days.

Patients with swallowing difficulties or unable to take medicines orally: Instruct to open

capsule and mix contents with 10ml water. Zanamivir dose: Adults and children over 5 years: Two 5mg blisters to be inhaled (using the diskhaler) twice a day for 5 days.
Ward to be instructed to obtain a supply from the emergency cupboard. Durham locality wards to access from Mediwell cabinet at Lanchester Road Hospital via the Standing In Nurse. Darlington locality wards to access from emergency cupboard at West Park Hospital via the Standing In Nurse. North and South Tees locality wards to access from the Mediwell cabinet at Roseberry Park Hospital via the Duty Manager. Scarborough and Ryedale locality wards to access from emergency cupboard at Cross Lane Hospital via the Nurse in Charge.
Instruction to the ward when removing supplies of antiviral medication from the emergency cupboard: Complete the following information on the stock control sheet • Date • Patient's name • Ward • Quantity • Batch no & expiry date • Name of prescriber • Name of person removing supply • Stock balance
The box is overlabelled and the patient's name should be completed on the label. See Appendix 1 & 2 Emergency Cupboard instruction sheet and stock control sheets
The next working day the On-Call Pharmacist to notify the relevant Technical Services Manager at Lanchester Road Hospital, West Park Hospital or Roseberry Park Hospital to notify of supplies taken from the emergency cupboards.

Action Card

For obtaining a supply of antiviral medication for inpatients out of normal working hours in Hambleton, Richmondshire and Harrogate

The 1st On-Call to contact the Emergency Duty Pharmacist via the Acute Trust switchboard:

The Friarage switchboard– 01609 779911

Harrogate District Hospital switchboard - 01423 885959

to request a supply of antiviral treatment. 1st on call will advise the second on call manager who will in turn advise the Director on Call.

The following details will be required: -

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Patients with swallowing difficulties or unable to take medicines orally: Instruct to open capsule and mix contents with 10ml water. Zanamivir dose: Adults and children over 5 years: Two 5mg blisters to be inhaled (using the diskhaler) twice a day for 5 days.
The Emergency Duty Pharmacist will arrange for a supply to be issued to the ward.

Action Card
On-Call

WHO Level 4
1. Existing on call arrangements to continue, i.e. Director on-call, Second on-call, First on call.
2. Weekly briefing of Director on-call and 2nd General Manager on-call by Director of Flu – Friday pm.
WHO Level 5
1. Existing on-call arrangements to continue, i.e. Director on-call, Second on-call, First on-call.
2. North and South localities first on-call managers, to act as "partners" in providing any additional support to each other if required.
3. Weekly briefing of Director on-call and 2nd General Manager on-call by Director of Flu – Friday pm.
4. Director of Flu to brief Director on-call / GM on-call on out of hours activation of ECR.
WHO Level 6
1. Command and Control Team Leader to escalate on-call arrangements and log decision appropriately. On call to move to 'on standby'.
2. There will be TWO first on-call managers in EACH of North and South localities, to provide additional support.
3. Enhanced second on-call rota to be activated as below: • additional shadow manager identified at second on-call level • period of on-call to continue on a planned weekly basis
4. Named individual responsible for co-ordinating rota to contact those named and advise of escalation.
5. Escalation arrangements to be briefed through 0800 full report, as per PICT Plan reporting agreement, to: • EMT Members • On-call Directors • Board of Directors and Clinical Directors • On-call communications manager.
6. The Chief Executive to provide additional briefing to the Chairman and Non Executive Directors, as required

WHO Level 6
1. Command and Control Team Leader to escalate on-call arrangements and log decision appropriately. On-call Director/Manager to be based in ECR 6.00 p.m. to 6.00 a.m. daily.
2. There will be TWO first on-call managers in EACH of North and South localities, to provide additional support. Period of on-call to be rotated on a daily basis.
3. Enhanced second on-call rota to be activated as below: • There will be TWO managers allocated at second on-call level • period of on-call to be rotated on a daily basis
4. Named individual responsible for co-ordinating rota to contact those named and advise of escalation.
5. Escalation arrangements to be briefed through 0800 and 1600 full reports through either electronic email or conference call facilities as per PICT Plan reporting agreement, to: • EMT Members • On-call Directors/General Managers (1600 hours only) • Board of Directors and Clinical Directors • On call communications manager.
6. The Chief Executive to provide additional briefing to the Chairman and Non Executive Directors, as required
POST FLU CON
1. Command and Control Team Leader to de-escalate on-call arrangements and log decision appropriately.
2. De-escalation to be briefed through full reports (0800/1600 hours), as per PICT Plan reporting agreement, to: • EMT Members • On-call Director/General Managers • Board of Directors and Clinical Directors
3. Named individual responsible for co-ordinating rota to contact those named and advise of de-escalation.
4. Carry out review to establish lessons learnt and areas of good Practice.

Action Card
Ordering of Personal Protective Equipment (PPE) for clinical staff

BACKGROUND

For the management of H1N1 Swine Flu it is recommended that all clinical areas and community teams hold an agreed stock of PPE (1 month supply). Details of when to use PPE can be found in the Infection Prevention and Control Guidelines and Swine Flu Action Cards – available on the Trust Intranet.

1.	All clinical leads must ensure they have a minimum 2 weeks stock of the following: • Disposable gloves • Disposable aprons • Eye protection • Disposable surgical face masks • Tissues • Paper towels • Detergent wipes • Liquid soap • Waste bags Staff should ensure that all stocks are maintained and replenished.
2.	Ensure you re-order stocks using normal supply chain route.

APPENDIX 1

Infection Prevention and Control Guidelines during Pandemic Influenza

1. PREVENTION AND CONTROL MEASURES

In the event of a pandemic, clear guidance will be issued based on the advice of the UK National Influenza Pandemic Committee, guidance from the WHO or real time modelling as the evidence evolves or the need arises. However it is likely that strategies for the prevention and control of influenza in health care facilities will include the following: influenza vaccination (when available) for person at high risk for complications, vaccination (when available) for health care personnel, respiratory hygiene/cough etiquette programmes, Standard Precautions and Droplet Precautions, use of antivirals and restriction of ill visitors and personnel.

In the early stages of pandemic, it is likely that there will be a lag between virus identification and manufacture of vaccine supply of up to 6 months. It is also unclear whether antivirals will be effective and/or widely available. Therefore infection control procedures outlined here will focus on Standard Precautions (including hand hygiene), respiratory hygiene/cough etiquette programmes, Droplet precautions and restricting unnecessary social interactions as much as possible.
The adherence to the following Infection Prevention and Control (IPC) control measures will minimise the risk to patients, staff and visitors to the organization.

2. HAND HYGIENE

2.1 Introduction

Hand hygiene using recognised techniques is the single most effective means of reducing the risk of cross-infection. There is no limit to the varieties of organisms both pathogenic and non-pathogenic that may be on the skin at any one time.

2.2 Aims of Hand Hygiene

To prevent potential pathogenic organisms colonising the hands of staff and being transported to others, therefore creating a risk of infection

2.3 Levels of Hand Hygiene

1. Thorough hand washes with liquid soap and water, rinsing and thorough drying with a disposable towel will remove transient organisms and reduce the level of resident organisms.
2. Alcohol hand rubs are a rapid decontamination method and are very effective at removing transient bacteria. They must only be used if the hands are physically clean.

Frequently for hand hygiene is determined by actions: those completed and those intended to be performed.

2.4 Hand Decontamination

Before regular hand decontamination begins all wrist watches, and ideally, hand jewellery, should be removed. Cuts and abrasions must be covered with waterproof dressings before starting work.

2.5 Handwashing

When to wash Hands

Hands must be decontaminated before and after every episode of patient contact and

- whenever hands are visibly dirty
- after visiting the toilet
- before preparing, handling or eating food.

When to Decontaminate Physically Clean Hands with Alcohol Hand Rub

Examples:

- before caring for any patient
- after removing gloves, aprons and masks
- between patient contacts
- after contact with paper tissues

Respiratory Hygiene/Cough Etiquette Programs

Respiratory hygiene/cough etiquette should be implemented at the first point of contact with a potentially infected person to prevent the transmission of all respiratory tract infections in health care settings. Respiratory hygiene/cough etiquette programs include:

- Posting visual alerts instructing patients and persons who accompany them to inform health care personnel if they have symptoms of respiratory infection.
- Ensure that supplies for hand washing areas available where sinks are located; providing liquid soap, disposable paper towels and dispensers of alcohol-based hand rubs.
- Encouraging coughing persons to sit at least 3 feet away from others, if possible.

Standard Precautions

During the care of any patient with symptoms of a respiratory infection, health care personnel should adhere to standard precautions;

- Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.
- Wear an apron if soiling of clothes with a patient's respiratory secretions is anticipated.
- Change gloves and apron after each patient encountered and perform hand hygiene
- Decontaminate hands before and after touching the patient, after touching the patient's environment, or after touching the patient's respiratory secretions, whether or not gloves are worn
- When hands are visibly soiled or contaminated with respiratory secretions, wash hands with liquid soap and water
- If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in clinical situations. Alternatively, wash hands with liquid soap and water.

Droplet Precautions

In addition to Standard Precautions, health care workers should adhere to Droplet Precautions during the care of a patient with suspected or confirmed influenza:

- Place patient into a single room. If a single room is not available, place suspected influenza patients with other patients suspected of having influenza. (Cohort Nursing)

- Wear a surgical or procedure mask upon entering the patient's room or when working within 3 feet of the patient. Remove the mask when leaving the patient's room and dispose of the mask as hazardous waste.
- If patient movement or transport is necessary, have the patient wear a disposal surgical face mask, if possible.

3. STANDARDS FOR CLEANLINESS DURING A PANDEMIC INFLUENZA

The standards of cleanliness during a Pandemic Influenza will be influenced by:

- Staff levels
- Cohorting of patients with influenza
- Reduction in non essential services

The Hotel Services staff will ensure that minimum standards are maintained within the resources they have available to them.

Key target areas which must be cleaned daily include:

- Those wards with patients with pandemic influenza.
- Bathroom and toilet areas of all inpatient facilities
- Prompt correct and disposal of all used tissues, face masks

4. CONTROL OF INFLUENZA OUTBREAKS IN HEALTH CARE SETTINGS

When influenza outbreaks occur in health care settings, additional measures should be taken to limit transmission. These include:

- Identify influenza virus as the causative agent early in the outbreak by obtaining rapid influenza virus testing of patients with recent onset of symptoms suggestive of influenza. In addition, obtain viral cultures from a subset of patients to determine the infecting virus type and subtype.
- Implement droplet precautions for all patients with suspected or confirmed influenza.
- For management of admissions/patients who develop flu or fulfil the criteria set out by the HPA – see Action Plans in PI Plan.
- Separate suspected or confirmed influenza patients from asymptomatic patients.
- Restricted staff movement from areas with outbreaks to other units and buildings.
- Curtail or eliminate elective admissions on advice from Command and Control
- Obtain anti-virals for any symptomatic patients using the agreed Department of Health procedures via local PCTs where the patients NHS number will be required

Restrictions for Relatives and Visitors

If there is no or only sporadic influenza occurring in the surrounding community:

- Discourage persons with symptoms of a respiratory infection from visiting patients. Inform the public about restricted visitation through educational activities.
- Follow SHA/DoH guidance for informing the staff and general public ie developments.

If widespread influenza activity is in the surrounding community:

- Actively communicate to the public at large (e.g. via public service announcements) and visitors (e.g. via posted notices) not to visit for 5 days following the onset of a respiratory illness.

For further guidance for visitors see Appendix (ii).

5. Management of Patients in Community Settings

Influenza patients who are unable to access secondary care will need to be cared for in their own home or residential settings as far as possible and where required and appropriate care taken to them. Advising those who are ill with the influenza virus to stay at home asked to self care (if they are able to) or access care from their own home is likely to be the most effective way of slowing or limiting the general spread of infection.

Users of mental health and learning disability services presenting symptoms of pandemic influenza should approach health services in the same way as the rest of the population. This includes accessing anti viral treatment and information via the local PCTs.

However for many people who cannot do this directly their families, neighbours and Trust staff, may need to arrange access to services on their behalf.

6. PROTECTIVE CLOTHING

6.1 Disposable Aprons

- Staff must wear a disposable and water repellent plastic apron to protect uniforms and clothes during patient contact when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat.
- Plastic aprons should be worn as single-use items, for one procedure or episode of patient care.
- The clothing of health care workers will require protection during certain procedures.
- The use of disposable and water repellent plastic aprons will prevent:
    a. Heavy contamination of the uniform with micro-organisms
    b. Moist soilage of the uniform.

6.2 Gloves

- The use of gloves should never be viewed as a substitute for appropriate hand hygiene. Provided gloves are correctly used they are an important aid in reducing the transfer of micro-organisms.
- For gloves to be effective health care staff need to wear them appropriately.
    - Gloves must be change both between patient contact and between performing separate procedures on the same patient.
    - Gloves must be removed immediately after completion of the patient process for which they were worn.
    - Gloved hands should neither be wiped with any form of alcoholic substance nor washed.
    - Gloves must be correct size.
    - Gloves are not required for routine care of patients with pandemic flu, but are worn when standard universal precautions are necessary e.g. contact with body fluid including respiratory secretions.

6.3 Surgical Face Masks

- Required for close patient contact with symptomatic patients (e.g. within 3 feet).
- Surgical face masks should cover both the nose and the mouth and not be allowed to dangle around the neck after usage.
- Must not be touched once put on.
- Must be changed when they become moist.
- Must only be worn once and discarded in an appropriate receptacle as hazardous waste. Hand hygiene must be performed after disposal is complete.

- Must be worn by staff when undertaking any aerosol generating procedures in health care settings.

6.4 **Gowns**

- Gowns are not required for the routine care of patients with influenza.
- Gowns are only required on the rare occasion when extensive soiling/splashing of uniform/clothing is anticipated e.g. intubation and activities which require the patient to be held close. Example: medical emergency, resuscitation.

6.5 **Cohorted Areas (Where patients with symptoms are nursed together)**

- May be practical for staff to wear a single surgical face mask upon entry to clinical area and keep on for duration of activity or until the mask needs replacing eg when it becomes moist approximately after 20 minutes.
- Gloves/aprons must be removed between patients and hand hygiene performed.
- All contaminated PPE must be removed before leaving a patient care area.
- Surgical face masks must be removed last followed by thorough hand hygiene.
- Environmental cleaning must be maintained in all key areas.

6.6 **Hand Hygiene**

- Hand hygiene must be carried out after removing protective clothing.
- Patients and staff should be encouraged to cover their nose and mouth when coughing or sneezing. Paper tissues should be disposed of immediately after use and hand hygiene performed.

6.7 **Occupational Health**

- Prompt recognition of Health Care Workers (HCW) with influenza is essential to limit the spread of the pandemic.
- HCW with pandemic influenza should be excluded from work; exceptions may be necessary.

- HCW at high risk of complications should not provide direct care.
- Bank and agency staff should follow the same deployment advice as permanent staff.
- If a member of staff develops symptoms whilst on duty he/she must report to their manager **immediately**.
- Those with symptoms of pandemic flu should be excluded from work.

Staff who have recovered from pandemic flu

- All HCW who have recovered from flu should report to their manager **before** resuming work.
- All staff illness should be recorded as it may affect future deployment.
- This group of HCW can care for people with influenza.

Workers at risk from complications from Pandemic Flu

Pregnant women and immunocompromised staff should be considered for alternate work assignment away from direct care for the duration of the pandemic.

This must be agreed prior to outbreak by line manager, staff member and OHD.

10. Document control

Date of approval:	March 2013	
Next review date:	March 2016	
This document replaces:		
Lead:	Name	Title
	Angela Ridley	Head of IPC and Physical Healthcare (Nursing)
Members of working party:	Name	Title
	EP and BCP Group	Brent Kilmurray (Lead Director)
This document has been agreed and accepted by: (Director)	Name	Title
	Brent Kilmurray	Chief Operating Officer
This document was approved by:	Name of committee/group	Date
	EP and BCP Group	24th March 2014
This document was ratified by:	Name of committee/group	Date
	EMT	
An equality analysis was completed on this document on:	13th April 2012	
Amendment details:		