PANDEMIC INFLUENZA PLAN

Sheffield Health and Social Care (SHSC)
NHS Foundation Trust

In the event of a Flu Pandemic turn to Page 11: Action Cards for the Accountable Emergency Officer in the first instance

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<td>Senior Nurse –Infection Prevention and Control</td>
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Amendments:
It is the duty of all plan holders to inform the emergency planning officer of any information concerning changes which will consequently impact upon this plan.
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1. **Authorisation & Agreement of Plan**

Accountable Emergency Officer and Chief Executive hereby approved this plan:

**Chief Executive**

**Accountable Emergency Officer**

This Plan was approved by the SHSC Risk Management Group on:

1.1 **DISTRIBUTION LIST**

Filled in by those distributing in locality

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1.2 PLANS TO BE READ IN CONJUNCTION WITH THIS PLAN

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<td>SHSC Major Incident Plan</td>
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1.3 SHSC POLICIES TO BE READ IN CONJUNCTION WITH THIS PLAN

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<td>Management of Outbreak of Infection Policy</td>
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<td>Infection Control Policy for the Surveillance, Prevention and Management of Infections</td>
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<td>Protocol for supporting staff following adverse events/incidents</td>
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<td>Use of Personal Protective Equipment during a pandemic</td>
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<td>Infection Control Policy</td>
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<td>Isolation Precautions</td>
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<td>UK Influenza Pandemic Preparedness Strategy</td>
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Related Documentation and References

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<tr>
<td>DH (2013) Preparing for Pandemic Influenza – Guidance for Local Planners</td>
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<tr>
<td>Centre for Health and the Public Interest (2013) – Getting Behind the Curve – Is the new NHS ready for Pandemic Flu?</td>
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<td>DH (2012) Health and Social Care Influenza Pandemic Preparedness and Response</td>
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<td>DH (2011) UK Influenza Pandemic Preparedness Strategy 2011</td>
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<td>DH (July 2009) Psychological Care for NHS staff during an Influenza Pandemic</td>
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<td>DH (2007) “Responding to Pandemic Influenza. The Ethical Framework for policy and planning”.</td>
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List of Amendments

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Flu Pandemic Response Flowchart
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.

Towards this a series of stages have been identified, referred to as ‘DATER’.

- Detection
- Assessment
- Treatment
- Escalation
- Recovery

The stages 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 stages. It should also be recognised that there may not be clear delineation between stages.

Accountable Emergency Officer (AEO) or Executive Director Level Equivalent will take charge of coordinating the response (ensuring liaison with the Chief Executive) at each level of Flu Alert as follows:

DETECTION STAGE
This is known by the WHO as the Alert stage or stage when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase.

DETECTION / ASSESSMENT STAGE
The indicator for moving to the assessment stage would be the identification of the novel influenza virus in patients in the UK.

TREATMENT & ESCALATION STAGE
The indicator for moving to the Treatment stage would be evidence of sustained community transmission of the virus, i.e. cases not linked to any known or previously identified cases.

RECOVERY STAGE
The indicator for this stage 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.
2.0 Aim

The aim of the Pandemic Influenza Plan is to assist with the timely, resilient and integrated response to a Flu Pandemic where a different strain of the flu virus appears to which most people do not have immunity. This is not a stand-alone document; it supplements the Trust’s existing Major Incident and Business Continuity Plans by providing additional and specific information to Pandemic Flu. It is intended to help mitigate the effects of the Pandemic on patients and staff by doing the following:

- Reduce the spread of Pandemic Influenza.
- Limit the morbidity and mortality from Pandemic Influenza.
- Protect patients, staff and visitors against adverse effects where possible.
- Show how SHSC would be expected to work alongside partner agencies before, during and after a flu pandemic.
- Set out clear actions to be performed by SHSC staff in the event of a flu pandemic.
- Provide added detail and context to assist with the delivery of critical services.
- Provide guidance on vaccination if and when suitable vaccines become available.
- Assist a return to normality with the resumption of normal services as quickly as possible.

As a category 1 responder under the Civil Contingencies Act 2004 SHSC will play a role in responding to any Flu Pandemic and will work alongside, and may be required to assist partner agencies across all regions where SHSC provides a service.

SHSC will also need to warn and inform staff, patients and the public during a Flu Pandemic incident and give ongoing advice coordinated through the Multi Agency Strategic Coordination Group (SCG).

2.1 Scope of the Plan

The Plan describes the actions taken by SHSC in the preparation and response to, and recovery from a Flu Pandemic. Should a Major Incident be declared, staff should also refer to the SHSC Major Incident Plan.

Extensive background information is published in guidance referred to on page 4; all will not be repeated in this document in detail.
3.0 Definition of Flu Pandemic

The World Health Organisation (WHO) defines a pandemic as:

“The worldwide spread of a new disease. An influenza pandemic occurs when a new influenza virus emerges and spreads around the world, and most people do not have immunity.”

There are seven factors to consider in the event of a pandemic:

**Uncertainty**: there will be little or no information at the outset of a new pandemic about the severity of the illness. This will require accurate and detailed surveillance data, including numbers affected, hospital and critical care admissions, to be gathered as an early priority.

**Speed**: in local areas, the number of cases and demand for services can be expected to develop with great pace, requiring an agile yet coordinated response.

**Local hotspots**: the demands of the pandemic are unlikely to be uniform, but different areas will be under pressure at different times (and some not at all), requiring flexibility of approach, as well as planning for easy access to antiviral medicines.

**Profile**: the media, public and professional appetite for information is likely to be Intense at times, requiring frequent, consistent and coordinated communications.

**Duration**: a pandemic wave can be expected to continue for many weeks, requiring robust arrangements to support individuals involved in the response. In time, further waves may also occur.

**Cross-sector**: whilst the health sector will be under particular pressure, the response will span different sectors and organisations, requiring close working and mutual support.

**Wider applicability**: the response to the H1N1 (2009) influenza pandemic built on, and enhanced, the response to more routine pressures such as those arising from severe weather.
4.0 Stages of a Pandemic:

The government judges that one of the highest current risks in the UK is the possible emergency of a Flu Pandemic.

A Flu Pandemic could occur at any time. The Pandemic virus is almost certain to arise outside the UK. Cases could begin to occur in the UK within one month of the start of the Pandemic. Once in the UK, the pandemic may spread to most major population centres within weeks.

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.

Towards this a series of stages have been identified, referred to as ‘DATER’.

- Detection
- Assessment
- Treatment
- Escalation
- Recovery

The stages 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 stages. It should also be recognised that there may not be clear delineation between stages.

Detection

This stage would 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 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 stage would be the identification of the novel influenza virus in patients in the UK.

Assessment

The focus in this stage 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;
  - self-isolation of cases and suspected cases; and
treatment of cases / suspected cases and use of antiviral prophylaxis for close / 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 stages 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.

**Treatment**

The focus in this stage would be:

- 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.
- 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 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, 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 pandemics, it would be prudent to prepare for the implementation. Further NHS Surge Guidance will be issued in spring 2014.

**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 e.g. 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.
• 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 services’ capacities are able to meet demand will also inform this decision.

5.0 Attack & Death Rates:

Currently it is impossible to forecast the exact characteristics, spread and impact of a new influenza strain. However modelling provided by The Cabinet Office (CO) suggests that:

• A reasonable worst case would be cumulative clinical attack rates of up to 50% of the population in total, spread over one or more waves each of around 12-15 weeks, each some weeks or months apart. If they occur, a second or subsequent wave could be more severe than the first. Response plans should recognise the possibility of a clinical attack rate of up to 50% in a single-wave pandemic. Some of this activity may occur even after the WHO has declared the pandemic over.

• Potentially up to 2.5% of those with symptoms would die as a result of influenza, assuming no effective treatment was available. Up to 4% of those who are symptomatic may require hospital admission.

• As the H1N1 (2009) pandemic showed, the demands of the pandemic are unlikely to be uniform, but different areas will be under pressure at different times and some not at all, requiring flexibility of approach. Local epidemics may even be over faster and be more highly peaked than the national average. Local epidemics may only last for 6-8 weeks, or they may last longer.

• Whilst there is likely to be local variability, there should be an expectation of between 10-12% of the local population becoming ill each week during the peak of the local epidemic, reaching to 22% in the peak week. It should be assumed that peak figures (based on the 50% clinical attack rate) could be sustained over a period of 2-3 weeks.

• The incubation period will be in the range of one to 4 days (typically two to three). Adults are infectious for up to five days from the onset of symptoms. Longer periods have been found, particularly in those who are immune-suppressed.

• Children may be infectious for up to 7 days. Some people can be infected, develop immunity, and have minimal or no symptoms, but may still be able to pass on the virus; and all ages are likely to be affected, but those with certain underlying medical conditions, pregnant women, children and otherwise fit younger adults could be at relatively greater risk. The exact pattern will only become apparent as the pandemic progresses. It is likely that SHSC patients and staff would be infectious, with some groups at greater risk.
The impact a pandemic has on the population and wider society will be determined by three interdependent factors:

**Disease characteristics**: the number of cases and deaths, the proportion of severe disease in the population, the clinical groups most affected and the rate of onward transmission. This will only become possible to assess once sufficient data is available.

**Service capacity**: the number of patients presenting at primary care services and/or admitted to hospital and intensive care and specialist treatment and the capacity of public services, utilities and businesses to cope with increased demands and staff absence.

**Behavioural response**: the levels of concern experienced by the population, positive reactions to good respiratory and hand hygiene campaigns, the likely uptake of antiviral medicines and vaccination and the way health services are accessed and used.

So, for example:

- A highly transmissible virus producing relatively mild symptoms may still cause significant disruption to businesses and individuals as well as to health and social care services, due to the high incidence of sickness and staff absence over an extended period.

- A concentrated wave of infection, where a large number of people are infected over a short period with a more severe illness is likely to have a greater impact on society and service capacity than the same number of cases spread over a longer period.

- Uncertainty about the severity of a new pandemic, and any alarmist reporting in the media, may drive large numbers of people to seek reassurance from health providers, placing strain upon primary and secondary care services.
6. Flu Pandemic Action Card: Summary

The Accountable Emergency Officer (or Executive Director Level Equivalent) will take charge of coordinating the response (ensuring liaison with the Chief Executive) at each level of Flu Alert as follows:

**DETECTION STAGE**

This is known by the WHO as the Alert stage or stage when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase:

B. Liaise with Head of Communications to ensure all staff are aware of situation.
C. Advise all teams to review arrangements in team business continuity plans for potential staff loss due to pandemic influenza.

Such business continuity planning may include:
- Whether staff have dependents.
- Whether staff underlying health conditions that may make them more at risk from influenza.
- Where staff live and how they travel to work.
- Whether staff are prepared to “live in” at work during the pandemic (if possible or required).
- Review of essential functions and production of action cards for those functions that may be used by new or temporary staff from other services if required.
- Checking of business continuity arrangements of essential contractors.
- Review of staff skill mix to identify vulnerabilities if staff loss were to occur.
- If receive any requests for information from PHE/NHS England or CCGs ensure all teams cooperate to provide prompt response

**DETECTION / ASSESSMENT STAGE**

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

- Follow guidance issued by PHE/NHS England.
- Liaise with Head of Communications to ensure all staff are aware of situation.
- Advise all teams to review arrangements in team business continuity plans for potential staff loss due to pandemic influenza.
- If receive any requests for information from PHE/NHS England or CCGs ensure all teams cooperate to provide prompt response.
- Consider moving SHSC to Major Incident “Standby”. (See Major Incident Plan).
- Convene a special meeting of EDG and the Emergency Planning Strategy Group
- Consult Infection Prevention Control Team (IPCT). Ensure infection and control procedures are in place as soon as possible to reduce the spread of the infection and refresher training given to all staff with special regard to Flu.
- Confirm arrangements for investigating and managing any suspected cases for patients and staff across all teams. Ensure that details of those affected are collected on a regular basis and passed to AEO in order to keep a record of numbers affected for outside agencies such as CCGs, PHE and NHS England.
- Provide local guidance about use of antivirals (if available) for early cases (liaise with partners for further details).
- Review plans for supply and distribution of essential medicines/supplies with Chief Pharmacist.
- Consider convening Seasonal Flu Vaccination Group to prepare arrangements for possible vaccinations of patients and staff for flu pandemic e.g. ordering of equipment. If there is a decision by the government that a general pandemic has been declared it will take 7-10 days for national stockpiles of PPE and anti-viral medicines to be issued therefore there needs to be
in place all anticipated required stock locally to last 7-10 days.

- If local meetings are called to discuss response to potential Flu Pandemic ensure attendance by suitable officer and ensure feedback from meeting is shared appropriately.
- Consider adding to membership of Emergency Planning Strategy Group if Major Incident declared. Guidance can be found in Major Incident Plan. For a Flu Pandemic individuals to take part in Emergency Planning Panel should also include:
  - Chief Pharmacist (e.g. to report on access to medicines)
  - Deputy Director of Nursing
  - Senior Pharmacy Technician.
  - Lead for Infection Control.

- Ensure regular feedback from IPCTs on training and monitoring of arrangements on wards.
- Ascertain if teams are taking special measures to deal with vulnerable groups if affected by flu pandemic

**TREATMENT & ESCALATION STAGE**

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

- Follow guidance issued by PHE/NHS England.
- Declare Major Incident “Implement” as per instructions in Major Incident Plan.
- Liaise with Head of Communications to ensure all staff are aware of situation.
- Alert all staff and partners including NHS England via Communications Team of decision to declare “Major Incident”.
- If receive any requests for information from PHE/NHS England or CCGs ensure all teams cooperate to provide prompt response.
- Make arrangements to provide pre-pandemic vaccination if available to front line staff as per national policy.
- If appropriate cooperate with any local media campaign coordinated via PHE/NHS England, liaise with partners.
- Review local sitrep reporting arrangements and decide timetable for sitrep returns from teams to complement requests from outside agencies.
- Issue reminders to all patient facing staff of infection prevention advice.
- Review arrangements for any local antiviral distribution/patient assessment.
- Ensure contractor business continuity arrangements continue to be in place.
- Support the set up anti-viral collection points in hotspots if required.
- Support to the setup of local anti-viral delivery points if required. This should be available to receive deliveries 24 hours a day and cannot rely on the current NHS supply chain.
- Consider closure of non-essential day care services to reduce risk of spreading infection.
- Consider discharge of inpatients if appropriate.
- Teams to examine need to support Contingency plans for Carers.
- Teams to begin regular liaison with suppliers and contractors to ensure continuity of supply in event of staff absence.
- If local meetings are called to discuss response to potential Flu Pandemic ensure attendance by suitable officer and ensure feedback from meeting is shared appropriately.
- Monitor local health and social care response via liaison with partners.
- Monitor essential services and business continuity via situation reporting.
- Maintain regular contact between Emergency Planning Strategy Group and IPCT.
- Convene a Recovery Coordination Group to facilitate move back to normal business when pandemic recedes.
- Restrict leave arrangements where local indications are that severe staff shortages are expected and this will dependent on whether it is expected to be low, medium or high impact and may be reviewed as further information is collected link to the HR policy.
RECOVERY STAGE

The indicator for this stage 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.

- Follow guidance issued by PHE/NHS England.
- Liaise with Head of Communications to ensure all staff are aware of situation.
- If receive any requests for information from PHE/NHS England or CCGs ensure all teams cooperate to provide prompt response.
- Monitor local health and social care response via liaison with partners.
- Monitor essential services and business continuity via situation reporting.
- Consider transfer of staff from non-critical services to begin supporting areas that will be most heavily impacted by the pandemic.
- Increase use of bank staff if possible to deal with staff shortages and consider mutual aid if available.
- Introduce more flexible working arrangements to support staff to attend work.
- Review local vaccination arrangements and antiviral arrangements as appropriate.
- Maintain regular contact between Emergency Planning Panel and IPCT.
- Consult Recovery Coordination Group on progress to facilitate move back to normal business when pandemic recedes.
- Restrict leave arrangements where local indications are that severe staff shortages are expected and this will dependent on whether it is expected to be low, medium or high impact and may be reviewed as further information is collected link to the HR policy.
- Consider closure of non-essential day care services to reduce risk of spreading infection.
- Consider discharge of inpatients if appropriate.
- Teams to begin regular liaison with suppliers and contractors to ensure continuity of supply in event of staff absence.
- If local meetings are called to discuss response to potential Flu Pandemic ensure attendance by suitable officer and ensure feedback from meeting is shared.
7.0 Response

7.1 Key Principles

Given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles should underpin all pandemic preparedness and response activity:

**Precautionary:** the response to any new virus should take into account the risk that it could be severe in nature. Plans must therefore be in place for a Flu Pandemic with the potential to cause severe symptoms in individuals and widespread disruption to society. This means each team’s business continuity plan must include contingencies for a “worst case scenario”.

**Proportionality:** the response to a pandemic should be no more and no less than that necessary in relation to the known risks. Plans therefore need to be in place not only for high impact pandemics, but also for milder scenarios, with the ability to adapt them as new evidence emerges. This means that each team’s business continuity plan must have adaptable contingencies to fit in with the impact of the pandemic.

**Flexibility:** there will need to be local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection. This means that contingencies in Business Continuity Plans must take into account how the different stages might affect team business and that of partners.

In the sections below this plan sets out how SHSC would respond to a Flu Pandemic to ensure a unified and comprehensive approach.

7.2 Declaring a Pandemic

In June 2013, the World Health Organisation (WHO) published revised pandemic influenza guidance. This has moved away from the six previous clearly delineated pandemic stages, and instead uses a risk-based approach to pandemic influenza represented as a continuum of global stages (interpandemic, alert, pandemic and transition) that describe the spread of a new influenza subtype, taking account of the disease it causes, around the world.

Whilst referring to and recognising the importance of WHO arrangements, the UK response is not completely or solely predicated on a WHO alert and as such is not necessarily reliant on this information to activate NHS pandemic response plans.

As the threat of a Flu Pandemic increases, NHS England may delegate decisions to reduce NHS services to the provision of essential care only, and around the modification of/or suspension of performance targets to local/ regional decision making.

7.3 Notification of a Pandemic to SHSC & Activation of Plan:

The Department of Health will inform the Cabinet Office and Public Health England (PHE) should there be a danger of a Flu Pandemic or there is a significant change in the threat assessment.

The Cabinet Office will alert other government departments and work with the Department of Health to develop, update and circulate top-line briefings via the News Coordination Centre (NCC).
The Department of Health will also alert SHSC via the NHS England Local Area Teams and PHE who will in turn contact NHS Providers. In the case of SHSC this will be received by the Accountable Emergency Officer and Emergency Planning Officer.

This plan sets out all actions to be taken in up to the declaration of a Major Incident. Once a Major Incident has been declared reference should be made to the SHSC Major Incident Plan in conjunction with this plan.

7.4 Communications

The Head of Communications is the focal point for communications within SHSC and with outside agencies.

If a Major Incident is declared The Head of Communications working in conjunction with the Emergency Planning Panel is responsible for working with partner organisations, government departments and media to ensure coordinated, timely, accurate and consistent communications. For further information refer to the Trust Communications Strategy, Major Incident Plan and the NHS Document Operating Framework for Managing the Response to Pandemic Influenza.

7.5 Multi-Agency SCG

If a local multi-agency strategic co-ordinating group (SCG) is activated then SHSC may be asked to send a representative to each meeting or participate in a telephone conference. If invited, attendance is compulsory and should be someone of sufficient seniority, e.g. at Director level. Usually the NHS England Local Area Team would represent NHS Providers but for a Flu Pandemic there may be requirement for representatives of individual Trusts to attend. Alternatively there may be teleconferences set up to avoid the need for groups to meet in person. The dates and times of such telephone conferences will be publicised by the NHS England Area Team and communicated to the Emergency Planning Officer and Accountable Emergency Officer. As SHSC covers a wide geographic area there may be a requirement to participate in Multi Agency SCGs that affect South Yorkshire, South Humber and Manchester areas.

A diagram showing how NHS Providers fit into the operating model for response if a multi-agency SCG is called can be found at Annexe A.

A multi-agency SCG set up in response to a Flu Pandemic would require updates on how NHS providers like SHSC were coping in the form of regular situation reports.

A Multi Agency SCG would set up a media cell which would give advice and support to the group in coordinating the communications of all members. SHSC communications would need to be fully coordinated with the SCG media cell to ensure consistency of information and advice being supplied to responding agencies and the public. Local communications, coordinated between the health providers and the SCG may be issued to help inform the general public, patients and carers on how best to protect themselves and others from the virus, indicating the most appropriate way of utilising local health services during the pandemic.

7.6 Situation Reporting within SHSC

As the pandemic reaches the UK and numbers of cases increases, there will be a regular requirement for situation reports (sitreps) from the SCG. The timetable or “battle rhythm” for
sitreps may change as the pandemic is takes effect and will vary as the impact varies. Clarity will be provided as the pandemic progresses. To minimise the burden of reporting the sitrep reporting within SHSC should be coordinated with requests for information from external sources.

Within SHSC the Emergency Planning Panel will, unless advised otherwise, in the event of a Major Incident being declared, use the sitrep template provided in the Major Incident Plan to ascertain the pressures on each team in the Trust.

Sitreps may be requested as per the requirements of the Emergency Planning Panel but ought to be timetabled so as to ensure decisions can be made on the latest information and fit into the timetable set by the SCG for sitreps from NHS providers.

The sitrep template includes generic questions about how a team is performing but may be amended to request other information such as:

- The situation of the specific area of business.
- Possible changes in practice or duties in response to the situation/staffing levels.
- The projected likelihood of continuation of business.
- The consequences on a specific area from the transfer of service users from other areas of the Trust.
- The projected demand in light of the pandemic on the specific area of business.

Once compiled the SHSC sitrep should inform communications made to staff. It is imperative that staff across all teams are kept informed of the:

- The national situation. (This may be in the form of a “Top Lines Briefing” received from Government RED team or SCG.)
- The regional and/or local situation. (Information available from the SCG Sitrep).
- Trust situation (Information from SHSC Sitrep)
- The general course of action to be taken by staff in the event of influenza symptoms.
- The need for priority and wherever possible flexibility to be given to those members of staff who may have caring responsibilities at home.

8. Infection control

Infection prevention and control standard precautions are fundamental in limiting the transmission of the virus.

Strict compliance with the **Standard Infection Prevention and Control Precautions Policy** is essential and this policy should be read in conjunction with other Trust Policies such as:

- Hand Hygiene Policy.
- Waste Policy.
- Decontamination Policy.
- Isolation Policy.
- Management of Outbreak of Infection Policy.
- Sharps Policy – Safe use and Disposal ofSharps and Management of Contamination Injuries.
In normal business the Trust policy and its implementation will be monitored through the Infection Prevention and Control Committee, reporting into the Clinical Governance Group. The Infection Prevention and Control Committee are responsible for ensuring that the risk of transmission of influenza to existing and newly admitted patients is minimised. During a Flu Pandemic this committee will be overseen by, and report to, the Emergency Planning Panel if a Major Incident has been declared.

Applying basic infection prevention and control measures and encouraging compliance with public health advice are likely to make an important contribution to the UK’s overall response. Simple measures will help individuals to protect themselves and others. The necessary measures include:

- Covering the nose and mouth with a tissue when coughing or sneezing.
- Disposing of dirty tissues promptly and carefully – bagging and binning them.
- Washing hands frequently with soap and water to reduce the spread of the virus from the hands to the face or to other people, particularly after blowing your nose or disposing of tissues.
- Making sure children follow this advice.
- Cleaning hard surfaces (e.g. kitchen worktops, door handles) frequently using a normal cleaning product.
- Avoiding crowded gatherings where possible, especially in enclosed spaces.

Should a service user be diagnosed with pandemic flu, the Trust’s source isolation precautions, which is part of the infection prevention and control precautions, is designed to protect staff, patients and visitors by reducing exposure to potentially pathogenic organisms. It allows staff to make risk assessments and instigate appropriate precautions based on the transmission route of each particular organism, whilst maintaining as much individualised care as possible. Any new guidance on infection prevention relating to a Flu Pandemic will be provided by PHE and distributed to all NHS Providers.

8.1 Objectives in Infection Prevention and Control

- To provide a safe environment for staff, visitors and service users.
- Identify risks posed by infections and the causative organism.
- Use principles of risk assessment to provide quality and individualised care for service users requiring isolation.

The Infection Prevention and Control Team will undertake routine surveillance on a daily basis of ‘alert organisms’. This is continuous monitoring of infection risk in hospital caused by specific high-risk organisms. In addition, ward-based surveillance will be carried out. The level of surveillance will continue to be dictated by the resources available to the Infection Prevention and Control Team. Infection Control Policy

8.2 Personal Protective Equipment (PPE)

A funding allocation may be received from the DH in order to support the Trust’s stock piling arrangements for PPE across all regions. The Head of Purchasing will ensure that the Trust’s PPE has been distributed across all localities and consists of:

- Plastic apron.
- Eye protection.
- Soap, water and hand towels/alcohol hand rub.
- Gloves.
- Surgical face mask for exposure prone procedures.
• Respirators.

PPE for Pandemic flu when used in a community/home environment, is classified by SHSC as normal healthcare waste, and should be dealt with according to normal procedure.

The **Use of Personal Protective Equipment during a pandemic** deals with PPE use and selection from an infection prevention and control perspective, which applies to all staff employed by the Trust in all locations whether the premises are owned or leased by the Trust or owned by third parties.

### 9.0 Staffing

In preparation for a Flu Pandemic all teams will ensure that Business Continuity plans are in place to ensure adequate staffing for the maintenance of services. Care should be taken to ensure that staffing is maintained at safe levels.

### 9.1 Staff Absence

The level of staff absence from work during a pandemic will depend significantly on the nature of the pandemic virus when it emerges. SHSC Business Continuity Plans contain some contingencies for mitigating the effect of staff absence but it is a possibility that some teams may be severely short staffed and would require assistance in order to perform their functions. In such a situation the Emergency Planning Panel may be needed to decide what functions a team may suspend in order to maintain critical services.

During a pandemic, staff will be absent from work if:

- They are ill with flu. Numbers in this category will depend on the clinical attack rate. If the attack rate is the 50% figure given in the reasonable worst case, half of staff in total will be sick (and hence absent from work for a period) at some point during the course of the pandemic. This could give absence rates of 15-20% in the peak weeks of the pandemic assuming it occurs in one wave over a period of 12-15 weeks. But there may well be more than one wave, with absence from work being spread across those waves.

- Absence is likely to be 7 working days for those without complications, and 10 for those with
  - a) A need to care for children or family members who are ill
  - b) A need to care for (well) children due to the closure of schools
  - c) They have non flu medical problems or
  - d) they have been advised to work from home.

National guidance states that as a rough working guide, organisations employing large numbers of people, with flexibility of staff redeployment, should ensure that their plans are capable of handling staff absence rates of up to the 15-20% set out above (in addition to usual absenteeism levels). SHSC is a large organisation made up of smaller separate clusters spread over a wider geographic areas and as a result may see higher or lower rates of absenteeism depending on the area. National guidance estimates absences of up to 35% in some cases.

As a result SHSC business continuity plans need to be flexible enough to ensure safe staffing levels for critical services. If a Major Incident is declared the Emergency Planning Panel would be required to prioritise critical services and deploy staff appropriately. This may require staff being re-assigned to different duties.
The Emergency Planning Officer has access to files that list all the critical services provided by each team within SHSC. This information is based upon each Business Continuity Plan and may be used to identify high priority functions. All teams will be required to update this information if a Flu Pandemic is detected to ensure information is up to date.

Each team manager should also be aware of the following staff information to aid their decision making during a Flu Pandemic:

- Whether staff have dependents.
- Whether staff have underlying health conditions that may make them more at risk from influenza.
- Where staff live and how they travel to work.
- Whether staff are prepared to “live in” at work during the pandemic (if possible or required).

This will clearly affect how the Trust will cope in a situation of increasing demand, particularly as the country’s infrastructure in terms of food, water, power and fuel distribution may be affected. Business Support Unit representatives as part of the Emergency Planning Panel would assist with decision making about the prioritisation of services during a flu pandemic by reviewing Business Continuity Plans.

9.2 Psychological Support for Staff

A Flu Pandemic could put staff under considerable pressure. Conflicts may arise between staff members’ professional obligations and personal responsibilities. Support should also be available to individual staff to address ethical dilemmas that may arise. Guidance on psychosocial care for staff is available at DH (July 2009) Psychological Care for NHS staff during an Influenza Pandemic and at Annexe C.

In the immediate aftermath of sudden events and after people’s initial involvement in longer and more sustained emergencies such as a Flu Pandemic a very substantial proportion of survivors show a stunned reaction from which the vast majority recover given basic humanitarian and welfare aid.

9.3 Training for Staff

In the Detection and Assessment stages of a Flu Pandemic special attention must be given to ensure all staff are familiar with infection control advice and basic care skills that may avoid the need to transfer patients with flu-like symptoms to other services. IPCTs are to play a key role in the response to a Flu Pandemic and specific actions for IPCTs are included in the actions card for the AEO at Annexe A.

Staff Training and Development may be affected by an influenza pandemic. If the threat of an imminent pandemic is identified, then normal scheduled training may be halted. It would be replaced with refresher courses for staff that have clinical skills, to enable them to practice safely until normal training provision is resumed upon the direction of the Emergency Planning Panel.

Mandatory training may not be able to be delivered in the normal way; however, training could be delivered within the workplace through the use of electronic media and team level training.
10.0 Continuity of Care

Continuity of care within SHSC relies on individual team Business Continuity Plans. Teams must ensure they have analysed their functions to identify those that are of a high, medium and low importance. This will allow them to identify critical functions and investigate suitable contingencies to ensure these functions are performed if the team is affected by a Flu Pandemic.

As data about a Flu Pandemic is gathered this will inform the response through scientific advice and modelling. This will not provide a definitive prediction but will allow contingencies to be tailored at team level. As information about the Flu Pandemic is available this will be shared with staff.

Initially SHSC will most likely be asked to engage with other NHS providers, providers of social care and other partners to agree strategy and coordinate response. This may take place through existing networks or require extra commitment. In order to contribute properly SHSC would need to ensure attendance at such groups by a suitably senior member of staff.

At a local level public health services would play a lead role in informing response through surveillance via GPs, community services and hospitals to e.g. identify outbreaks and assess mortality rates. As a result there may be a requirement on SHSC to contribute toward this surveillance work and this would be a priority throughout the duration of the Pandemic.

10.1 Vulnerable Groups

The following vulnerable groups will be considered at each phase of the pandemic to ensure that services take into account their circumstances. Some patients may fall into more than one group. Existing networks such as Doncaster Surge & Escalation Group may be used as a forum to discuss response to the Flu Pandemic and how vulnerable groups may be served. Advice to each group must be tailored and agreed between all responding agencies via communication teams.

**Vulnerable Group**

<table>
<thead>
<tr>
<th>Vulnerable Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-English speakers</td>
</tr>
<tr>
<td>May be disadvantaged in terms of understanding the information cascaded from the</td>
</tr>
<tr>
<td>NHS England and PHE. SHSC policy to be used to ensure patients have access to</td>
</tr>
<tr>
<td>effective communication.</td>
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<tr>
<td>Service users with Children - May need help in understanding the implications of</td>
</tr>
<tr>
<td>a flu pandemic with regards to children</td>
</tr>
<tr>
<td>Service users - Children including those that have conditions that that increase</td>
</tr>
<tr>
<td>the risk of complications from influenza</td>
</tr>
<tr>
<td>Service users - Older people (65+)</td>
</tr>
<tr>
<td>Service users living alone</td>
</tr>
<tr>
<td>Service users in Residential care</td>
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<tr>
<td>Service users whose good health is dependent on taking regular medications</td>
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<tr>
<td>Service users with a mobility or sensory impairment</td>
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<tr>
<td>Service users not registered with a GP</td>
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<tr>
<td>Service users who may be homeless/travellers/illegal immigrants</td>
</tr>
<tr>
<td>Unlikely to attend GP surgery and may have no NHS number</td>
</tr>
<tr>
<td>Service Users in long stay care facilities where rapid spread is likely to cause</td>
</tr>
<tr>
<td>high mortality.</td>
</tr>
<tr>
<td>Service Users with chronic respiratory disease including asthma.</td>
</tr>
</tbody>
</table>
Service Users with Chronic heart disease, chronic renal disease, diabetes, chronic liver disease or with a suppressed immune system.
Health and Social Care staff involved in patient care.

10.2 Access to Medications

Access to medicines as part of normal business will continue during a flu pandemic.

Continuing access to medicines for patients requires a local response. The SHSC Chief Pharmacist has liaised with partners and suppliers to ensure they have adequate business continuity arrangements to maintain necessary supplies of medicines during a pandemic. During a pandemic the Chief Pharmacist’s team would liaise regularly with partners and suppliers to ensure that these arrangements were maintained. Any issues would be reported to the Emergency Planning Panel.

When service users, who may not have capacity to consent to treatment, need influenza-related medicines, usual consent procedures should be followed as set out in the Mental Capacity Act 2005 and its Code of Practice. The Mental Capacity Act 2005 gives the right to make Lasting Powers of Attorney (LPA) which enables other identified persons to make decisions on the patient’s behalf if they are unable to do so (unless the treatment is covered by other mental health legislation).

Should a service user have made a lasting power of attorney (LPA) for welfare matters under the act, the attorney would need to be consulted about the person’s treatment. This consultation may be affected if the LPA is affected by flu. Contingency plans will need to be in place to meet this. In relation to non-compliance, the Mental Health Act 1983 only permits the treatment of a mental health disorder without consent. However in urgent cases, treatment for influenza may be possible under common law, but a legal opinion will need to be sought for continued treatment.

It may be necessary to transfer a service user detained under the MHA 1983, to another mental health hospital or general hospital bed for treatment in relation to contracting flu. Trust procedures for this can be found within: [http://xct/images/stories/documents/policies/APPROVED/clinicalhandoverofcarepolicy.pdf](http://xct/images/stories/documents/policies/APPROVED/clinicalhandoverofcarepolicy.pdf)

10.3 Antivirals

Antiviral medicines will be free for those who have a clinical need. Centrally held stocks of facemasks and antivirals may take up to 10 days to be distributed. PHE hold responsibility for the national stockpile. Depending on the severity of a pandemic, a National Pandemic Flu Service (NPFS) may be available to provide symptomatic members of the public with rapid access to assessment, advice, triage and if appropriate, authorisation of antiviral medicine treatment. NHS Direct will set up and manage this service.

LRFs will need to understand local plans for the delivery of antivirals and support the NHS as appropriate. It is likely that depending upon the attack rate, each country’s arrangements for providing antivirals will build on normal structures through primary care services as far as possible.

It is the responsibility of local NHS commissioners and providers in England to also:

- Identify collection points (the locations from which antivirals can be collected on referral from the National Pandemic Flu Service (NPFS) or a healthcare professional), and other
locations that may need antiviral medicines on their premises. All antiviral collection points and points of use must have appropriate operational, business and resilience procedures in place which are kept under review. They must also be properly risk assessed for suitability with police advice as appropriate;

- Make arrangements for the issuing of antiviral medicines at these local collection points (e.g. on referral from the NPFS), monitor consumption of antivirals across the locality (in England by using a nationally developed stock management and reporting system)
- Ensure plans are in place to enable authorisation and delivery of antivirals locally where people are unable to access antivirals via the NPFS or do not have a FluFriend to collect their antivirals for them and ensure a “back up” plan is in place in the event that the NPFS is not functioning as required; and
- Nominate a team of appropriately skilled staff who are responsible for antiviral distribution coordination with the local NHS organisation. This team should be part of the NHS Organisation/Health Board coordination centre.

Further guidance on antiviral collection points including service requirements and specifications is to be issued by PHE in Spring 2014.

10.4 Social Care

Social care services could experience little pressure in the initial stages of a low impact Flu Pandemic. However, public health services and some SHSC services may consider the early closure of specific day care centres to reduce the risk of spreading infection to vulnerable individuals. Staff and volunteers from these services may then be re-deployed as appropriate.

SHSC bed based services and Community Mental Health Staff should ensure they are promoting good infection control measures amongst service users and staff, paying particular attention to those service users that arrange their own care. Efforts should be made to ensure that vulnerable people who have no one else are able to collect medication and are provided with care. This should be done via close liaison with partner agencies such as the local authority and CCG. Existing channels such as Sheffield Surge & Escalation Group may be used to share intelligence between providers to ensure services can react to changes in pressures.

Wherever possible patients should be managed and cared for at home, avoiding hospital admission unless this becomes essential. It remains the responsibility of all NHS organisations to deploy the right healthcare resources to care for those affected by Pandemic Flu.

10.5 Admissions criteria

SHSC would consider actions to mitigate pressures including the early discharge of inpatients with lower level needs, and transferring staff from other areas to ensure maximum flexibility. In extreme circumstances the Trust may be forced to close some or all inpatient areas with the possible exception of low secure, psychiatric intensive care and the Hospice.

Discharging service users from general inpatient wards to the community may be difficult during a Flu Pandemic. It will be necessary to evaluate the risk of discharge to the service user, and to others, compared with the risks of catching flu if remaining as inpatients and any loss of liberty that might be involved. This assessment should include assessing the level of support at home for individuals ready to be discharged, and the capacity of community services to provide care when their workloads may have already been increased by a pandemic.
10.6 Mental Health Services

In the medium and long term, a serious pandemic may precipitate serious mental disorders. Some people may suffer anxiety and/or depressive disorders consequent to a pandemic. People who are vulnerable to serious mental illnesses may relapse. Also, people are likely to continue to develop mental disorders that are not directly or indirectly connected with the pandemic.

Thus, additional pressures within the caseloads of mental health services in both primary and secondary care are likely to include new service users as well as existing users. Therefore, it is also possible that more requests for help will be made both during a wave of a pandemic and in its aftermath. This will be at a time when mental health services will have a limited capacity to respond. As such teams will need to prioritise their workload and consider actions such as merging caseloads and performing assessments by phone.

People with severe mental illness and/or learning disabilities have high rates of physical morbidity are at risk of social exclusion and discrimination. Crisis need to be anticipated and prevented and, if a crisis does occur, the patient involved requires prompt and effective help. This includes timely access to appropriate and safe mental health placements or hospital beds that are as close to home as possible. During a pandemic, such access will be affected and limited.

A large number of patients, such as people who have a learning disability, rely on family members or friends. These informal carers are a vitally important resource within community and mental health care, and contingency plans should be agreed where possible. Carers may find it difficult to cope during the pandemic, requiring support. Provision of information to inform carers on how they can both protect themselves from contracting influenza and care for a service user with influenza will be critical. This includes advice on what to expect and what to do in the event of an outbreak and how certain services should be accessed, alongside hygiene and infection control measures.

It is anticipated that there will be a marked increase in demand for emergency short-term care for service users when their carers fall ill, impacting at a time when capacity and staffing are limited. SHSC will liaise with partners to plan and prioritise how they may meet this increased demand, with a view to patients remaining in their own homes if possible. Specific care plans may be needed enabling straightforward passing of care from carer to health professional, or between health professionals.

In a moderate or serious impact pandemic, pressures may mean that units cannot transfer service users who develop increased physical health needs to acute hospitals as regular practice would require. Access to primary care could also be limited, and SHSC may be required to care for existing and new service users who are suffering from influenza or its complications. The Trust IPCT will ensure teams are fully briefed on how to deal with such service users.

Forensic services would consult their business continuity plans for contingencies for patients requiring legal proceedings or transfer for medical care during a pandemic that affected staff levels.
11 Supply Chain Resilience

Provision of supplies to meet the requirements of a surge caused by a Flu Pandemic will be assisted by partnership working through critical care networks and with leadership and advice from CCGs, PHE and NHS England to meet the anticipated need. SHSC Teams will need to stay in close contact with suppliers in order to receive warning of any disruption to supply so they can act accordingly.

12 Waste Disposal

The Trust has contracts in place with Waste Disposal Contractors for the disposal of:

- General Household Waste. (This would include all recycling waste)
- Healthcare Waste.

Healthcare Waste arising during an outbreak will increase substantially and the existing Waste Disposal Contractor would be expected to deal with the initial surge. Over long periods of an outbreak consideration would need to be given to the possibility of providing a designated storage area on site for holding the excess waste until it can be collected for disposal. If the build-up is excessive then it may be necessary to arrange for the burning (incineration) of the waste on site in specially provided units. Guidance would be sought from the Environmental Health Department of the Local Authorities. However it is envisaged that there is sufficient waste storage facilities available on the St. Catherine's site.

13 Vaccination

Immunisation is the most effective counter-measure against influenza. Everything will be done to produce a vaccine as quickly as possible, but production of a vaccine could take at least 6 months or longer.

Prioritisation of flu vaccines will predominately be based on risk and is likely to target those in essential work (front line staff) and those with health conditions that put them at risk.

SHSC will follow NHS England & PHE Directives/National Protocols regarding the ordering, storing and prescription of vaccines once they are communicated. However SHSC will also be able to convene its Vaccination Planning Group for Seasonal Flu and use their experience to plan a vaccination programme for a flu pandemic in advance of vaccines becoming available.

13.1 Pre - Pandemic and Pandemic Specific vaccines

There are two distinct types of pandemic vaccine:

**Pre-pandemic vaccines** that are produced in advance of a pandemic and are designed to protect against a strain of influenza virus that expert’s judge to be a Potential cause of a future pandemic, e.g. H5N1. The degree of protection will depend on how similar the pandemic viral strain is to the strain used to prepare the Vaccine.

**Pandemic-specific vaccines** that are developed specifically to protect against the Pandemic viral strain once it has been isolated. Once available, a pandemic specific Vaccine should protect most recipients from clinical illness and may also reduce illness severity, hospitalisation and death and therefore the national impact of subsequent waves of the virus.
13.2 Pre-pandemic vaccine

The Government currently holds a limited supply of H5N1 vaccine. This could potentially offer some protection. However, this vaccine would not necessarily be well-matched to the specific pandemic strain once it emerges and so the level of protection offered by the vaccine would not be known until a new pandemic virus emerges.

Taking account of this and the current Joint Committee on Vaccination and Immunisation (JCVI) advice, the Government’s policy is that these vaccines, if useful, would be prioritised for the protection of frontline healthcare workers and those in clinically at-risk groups.

13.3 Pandemic-specific vaccine

The development of a new pandemic-specific vaccine can only begin once the new pandemic influenza viral strain has been identified and isolated. Arrangements have been put in place by the European Medicines Agency (EMA) to enable manufacturers to conduct studies with prototype pandemic-specific vaccines and seek approval of ‘mock up’ licences in the inter-pandemic period. These studies mean that the form of Pandemic-specific vaccine will already have undergone detailed clinical trials, including safety studies, which allows the new vaccine to be licensed and available for use as quickly as possible.

The production process is highly complex and it is likely to take at least four to six months after the start of a pandemic before a pandemic-specific vaccine would start to become available.

As a contingency measure, the Government is currently in discussion with manufacturers about the possibility of securing new advance supply agreements for a pandemic-specific vaccine to be available as soon as it is developed. However, it is not realistic to expect that vaccination with a pandemic-specific vaccine will have an impact during the first wave of an influenza pandemic although pandemic specific vaccines could be an important tool in preventing further cases and protecting the vulnerable, particularly if further waves of infection occur.

13.4 Vaccination Planning

In order to deliver a successful vaccination programme, the Trust will deliver its own immunisation programme across all patches by ensuring:

- The retention of an up to date list/data on those staff members who are fully trained to immunise. The seasonal flu vaccination group is able to provide this data.
- The release of those staff members from duty to undertake the immunisation programme.
- Protocols for administration of vaccine may use existing seasonal flu vaccination arrangements unless dictated otherwise by NHS England.
- Existing vaccination arrangements contain robust data gathering arrangements to ensure records of those vaccinated are completed.
- Equipment required for a mass immunisation programme is ordered with enough notice to be delivered before it is required. This must take into account the likelihood of large numbers of orders being placed at the same time from other organisations.

Staff that have received the training to administer the vaccines will be responsible for:

- Keeping up to date with any guidance issued in relation to pandemic influenza enabling them to answer questions regarding the vaccine.
- Completing pre vaccination screening.
- Recording details of the vaccination.
- Reporting any adverse reaction.
• Transfer of information/data to the appropriate person/department for collation/reporting mechanisms.

Service directors/clinical directors responsible for front line clinical services are responsible for:

• Making staff aware of the immunisation program.
• Encouraging and supporting staff to receive the vaccination.
• Releasing staff from duty who wish to attend for vaccination.
• Identifying staff that can be trained to administer the vaccine.

Front line clinical staff that are offered the vaccination are responsible for:

• Accepting or declining the offer of the vaccination.
• Notifying the administering nurse of any underlying health conditions.
• Attending their GP practice in the event that they are referred on by the administering nurse for any reason and advising the appropriate person/department of their visit to the GP for collation/reporting mechanisms.
• Informing their GP Practice of the vaccination to update their personal health records.

After immunisation, antibody levels may take up some time to provide protection, the expected period this will take will be made clear once the vaccine has been produced.

The Trust will identify a hierarchy of vaccination for staff as supplies are provided, consistent with the following general guidance.

### 13.5 Priority Groups for Vaccination

The Government would take advice on priority groups for vaccination from the SAG (Scientific Advice Cell) and JCVI Joint Committee on Vaccination and Immunisation. Vaccination may be limited to health and social care workers and clinical “at risk” groups thereafter, depending on advice issued.

Initial assumptions are that the usual seasonal flu clinical at risk groups will be at greatest risk but there may be rapid modifications to these priorities once more is known about the characteristics and impact of the new virus. A virus may attack groups assumed to be less vulnerable. For example the 1918 pandemic saw 99% of deaths occurring in adults aged under 65 years with over 50% aged 20-40. Local communication, and flexibility in delivery models to encourage vaccine uptake will be critical.

Frontline health and social care staff will be a priority group for vaccination. Encouraging vaccine uptake to become the norm in inter-pandemic years, ensuring open communication about the risks and benefits, providing opportunities for staff to access the vaccine easily both in and out of hours, and providing leadership through example, all contribute to successful uptake. Professional bodies may also play a role in encouraging uptake. A best practice document “Learning the lessons from the H1N1 vaccination campaign for Health Care Workers” was issued in July 2010. Successful initiatives include:

• Training additional staff to administer vaccine to staff in support of occupational health depts.
• Using private providers to immunise staff.
• Local leadership to promote vaccination e.g. lead clinicians having the vaccine as soon as it is available.
• Using roving clinics to take vaccine to staff.
• Engaging with staff side to promote the vaccination campaign.
• Holding clinics outside normal working hours.
• Enabling staff to take time out of their normal working day to receive the vaccine.

The Trust Seasonal Influenza Vaccination Group has a large amount of experience and expertise in this area.

13.6 Vaccination Storage

Fridges used in the seasonal flu vaccination programme may be used to store pandemic flu vaccines, subject to PHE advice. These fridges will be located and set aside for this use during the “detection phase” of a flu pandemic.

14 Recovery

As the impact of the influenza pandemic activity wanes, the UK will move into a recovery phase. Although the objective is to return to inter-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, on-going demands, backlogs, staff and organisational fatigue, and continuing supply difficulties in most organisations.

Therefore, a gradual return to normality is to be expected. This may be co-ordinated through a multi-agency recovery co-ordination group which may be established to ensure a joint approach to this phase. Further waves may occur so it is important to allow staff leave and rest to ensure staff recovery in preparation for a second wave and further sustained response. Within SHSC a Recovery Coordination Group will be set up to consider the effects of the Pandemic and return to normal business. This Group may lead on, or work alongside those charged with debriefing and learning lessons from the incident.

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 Activities that may have been scaled-down as part of the pandemic response e.g. re-schedule 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 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 services’ capacities are able to meet demand will also inform this decision.

Health and social care services may experience persistent secondary effects for some time, with increased demand for continuing care from:

• Patients whose existing illnesses have been exacerbated by influenza.
• Those who may continue to suffer potential medium or long-term health complications.
• A backlog of work resulting from the postponement of treatment for less urgent conditions.
• Possible increased demand for services through post-pandemic seasonal influenza.
The reintroduction of “business as usual” also needs to recognise that there may be reduced access to skilled staff and their experience. Many staff will have been working under acute pressure for prolonged periods and are likely to require rest and continuing support. Facilities, essential supplies, and medicines 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.

Other sectors and services are likely to face similar problems and may also experience difficulties associated with income loss, changes in competitive position, loss of customer base, lack of raw materials, the potential need for plant and machinery start-up and so on.

Although recovery is characterised as a move back to normality, it is not possible to predict further waves of the pandemic or the shape and impact of the pandemic virus as it becomes a future seasonal influenza virus, which will emerge and which will again require organisations to regroup and respond. In this sense, expectations around the performance of health and social care services should be managed as effectively as possible.
Traumatic/stressful incident/event occurs

Meeting arranged for staff member with line manager or other appropriate manager (if meeting with line manager might compromise any investigation). Timescale: preferably within 24 hours

Options for support are discussed

Options available

- Offer entry into staff counselling scheme
- Further sessions of managerial support/supervision
- Temporary adjustment to working arrangements
- Refer to Occupational Health

Regular meeting with, and review by, line or appropriate manager for a period of four weeks to assess for symptoms of continuing adverse impact on member of staff.

Where severe symptoms are reported and/or evident refer

Further interview with manager to take place routinely after four weeks to ascertain impact of event/experience on staff member and effectiveness of support to date.

No symptoms reported or evident – no further action

Symptoms reported or evident – refer (back) to Occupational Health
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACP</td>
<td>Anti-viral Collection Point</td>
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<tr>
<td>AEO</td>
<td>Accountable Emergency Officer</td>
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<tr>
<td>BCP</td>
<td>Business Continuity Plan</td>
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<tr>
<td>CBRN</td>
<td>Chemical Biological Radiological &amp; Nuclear</td>
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<tr>
<td>CCC</td>
<td>Civil Contingencies Committee</td>
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<tr>
<td>CCDC</td>
<td>Consultant Communicable Disease Control</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CI</td>
<td>Critical Infrastructure</td>
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<tr>
<td>CNI</td>
<td>Critical National Infrastructure</td>
</tr>
<tr>
<td>COBR</td>
<td>Cabinet Office Briefing Rooms</td>
</tr>
<tr>
<td>COMAH</td>
<td>Control of Major Accident Hazards (Regulations)</td>
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<tr>
<td>CRIP</td>
<td>Commonly Recognised Information Picture (A Sitrep by another name)</td>
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<tr>
<td>CRR</td>
<td>Community Risk Register</td>
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<tr>
<td>DH</td>
<td>Department of Health (England)</td>
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<tr>
<td>DIPC</td>
<td>Director Infection Prevention &amp; Control</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>EA</td>
<td>Environment Agency</td>
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<tr>
<td>EMAS</td>
<td>East Midlands Ambulance Service</td>
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<tr>
<td>EPO</td>
<td>Emergency Planning Officer</td>
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<tr>
<td>EPRR</td>
<td>Emergency Preparedness Resilience and Response</td>
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<tr>
<td>GLO</td>
<td>Government Liaison Officer</td>
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<tr>
<td>HAZMAT</td>
<td>Hazardous Materials</td>
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<td>HPA</td>
<td>Health Protection Agency</td>
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<tr>
<td>ICC</td>
<td>Incident Control Centre</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>IPCT</td>
<td>Infection Prevention Control Team</td>
</tr>
<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccination &amp; Immunisation</td>
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<tr>
<td>LGD</td>
<td>Lead Government Department (E.g. DH for a Flu Pandemic)</td>
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<tr>
<td>LHRP</td>
<td>Local Health Resilience Partnership</td>
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<tr>
<td>LRAG</td>
<td>Local Risk Assessment Guidance</td>
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<td>LRF</td>
<td>Local Resilience Forum</td>
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<td>MIP</td>
<td>Major Incident Plan</td>
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<tr>
<td>NHS CB LAT</td>
<td>NHS Commissioning Board Local Area Team</td>
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<tr>
<td>NPFS</td>
<td>National Pandemic Flu Service</td>
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<tr>
<td>NRE</td>
<td>National Resilience Extranet (Web based info sharing system)</td>
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<tr>
<td>OGD</td>
<td>Other Government Department</td>
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<tr>
<td>OOH</td>
<td>Out of Hours</td>
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<td>Scientific Advisory Group</td>
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<tr>
<td>SAGE</td>
<td>Scientific Advisory Group for Emergencies</td>
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<td>SCC</td>
<td>Strategic Coordination Centre (Set up for Gold in terrorist event)</td>
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<td>Strategic Coordinating Group</td>
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<td>SITREPO</td>
<td>Situation Report</td>
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<tr>
<td>TCG</td>
<td>Tactical Coordinating Group</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>YAS</td>
<td>Yorkshire Ambulance Service</td>
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