HARROW PCT INFLUENZA PANDEMIC PLAN

WITH REFERENCE TO
THE PLANS OF ALL OTHER NHS TRUSTS AND
OF PARTNER ORGANISATIONS IN HARROW

DOCUMENT CONTROL SUMMARY

Title	Influenza Pandemic Plan
Lead Director	Director of Public Health
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VERSION CONTROL SUMMARY

Version	Date	Status	Comment/Changes
1	2006	DRAFT	Update
2	2007	DRAFT	Update
3	2007	DRAFT	Update
4	Nov 08	DRAFT	Update and restructuring of plan to include updated guidance on key areas.
5	Dec 08	DRAFT	Update to business continuity and critical services
5.1	Feb 09	DRAFT	Update
6	Aug 09	DRAFT	Revision of plan
6.1	Aug 09	DRAFT	Revision of plan

Please note that guidance is still awaited from government in a number of key planning areas and this plan is subject to further revisions. Directors should ensure that any subsequent drafts are made available to their staff when published.

1. Introduction

This plan provides detailed arrangements for NHS Harrow's response to an influenza pandemic. It covers the actions to be taken by the PCT and primary care services. The plan is supported by a number of appendices and where relevant will highlight where the plan links to other PCT plans and policies. It is a supplement to the PCT major incident, corporate business continuity plan and individual departmental business continuity plans.

The impact of a pandemic and the likely spread of the disease can be unpredictable therefore this plan has been developed to provide a framework in which to respond whilst ensuring flexibility when required.

1.1 Aims

The aims of this plan are to:

- reduce the impact of influenza in the local population
- maintain core health services (including supporting independent primary care contractors)
- implement national requirements as detailed within the Civil Contingencies Act 2004 in respect of managing an emergency situation

1.2 Objectives

The objectives are to:

- reduce the spread of influenza
- limit morbidity and mortality from influenza
- provide treatment and care for people with flu and its complications
- make provision for large numbers of patients
- reduce impact on core health and social services
- ensure essential services are maintained
- reduce the impact on daily life and business and minimise economic loss

An influenza pandemic will present unique, national and local challenges to the delivery of health & social care producing case numbers far in excess of the capacity and capability of both systems to cope in conventional ways. Most influenza sufferers will need initial assessment and the majority of their subsequent care and support outside health care settings, thus creating particular pressures on primary and social care.

2. Planning

2.1 SHA Coordination of planning

The response to a pandemic will be coordinated across the Strategic Health Authority by the SHA incident team, led by the Flu Resilience Director supporting the Regional Director of Public Health.

2.2 Multi agency cooperation

For the purposes of external multi agency pandemic planning within the Harrow locality, there is a strategic level influenza pandemic committee chaired by the Chief Executive of NHS Harrow or nominated deputy. The purpose of this group as defined by the national guidance **(Source: Pandemic influenza: A national framework for responding to an influenza pandemic)** is to coordinate local planning including within the PCT, its neighbouring health organisations and multi agency partners. The group is attended by senior representatives including directors of the Local Authority, Chief Executive and or the Flu Resilience Director for the Acute trust, Borough Police Commander, Voluntary Sector. Members are required to send deputies with the appropriate level of authorisation if they are unable to attend. Whilst in the planning phase the group has been meeting quarterly, in the response phase of the pandemic it will meet as often as deemed necessary to support the localised response.

2.3 NHS Harrow preparedness

The PCT has established an internal influenza response group Chaired by the Joint Director of Public Health / Executive Lead for Emergency Planning which has responsibility for coordinating the overall response of the organisation to the disease including situation reporting. The group is attended by a core group of senior managers all of who have been assigned key areas of responsibility to manage and coordinate. The group meets at least twice per week to consider any revised national guidance, numbers of patients presenting, implications upon primary and secondary care services and to assign any additional tasks. For the purposes of governance, the Chair is this group reports directly to the PCT executive team and is aligned to the emergency planning group.

In the event that the response of NHS Harrow is deemed to require exceptional or extraordinary resources beyond those that can be managed as part of normal planning processes, the Joint Director of Public Health and Chief Executive in consultation with colleagues from the SHA will decide whether a major incident should be declared at which time the internal influenza response group will cease to exist and the major incident plan and its supporting mechanisms will be invoked to manage the situation.

There are a number of different mechanisms and plans used to support any extraordinary pressures upon primary and secondary care. Planning is already underway for “Winter Planning”, a process for managing increased bed activity during the winter months when traditionally illnesses such as seasonal flu causes more admissions. In the most severe of circumstances as highlighted in the paragraph above, the major incident plan can be initiated to support the local health system.

2.4 Clinical Management

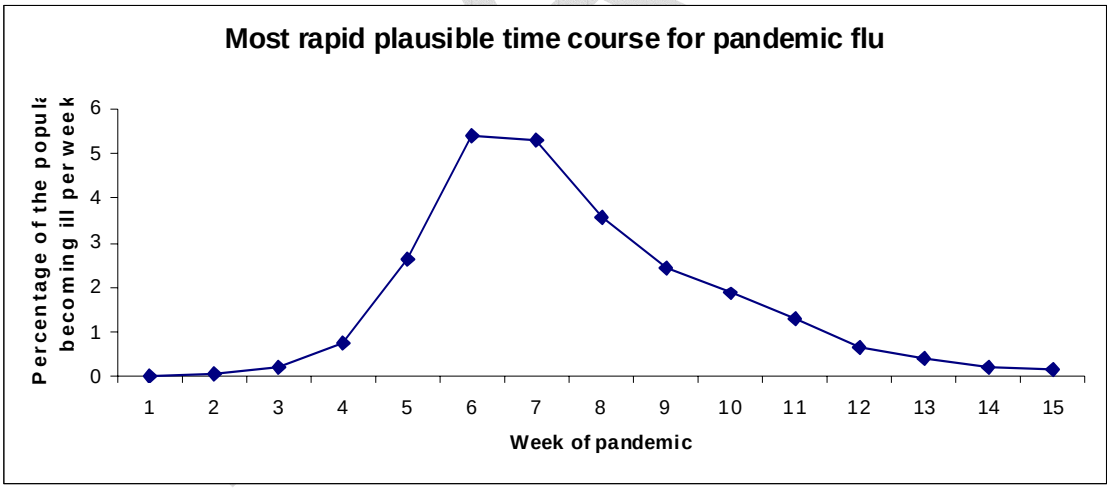
NHS Harrow in association with colleagues from NHS Ealing and Harrow Community Services have established processes for the surveillance of symptomatic patients and this service has the ability to operate out of hours. Whilst we have moved nationally from the containment to treatment phase, the surveillance process which includes the

swabbing of individual patients can still be re-established should it be deemed necessary.

2.5 Planning Assumptions

A wave of pandemic influenza in the UK would be expected to cause disease in at least 30% of the population with a significant number of those predicted to seek medical advice from primary care services. Government plans are base this estimate on a single wave which would occur over approximately 3 months. Often pandemic flu comes in more than one wave with a number of months between each of the waves. The Department of Health have asked Trusts to develop response plans for a revised 30% attack rate in a single wave with an anticipated complication rate of 15% and 2% of those patients requiring hospital admission.

Data modelling has shown that when flu occurs it arrives as a wave over about 3 months. There may be some weeks or even months of warning if the disease is first identified in other countries. The trajectory of the existing disease has suggested that we may have already reached the highest point of infection rates and the following figure shows how cases might have occurred over time once the pandemic became established in the UK. In the first few weeks there were few cases but by week 6, cases had peaked. This figure presents a rapidly developing pandemic with the highest peak that is likely. Pandemic influenza can also follow a slower course, rising more slowly and peaking with about 3% of the population becoming ill per week but still affecting approximately the same overall proportion of the population over a longer time.



3. Management of the response

3.1 Command and Control

In the initial stages as indicated above, the internal influenza pandemic response group will take responsibility for responding to the situation. As the disease emerges and pressure intensifies upon primary and secondary care, the Chief Executive of NHS Harrow in consultation with partners will decide whether or not to declare a major incident and establish the Emergency Operations Centre at the trust HQ as outlined

within the **major incident plan.** A number of specific action cards exist to support the management of the operations centre as detailed in appendix 6.

The role and function of this centre is to monitor the PCT's health response and make strategic and operational decisions relating to escalation on a day to day basis. As all plans have been made on modelling assumptions the actual situation as it evolves will depend on the severity of the pandemic, case fatality rate (CFR) and numbers of staff affected. This will affect operational decisions on a daily basis

The IPC will remain in place as a local coordination and advisory committee.

3.2 Daily reporting timetable

The process by which the PCT manages its response to pandemic influenza will be dependent upon numerous external factors for which it is unlikely to have any control over. The reporting timetable below is based upon the present reporting arrangements to NHS London but will only be implemented should the PCT Flu Director deem it to be necessary.

08.30	GP's to advise the PCT of any staff shortages
09.00	Internal Influenza Response Group to meet in CR3 with teleconferencing available for remote workers. Standing agenda to include: - Staffing levels - Business continuity & critical staffing levels - Surge capacity
09.45	Teleconference with LA representatives to confirm impact upon Social Care
10.00	All PCT staff to contact their managers with their availability to work
12.00	Noon briefing issued by NHS London
12.30	Noon briefing disseminated to PCT officers
13.00	Situation Report advising of flucon status to be submitted to NHS London
16.00	Internal Influenza Pandemic Group reconvenes to consider and review any actions arising from the noon briefing

3.3 Situation Reporting

Using a template, each PCT in London is required by the SHA to submit daily status reports alerting to any service pressures within primary and secondary care. The responsibility for collating and completing this report within NHS Harrow is that of the information team.

3.4 Managing the workforce

To work within the context of the PCT business continuity plan: current modelling suggests that up to 50% of staff could be affected by flu and or by caring responsibilities during the course of a pandemic with 15% absent at the peak.

- Routine work will be gradually reduced and finally postponed as demand rises and all staff will be required to work together to maintain essential services
- Each service has been asked to identify and agree minimum staffing levels
- Locality working and redeployment to areas of need has been agreed with staff partnership forum.

The HR department will be the workforce hub: The mechanism for reporting sickness absence to them will be via their service managers:

- Staff members phone in sick to their base by 10.00am
- The information is passed by colleagues onto service leads
- Service lead collates data and identifies gaps in essential service delivery that are impossible to cover in the locality
- Requests for additional staffing for the following made to the second meeting of the Internal Influenza Response Group by 16.00
- The skills register, which also identifies staff's caring responsibilities will be used to identify staff who could be re deployed
- Working staff will be contacted by their manager with a request to be re deployed to the area of need
- All clinically trained staff not currently working in clinical areas including senior managers maybe re-deployed to support the front line of clinical services if within their competencies.

The Internal Influenza Response Group will assist service leads to ensure that safe staffing levels are maintained

- It is important to re-emphasise that staff rotas allow for sufficient breaks and days off to maintain the health of those working through this time
- Immuno compromised or pregnant members of staff must not work in a "flu" area
- Staff must report sick if ill with flu and not come into work. They must phone their own GP for a treatment course of antivirals unless a priority list is in operation in which case arrangements to issue antivirals to priority groups will be established at the time. Current guidance states that they are not to be used for prophylaxis. They attenuate the infection if started within 48 hours ideally within 12 hours shortening the duration of flu by 24hours
- Occupational Health will monitor the health and well being of staff, assessing the fitness of staff to return to work following influenza infection if it includes phased or graduated returns and their suitability to work in frontline areas
- Once a member of staff returns to work fit to work, following flu, they can be readily deployed to work with flu patients
- All study leave will be cancelled
- Annual leave will be negotiated with staff depending on the staffing crisis

In support of identifying the impact upon the workforce, the HR department is completing monthly returns to the SHA to confirm the level of sickness and absence.

Please see appendix 1 for a copy of the full HR workforce plan.

3.5 Local Flu Line

The PCT has established and has the ability to re-establish a “local flu line” in support of General Practice. The telecommunication systems within the PCT enable the organisation to scale up its response should it be deemed necessary.

Please see appendix 2 for a full copy of the local flu line plan.

3.6 Anti-virals

It is vital that the anti viral drugs are used efficiently for the treatment of cases at high risk of complications and to prevent infection. The early use within 48 hours of anti viral drugs to treat influenza may shorten the period of illness by a day, ameliorate systems and reduce the need for hospitalisation by 50%.

The DH has requested that PCT’s establish “Limited Access” and “Public Collection Points” for anti viral distribution centres using a prescribed checklist of contents that are required at the different types of sites.

Limited Access sites will be used by PCT’s for local centralised storage. Additionally a proportion of the stock will be held for the OOH (Out of Hours Service) that may visit symptomatic patients in their own homes that have no physical way of collecting them. For security purposes, the address of the limited Access site will remain confidential.

Public Collection Points have already been identified and established throughout the PCT area and include a multitude of pharmacies. This model has been chosen to offer the most appropriate and suitable level of advice as possible. In the event that the numbers of patients attending the pharmacies become overwhelming, a plan exists to open two large scale anti-viral centres which can accommodate a much greater level of footfall.

Please refer to appendix 3 for the anti-viral plan.

3.7 Vulnerable People

Using national guidance, the PCT has been working with partners to develop appropriate protocols to manage and support vulnerable people. National guidance states that the six identified groups in society that are considered vulnerable are:

- disabled people and those with long term health conditions
- people belonging to some ethnic minority groups
- excluded older people
- younger people with complex needs
- people with low levels of literacy
- disadvantaged people who move frequently

In the event that the pandemic becomes more widespread, partner agencies across Health and Social Care supported by colleagues from the voluntary sector will initiate plans to streamline support to those most in need.

3.8 Infection Control

Specific infection control guidance is available for hospitals, primary care and some other settings but generally limiting the transmission of pandemic influenza requires the application of tried, tested and proportionate basic infection control measures such as:

- staff and public education
- local risk assessments to inform decisions on control and protective measures as required by the Control of Substances Hazardous to Health Regulations 2002
- documenting proportionate procedures, operational protocols and checklists
- the consistent application of basic hygiene and infection control measures
- timely recognition of symptomatic patients
- segregating (isolating) any symptomatic patient and limiting external contact
- using voluntary quarantining measures if necessary
- clustering patients who become symptomatic in specific wards/areas
- ensuring that staff are well informed about and adhere to procedures for the prevention and transmission of influenza
- providing personal protective equipment if occupational risk assessments have indicated that to be necessary and ensuring that staff are trained in its correct wear, limitations and use
- implementing enhanced cleaning routines to minimise the risk from contact with hard surfaces.

Throughout the pandemic coordination process, these principles will be implemented to limit the spread of disease.

3.9 Managing surge demand

Initially it would be planned that the local health community would utilise and invoke the normal procedures associated with bed pressures to cope with increased numbers of inpatients.

When the situation deteriorates beyond a position which can typically be managed by escalation procedures, advice will be from the SHA regarding the most appropriate time to reduce or stop elective surgeries.

A number of strategies will be used to manage the expected increase in surge demand including but not limited to:

- Accelerated discharge of patients into community facilities
- Reduction / stop of all elective surgeries
- Increasing of bed capacity by the local PCT within its own facilities
- Initiatives with private hospital providers to increase capacity by utilising their establishments

However, all of these actions are dependent upon there being an available workforce that could support such actions.

3.10 Supporting patients in the community

As with our response to manage surge demand in this situation, we will utilise a number of strategies including but not limited to:

- Engaging with patients in the community to educate about "self help"
- Working with partner agencies to reduce any duplication of visits by health and social care teams
- Reducing the regularity of visits by district nursing staff where it is clinically safe to do so
- Increasing appropriate levels which we use to determine and prioritise patients

3.11 Supporting "end of life care"

As indicated in the section above, when services are stretched to their maximum, the benchmark by which we determine and prioritise patients in the community will need to be raised. In these exceptional situations we will extend our working arrangements with colleagues from partner agencies and the voluntary sector to ensure that support and dignity is available to those in receipt of end of life care.

3.12 Business Continuity

The PCT has a Business Continuity Policy which is aligned to the BS25999 standard which is reviewed annually. In support of the service areas, the policy includes a standard template which can be used by the service areas to develop their own individual BCM plans based upon a pre-determined set of risks including loss of workforce, fuel disruption and the threat of a pandemic. In some circumstances, localised risks will also be included in service plans.

The PCT has identified all of its services and in recognition of the extreme circumstances that a pandemic will present, these services have been placed into three categories; non essential, essential and critical.

3.13 Communications

Whilst the majority of communications will be coordinated nationally and regionally, the PCT has developed a strategy to manage communications throughout the pandemic which includes advising people self care and reiterating national messages.

A copy of the full strategy is attached as appendix 4

4. Testing of plans

Plans of all organisations will be regularly tested to ensure they are effective and coordinated. The testing will be undertaken by the IPC.

5. Standing down

The decision to stand down the Influenza Pandemic Committee and the Internal Influenza Response Group or the Major Incident Team will be taken either at national or

regional level. It will be important to maintain planning and vigilance until well after the visible signs of the pandemic have ended. It is not clear whether the pandemic will occur in more than one wave, but the planning scenario is to expect at least two waves. Although the PCT may stand down its activity, the Influenza Pandemic Committee Chaired by the Chief Executive may continue to operate a planning and preparedness function.

Additionally, continuous surveillance will be essential to both detect any re-emergence and to ensure that the pandemic has finished locally.

6. Recovery

Recovery from a severe pandemic will take months if not years. It will be necessary for organisations to continue to meet regularly to ensure that public services are maintained and returned to normal as soon as possible.

Specific service needs in the aftermath of a pandemic could include bereavement counselling services and care of vulnerable people in line with standing Emergency Plans for any major incident.

As we move through wave one and in anticipation for wave 2 the PCT is actively pursuing processes to coordinate the recovery of services which is aligned to business continuity processes and includes but not limited to identifying all targets which could be affected in the next few months, what additional support may be required and the impact on staff in the longer term.