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CWP Pandemic Influenza Plan 2019

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Type of document	Guidance
Target audience	All CWP staff
Document purpose	To provide a framework for response and recovery to influenza pandemic; Ensuring that Cheshire and Wirral Partnership NHS Foundation Trust are prepared and coordinated to respond to increased needs and service demand throughout an infleunza pandemic period

Approving meeting	Emergency Planning Sub-Committee	12-Nov-19
Implementation date	12-Nov-19	

CWP documents to be read in conjunction with	
GR7 EP1 IC9 HR3.3 HR3.5 HR3.6 GR12	Major Incident Plan 2019 Business Continuity Management Policy and Procedures Pandemic Influenza policy Trust disciplinary policy and procedures Managing attendance Flexible working and special leave Media relations Service and Team Business Continuity Plans

Document change history	
What is different?	1. Updated to new CWP Template 2. Incorporate updated plans from NHS England and Operating Framework for Managing the Response to Pandemic Influenza
Appendices / electronic forms	N/a
What is the impact of change?	N/a

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Julie Spendlove (Head of IPC), Helen Davies (IPC Specialist Nurse), Jane Critchley (East EP), Glenda Bryan (Wirral EP), Sharon Vernon (West EP)
Corporate services	Published on CWP Intranet Noticeboard
External agencies	No

Financial resource implications	None

External references
1. NHS England Operating Framework for Managing the Response to Pandemic Influenza (December 2017) 2. NHS England Guidance to the NHS on current and future preparedness for an influenza pandemic (April 2016) 3. Pandemic Influenza Response Plan, Public Health England (August 2014) 4. Preparing for Pandemic Influenza - Guidance for Local Planners (July 2013) 5. Department of Health and Social Care Influenza Pandemic Preparedness and Response (April 2012) to be read in conjunction with DoH UK Influenza Pandemic Preparedness Strategy (2011)

Equality Impact Assessment (EIA) – Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

1. Introduction

Pandemic Influenza remains the highest risk on the national risk register It is now generally accepted that it is not a case of if there will be another pandemic but when. The Department of Health is the lead UK agency for the national response to pandemic flu.

The Department of Health and Social Care Influenza Pandemic Preparedness and Response (2012) guidance is intended to support preparedness and response planning to revise plans to reflect the learning from the pandemic in 2009 and the latest scientific evidence. The potential for a new influenza remains unchanged although the timing and severity of future pandemic remain unpredictable.

All Public Health, NHS and social care organisations, including Mental Health Trusts are required to have plans detailing their contingency arrangements for pandemic flu. Furthermore, it is essential that the Trust feeds into the local Health and Social Care economy plans; work is ongoing with partner organisations.

This plan incorporates updates from NHS England and Public Health England which have incorporated the learnings from the national multiagency pandemic influenza Exercise Cygnus in late 2014 together with lessons identified during the response to the 2009 pandemic

1.1 Background

Each year, seasonal influenza affects many thousands of people in the UK. Occurring mainly in winter, it is an infectious respiratory disease capable of producing symptoms ranging from those similar to a common cold, through to very severe or even fatal. It brings about variable effects in successive winters and in some years causes intense pressure on health and social care services and significant levels of absence from the workplace and schools.

From time to time, with unpredictable frequency, a distinctly different strain of influenza virus will emerge that spreads rapidly across the world, causing an influenza pandemic. The World Health Organization (WHO) currently 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."

The Department of Health & Social Care UK Influenza Pandemic Preparedness and Response (2012) sets out the key changes to the previous approach, reflecting the lessons learnt from the H1N1 (2009) influenza pandemic (colloquially called swine flu). These aim to develop better plans for the response to a new virus, when the focus should be on rapid and accurate assessment of the nature of the pandemic virus and its effects, and ensure a response is proportionate to a range of scenarios reflecting pandemic viruses of low, moderate and high impact.

It is uncertain when a new pandemic virus might appear. Until it emerges and affects a significant number of people, it will not be possible to identify the key features of the disease, such as any pre–existing immunity, the groups most affected, and the effectiveness of clinical countermeasures.

Given this, there are three main principles that must underpin planning and response;

- Precautionary – plan for an initial response that reflects the level of risk, based on information available at the time, accepting the uncertainty that will initially exist
- Proportionality – plan to be able to scale up or down in response to the emerging epidemiological, clinical and virological characteristics of the virus and its impact at the time.
- Flexibility – plan for the capacity to adapt to local circumstances that may be different from the overall UK picture – for instance in hotspot areas.

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 are available.
- **Service capacity-** the number of patients presenting at primary care services and / or admitted to hospital and intensive care and specialist treatment (e.g. extracorporeal membrane oxygenation (ECMO)), 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.

1.2 Aims and objectives

The CWP Pandemic Influenza Plan aims to describe proposals for an updated strategic approach to planning for and responding to the demands of an influenza pandemic.

The objectives of the CWP Pandemic Influenza Plan are;

- Save lives and alleviate illness,
- Cope with large numbers of people ill, at home and in the hospital,
- Ensure CWP essential services are maintained,
- Work in partnership with the health and social care economy partners to provide timely, authoritative and up-to-date information for professionals, the public, staff and the media at all stages.

1.3 Scope

This approved plan sets out the overall plans for services managed by the Trust.

1.4 Mutual aid

While it is anticipated that this principle will be difficult to fulfil during an influenza pandemic, it must be acknowledged that some expertises and mental health resources are distributed across Cheshire, Merseyside and Greater Manchester health and social care economies. All health and social care partners will be required to work closely together and coordinate their activities in order to support essential care provision.

1.5 Working with joint health and social care partners

A number of our services are jointly managed and staffed. In the event of a pandemic situation it is the expectation of the Trust that joint health and social care staff follow CWP's influenza pandemic planning arrangements unless informed otherwise by a health or social care senior officer.

1.6 Support vulnerable people

Whilst the Trust service users may be considered vulnerable, this plan supports their continued care.

1.7 Plan review

This plan will be the responsibility of the Trust Emergency Planning Sub Committee; this sub committee will revise this plan in light of new guidance. During an influenza pandemic this plan will remain a working document and will be reviewed regularly.

This plan will be reviewed in light of learning from incidents, exercises and comments received.

At local level, local authorities will have a much stronger role in shaping services, and will take over responsibility for local population health improvement

1.8 Testing and Validation

This plan will be tested and validated through exercises developed as part of CWP's annual emergency planning training and exercise programme, the responsibility for which lies with the Emergency Planning Sub-Committee.

1.9 Ethical considerations

Ethical considerations are important in determining how to make the fairest use of resources and capacity. The routine use of the principles outlined by The Committee on Ethical Aspects of Pandemic Influenza (CEAPI) can act as a checklist to ensure all ethical considerations have been considered.

2. Context

2.1 Key Assumptions

Whilst the profile of the next pandemic remains unknown, there are some key assumptions that will help to inform planning;

- A pandemic is most likely to be caused by a new subtype of the Influenza A virus but plans could be appropriately adapted and deployed for any epidemic infectious disease.
- An influenza pandemic could emerge at any time of the year anywhere in the world, including in the UK. Regardless of where or when it emerges, it is likely to reach the UK very rapidly and, from arrival, it will probably be a further one to two weeks until sporadic cases and small clusters of cases are occurring across the country.
- The potential scale of impact, risk and severity from related secondary bacterial infection and clinical risk groups affected by the pandemic virus will not be known in advance.
- It will not be possible to completely stop the spread of the pandemic influenza virus in the country of origin or in the UK, as it will spread too rapidly and too widely.
- Initially, pandemic influenza activity in the UK may last for up to three to five months, depending on the season. There may be subsequent waves of activity of the pandemic virus weeks or months apart, even after the WHO has declared the pandemic to be over.
- Following an influenza pandemic, the new virus is likely to persist as one of a number of seasonal influenza viruses. Based on observations of previous pandemics, subsequent winters are likely to see increased seasonal flu activity compared to pre-pandemic winters.

2.2 Pandemic Planning Assumptions

Pandemic influenza planning in the UK is based on an assessment of the 'reasonable worst case' derived from experience and a mathematical analysis of seasonal influenza and previous pandemics. The national planning assumptions in the UK Influenza Pandemic Preparedness Strategy 2011 indicates that:

- up to 50% of the population could experience symptoms of pandemic influenza
- during one or more pandemic waves
- lasting 15 weeks
- although the nature and severity of the symptoms would vary from person to person

Analysis of previous pandemics suggests that we should plan for up to 2.5% of those with symptoms dying as a result of influenza, assuming no effective treatment was available. It is recognised that the combination of high attack rates (as described above) and a severe disease is relatively (but unquantifiably) improbable and also that there are a range of countermeasures and interventions available and consequently suggests planning for a lower level of population mortality is sensible. Therefore the NHS should ensure plans are flexible and scalable for a range of impacts.

Although all parts of society will be affected by a pandemic, the NHS is likely to be particularly impacted due to an increase in demand for services coupled with a potential reduction in staffing (due to a variety of factors including personal illness and caring responsibilities) and possible supply chain disruptions.

Planning at all levels needs to be comprehensive and flexible to address the breadth of possible scenarios. A proportional, graded response that can be adjusted as the threat alters, including cessation or commencement of certain functions, is required.
However, the 2009 pandemic did not manifest as anticipated being generally mild for most patients, thus illustrating the uncertainties behind pandemic preparedness.

2.3 Health and Social Care Planning Assumptions

Staff absence is likely to follow the wider community profile. In a wide spread and severe influenza pandemic affecting 50% of the population, between 15-20% of all staff might be absent on any given day during peak weeks, with smaller teams potentially experiencing increased absence percentages. These figures may be reduced by the impact of antiviral and antibiotic countermeasures depending on the effectiveness of these measures.

2.4 Essential Services in the event of an Influenza Pandemic

In the event of an influenza pandemic all CWP services users are deemed as vulnerable for the purpose of Pandemic Flu.

Wherever possible clinical and non-clinical staff will be redeployed to support the above areas in the event of influenza pandemic, however this will be done without disproportionately increasing risk of patients within other services.

2.5 Essential external support services identified in CWP

It is important for all services to identify, ahead of influenza pandemic, those externally contracted support services that enable them to provide a service. The Trust will maintain relationships with these external contractors in all phases of influenza pandemic.

2.6 Avian Influenza

Avian influenza is still considered a threat, particularly H5N1 and algorithms outlined by PHE have been developed to reflect this. However, they are flexible enough to be used should another event capable of causing human disease be identified.

Government Avian influenza: guidance

3. Definitions

Pandemic - a pandemic is a global outbreak requiring coordination at national level with close working between the NHS, public health and social care services.

Business Continuity - Business Continuity Management (BCM) is an essential tool to enhance the Trust's ability to withstand the effects of potential widespread disruption as a result of a flu pandemic. BCM embraces all parts of the organisation and is underpinned by services' specific plans to respond to the impact of the pandemic.

Recovery - The process of rebuilding, restoring and rehabilitating the community following an emergency.

4. Procedure

The UK approach using these indicators for action in a future pandemic response was developed in 2011, taking into account a series of phases moving from one phase to another;

- Detection
- Assessment
- Treatment
- Escalation, and
- Recovery.

These phases aren't numbered as they are not linear and may not be a clear delineation between phases.

Detection

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.

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.

Escalation
The focus in this stage would be:

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

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;
- Post-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt;
- Taking steps to address staff exhaustion;
- Planning and preparation for a resurgence of influenza, including activities carried out in the Detection phase;
- Continuing to consider targeted vaccination, when available;
- Preparing for post-pandemic seasonal influenza.

4.1 Health and Social Care Structures; Pandemic preparedness and response

At the start of the pandemic there will be a transition from business as usual, where operational decisions are devolved at the local level, to a command and control system led at a national level that is able to coordinate the response.

It is the responsibility of each local area to ensure that preparedness plans are drawn up and tested.

Local planning and health and social care level will incorporate;

- Communications plans – integrated with the national communications strategy;
- Individual school closures, within the guidelines specified in the UK Influenza Pandemic Preparedness Strategy 2011;

- Receipt, storage and onward distribution of national countermeasure stockpiles across each local area;
- Location and operation of ACPs;
- Movement from initial response phases of Detect and Assess to Treatment and Escalation in hotspot areas with advice from local and national public health services;
- Escalation and de-escalation of response in local service areas – within the context of national arrangements;
- Mutual aid arrangements across local and sub-national organisations;
- Flexibility in commissioning plans to enable money to follow appropriate interventions in different settings, e.g. the vaccination of at risk groups;
- Vaccination implementation plans, including those for health and social care staff;
- Recovery, audit and return of unused national countermeasures, and
- Real-time feedback on coverage across local areas.

4.1.1 Reporting

In the response phase of influenza pandemic, there will be a requirement for the Trust to submit situation reports to commissioners providing an update on the Trust current position and any operational areas experiencing significant pressures.

These requests for information will be coordinated by the major incident team and made available to the business continuity leads for completion at a local level. The influenza pandemic lead will liaise with business continuity leads ahead of any submission to ensure that information is collected in the most effective and efficient way.

4.1.2 Core principles

The key “must do’s” in influenza pandemic planning, as directed by the health and social care influenza pandemic preparedness and response guidance are;

- A **future influenza pandemic remains a threat** and may have a more severe impact than in 2009;
- **Joint planning** between all organisations, together with a cohesive approach for every response phase is essential;
- **Exercises and testing** are still needed on an ongoing basis within individual organisations and with partner organisations to test assumptions and interrelated aspects of plans;
- **Coordination** of a pandemic response is key to ensure best use of resources and to achieve the best outcome for the local area, and
- **Continuity** plans are needed to underpin pandemic influenza response, in common with many other emergency response plans.

4.2 Preparing to Respond

People infected with the virus are likely to experience typical influenza symptoms of varying severity. Pivotal to all local plans are;

- A sustainable community-based response -with effective arrangements for providing initial assessment, access to antiviral medicines (and vaccines, when available), treatment of complications, home care and access to hospital care;
- An integrated approach to planning and response that effectively employs all of the health and social care services in a local area, using flexible working across all agencies and making best use of potentially scarce facilities and resources, including the skills of volunteers;
- Clear and comprehensive arrangements for admission, discharge and transfer between appropriate levels of health and social care based on established ethical and equalities frameworks to assist in managing local demand;
- Effective monitoring and communications systems and dialogue to permit: (i) timely exchange of essential information needed for management of the influenza pandemic and; (ii) local messaging to the public and staff, and
- Effective management of the increases in demand resulting from the pandemic including:
    - a graded approach to configuring services, (i.e. identifying non-essential activity that can be reduced or ceased to increase capacity, and indicating when these changes will need to

take place) allowing the local response to be proportionate to the severity of the pandemic and be escalated and de-escalated as needed;
- continuation of essential care including mechanisms for recognition and management of patients with urgent non-flu medical conditions, other emergencies and individuals with long-term conditions requiring regular intervention, and
- psychosocial support for staff and patients/clients when needed including plans to afford necessary rest time for hard-pressed staff.

4.2.1 Leadership

In influenza pandemic, leadership challenges may include high levels of uncertainty during the initial response phase requiring flexibility and rapid adaptability of plans, and increased demand on services, which may be exacerbated by staff absence.

4.2.2 CWP Influenza Pandemic Lead

The Deputy Director of Nursing and Therapies, Head of Infection Prevention and Control and Emergency Planning Co-ordinator will form the Influenza Pandemic Lead.

The CWP Influenza Pandemic Lead will be supported by the Emergency Planning Sub Committee, Influenza Pandemic Group and Emergency Planning Team to provide leadership, direction and ownership of the CWP Influenza Pandemic Plan and local Influenza Pandemic Business Continuity Plans.

4.2.3 Infection Control

The incubation period can range from one to four days. People are most infectious soon after they develop symptoms, though they can continue to shed the virus, for example in coughs and colds for up to five days (longer in children). Once the symptoms are gone, people can be considered as no longer infectious to others.

The meticulous use of infection control procedures such as segregation, isolation and cohort nursing are fundamental in limiting the transmission of the virus. Local risk assessments for required levels of infection control should be performed. Stringent attention to hand and respiratory hygiene should also be observed.

Staff can refer to the Infection Control Policy Pandemic Influenza (IC09) policy for further information and guidance.

Vaccination of frontline health and social care workers should be carried out as soon as pandemic influenza vaccine becomes available.

4.2.4 Business Continuity

Business continuity planning for all aspects of the Trusts operational activity will be important in underpinning the influenza pandemic plans. Assurance of sufficient supplies requires a detailed understanding of the potential impact of a pandemic on the supply of consumables, medicines and other services that are critical to maintaining essential services.

4.2.5 Human Resources

Pandemic influenza planning should cover training, appropriate health protection and welfare for staff and volunteers, and should take into account the specific needs of those who are pregnant or who are in risk groups. It is essential that the Trust ensures that staff are prepared, trained and available to be deployed within the Trust to maintain essential services.

An influenza pandemic will affect NHS Staffing in four ways:

- NHS staff may themselves become infected, which is likely to lead to an unprecedented level of sickness absence during a pandemic;
- Some staff may have fears of being infected while at work and, in particular, of passing on the infection to their families and friends;

- Stress levels will be high because of pressures on staffing;
- Staff with caring responsibilities may be adversely affected. As a result these staff may wish to stay at home to care for dependent children and, in other cases, staff may be caring for partners or other dependents, such as older relatives.

In order to maintain the delivery of essential services during pandemic influenza, it is essential that:

- The pool of available staff is as large as possible;
- Staff are deployed as flexibly as possible;
- Infrastructure and support mechanisms are in place to ensure that staff who are fit to work are able to come to work;
- Systems are in place to enable effective and timely information on the Trusts staffing levels/status to be supplied to the command and control structure as required;
- All existing staff and additional staffing are trained and inducted as appropriate.

Staff can refer to the Flexible working and special leave (HR3.6) policy for further information and guidance.

Internal temporary redeployment;
The main method of responding to absence will be internal temporary redeployment; Provided that it does not compromise infection control, where necessary, staff may be asked to change their normal place of work.

Some managerial, administrative and clinical staff, especially those with clinical skills, may also be redeployed if normal duties / activities deemed not to be essential during the pandemic are suspended. Pharmacist and nurse prescribers could play an important role in prescribing medicines for those people who cannot access their usual prescriber where required.

In all such instances, the employee's personal circumstances will be considered: however, the exigencies of continuous service delivery may have to supersede the need to be in the normal work location.

As far as practicable, redeployment will be voluntary: however, that may not be possible and, if absolutely necessary, an instruction may be issued. In all cases where staff are temporarily redeployed, redeployed staff will:

- Be given appropriate line management support;
- Only be asked to take on tasks within their competence;
- Have any reasonable additional costs reimbursed by the trust (in accordance with normal policy provisions).

Increasing the pool of staff;

- **Recently retired staff** - may be contacted to ask if they will be willing to work for the trust in an emergency. Issues regarding refreshing skills and restoring staff to professional registers on a temporary basis, etc will need to be addressed, as will consideration given to assisting with registration fees.
- **Secondments** - although there is a working assumption that there will be little scope for reciprocity between organisations during the major impact of a pandemic, the option for staff to work for other NHS Trusts which are located nearer to their home may be discussed regionally and will be considered on a case by case basis.
- **Bank staff** - may be asked to work additional hours and travel to priority areas. Travelling expenses will be reimbursed for bank staff traveling to areas outside of their usual work areas. Wherever possible the Trust will provide support for those bank staff traveling outside their usual work areas.
- **Student nurses** – links with the University will be made to ensure that students and/or teaching staff may be contacted as required.
- **Commercial agencies** – those, with which we already have contracts, may also be used.

- **Independent providers** - services with links to independent providers should also be contacted to see if they have staff who could work for the trust if their normal work is suspended.
- **Existing volunteers** - will be asked if they are willing to help out but ensuring that their remit is clear and that they are covered by an honorary contract as necessary.
- **Trainees** - it is likely that in a pandemic there would be embargo on rotational moves for trainees (junior doctors). Initial discussions have taken place with the Deanery, who will need to work with the trust in line with respective business continuity plans.

The usual pre-employment check processes will be carried out on all staff asked to work with vulnerable adults or children in line with the trust's current procedures.

Training;
Priority will be given to ensuring that induction and mandatory training needs are covered for all staff moving temporarily into new areas of work. Induction for newly appointed staff will also continue to be given priority.

Ongoing staff training throughout the pandemic is an important part of routine contingency plans. Where there may be a need for staff to work outside their normal role or in unfamiliar situations, it is important that this work remains within the scope of their competence.

4.3 Health and Social Care Response; Detection and Assessment Phase

The detection and assessment start when human to human transmission of a novel influenza virus with pandemic potential which poses a substantial risk to human health is detected in the UK. During these initial phases the main requirement is to identify the virus and to gain an understanding of its clinical, epidemiological and virological characteristics, such as risk groups for severe disease.

This phase therefore focuses on intelligence gathering, enhanced clinical surveillance, the development of laboratory diagnostic tests, swab testing by GPs and testing in hospitals of suspect cases, presumptive treatment for affected individuals, possible prophylaxis of contacts, and good communication. As data becomes available, scientific advice and modelling at a national level will help inform the response.

At the outset, the eventual severity of the pandemic will not be clear, nor will its impact on health systems. Initial response plans should therefore adopt a risk based approach but remain flexible and capable of proportionate scaling up or down.

4.3.1 Public Health Services

The initial response will be resource intensive for public health and primary care services, GP's, public health and local NHS providers will need locally agreed mechanisms to share tasks and collaborate, to minimise the risk of individual service failure and to sustain response.

4.3.2 School closures

It is unlikely that widespread school closures will be required, except in a very high impact pandemic. Locally school closures may be advised in specific circumstances to reduce the initial spread of infection whist awaiting more information about the spread of the virus. Head teachers and the Board of governors will take the ultimate decision on school closures.

4.3.3 Stockpiles of countermeasures

There will be a number of stockpiles of clinical and non-clinical countermeasures held in locations across the country for deployment when needed. These will be available to health and social care staff. The stockpiles are composed of:

- personal protective equipment (PPE)
- antivirals and antibiotics
- consumables necessary to deliver pandemic specific vaccine

In the event of an influenza pandemic, items will be delivered direct to healthcare providers.

4.3.4 Antiviral medicines

The Government currently holds a limited supply of H5N1 vaccine. This could potentially offer some protection in the event of an increased threat of a new pandemic, however, this vaccine would not necessarily be well-matched to the specific pandemic strain. 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.

Antiviral collection points (ACPs) are likely to be required, irrespective of whether the NPFS is in use, which are nominated locations within the community where flu friends can collect antiviral medicines on behalf of a symptomatic person, on presentation of the person's valid authorisation. This enables symptomatic patients to remain and minimises the impact on healthcare facilities. Hospitals will have antiviral medicines only for inpatients and GPs will not have stocks of antiviral medicines.

The majority of ACPs during the H1N1 (2009) influenza pandemic operated out of pharmacies and this worked well in a relatively mild pandemic and discussions.

4.3.5 Personal Protective Equipment (PPE)

The bulk of the stockpile consists of PPE designed to protect healthcare workers from contracting pandemic influenza while caring for patients. This includes surgical facemasks, FFP3 respirators, gloves and aprons, plus hygiene consumables.

4.3.6 Social Care

Social care services could experience little pressure in the initial phases of a low impact pandemic.

4.3.7 Secondary Care, including Mental Health

Secondary care services, including mental health, are less likely to be under pressure during the initial phase of a low impact pandemic.

4.4 Health and Social Care Response; Treatment and Escalation

Once there is evidence of sustained transmission of the virus in the community, the focus will be moved to treatment. The decision to move to treatment and escalation will be taken nationally, although some areas may have already moved to this phase following consultation with local NHS and public health services, and those at national level.

Diagnosis will be based on clinical assessment, with antiviral treatment of clinical at risk groups and those who may be at risk of serious complications. A possible "treat all" strategy may be adopted depending on the behaviour of the virus.

At this phase, all health and social care services should be undertaking vaccination planning although initial vaccine supplies may be unavailable for four to six months from the emergence of the new virus.

Public health services will continue to gather data and monitor the virus through the pandemic.

During the treatment and escalation phase, in particular within a moderate to high impact pandemic, service activity may need to be prioritised and flexible as part of business continuity planning. The following arrangements may be considered;

- Prioritisation of referrals for assessment (according to urgency)
- The use of telephone assessment; consider only doing home assessments where absolutely necessary;
- Greater use of self-assessment (e.g. Internet);
- A one-stage referral and assessment model;
- Deferral of non-urgent referrals until after the pandemic;
- Redeploying staff from other tasks to delivery of actual support/care, and
- Temporarily reallocating support from those with lower levels of need to those in higher levels.

CWP services and departments may be required to activate Business Continuity Plans at this stage.

If pressure on services reduces available capacity to the extent that only the needs of those assessed as having a “critical” need can be met, prioritisation criteria will include where:

- Life is or will be threatened;
- Significant health problems have developed or will develop;
- There is little or no control over vital aspects of the immediate environment;
- Serious abuse or neglect has occurred or will occur, and
- There is or will be an inability to carry out vital personal care or domestic routines.

4.4.1 Primary and Community Care

In a pandemic of moderate severity there may be a requirement for primary and community care services to suspend non urgent clinical care and non-urgent clinical activities to free up additional capacity. This is to be done so in conjunction with existing business continuity arrangements.

In a high impact pandemic, primary care and out of hours services (for example, West Neighbourhoods Out of Hours service) may be relying on telephone advice systems such as NHS 111, where and when operational, to support urgent and emergency calls.

Clear arrangements for admission and discharge to various levels of the health and social care system will be critical in managing local demand.

It is intended that service users will be supported to continue receiving primary and community care services where required.

Where patients have physical health complications as a result of the influenza pandemic these will be assessed and the appropriate referral to other health and social care services will be made. There may also be a requirement to provide additional support for end of life care.

Antiviral medicines

Influenza antiviral medicines are likely to be the first line of defence until a pandemic specific vaccine becomes available.

4.4.2 Mental Health Services

It is important to have plans in place to enable mental health services to deal with increased staff shortages during a pandemic; in particular plans need to ensure the continued ability to safeguard patients in accordance with the Mental Health Act 1983.

Acute illness, such as influenza, can worsen depression, which can complicate risk assessment, treatment and recovery for some service users.

In a moderate impact pandemic, pressures on local acute services may mean that mental health units cannot transfer service users who develop increased physical health needs to acute hospitals as regular practice would require. CWP staff training will continue to have education and training in relation to improving their skills in physical health as part of an ongoing programme Trust wide. This will include Infection Prevention & Control training, basic life support, physical health skills (such as Venepuncture), which are appropriate for Mental Health Services.

Discharging service users from general inpatient wards into the community may be difficult during a pandemic. Forensic services pose an additional challenge in that some service users are on restriction orders imposed under mental health legislation (administered by Ministry of Justice); court appearances may be affected.

Inpatients that contract the flu will be supported and treatment will be given in accordance with the Trust’s Infection Prevention & Control Policies.

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 . 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 locally within services to meet this.

There are certain drug treatments that may require additional contingency planning. For example, Clozapine, which is used to treat schizophrenia, may reduce the white blood cell count, so clients require regular monitoring. The Medicines and healthcare Products Regulatory Agency (MHRA) have stated that this requirement will not change. CWP will be required to maintain monitoring requirements based on their own resources.

4.4.3 Human Resource policies;

Absence management and monitoring

In order that employees continue to be paid accurately, ESR must be up dated in the usual way. Normal sickness absence reporting routines should be observed for any employee unable to attend work owing to illness; including where that illness is understood to be flu related. However, in giving priority to service continuity, it is acknowledged that some time may elapse before managers are able to carry out 'trigger' interviews with employees.

All staff are required to adhere to the Trust policy during a pandemic.

Managing attendance policy & procedures (HR3.5)

Staff who fail to attend work because of fear of infection should be properly advised that they have no right to refuse to attend work during a pandemic unless there is a clear health and safety risk. If necessary, managers will need to ensure that individual employees understand that to refuse to come into work could mean that the employee is in breach of contract and that professional staff may be in breach of their professional codes of practice in which they have an obligation to provide care to those in need.

Generally, the Trust's managers will seek to persuade staff to attend work rather than penalise them. However, the ability of managers to maintain service delivery is dependent upon having staff that are not ill at work and all employees are expected to take reasonable steps to make themselves available for work. Whilst it is unlikely that disciplinary action will be taken, it will be considered on a case by case basis; for example, where an employee has been offered immunisation against flu has chosen not to take it and subsequently becomes unable to work owing to illness with flu.

Staff with school age children or other dependents (leave of absence)

The trust acknowledges that staff may be affected should their children become infected or the schools and/ or child care facilities close. However staff must ensure in advance that they have contingency plans in place for child care.

Where staff have to stay at home to look after dependants, the trust the Flexible working and special leave (HR3.6) should be applied in the normal way.

As usual, other options such as annual leave or unpaid leave may be considered, decisions being dependent on the manager's assessment of the staffing situation.

Working flexibly

Where staff temporarily take on different roles or work in unfamiliar situations, the following guiding principles should be observed;

- Non registered staff who temporarily take on new or additional tasks should receive appropriate training and receive appropriate supervision. These tasks do not set a precedent for longer-term role changes, as issues that staff face during a pandemic are very different from the usual ones;

- Registered staff who temporarily take on different roles should refer to their existing codes of practice. The NMC has developed the following statement - 'Registrants will not be professionally compromised provided they are competent (and have been assessed as such), to carry out any practice being requested of them. They remain answerable at all times for their actions or omissions'. Staff can refuse to undertake duties if they reasonably consider them to be outside their competence;
- During a pandemic itself, emergency situations may arise which need to be dealt with on a case-by-case basis, balancing the needs of patients against any risks in asking staff to take on unfamiliar roles;
- No permanent changes will be made to staff working patterns or other arrangements during a pandemic. Any requests by staff for flexible working on an indefinite basis will be considered on a case by case basis after the main impact pandemic period and in the light of normal (i.e. non pandemic) operational and service needs.

Working flexibly does not mean that managers should be requiring staff to regularly work in excess of their contracted weekly hours during a flu pandemic. Where additional hours are worked, the provisions of the European Working Time Directive (EWTD) should be borne in mind and normal provisions for remuneration of additional hours applied. Managers are advised to seek further guidance from Human Resources where required.

Indemnity and litigation

Where staff or students are working outside their normal role they should do so only within their scope of competence and should receive adequate training and supervision. Provided these are in place, there should not be any greater risk than normal of litigation during a pandemic period.

The trust will have an ongoing responsibility to make adequate provision for health and safety of staff during a pandemic and take all reasonable steps to safeguard staff.

While taking a balanced approach, the trust will continue to address any instances of misconduct that places staff, patients or the public at risk and deal with them robustly. Disciplinary procedures will remain in place but their application maybe delayed until after the difficulties caused by a significant impact of the pandemic period. Staff may be suspended, if necessary, pending further investigations.

Annual leave

New requests for annual leave likely to fall during the (anticipated) major impact of a pandemic period will not be granted. New requests for leave will be filed by the appropriate manager and will subsequently be considered in the order they were submitted and in line with the normal annual leave policy once all the major waves of the pandemic have passed.

The trust will endeavour, as far as is reasonably practicable, to honour pre-booked annual leave for staff. However the trust, in exceptional circumstances and as a last resort, retains the right to ask staff to cancel pre-booked annual leave should this be absolutely necessary to maintain patient care. The trust would appreciate any offers from staff to cancel pre-booked annual leave, in extremely busy or short-staffed areas although it may not take up the offer.

In cases where annual leave is not taken or cancelled as a result of service need, staff will be allowed to take the time off at a later stage or by agreement carry over leave into the following leave year.

Similarly, staff and managers will be expected to exercise reasonable flexibility in agreeing arrangements for taking any time off in lieu accumulated.

If the trust has asked the member of staff to cancel a pre booked holiday, the trust will reimburse the employee the full costs of the cancellation incurred at the time, on production of receipts.

Disciplinary issues
The agreed local disciplinary procedures as outlined within Trust Disciplinary Policy & Procedure (HR3.3) remain in place during the pandemic period and there is no change to the normal responsibilities for responding to any instances of possible misconduct.

However, it is recognised that the service delivery pressures arising during the key impact of the flu pandemic may mean that;

- There is delay in dealing with less serious matters of misconduct;
- Those pressures may, of themselves, be a mitigating factor to be considered in reaching decisions on matters of employee conduct;
- Managers have to be sure that they gather and keep secure information which may later form part of a disciplinary investigation or process;
- It is less easy to find suitable alternative redeployment pending investigation of possible gross misconduct and as such suspension is likely to be the most appropriate decision.

All line managers remain responsible for ensuring the appropriateness of workplace conduct / behaviour and professional codes of practice continue to apply.

Working time regulations
During a pandemic the Working Time Regulations (WTRs) (1998) will remain in force. However, night work limits, right to rest periods and rest breaks under the regulations do not apply where the worker's activities are affected by taking account of the following exceptions to the WTRs;

- An occurrence due to unusual and unforeseeable circumstances, beyond the control of the employer, or
- Exceptional events, the consequences of which could not have been avoided despite the exercise of all due care by the employer.

As the trust allows 'opt outs' from the regulations, this arrangement will continue - as will the 26 week reference period for calculating average working hours.

However, even during a pandemic, and allowing for increased flexibility of staff wherever possible, compensatory rest should be given where staff work beyond the length of shift. It is recognised that rest breaks will also still be necessary if staff are to function effectively and staff need to be strongly advised to take breaks in order to maintain safety.

Excessive working hours should be avoided and where it is identified that staff may need to work longer hours;

- They should be asked if they wish to formally 'opt out' for the duration of the pandemic;
- Records should be kept by line managers of the hours actually worked by those staff.

Health and safety
It is recognised that the trust has the same duty of care to staff during a pandemic as in other circumstances. Issues relating to health and safety are addressed in local and trust wide emergency plans.

Staff support
Maintaining staff morale and motivation will be essential during a pandemic and clear communications will be key. Staff will be provided with up to date and honest information about the pandemic either face to face or electronically.

The usual access to occupational health, staff support services and religious facilities to support them practically and emotionally will continue (subject to the resource levels of those support services).

Provision will be made for ongoing access to occupational health and staff support services in recognition that there may be increased demand for bereavement counselling or support in dealing with post-traumatic stress.

Staff development activities

- KSF – PDR processes and gateway assessments may be postponed;
- Mandatory training – courses may need to be cancelled and taken forward after the main impact of the pandemic has passed;
- Management training– It may be necessary to any management training until the main impact of the pandemic has passed;
- Study leave - may need to be cancelled.

Other human resource policies

- **Grievances** – all but the most serious of issues may be put on hold and taken forward after the main impact of the pandemic has passed.
- **Capability issues** – all but the most serious of issues may be put on hold and taken forward after the main impact of the pandemic has passed. Where patient safety is considered by management to be at risk, consideration will be given to redeployment of the member of staff or, in exceptional circumstances, suspension.
- **Restructuring processes** – may need to be put on hold and taken forward after the main impact of the pandemic has passed.
- **Job grading processes** - may need to be put on hold and taken forward after the main impact of the pandemic has passed.
- **Recruitment and selection processes** - may need to be put on hold and taken forward after the main impact of the pandemic has passed

4.4.4 Social Care

Social care services, including those providing care home placements, may come under strain, particularly at the height of the pandemic.

4.4.5 Community Care

As demand for hospital care increases, patients discharged home may require a greater level of care than they would do normally. Close working relationships across health and social care organisations will be essential to sustaining services during a pandemic as much pandemic influenza treatment will take place in the community.

4.4.6 Carers

Many people are supported by unpaid carers, significant numbers of carers will either have flu themselves; need to provide increased care for the person they care for because of flu, or in addition need to look after someone else who has flu. Health and social care organisations should work together to ensure that their overall resources are used to best affect and carers are given help to assess their own needs.

4.4.7 Secondary Care

In a low impact pandemic there may be no significant deferral of normal activities.

In a pandemic of moderate impact, hospitals will need to respond to increasing referrals of respiratory patients requiring high levels of care. It will be important here for local health economies, in particular community services, to agree prioritisation across the local area.

In a high impact pandemic, staff absence may add to the difficulties. A key challenge will be to sustain essential activity, whilst being flexible to and cooperative across health economies.

4.4.8 Potential for legislative changes

In a high impact pandemic, consideration may be given to areas where changes in legislation may be required to enable continuity of services. This is unlikely in all but the most extreme scenarios. This may include legislation changes to;

- Prescription charges;
- Mental health;

- Sickness certification.

4.4.9 Vaccination

Planning for vaccination should begin at an early stage of a pandemic, to be led locally within the Trust by CWP Workforce Wellbeing. Local areas will need to plan for receiving vaccine supplies, storage of the vaccine in appropriate conditions, distribution and staffing of vaccine clinics.

It is expected that vaccine specific to the influenza pandemic will not be available until after the first wave of the pandemic, as the manufacturing process can only start once the pandemic viral strain has been isolated.

Front line health and social staff will be a priority group for vaccination.

4.5 Health and Social Care Response; Recovery Phase

The recovery phase will start once demands on services reduce to a level that there may be a gradual return to "normalisation" of services. It may not be possible to predict further pandemic waves, so regrouping during this phase is important. This will be declared nationally by the Department of Health.

The retention of knowledge and incorporation of lessons identified will be an important part of this phase. Planning for recovery should be integrated into business continuity planning.

There will be increased demands on some services from patients whose existing illnesses have been exacerbated by influenza, or from those who may continue to suffer long term health implications. Some staff members may also not return to work due to altered family circumstances, severe illness or death.

As part of the recovery process, CWP will undertake the following overlapping activities to be led by the CWP recovery team;

- Restoring essential services;
- Restoration of the well-being of individuals, communities, the infrastructure which supports them and the organisation itself;
- Conduct a structured debrief, identifying potential improvements and applying lessons learned in order to improve any future response.

On local declaration of a pandemic, a recovery team will be identified by the CWP Influenza Pandemic Lead. This team will establish plans for recovery based on the services which have ceased to function and those that have been scaled down. It is acknowledged that services may look different following the Pandemic.

The recovery team leader will be the Director of Operations and they will have discussions with health and social care partners regarding contracts and resuming services.

5. Duties and responsibilities

CWP will;

- Test and exercise local influenza pandemic arrangements;
- Work with health and social care partners to agree local mechanisms for sharing tasks and care, and collaborating to minimise the risk of local service failure and increased risk to patients;
- Establish and maintain relationships with external suppliers to ensure continuity of service during influenza pandemic;
- At the treatment and escalation phase, maintain arrangements for vaccinating staff and service users;
- Ensure staff are trained and aware of the signs and symptoms of influenza;
- Provide advice on the use of facemasks and respirators, as well as their provision and training;
- Provide guidance for managers on the expectations of staff during a pandemic;
- Maintain a good standard of infection control Trust wide;
- Provide advice of self-care to staff, service users and carers where required;

- Consider the impact on the Trust, and health and social care economies, at all levels of a pandemic;
- Plan for receiving influenza pandemic vaccine supplies, storage of the vaccine in appropriate conditions, distribution and staffing of vaccine clinics;
- Plan for recovery of an influenza pandemic.

Detailed action cards found within Appendix 1 of the plan outline the specific actions of staff for aiding an appropriate response to influenza pandemic.

5.1 Local Duties and Responsibilities

CWP Board of Directors
CWP Board of Directors will;
- Nominate a member of the board to be a member of the influenza pandemic group;
- Ensure executives are trained appropriately and are aware of the command and control structures.

Lead Executive for Emergency Planning (Director of Operations)
The Lead Director, supported by the Executive Team, must ensure that the CWP Influenza Pandemic Plan is implemented and to nominate a responsible officer, to be known as the Emergency Planning Officer, and adequate resources from within the organisation to ensure that Pandemic Influenza Plans are implemented where required.

CWP Influenza Pandemic Lead (Deputy Director of Nursing and Therapies, Director of Infection Prevention and Control and Emergency Planning Co-ordinator)
CWP Influenza Pandemic Lead will;
- Lead the Trust preparedness, response and recovery to a pandemic;
- Feed required information into the Trust board of directors;
- Liaise with Business Continuity Leads for cascade of information to local services and departments;
- Liaise with health and social care partners, and Cheshire Local Resilience Forum (LRF) on all matters relating to influenza pandemic;
- Maintain an overview of the internal command and control structure, ensuring that all levels have appropriate representation.

Emergency Planning Sub Committee
The Trust Emergency Planning Sub Committee will;
- Take ownership of the CWP Influenza Pandemic Plan;
- Report into CWP Operational Committee and subsequently CWP Board of Directors;
- Facilitate influenza pandemic training and exercising;
- Respond to requests for information and SITREPS where required;
- Liaise with health and social care partners to assess areas that jointly could be provided during a pandemic;
- Convene a subgroup to be known as the influenza pandemic group on the activation of the CWP Influenza Pandemic Plan;
- Ensure that the Trust can maintain a stock of facemasks and antivirals for 7-10 days to allow for a delay in the distribution of national stockpiles;
- Consider those pharmaceuticals that may require additional contingency planning, for example the use of Clozapine, which is used to treat schizophrenia;
- Ensure that an influenza pandemic vaccine campaign links in with the existing CWP vaccine campaign arrangements;
- Ensure robust recovery plans are in place;
- Consider the longer term implications of an influenza pandemic, in particular those services where activity was rescheduled.

Influenza Pandemic Group
The influenza pandemic group will;
- Report into the Emergency Planning Sub Committee;
- Contribute to the completion of SITREPS where required;
- Liaise with other health and social care providers, in particular mental health trusts, for support and discussion of specific needs, and to share best practice during a pandemic;
- Undertake a structured debrief of the pandemic.

Major Incident Team
The major incident team will;
- Liaise with the influenza pandemic group as required;
- Contribute to the completion of SITREPS where required;
- Coordinate response to NHS England Cheshire & Merseyside requests for information;
- Support the CWP Influenza Pandemic lead in response to an influenza pandemic;
- Contribute to the recovery and debrief of a pandemic;
- Support the activation of the major incident room.

Recovery Team
The recovery team will;
- Liaise with the influenza pandemic group as required;
- Develop timely plans for return to normal working;
- Coordinate a review of Trust premises and identify those fit for purpose following the pandemic;
- Coordinate a deep clean of all the areas prioritising patient care areas to support resumption of "normal" services;
- Facilitate the Head of HR to complete an up to date form of staff skills and identify gaps and hot spots which will need to be addressed;
- Support the recruitment team to be scaled up to recruit new staff for the Trust;
- A significant number of staff may require psychological support during and after an influenza pandemic, for example, if a family member or friend dies as a result of influenza. Workforce Wellbeing services should be utilised for staff who may require counselling services ;
- Conduct an assessment of both staff and service users long term psychological needs as a result of influenza pandemic.

Business Continuity Leads
Business Continuity Leads will;
- Nominate a business continuity deputy where there is not one in place;
- Nominate a representative to be a member of the Emergency Planning Sub Committee and Influenza Pandemic Group where required;
- Promote and raise awareness of business continuity plans locally;
- Implement local business plans where the pandemic requires it;
- Contribute to the completion of SITREPS where required;
- Ensure a system of cascade for information and key messages during all phases of the pandemic;
- Ensure local notice boards contain the most up to date pandemic influenza information;
- Assess the local impact of a pandemic on the supply of consumables, medicines and other services are critical to maintaining essential services;
- Adopt a risk based approach to pandemic planning, ensuring that business continuity plans are flexible and capable of scaling up or down;
- Ensure arrangements are in place for the transfer of service users to acute medical care including the potential impact on staffing requirements;
- Where required, liaise with local authorities to ensure arrangements are in place for responding to increased service demand across joint health and social care teams;
- Maintain relationships with local suppliers to ensure continuity of service, escalating any issues, where required, to the Emergency Planning Sub Committee and Influenza Pandemic Group;
- Promote and share information on influenza pandemic related infection prevention and control training;

- Ensure recovery planning is imbedded into local business continuity plans.

Workforce Wellbeing
The Workforce Wellbeing service will;
- Lead on the influenza pandemic vaccine campaign locally within the Trust.

Head of Communications and Communications Team
The CWP Head of Communications and Communications Team will;
- Nominate a pandemic influenza communications lead;
- Draft a pandemic influenza communications plan, in conjunction with the influenza pandemic group;
- Liaise with local partners to draw up local public communications plans;
- Ensure timely, consistent and clear communication to health and social care professionals;
- Support and facilitate internal and external communications;
- Issue specific guidance to staff, and consider the use of an “influenza pandemic” newsletter.

Infection Control
Infection control will;
- Carry out local infection control risk assessments where required;
- Undertake swab testing of symptomatic patients where required;
- Provide infection prevention and control training for staff where required;
- Promote hand hygiene in accordance with the Trust’s Hand Hygiene Policy.
- Liaise with service leads and general managers to ensure personal protective equipment (PPE) is made available to all clinical areas, to include surgical masks (where appropriate), gloves and aprons;
- Maintain an overview of environmental issues, addressing additional cleaning and disinfection.

Staff side representatives
Staff side representatives will;
- Support the Trust in its objective of continuing to provide the highest possible level of patient care in challenging circumstances;
- Support this objective by prevailing upon staff to attend work and provide flexibility;
- Ensure their familiarity with the content of this plan and provide advice and support to staff, as required;
- Meet regularly with Human Resources staff during the period of the pandemic to review the application in practice of the special measures outlined in this document and, where necessary, amend its content.

All staff
All staff will;
- Encourage service users, visitors and carers to wash and dry their hands at regular intervals;
- Continue to give priority to patient care by attending work normally unless personally suffering from illness (including symptoms of flu);
- Be prepared to work flexibly in terms of their personal hours / shifts / days / duties (subject to competence) / work base in co-operation with line management;
- Refrain from attending the work place if they have flu like symptoms and take every reasonable step to achieve an early full recovery and return to work.

5.2 Wider Duties and Responsibilities

Director of Public Health
The Director of Public Health will provide advice to the health and social care economy, providing support and specific advice on issues such as; localised school closures, monitored levels during the pandemic; and collection and publication of surveillance data.

Public Health England
Public Health England will provide, at all levels, the health protection services, expertise and advice. It will deliver specialist services to national and local government, the NHS and the public, working in partnership to protect the public against infectious disease such as pandemic influenza.

At the local level public health will take a lead role in informing the response.

Department of Health
The Department of Health key national level information sources, decisions and actions include;

- National scientific advice to the Government through the Scientific Advisory Group for Emergencies and the Joint Committee on Vaccination and Immunisation (JCVI) – also communicated to all areas to inform local response;
- A national communications strategy (allowing for appropriate local communications, e.g. in hotspots);
- Any departure from normal practice recommendations, e.g. National Institute for Health and Clinical Excellence guidelines;
- National advice on social distancing actions (but allowing for local discretion according to the situation on the ground);
- Any alteration to the schedule of GP or pharmacy contractual payments agreed nationally;
- Any alteration of health and social care "targets" or nationally commissioned service-level agreements;
- Any decision to deploy and/or cease the NPFS;
- Development and use of clinical algorithms/protocols to support treatment;
- managing antiviral medicine and other consumable stockpiles and distribution (but with continuity Plans at local level until supplies received);
- Managing vaccine purchase and distribution and policy on priority groups, and
- Consideration and decision on legislative and regulatory changes if required.

6. Communications

6.1 Local Communications

The main aim of the Communications Team is to ensure information is clear, reliable, timely and reaches all intended recipients Trust wide at all stages of a pandemic. It will promote confidence that the Trust is responding effectively to the threat of an outbreak of influenza pandemic to minimise its impact and disruption.

Timely, consistent and clear communication to health and social care professionals will also be important during the pandemic. Local communications between health and social care partners is important.

In order to achieve this high level of communications, the communications team will work closely with the influenza pandemic group, major incident team and business continuity leads during influenza pandemic, proactively agreeing a strategy for effectively communicating with staff, service users and other key stakeholders that will follow national, regional and local communications guidelines.

CWP will have pre-planned messages for internal and external distribution. The following communications methods will be utilised in the event of a disruption to road fuel supplies;

- CWPessential – bi-weekly e-newsletter
- CWP communications bulletins – urgent daily emails if necessary
- CWP internet
- CW Life – quarterly printed/e newsletter
- CEO blog – fortnightly (intranet)
- Social networking sites including @cwpnhs twitter account
- Emails direct to Trust BCP leads
- CWP TV

Media handling
The Department of Health will be engaged in extensive explanatory media activity during the inter-pandemic period. Regional and national newspapers, radio and rolling TV news bulletins will be a crucial mechanism for conveying key messages.

Any direct Trust media contact however will be managed as part of the Trust's Media Policy (GR12).

6.2 Wider Communications

The aim of the national communications strategy will be to instill and maintain trust and confidence by ensuring the public and professionals know;

- what is going on, both nationally and in their local area;
- where they can find reliable answers to questions they may have, and
- How to access relevant information on self-care and medical support if required.

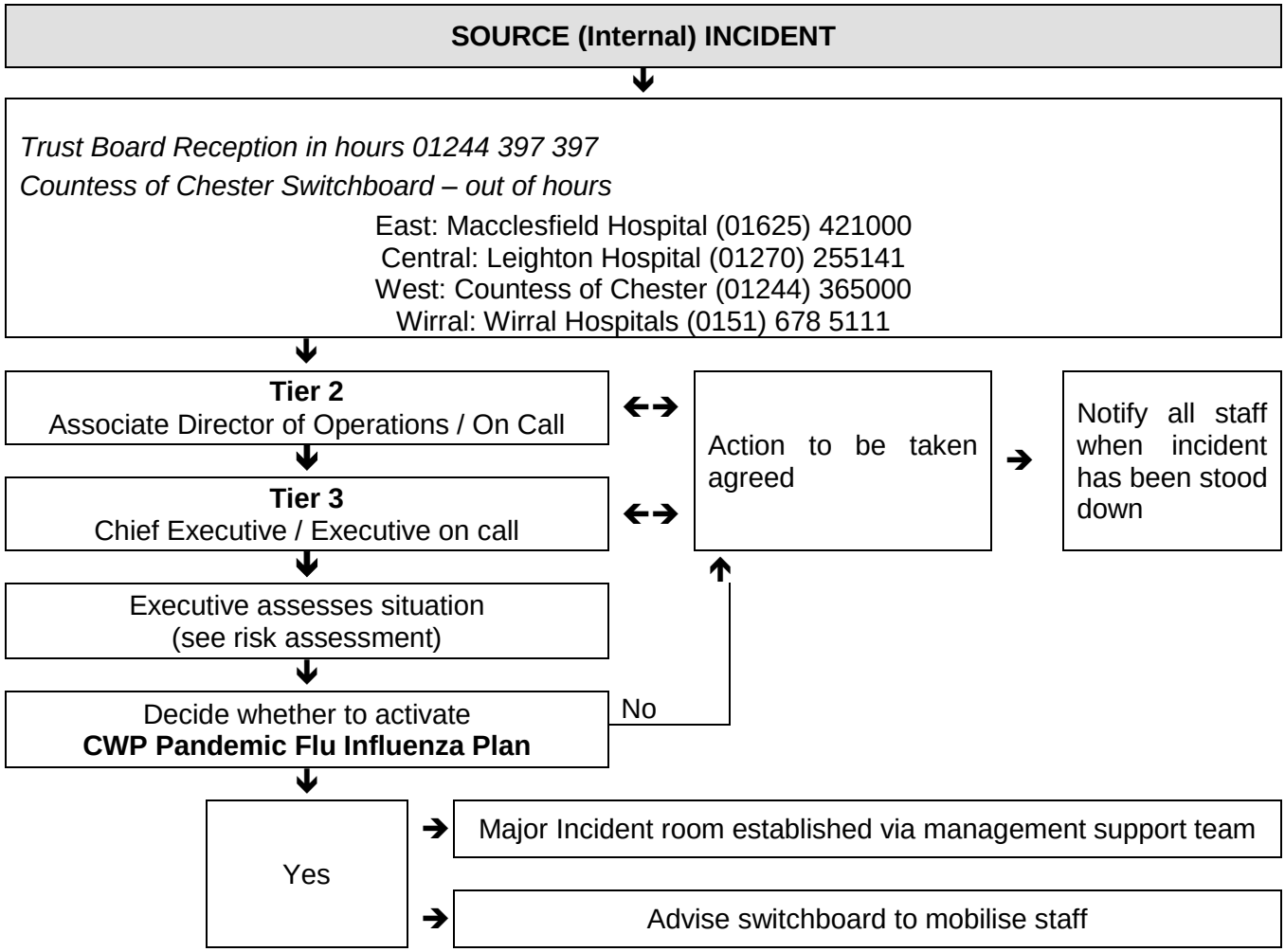
Good liaison between local and national communications teams is essential so that both are aware of the content and changes. Local public communications plans will be drawn up to include;

- roles, responsibilities and methods during a pandemic;
- arrangements for communications with the public about necessary prioritisation of services;
- provide details of location and how to access antiviral collection points (ACPs);
- strategies to challenge incorrect information to mitigate the risk of misinformation (such messages need to be communicated clearly and promptly to the local population as their behaviour will contribute to the effectiveness of the response);
- public messages that encourage good hygiene behaviours, such as respiratory and hand hygiene (those used for seasonal influenza and the lessons from the H1N1 (2009) influenza pandemic should be reviewed when preparing these messages), and
- Transparent and open.

7. Command and Control

Staff are advised to refer to the Trust Major Incident Plan (GR7) for further information on emergency command control structures. On activation of this plan, command and control arrangements will be activated.

7.1 Internal Command and Control



CWP Executive Team (Strategic)
During pandemic flu, decisions to instigate this plan, and initiate the Influenza Pandemic Plan will be taken by the Executive Team.

CWP Influenza Pandemic Group (Tactical)
The role of this group will be to analyse and process all internal and external information to inform decision making by the CWP Executive Team.

CWP Influenza Pandemic Group membership will include but is not limited to;

- CWP Influenza Pandemic Lead - Deputy Director of Nursing and Therapies, and Director of Infection prevention and Control (Chair)

Plus representatives from:

- Emergency Planning Team
- Learning Disabilities
- Specialist Mental Health
- Neighbourhoods
- Childrens & Young People
- Governance
- Pharmacy
- Facilities
- Estates
- Human Resources
- Communications

- Infection Prevention and Control
- Staff Support
- Staff Side
- Temporary Staffing
- ICT
- Finance

This group will be an extension of the Trust Emergency Planning Sub Committee and will meet daily during the pandemic phase via the Trust's video conferencing network. It can be suggested that representatives of this group are the existing Business Continuity Leads.

Local outbreak teams (Operational)
The Local Outbreak Teams in Wirral, West Cheshire and Central and East Cheshire will be responsible for providing local support and guidance across the Trust. The local outbreak teams will have a key role in providing specialist knowledge and guidance to the Influenza Pandemic Group. It can be suggested that the Chair of the local outbreak teams will attend the influenza pandemic group meetings, thus feeding information back to the local outbreak teams. It can be suggested that they are based on the membership of the local Emergency Planning groups based in Wirral, West Cheshire and Central and East Cheshire.

Local outbreak team membership will include but is not limited to;
- Chair Locality BCP Leads
- Heads of Clinical Services
- Pharmacy
- Occupational Health
- Infection Prevention & Control Nurses Link Nurses
- Staff side

7.2 External Command and Control
Notification of an influenza pandemic to CWP will come from NHS England Cheshire & Merseyside.

8. Technical Advisory Section
The following technical advice has been taken from Department of Health's Health and Social Care Influenza Pandemic Preparedness and Response (2012).

8.1 Advances in the management of severe respiratory failure
Experience during recent severe influenza events has demonstrated that some patients, especially those with exacerbation of chronic pulmonary disease, can benefit from non-invasive respiratory support (continuous positive airways pressure, or non-invasive ventilation with oxygen replacement).

All patients with flu-related exacerbations of asthma should be treated according to national guidelines with corticosteroids and bronchodilators, as well as with antiviral medicines and antibiotics.

For patients who require intermittent positive-pressure ventilation, it has been found that the use of 'protective ventilation' (utilising low inspiratory volumes, and avoiding high inflation pressures) leads to improved outcome, and can avoid the need to escalate treatment to more specialist procedures such as extracorporeal membrane oxygenation (ECMO). Avoiding very high levels of intravenous fluid loading also improves outcomes in the setting of infection-related lung injury. It is likely that these measures will increasingly be used in managing respiratory failure caused by severe infections such as influenza.

8.2 Specialist respiratory support
Some patients, particularly with severe hypoxia caused by infection, can benefit from more specialist respiratory support, such as high frequency oscillating ventilation or ECMO. During the H1N1 (2009) influenza pandemic, and to a greater extent in the winter following, ECMO centres came under intense pressure, as bed numbers were limited, particularly for paediatric patients. Advice on referral criteria,

procedures for requesting ECMO services and transport of ECMO patients are available at the Glenfield Heart Centre website.

8.3 Facemasks and Respirators

Surgical facemasks and respirators have a role in providing healthcare worker protection, as long as they are used correctly and in conjunction with other infection control practices, such as appropriate hand hygiene. Fluid repellent surgical masks provide a physical barrier and minimise contamination of the nose and mouth and should be worn by health and social care workers for any close contact with patients with symptoms of influenza.

There is a national stockpile of surgical facemasks for health and social care workers.

Respirators provide respiratory protection against the inhalation of fine or very small airborne particles, which might contain viruses and other microorganisms which is important in the context of influenza. This can only be achieved if the respirator is fitted correctly and there are no gaps between the face and the mask for unfiltered air to pass through.

The current recommended respirator is FFP3, and this model is held in the national stockpile in the event of a pandemic.

Employers have a duty of care to ensure that anyone who might be required to wear a respirator be trained in its use and fit-tested to ensure that an adequate seal can be achieved. These respirators should be worn when performing procedures that have the potential to generate infectious aerosols such as intubation, extubation and bronchoscopy. Although only a relatively small group of workers will need to consider wearing respirators there is a very small possibility that this could increase if there was growing evidence that the virus was causing severe infection risks.

Although there is a perception that the wearing of facemasks in the community and in households may be beneficial, there is in fact very little evidence of widespread benefit from their use in these settings.

Facemasks must be worn correctly, changed frequently, removed properly, disposed of safely and used in combination with good universal hygiene behaviour in order for them to achieve the intended benefit.

Employers will need to undertake risk assessments to determine whether the provision of facemasks or respirators is appropriate for their staff. Infection prevention and control support and guidance will be made available to all managers on declaration of influenza pandemic enabling them to determine whether the provision of facemasks or respirators is required.

Workers who need to wear a facemask or respirator will need to receive training in their safe use, removal and disposal to minimise the risk of cross contamination.

8.4 Antiviral Strategy

There are three main aspects of the antiviral strategy;

- Providing rapid assessment and authorisation of antiviral medicines during an influenza pandemic. This includes the potential for using the National Pandemic Flu Service (NPFS) to enable people to stay at home and to reduce the pressures on primary care services;
- Ensuring that there is a robust system in place to distribute antiviral medicines (i.e. antiviral collection points (ACPs) and local arrangements), and
- Ensuring that there is a robust system in place to manage antiviral stock during a pandemic (i.e. stock management, storage and distribution).

There are currently two medicines recommended for the treatment of influenza in the UK, oseltamivir (Tamiflu) and zanamivir (Relenza), both neuraminidase inhibitors. They will mainly be used for treating symptomatic individuals. However, in certain situations, where individuals with a serious underlying condition or who are pregnant have been in close contact with an infectious case, clinical judgement may be used to offer a course of prophylaxis to protect against infection and reduce the risk of life

threatening illness. In addition, prophylaxis with antiviral medicines of close contacts might be considered in the early stages of an outbreak but will not routinely be given to contacts of a case of pandemic influenza infection.

Further information and dosage guidance can be found within Health and Social Care Influenza Pandemic Preparedness and Response (2012).

An information leaflet for both the oseltamivir Suspension and the Oral oseltamivir Solution will be provided when appropriate. Consumables such as bungs and oral syringes are provided for use with these products.

As well as antiviral medicine treatment being available through the National Pandemic Flu Service (NPFS), GPs and other healthcare professionals will be able to authorise the supply of antiviral medicines without a prescription using special authorisation vouchers (or the right hand side of the FP10SS for patients aged 13 or over).

National protocols for the supply and administration of oseltamivir and zanamivir have been developed with advice on how they should be used. Access to these two named prescription-only medicines without a prescription, and from premises that are not registered pharmacies under the supervision of a pharmacist, will be possible only during a pandemic. This will be notified at the time.

The UK has a stockpile of antiviral medicines sufficient to treat up to half of the population in the event of a high impact pandemic involving a clinical attack rate of 50 per cent. For maximum treatment benefit, antiviral medicines need to be taken as soon as possible. Operational plans are built on the basis of treating all symptomatic patients within 7 days of symptom onset and ideally within 48 hours. Developing sufficient capacity in primary care to assess patients promptly is therefore critical to the effective provision of antiviral medicines.

At the beginning of the initial response phase, a quantity of the UK antiviral medicine stockpile will be distributed to points of issue identified by local areas across England. However, small levels of stocks are already held locally by Health Protection Units. The quantities of antiviral medicines and points of issue will vary depending on local needs. I

Initial distribution and the subsequent replenishment of stock will be controlled centrally by the Department of Health; specifically the National Incident Coordination Centre (NICC) which will be established at the time of a response.
Further detailed guidance relating to antiviral distribution is currently being updated.

8.5 National Pandemic Flu Service

When there is evidence of sustained community transmission or a large number of de novo cases, an England-wide decision will be made to move from the initial response phase to a response designed to mitigate the impact of the disease on the individual, society and the NHS.

The decision to mobilise the NPFS will be taken nationally with implementation in all areas across England. The lead time for the NPFS to become operational is three weeks, during which time arrangements for implementation of Antiviral Collection Points in all local areas will need to have been completed. The NPFS aims to:

- reduce pressure on primary care services;
- allow people with flu like symptoms to remain at home;
- enable rapid self-service assessment, care advice, GP referral and antiviral authorisation, and
- Provide an additional source of data relating to trends in activity and profile of people assessed as suffering from pandemic symptoms.

The service will be available through the web or a dedicated call centre facility for members of the public to be assessed and authorised antiviral medicines if appropriate. The telephony service can be

accessed via Text phone and the web version is available in a number of different languages. The process is:

- A symptomatic individual, or their Flu Friend, will contact the NPFS and an assessment using a clinical algorithm will be undertaken.
- If required, the individual will be authorised to receive an antiviral medicine. The individual will then need to note down an authorisation number (12 alphanumeric characters). A Flu Friend can do this on behalf of a symptomatic individual.
- The Flu Friend (with their own identification and the symptomatic individual's) will then attend an ACP, provide the authorisation number and collect the antiviral medicines. The NPFS will also direct patients to a GP practice or other NHS service should they require any additional advice or treatment.

NPFS assessment is based on a clinical algorithm, which is subject to update dependent on the nature of the pandemic. The algorithm has been developed with input from expert clinicians and contains questions, which assess the need for urgent medical assessment or other actions, as well as the symptoms of flu.

While the NPFS is operating, healthcare professionals will still need to assess people with no access to the NPFS and those referred directly to primary care

8.6 Antiviral Collection points

Antiviral collection points (ACPs) are nominated locations within the community, to be identified on activation of the treatment and escalation phase, where flu friends can collect antiviral medicines on behalf of a symptomatic person, on presentation of the person's valid authorisation. Antiviral collection points are likely to be required, irrespective of whether the NPFS is in use.

Specific arrangements for Antiviral Collection Points are to be agreed with clinical commissioning groups, and health and social care partners on declaration of a pandemic.

Local health and social care economy arrangements for antiviral collection points will be made on declaration of influenza pandemic, and/ or on activation of the treatment and escalation phase locally.

The purpose of an antiviral collection point is to:

- enable symptomatic patients to remain at home but still gain rapid access to antiviral medicines if necessary via a flu friend; and
- Minimise the impact on healthcare facilities, enabling them to retain their operational capacity for the assessment of patients who have non influenza illnesses.

9. Conclusion

The CWP influenza pandemic plan outlines the national and local arrangements in preparedness, response and recovery to influenza pandemic. Taking into account lessons learned from the 2009 H1N1 pandemic, the Trust will endeavour to support staff in responding to the influenza needs of patients, alongside the personal welfare of CWP staff.

The local technical aspects of influenza pandemic response will be agreed at local health economy level following completion of local health and social care influenza pandemic plans.

10. Appendices

Appendix 1: Action Cards

Appendix 1: Action Cards

ACTION CARD – Chief executive / 3rd Tier On-call/ Executive On-call In hours/ Trust incident director
Role • May be required to attend the Cheshire Local Resilience Forum Strategic Command Group as Trust representative. • Nominate a senior individual to perform actions identified on this card.
Reports to CWP Chief Executive

ACTION	Completed ✔(time)
1. Assess the implications of the influenza pandemic notification and subsequent organisational response	
2. Consider declaring a Trust major incident	
3. Liaise with the CWP Influenza Pandemic Lead	
4. Respond as requested by NHS England Cheshire & Merseyside	
5. Maintain liaison with health and social care partners providing regular updating reports of the Trust status and response	
6. Attend local health and social care meetings where required	
7. Seek advice from the Medical Director on all medical aspects	
8. Nominate other senior individuals to perform the above actions	

At the end of your shift you may hand over to someone else. Please make sure that you hand this action card to them. Make sure they know what arrangements are in place for storing records etc.

You may be working on a rota to cover a 24 hour period. Given the intensity of the work, you should ensure that you take regular short breaks to relieve stress and clear the mind.

ACTION CARD – CWP Influenza Pandemic Lead
Role Lead the CWP preparedness, response and recovery to the influenza pandemic.
Reports to CWP Chief Executive

ACTION	Completed ✔(time)
1. Nominate an influenza pandemic deputy	
2. Assess the implications of the influenza pandemic notification and start a decision log	
3. Activate the Influenza Pandemic Group where required, Chairing any subsequent meetings	
4. Initiate CWP Incident Control Room where required	
5. Liaise with Chief executive / 3rd Tier On-call/ Executive On-call In hours/ Trust incident director with regards to the declaration of a major incident	
6. Liaise with Chief executive / 3rd Tier On-call/ Executive On-call In hours/ Trust incident director with regards to the activation of other CWP response arrangements	
7. Liaise with Business Continuity Leads for cascade of information to local services and departments	
8. Direct the organisation's response to the influenza pandemic	
9. Set strategy for influenza pandemic preparedness, response and recovery in line with the national arrangements	
10. Convene a meeting for business continuity leads to brief them of the situation and to activate their Business Continuity Plans	
11. Convene a meeting for business continuity leads to brief them of the situation and to activate their Business Continuity Plans	
12. Based on information received from local influenza pandemic committees, decide the overall strategy for the organisational response, giving consideration to the recovery and return to normal services where required	
13. Provide briefings to the Chief Executive and Board of Directors where required	
14. Liaise with communications team to agree an appropriate communications strategy, to be reviewed at various intervals throughout the influenza pandemic	
15. Ensure that full records are kept of the entire incident. Ensure that all calls, decisions and actions are logged	
16. Ensure that essential services are maintained, or if not possible make alternative arrangements	
17. Ensure that the appropriate resources are available to support staff in their response (N.B. This will be over several months) and establish rotas for incident management teams	
18. Liaise with finance to activate system for recording expenditure during influenza pandemic period	
19. Lead on a review of the CWP Influenza Pandemic Plan where required	

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ACTION CARD – Head of Human Resources
Role Direct the CWP response to the influenza preparedness for all human resources and staff welfare issues.
Reports to CWP Influenza Pandemic Lead and CWP Chief Executive

ACTION	Completed ✔(time)
1. Nominate a human resource deputy	
2. Liaise with Management Team and temporary staffing and help ensure adequate staffing levels and relief staff by accessing staff contact details	
3. Start and maintain a human resources issues log	
4. Arrange for counselling services for staff if required through Occupational Health/Staff Support service and for patients/relatives through the mental health trust	
5. Consult with CWP Health and Safety Manager for advice and guidance where required	
6. Contact the Health and Safety Executive for advice and guidance if required	
7. Liaise with CWP Influenza Pandemic Lead in establishing a Communication Strategy	
8. Consider review of any Human Resource policies directly related to, or impacted by the pandemic	
9. Undertake any other duties assigned	

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ACTION CARD – Head of Communications & Engagement
Role • To work with Commissioning Support Service communications teams and NHS North West Communications Team to provide a coordinated communications response; • To support the Executive Team and Influenza Pandemic Group with communications issues; • Work with Local Resilience Forum, communications partners and coordinate the dissemination of public advice through local media and communications channels.
Reports to CWP Influenza Pandemic Lead and CWP Chief Executive

ACTION	Completed ✔(time)
1. Nominate a pandemic influenza communications lead	
2. Assign staff to support the influenza pandemic group and/ or major incident team	
3. Assess the implications and start a log	
4. Attend the Influenza preparedness planning group meetings	
5. Draft a pandemic influenza communications plan, in conjunction with the influenza pandemic group	
6. Maintain an overview of the CWP influenza pandemic intranet page in conjunction with Emergency Planning Team, providing relating advice and guidance for staff; for example, frequently asked questions	
7. Receive national media briefs and respond and/ or action accordingly	
8. Attend meetings of Cheshire LRF Media Officers and liaise with local media as required	
9. Support Executive Team and CWP Influenza Pandemic Lead	
10. Agree a communications action plan and strategy as required; to take into account communications channels and protocols	
11. Attend Major Incident room where required	
12. Set up the Media Briefing Room where required	
13. Coordinate the distribution of media briefs and reports to local media companies and channels	
14. Provide regular information updates to all CWP staff	
15. Post regular updates on the CWP website	
16. Make full use of the following communications channels; a. CWPessential – bi-weekly e-newsletter b. CWP communications bulletins – urgent daily emails if necessary c. CWLife – quarterly newsletter d. CEO blog – fortnightly (intranet) e. CWP intranet f. CWP internet g. Social networking sites including @cwpnhs twitter account	
17. Arrange any printing and signage production requirements	
18. Produce briefing for executives and experts for media interviews	
19. Undertake any other duties assigned	

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ACTION CARD – Business Continuity Leads
Role To manage the operations of core business locally and continue essential services within constraints of reduced staff; providing resources to the Management Team and providing regular reports on staff availability (Staff status report).
Reports to CWP Influenza Pandemic Lead, Clinical Service Managers and General Managers.

ACTION	Completed ✔(time)
1. Promote and raise awareness of business continuity plans locally; Assess the implications of the incident and start an action log	
2. Set up staff monitoring procedure to conduct daily updates on staff availability and services provided	
3. Implement local business continuity arrangements	
4. Confirm contact details for the influenza pandemic group and advise them of office contact details, phone, fax, mobile and e-mail	
5. Assign a staff member and a deputy to be the staff status co-coordinators	
6. Produce an initial status report, and submit report to influenza pandemic group as required (Agree frequency after initial submission)	
7. Oversee arrangements to maintain essential services	
8. Liaise with managers/directors/HR to decide what staff members can be released to support the major incident team for re-assignment if required	
9. Monitor provision of essential services to anticipate service escalation and de-escalation with implications	
10. Provide daily situation reports (SITREP) to the Major Incident Team	
11. assess the local impact of a pandemic on the supply of consumables, medicines and other services are critical to maintaining essential services	
12. ensure recovery planning is imbedded into local business continuity plans	
13. feed into the Trust debrief as required	
14. Undertake any other duties assigned	

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ACTION CARD – All staff
Role To support the organisation through the different phases of influenza pandemic
Reports to Line Managers

ACTION	Completed ✔(time)
1. Maintain an overview of the influenza pandemic communications notifications and bulletins	
2. Obtain the vaccine, where medically possibly, if front line staff	
3. Ensure that they are aware of business continuity plans locally	
4. Ensure that they are aware of who their local business continuity lead is	
5. Support business continuity leads responding to specific requests for information throughout the influenza pandemic period	
6. Highlight to managers whether you have a specific skills that could be utilised to support lifesaving and critical activities during a pandemic	
7. contribute to the Trust debrief as required	
8. Undertake any other duties assigned	

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