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Related Trust Policies (to be read in conjunction with)	Major Incident Plan, Internal Incident Plan Business continuity and emergency planning policy and strategy12009 Mass casualty plan Infection Prevention Policies Waste management policy 04088 Linen and curtain policy 08021 Cleaning policy 09033 Health and safety policy 09030

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7.0	Judy Holdsworth	Full review	11th July 2019

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1.0 Purpose

1.1 The aim of this policy and plan is to provide a planned response to an influenza pandemic with clearly described roles and responsibilities across the Trust, such that in the event of a serious flu outbreak, the organisation can coordinate and manage a safe and effective response to the demands such an incident will have on patients and staff while protecting and maintaining core services.

2.0 Scope

2.1 This pandemic flu policy and plan will apply to all staff and patients trust wide and is consistent with the philosophy of the Trust's Major Incident Plan and internal incident plan and business continuity plans. Hospital Command and Control and Trust Resilience teams will ensure business continuity plans are implemented, to mitigate the effects of the Pandemic and to properly plan a return to normal functioning as soon as practically possible.

2.2 The pandemic flu policy and plan will be used in conjunction with Infection Control Policies. Members of staff have a legal, moral and ethical responsibility to protect the health and safety of themselves and others. During a Flu Pandemic staff who are unwell with Flu/suspected Flu will not attend work for the duration of the illness.

2.3 This plan will complement existing resilience arrangements. These include the Trust's:

- Major incident plan;
- Internal incident and business continuity plan;
- Critical care surge plan;
- Mass casualty plan.

3.0 Aims and Objectives

3.1 As a Category 1 Responder under the Civil Contingencies Act 2004 (CCA), the Trust has a duty to prepare for emergencies. It must maintain plans for preventing emergencies, and for reducing or controlling the effects of emergencies. These must include a specific plan for pandemic influenza. It also has a responsibility to cooperate with other responders to ensure an appropriate response and communications.

3.2 The objectives are:

- To reduce morbidity and mortality from influenza illness;
- To be able to cope with large numbers of ill patients presenting in the hospital increasing the demand for specialist beds and a reduction of the workforce due to staff illness;
- To ensure that essential services are maintained;
- Reduce the impact of a pandemic upon the daily life and business of the Trust and to minimise economic loss.

4.0 National Requirements

4.1 The Department of Health and Public Health England (PHE) are responsible for controlling outbreaks of infection in both hospitals and community settings. If a new strain of virus is identified which has the potential to cause world - wide outbreaks, the World Health Organisation will inform the Department of Health and Public Health England. The Department of Health and the Chief Medical Officer will coordinate centrally the response to an Influenza Pandemic.

4.2 All regions and therefore NHS Trusts have been asked to have localised contingency plans for managing Pandemic Influenza. The Department of Health released an updated plan in November 2017 – UK Influenza Pandemic Contingency Plan (www.dh.gov.uk/pandemicflu) that clearly sets out the responsibilities for health organisations. This contingency plan reflects those requirements.

4.3 **Incident alert definitions 2016**

NHS England incident alert definitions will be applied or declared according to three levels and the determination of this will be dependent on the nature of the issue and incident forms of service disruption and agencies involved to manage the incident, and how each level will impact upon service delivery within the NHS; may undermine public confidence and require contingency plans to be implemented. The Trust should be clear on the nature of an issue when declaring an incident, this would be assessed by director, senior managers and clinical directors in the case of flu outbreaks before an incident is declared internally. Below is guidance as to the three incident declaration definitions.

- **Business Continuity Incident**

A business continuity incident is an event or occurrence that disrupts - or might disrupt - an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed).

- **Critical Incident**

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

- **Major Incident**

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

5.0 The Virus

5.1 Flu is an influenza virus which can usually be dealt with by the body's own defence mechanism or by vaccinations. Pandemics are caused when Influenza type A mutates into a new strain that the body has no previous immunity to.

5.2 The Influenza virus affects the respiratory system and is predominantly spread as an aerosol; however it can be transmitted through direct contact with contaminated hands etc. The virus can survive outside the body for some time:

Hard surfaces	24-48 hours;
Cloths	8-12 hours;
Hands	5 minutes.

5.3 The Spread of Pandemic Flu Strains

5.3.1 New Influenza viruses have previously emerged in the Far East, spread via Asia to Europe. Pandemic strains spread world-wide in about 6 months, although this may be shorter with the amount of international travel seen today.

5.3.2 The incubation period for the virus can be anything from 1 to 5 days and individuals can transmit the virus from the point of receiving it up to around 7 days. Active symptoms usually last anything up to 5 days, although associated illness can increase this period and the complexity of any medical interventions.

5.3.3 On average a pandemic lasts around 3 – 4 months although a second wave is traditionally experienced between 3 – 9 months after.

5.4 Complications

5.4.1 History has shown that Flu can affect any age, where as we traditionally think those most vulnerable to be the old and very young. The 1918 flu pandemic predominantly affected young adults. It is therefore right to assume that the next may hit any age group. The Influenza Virus can generate a number of medical conditions, predominantly;

Table 1:

Respiratory	Bacterial pneumonia (common) Combined Viral/ Bacterial pneumonia Pure Viral pneumonia
Cardiac	Atrial Fibrillation Heart Failure Myocarditis Pericarditis
Musculoskeletal	Myositis Rhabdomyolysis
CNS	Encephalitis Transverse myelitis Guillain- Barre Syndrome

6.0 Planning Assumptions

6.1 Historical data has enabled the World Health Organisation (WHO) to provide statistical information and planning guidance. Current guidance is that Trusts should plan for a range of clinical attack rates ranging from 25% 35% and 50%. In addition to this the hospital admission rate is projected to be 4% of those affected and a 2.5% fatality rate (previously mortality rate was 0.37% - DH guidance October 2005). The Trust's actual clinical attack rate and mortality will only be known during an outbreak.

6.2 Associated with this will be the absence of staff in equal percentages to the clinical attack rate. However it is likely that the staff absenteeism percentage will be higher as staff may need to stay home to nurse relatives or themselves; or supervise children as schools will be affected.

6.3 Once a new strain of influenza has been isolated a vaccine can take up to 6 months to create and produce. It cannot be assumed that a vaccine will be readily available to counteract the Flu Pandemic when its effects are manifest in the UK.

6.4 Another assumption that can be made during planning is that mutual aid will be limited, as it is likely that each Trust in the sector, region and nation will be affected by the demand.

7.0 Staff Immunisation

7.1 The Infection Prevention team, with advice from Virology, Pharmacy and Occupational Health, will advise on staff vaccination and use of antiviral medications. As and when vaccine/antivirals are available, Occupational Health clinics will be organised to provide staff vaccination. Staff will be informed when to attend and of the relevant treatment protocols.

8.0 Patient Immunisation

8.1 The Infection Prevention Team will advise regarding the patient groups to receive priority antiviral medication e.g. patients with chronic respiratory or heart disease, renal failure, diabetes or immunosuppression due to disease or treatment.

9.0 Treatment of Cases

9.1 There is no evidence that antibiotics have a place in the management of uncomplicated influenza. Treatment of secondary bacterial pneumonia will be guided by the Consultant Microbiologist.

10.0 Staff Management

10.1 Staff must report to their ward/departmental manager if they are unable to come to work, whether ill or caring for others. This will ensure that the directorates can implement contingency plans to ensure core services are delivered and that staff can be diverted elsewhere in the Trust depending upon need and skill provision.

11.0 Outbreak of influenza in the UK

11.1 The World Health Organisation is exchanging information with the UK Health agencies on a regular basis. Public Health England (PHE) maintains surveillance within the UK and advises the Department of Health (DOH) and the NHS regarding the types of flu virus and will draw attention to the possibility of pandemic.

11.2 Once an alert phase has been identified the DOH will convene a national Influenza Advisory Committee who will advise on national strategy and communicate to all Health agencies. The Influenza Advisory Committee will act as the clearing house for information from abroad and from the UK and will co-ordinate the response within the UK.

11.3 At the local response NHS England and local Clinical Commissioning Group (CCG) together with Public Health England (PHE) will set up a multi-agency response group, this will also include local authority representation and other relevant agencies. The group will manage the primary care response and information will be maintained with the Trusts infection prevention department or a Trust silver command if the outbreak is serious enough to invoke the Trusts internal incident plan.

11.4 The Trust will set up its own command and control structure of Silver command - tactical management and Gold command strategy management, the roles and responsibilities of the Trusts command and control structure will be in line with both the Trusts internal and major incident plans.

11.5 Once the pandemic flu plan has been activated the central and local reporting arrangement will be put into place. During Alert Levels 2 & 3 the CCG will provide a strategic platform for discussion and decisions to be taken to mitigate the impact of a pandemic in Mid Essex. Decisions will need to be taken at an early stage regarding the restriction of social interaction and provision of services.

11.6 During UK Alert Level 4 strategic decisions will continue to be made by the CCG and the Trust including financial and legal issues. Trust staff should work on a rota basis to maintain control room cover as agreed during a level 4 alert. During a pandemic the Trust will hold an Operations Sub-Group which will manage the day-to-day co-ordination and provision of services during the pandemic.

12.0 Use and Distribution of Anti Viral Medicines

12.1 Antiviral medication, if given within 48 hours of infection, is expected to shorten illness by around one day, reduce the severity of symptoms, and reduce the need for hospitalisation.

12.2 It is intended to treat all those with clinical symptoms but not to use antiviral drugs for prophylaxis, except, perhaps, in the very early stages of the pandemic. The antiviral selected on the basis of safety and effectiveness is Oseltamivir (Tamiflu). The Government is stockpiling this with the intent of distribution in the event of a pandemic, to reach local access points within 24 hours.

12.3 NHS England in conjunction with the CCG have responsibility for accessing, storage and distribution of the drug; the Trust will support them in these activities. NHS England / CCG will have no more appropriate medication than is needed for 50% of its resident population. If the stockpile does not meet need, treatment will be by clinical priority. Distribution will need to be 24/7 and will require a wide selection of distribution points.

12.4 Distribution must be carefully controlled, monitored and recorded; patient identification will be required. Antiviral treatment is presently intended to be initially available for all patients who have:

- An acute influenza-like illness; and
- Fever (more than 38ºC); and
- Have been symptomatic for no more than 2 days.

12.5 Tamiflu is not licensed for use in those aged less than one or weighing less than 15kg and, if used in this group, will require a named patient prescription by a clinician.

12.6 If necessary, national treatment priorities will be set on the basis of those most at clinical risk from influenza related respiratory complications in seasonal outbreaks.

13.0 Influenza Plan Activation Procedures

13.1 The Trust strategic lead will be the Chief Executive Officer (CEO), whilst the Trust operational lead will be a designated Director. The CEO will convene the Trusts Gold command and the designated Director will convene the Trusts Silver command team.

13.2 NHS England in conjunction with the CCG will assume initial strategic control in the county and take responsibility for implementing Command and Control structures and mechanisms. The Essex Resilience Forum Pandemic Influenza Plan contains full details of the operation, membership and other aspects of the Role and Responsibility of the Strategic Co-ordinating Group (SCG).

14.0 Escalation process upon Increased Threat level

14.1 When the threat level of a pandemic increases communication would be received normally through NHS England and the CCG. This information may be directly received into the Trust via the CEO, Directors, Emergency Planning Manager or senior members of the infection prevention team. Individuals receiving such notifications will immediately notify the Chief Medical Officer, Chief Nurse and Directors who will send immediate notification to Senior Management and the Board.

14.2 The membership of the Infection Prevention and Control Group (IPCG) will assist the Trust operational response during a pandemic by supporting the Hospital Silver Command Team with tactical decision making responsibilities once a major incident or critical incident has been declared.

15.0 Multi Agency Co-operation

15.1 The Trusts Silver Command and the Major Incident Command and Control Teams at the Local Authority and at NHS England will liaise both face to face and via conference call on an increasingly regular basis as the pandemic develops. Other external stake holders such as Essex Police, East of England Ambulance Service, Volunteers and Chaplaincy Team will also be represented at regular multi agency meetings.

15.2 The Trust will be represented at the Mid Essex Strategic Planning meetings (local health resilience partnership, Essex local resilience forum) in the first instance by the designated Trust Director however should they be unavailable other Executive Directors or the Chief Executive Officer will attend. Also present will be the Emergency Planning Manager.

16.0 Composition of MEHT command and control arrangements to manage the pandemic

16.1 Gold command membership consists of:

- Chief Executive Officer;
- Consultant, Infection Control;
- Director of Nursing;
- Medical Director and Director of Patient Safety;
- Director of Workforce;
- Head of Communications;
- Loggist / secretarial support.

16.2 The Silver Command Team membership consists of:

- The Designated Director;
- 2 nominated consultants;
- Deputy Director of Nursing;
- Deputy Director of Workforce;

- Deputy Director of Estates and Facilities;
- Infection prevention lead;
- Pharmacy lead;
- Emergency Planning Manager ;
- 2 Associate Directors of Nursing;
- Communications Manager;
- Procurement Lead;
- Security Manager;
- Ambulance Liaison;
- CCG Corporate Resilience Manager;
- Loggist / secretarial support.

17.0 Silver Command Room, incident control centre (ICC) (MAJAX) and Set up Arrangements

17.1 The ICC room, Silver command will be as per the Major Incident Plan (incident response plan) following the declaration of Pandemic influenza. This is where the Trusts Silver Command will convene. This room is equipped with basic items of stationery, copies of relevant plans, documents and action cards. A secondary control room, should this room be unavailable due to some unforeseen issue, would be identified at this point.

17.2 A daily situation report will be required which will include information on:

- Critical care capacity;
- Bed availability;
- Staff absences due to influenza and other conditions;
- Capacity reductions;
- Major operational issues;
- Supplies level;
- Pharmacy issues;
- Additional Infection prevention reports e.g. MRSA/Clostridium difficile;
- Any other relevant information e.g. equipment.

18.0 Roles and Responsibilities during Influenza Pandemic

18.1 When a Major Incident is declared roles and responsibilities are listed in the Trust Major Incident Plan and local departmental plans. The additional roles and responsibilities listed in this policy are complimentary and will need consideration.

18.2 As per the Major Incident Plan there is a responsibility for adequate logging and recording of decisions for the production of an audit trail and for a subsequent debrief report. This is the responsibility of everyone involved in the response to the outbreak within the organisation and should be co-ordinated through Silver command.

18.3 For the purposes of flu pandemic incident planning and co-ordinating the Trusts response, the Co-ordinator role will be undertaken by the Emergency Planning Manager with support from the Trusts clinical and support service leads.

18.4 Clerical Support for the purpose of the daily briefings and debriefing will be appointed by the designated Director. Support will be drawn from Corporate Office and Governance staff initially and additional resources will be identified by HR if required.

18.5 All decisions will be recorded in a logical and methodical manner by loggists. Stationery used for the recording of all decisions will be stored securely following the event and will be reviewed during the debrief stage. The secure storage of all logs will be coordinated by a designated member of the corporate secretarial team.

18.6 **Silver Command Team Roles and Responsibilities**

- Co-ordinate operational services to ensure business continuity and in peak of pandemic to ensure essential core services are maintained;
- Setup and maintain an effective log of all events, communications and decisions made during the time of a major incident;
- Set up a Trust Resilience & response Team (TRRT);
- Co-ordinate Trust response with NHS Commissioning Board Area Team / CCG (appoint appropriate person to represent the Trust, to sit on NHS Commissioning Board Area Team Multi Agency Influenza Pandemic Committee (IPC) as required);
- Work in conjunction with the Infection Prevention Team to effectively manage flu outbreaks identified within the Trust as well as presenting cares;
- Agree departmental/ward/site closures;
- Control admissions;
- Switch from elective to emergency admissions/surgery;
- Increase ICU facilities according to the 'Critical Care Surge Plan';
- Co-ordinate bed management including ward/departmental closures;
- Reducing patient visiting numbers;
- Staff absenteeism – to receive regular reports from lead nurses and service / department managers regarding staffing levels to coordinate service provision;
- Implement emergency staffing protocols to cover staff shortfalls;
- Coordinate the vaccination of patients across the Trust;
- Utilise non nursing personnel from closed departments to assist with service provision;
- Identify strategies to manage waiting lists, catch up and resume to normal services;
- Complete daily situation reports (SITREPS) and submit daily, including weekends as required;
- Co-ordinate multidirectional communication flows to ensure sharing of information with all appropriate wards and services for all directorates;
- Stand down Major Incident and recovery arrangements;
- Conduct a debrief and report according to existing procedures.

18.7 **Trust Resilience Response Team (TRRT) Roles and Responsibilities**

The membership of this team will be directed and decided by Silver Command according to the perceived extent and potential duration of the outbreak.

- To meet when directed by silver command (in the event of a rising tide incident such as Flu Pandemic the instruction to meet can be issued by Trust Executive Group);
- Maintain appropriate logs of all events decisions and communications;

- Review impact of major incident and identify challenges the Trust will face in forthcoming days/weeks/months;
- Identify actions required to meet challenges;
- Using information from silver command plan how recovery to normal business will be achieved;
- Identify communication needs of the Trust in the time leading up to full business activity;
- Plan to deliver communications to Trust and partner organisations.

18.8 **Infection Prevention Team**

To work as directed and in conjunction with Silver Command.

- Declare an outbreak and inform the On-call Director and the Chief Executive;
- Head and coordinate the epidemiological investigation;
- Maintain appropriate logs of all events decisions and communications;
- Prioritise which health care staff will be vaccinated (if available) e.g. staff with patient contact, staff carrying out essential services;
- Confirm the extent of the outbreak;
- Take reports from the infection prevention nurses;
- Take reports from the Occupational Health Manager;
- Provide professional advice to Silver Command;
- Collate infection control data;
- Provide infection control advice to health professionals and others;
- Ensure that infection control measures are working;
- Brief Senior Nurses and Ward Managers who will cascade the information to ward staff;
- Co-ordinate provision of Information Sheets for staff/visitors/patients (both pre and during pandemic).

18.9 **Virologist**

- Provide advice to the Team regarding patient and staff management;
- Maintain appropriate logs of all events decisions and communications.

18.10 **Site Lead, Occupational Health and Wellbeing**

- Provide professional occupational advice to Silver Command;
- Maintain appropriate logs of all events decisions and communications;
- Collect data and assist with epidemiological investigations; occupational health is always informed of flu and outbreaks by the IPCT;
- Coordinate the vaccination of staff.

18.11 **Heads of Nursing, service and department managers**

- Implement directorate / departmental contingency plan to mitigate staff absenteeism and increasing numbers of sick patients;
- Maintain appropriate logs of all events decisions and communications;
- Daily, or as instructed, report on staff availability throughout each directorate
- and effectiveness of directorate flu contingency plans;
- Post pandemic review staff welfare issues – flexitime, leave, time in lieu.
-

18.12 **Director responsible for Estates and Facilities**

Will appoint a Facilities Management coordinator to:

- Implement contingency plans to manage disruption to services: power, fuel, food supplies, transport;
- Maintain appropriate logs of all events decisions and communications;
- Provide 7 day a week domestic service to infected wards / areas;
- Provide extra cleaning supplies as required;
- Ensure extra provision of bed linen, towels and staff scrubs etc are available; including the coordination of extra deliveries and pick-ups;
- Identify vehicles possibly to be used for transporting bodies;
- Provide 24 hour driver service for various transportation needs should critical transport shortfalls exist.

18.13 **Chief Pharmacist**

- Ensure supplies of vaccine, antivirals, and antibiotics are distributed as per PHE instruction;
- Maintain distribution and administration records of countermeasure drugs and compile reports as required;
- Maintain appropriate logs of all events decisions and communications;
- Provide advice on pharmaceutical products including information on indications, contraindications and adverse reactions of countermeasure drugs;
- Liaise with manufacturers / pharmacies to obtain supplies as directed;
- Regularly liaise with Silver Command and TRRT.

18.14 **Emergency Planning Manager**

- Act as a tactical advisor for the Silver Command and TRRT teams;
- Arrange internal debrief sessions;
- Co-ordinate external debrief attendances as required;
- Represent the Trust at regional pan flu planning forums and exercises and invite key Trust staff as required;
- Report developments in regional or national planning arrangements to the Trust;
- Arrange table top exercises of Flu Plan in non-pandemic periods.

18.15 **Communications Department**

18.15.1 As per all major incidents, the Communications / Press team will be activated and will provide Silver Command with media support. Their responsibilities will be to brief the media and provide internal communications to Trust staff to apprise them of developments as a flu outbreak develops.

The Communications team will liaise with the NHS England communications teams as standard media messages may need to be confirmed and actioned by the Trust to the public and staff.

NB It is very important to note that there is a need to avoid contributing to the spread of rumours through dissemination of unconfirmed information and or speculation

18.15.2 All communications must be agreed through Gold Command for the Trust and Trust subject matter experts. Communications may also need to be approved by NHS England.

18.16 Roles of Other Agencies and Volunteers

18.16.1 The roles and responsibilities of the other agencies in Essex are set out in Essex Resilience Forum Pandemic Influenza Plan.

18.16.2 Trust Volunteers

All Trust volunteers will be managed by the Voluntary Services Managers to ensure this service continues.
Duties for volunteer staff would include:

- Bed making;
- Helping patients to eat and drink (under direction of clinical staff);
- Directional Services – helping patients/ visitors get from A to B.

18.16.3 **Call Handling:** The switchboard is likely to receive a larger than usual call volume during the pandemic. Major incidents in the past have tested the switchboard incredibly thoroughly. It can be expected that the system will continue to operate but with slower answering times. Where possible the business continuity arrangements for increasing staff should be activated for the Telecommunications team and automated messages may also be used relevant to known high call enquiries. The IT department will be involved in advising Silver Command of telecoms issues together with switchboard management.

18.16.4 **Command and Control Management:** During the pandemic the Silver Command Team will need to meet on a frequent basis. It is likely that whilst the Silver Command Room will not be manned 24/7 it will be necessary for the room to be operational for one or two hours every morning and afternoon. These times should be coordinated where possible to allow for up to date information be made available for commissioner control team reporting forums so that updates and queries can be effectively represented in a timely manner.

18.16.5 Human Resources Protocol and Staff Deployment

- All redeployment of staff will be through the Trust bank office;
- Where wards/departments require the services of agency or other temporary staff to complement staffing levels on a day-to-day basis, staff should follow the Trust bank policy and refer to the Human Resources algorithm;
  (Refer to Appendix 8)
- Staff, who are at high risk of complications from Pandemic Flu (i.e. pregnant women, immunosuppressed individuals) should be considered for alternate work assignment, away from direct patient care for the duration of the pandemic or until vaccinated;
- The HR department has provided managers with guidance on how to manage workforce issues such as attendance, annual leave, travel, accommodation, etc. in the Emergency Staffing Protocols given at Appendix 5.

19.0 Infection Control Procedures

19.1 All staff will adhere to Infection Prevention practices especially Mid Essex Hospital Services NHS Trust **Hand Hygiene** Policy (register number 04072).

19.2 Good hygiene measure for staff clients and visitors

- Cover nose and mouth with disposable single use tissues when coughing, sneezing, wiping and blowing noses;
- Dispose of tissue in the bag provided and then in the nearest waste bin;
- Wash hands after coughing, sneezing, using tissues or contact with respiratory secretions and contaminated objects;
- Keep hands away from mucous membranes;
- Patients may need help with containment of respiratory secretions; those immobile will need a receptacle (e.g. paper bag) readily at hand to dispose of tissues and hand wipes immediately;
- Frequently touched surfaces should be cleaned at least twice daily with high level disinfectant such as Tristel (or as per manufacturers guidance if electrical or metal equipment) and when known to be contaminated with secretions, excretions or bodily fluids.

20.0 Personal Protective Equipment

20.1 Personal Protective Equipment should be worn to protect staff from contamination with body fluids and thus reduce the transmission of influenza. Personal Protective Equipment should be put on when providing nursing care for patients with influenza like symptoms, in clinical area or when being transported around the hospital and when entering the isolation facility.

20.2 Personal Protective Equipment Table

	Entry to Cohorted area but no patient contact	**Close patient contact (less than 3 feet)**	**Aerosol generating procedures**
Hand hygiene	✓	✓	✓
Gloves	**X**	✓	✓
Plastic apron	✓	✓	**X**
Gown Water repellent	**X**	**X**	✓
Surgical mask	**X**	✓	**X**
FFP3 respirator	**X**	**X**	✓
Eye protection	**X**	**x**	✓

20.3. A FFP3 respirator mask (provides the highest possible protection factor available) should be worn by healthcare workers when performing procedures which have the potential to generate aerosols and such procedures include:

- Intubation;
- Extubation;
- Nasopharyngeal aspiration;
- Manual ventilation;
- Open suctioning;
- Chest physiotherapy;
- Bronchoscopy;
- Cardio pulmonary resuscitation.

20.4 In addition to an FFP3 mask, eye protection must be worn to prevent eye contact with infectious material during such procedures.

20.5 In accordance with Health and Safety Executive requirements, every user should be fit tested and trained in the use of the mask. Correct wearing of the mask is essential and checks should be carried out each time a mask is worn, by the user to ensure a good fit is achieved. The mask must seal tightly to the face or air will enter from the sides. A good fit can only be achieved if the area where the respirator seals against the skin is clean-shaven. Beards, long moustaches, and stubble may cause leaks around the respirator.

20.6 FFP3 masks should be replaced after each use if disposable or cleaned according to manufacturer's guidelines. If, during the process of providing care, the mask becomes contaminated with a patient's respiratory secretions they should be disposed of immediately. Masks should be disposed of as clinical waste according to Mid Essex Hospital Services Trust Waste Management policy; register number 04088.

20.7 The performance of aerosol generating procedures should be minimised as far as possible without compromising patient care.

20.8 A surgical mask should be worn for close contact with symptomatic patients (e.g. within 3 feet). This will provide a physical barrier and minimise contamination of facial mucosa by large particle droplets; this is one of the principal ways influenza is transmitted. Surgical masks should cover both the nose and the mouth and not be allowed to dangle around the neck after usage.

20.9 Surgical masks are single use items and should be disposed of in accordance with Mid Essex Hospital Services Trust Waste Management policy; register number 04088.

20.10 Surgical masks should:

- Cover both the nose and mouth and not be allowed to dangle around the neck after usage;

- Not to be touched once on;
- Be changed when they become moist;
- Be worn once and discarded in the clinical waste bin within the room;
- Hand hygiene should be performed after disposal.

20.11 Eye protection should be used where there is a risk of contamination of the eyes. There are three main methods of eye protection:

- Surgical mask with integrated visor;
- Full face visors;
- Polycarbonate safety spectacles or equivalent.

20.12 If reusable eye protection is considered then decontamination advice should be followed after each use.

20.13 The use of eye protection will be considered when there is a risk of contamination of the eyes by splashes and droplets, e.g. blood, body fluids, secretions and excretions generated through patient care. An individual risk assessment must be done at the time of providing care.

- Eye protection should always be worn during aerosol-generating procedures.

20.14 Gloves should be used only when there is contact with blood, other body fluids and secretions (including respiratory secretions) and when handling sharp or contaminated instruments. Gloves should not be used when undertaking routine care of patients.

20.15 Gloves should be used as per the Mid Essex Hospital Services Trust Personal Protective Equipment policy.

20.16 Disposable plastic aprons should be worn wherever there is a risk of personal clothing or uniform coming into contact with a patients blood, body fluids, secretions (including respiratory secretions) and excretions or during activities that involve close contact with the patient (e.g. examining the patient).

20.17 Gowns will be worn during aerosol generated procedures associated with splash risks, in accordance with the Department of Health Pandemic Influenza Flu Infection Control Guidelines for Hospital settings.

21.0 Patient Admission Process

21.1 In order that the Trust is able to manage the large number of admissions during a pandemic it will be necessary to control the manner in which admissions enter the hospital. This can best be achieved by using exclusion criteria, inclusion criteria, minimum qualifications for survival and a prioritisation tool that can be modified according to resources available.
(Refer to Appendix 3)

21.2 Exclusion criteria consist of three categories of patients: those who have a poor prognosis even if cared for in an intensive care unit; those who require resources that will not be available during a pandemic; and those with advanced illness whose

underlying illness means that they have a high likelihood of death even without their current, concomitant critical illness.
(Refer to Appendix 3)

22.0 Discharge Criteria

22.1 During a pandemic, if the usual standard of care were to be applied in intensive care, then it could be days or even weeks before the inevitability of a poor outcome was accepted, by which time several patients who might have benefited from treatment would have been denied treatment. During a pandemic when staffed critical care and acute beds are scarce, it will be important to identify at an early stage those patients not responding to treatment and therefore likely to have a poor outcome. It is proposed that, once treatment and care start, in addition to any routine monitoring and assessment each patient should have regular, formal periodic assessments to determine whether:

- They are responding to treatment and are fit enough to be discharged;
- They are responding to treatment and still need further treatment;
- They are not responding to treatment or are deteriorating despite treatment, and so further treatment should be withheld in favour of symptom relief and palliation.

23.0 A&E Arrival Streaming during Pandemic

23.1 During the pre surge and surge periods of the pandemic non elective admissions should enter the hospital via Accident and emergency (A&E) entrance. During the pandemic period the reception area and triage rooms opposite will operate as the main triage area for all pandemic flu symptom cases. Additionally A&E reception functions should also support this setup. Suspected Pandemic Flu cases should be triaged within the main reception area where reception staff can be provided some form of protection by the glazed reception desk.

23.2 All non flu patients reporting to A&E with an illness or injury requiring treatment should be sent immediately to the Minor Injuries Department within A&E for triage and treatment. Where appropriate, minor injuries patients should be directed to any existing CCG walk in centres. All services should be provided with minimal contact (where practicable) with the patients diagnosed with influenza. All patients attending this area should be provided with a mask by the receptionist.

23.3 Symptomatic patients should wear normal surgical masks, where possible, in common waiting areas or during transport (e.g. one area of the hospital to another or to another hospital) in order to contain respiratory secretions and reduce environmental contamination.

23.4 The Majors area of A&E will also be split with half of the side rooms being used for treatment of emergency pandemic flu patients and half remaining for non pandemic flu emergency cases. These side rooms will remain split this way throughout the pandemic period to reduce infection.

23.5 Where at all possible Resus will be treated the same way however the small number of bays will mean that this will be less successful. Additional cleaning processes should be adopted for this vulnerable part of the hospital.

24.0 Admission of Pandemic Influenza Patients

24.1 At the start of the Pandemic Influenza patients should be cohorted at Broomfield Hospital Emergency Assessment Unit. This will naturally require a large number of patient transfers however this will mean that vulnerable patients can be better segregated. This movement will happen in stages with a 'ward by ward' approach to the movement of patients.

24.2 As the pandemic progresses the Hospital will fill, when this occurs separate wards will be identified and used for pandemic and non pandemic patients. These separate wards should use ward specific staff at all times so as to minimise the risk of infection. Similarly equipment or other mobile facilities (i.e. patient hoists and hostess trolleys) should not be moved between pandemic and non-pandemic areas. Interconnecting wards should be avoided where the wards have infected and non-infected cohorted patients, this will prevent easy opportunity for cross infection.

24.3 Where inpatients fit the necessary criteria for prescribing antivirals these can be obtained via pharmacy who will liaise with NHS England / CCG who will hold all stockpiles of antivirals. However, this will be strictly for patients that are admitted. All other members of the public seeking antivirals from the hospital will be advised to contract their GP or pharmacy.

24.4 To increase the number of Trust critical care facilities the escalation plan for adults is to admit initial patients to identified areas as per the critical care surge and mass casualty plan. Side rooms should be utilised initially to minimise spread.

24.5 Clinical Operations Managers are to liaise with the Trust critical care leads and Essex Critical Care Network for bed availability. This will be mapped in the clinical operations department and regular updates provided to Gold and Silver control teams.

24.6 The second wave of patients, if requiring ICU / HDU facilities, will be admitted to cohort able areas identified with appropriate services, resources and staff skill set.

24.7 The first stage recovery area of the Zone A Theatres will admit subsequent ventilated patients once normal theatre activity has reduced. An increase of up to eighteen critical care beds can be created and will require adequate resources planning for 24 hour cover. The Trusts Critical Care Surge Plan will identify further creation and management of critical care capacity.

25.0 Care of Vulnerable Patients

25.1 All decisions to manage groups of patients in other ways than normal protocols dictate should be agreed and coordinated by Silver Command. Particular care should be taken of vulnerable patients during a pandemic, (e.g. immunosuppressed). In times of extreme pandemic a decision will be required from the Silver Command team to designate a ward to isolate the immunosuppressed patients to minimise their exposure.

25.2 Special consideration will be made to transfer immunosuppressed patients out of the hospital to other facilities, if space is available, as soon as reasonably practicable.

26.0 Children and Maternity Services

26.1 Once the flow of children or admissions increase above 20 per day the Children's area/OPD will cease activity and the assessment facility will revert back to an 8 bedded inpatient area.

26.2 Phoenix ward will be utilised for the care of children requiring medical care and including high dependency in consultation with the Paediatric Consultant, ICU and Children's Acute Transport Service (CATS) teams.

26.3 If no paediatric intensive care (PICU) bed is available, children over 10kg will be transferred to an adult intensive care bed within MEHT.

26.4 Children under 10kgs will be managed with non invasive support and CATS to be consulted to provide ongoing support.

26.5 Maternity facilities will be co-ordinated as normal with any Pandemic Influenza cases isolated or cohort nursed away from non infected mothers.

27.0 Visitors to Hospital Wards

27.1 Visitors to the wards should be kept to the minimum. Those that do visit should be briefed upon the local Pandemic Flu arrangements. They must use hand hygiene facilities prior to and after visiting.

27.2 Staff should discourage visitors from attending the hospital during a pandemic. If symptomatic, visitors must be excluded from visiting the ward. There will be a more flexible approach regarding visitors for terminally ill patients. Opportunities for 'virtual visiting' via IT applications such as 'Facetime' or 'Skype' should be actioned to reduce visiting and reduce community cross infection of flu.

27.3 In times of a full pandemic the Trusts silver command team can make a decision to close the hospital to all non patient attendees. An announcement of this will be declared by the designated Director and communicated through the Communications Team.

28.0 Cleaning and Disinfection

28.1 There is no need for specific cleaning for pandemic influenza and routine cleaning policies should be followed such as:

- Damp dusting rather than dry dusting should be used to avoid generating dust particles, ensuring that there is a routine in place to prevent redistribution of micro-organisms i.e. cleaning less heavily contaminated areas first, changing the cleaning solution and cloths frequently.
- Dedicated or single-use/disposable equipment should be used.
- Non-disposable equipment, including mop heads, should be laundered after use.

- Crockery and cutlery should be washed in a dishwasher with a hot rinse, rather than by hand washing. Purchasing disposable plates and cutlery is not necessary.
- Any spillages or contamination of the environment with secretions, excretions or body fluids should be treated in line with current practices

28.2 Staff should refer to the Trust's Cleaning Policy (09033) and Decontamination Policy (04070).

29.0 Laundry

29.1 As per standard contaminated linen practice, all linen used by influenza patients should be placed in pink dispersible water-soluble bag immediately after use and bagged at the point of use. Please refer to the Mid Essex Hospital Services Trust Linen and curtain policy (register number 08021) for handling infected linen.

29.2 Gloves and aprons should be worn for handling all contaminated linen.

29.3 Hand hygiene should always be performed following removal of gloves.

29.4 Where resources permit all curtains should be removed following patient discharge. Blinds, surfaces and metal should be cleaned with high level disinfectant such as Tristel. Hard to reach surfaces and areas should be cleaned with a steam cleaner.

30.0 Clinical and Non-Clinical Waste

30.1 There are no additional waste handling measures necessary for clinical and non-clinical waste during the influenza pandemic and regular Mid Essex Hospital Services Trust Waste management policy (register number 04088) should be followed.

30.2 Any clinical waste (e.g. gloves, aprons, masks and tissues) should be disposed of as clinical waste.

31.0 Supplies of Equipment

31.1 Clinical supplies will be reviewed to ensure an initial immediate supply of protected personal equipment is available in key areas across the Trust. Six week contingency store will be accessible via the Infection Prevention team and Service Co-ordinator out of hours.

32.0 Body Management

32.1 Upon declaration of the pandemic a mortuary capacity update will be obtained by a designated silver command Manager via the EDEN system daily, concerns regarding capacity should be discussed with the mortuary management and if necessary escalated to or possibility that the service will exceed capacity should be immediately escalated to the Silver Command and TRRT.

32.2 **Current Mortuary Capacity**

Broomfield: Standard 79;
Bariatric 20;
= Total 99.

32.3 In the event that body storage demand exceeds capacity the CCG should be contacted. The pathology department will activate their contingency plan to provide more body storage capacity.

32.4 Arrangements will be made with NHS England, the CCG and the local authorities for planning of emergency body management and the removal of bodies to the designated for onward management in line with existing Local resilience forum plans.

32.5 The body should be placed in a shroud and body bag. No additional protective measures are required for the handling of deceased patients unless otherwise advised.

33.0 Blood Supplies

33.1 The National Blood and Transplant services have collected blood to avoid shortages and to ensure the continuity of the blood supply chain during times of any emergency. A central contact point for NHSBT has been established to aid operational communications.

34.0 Staff Communication

34.1 Updates to the Pandemic Influenza plan either on the status of Pandemic Influenza or changes of procedure will be provided to all staff through the staff newsletters 'Focus' and Infection Prevention Updates.

34.2 Staff will all receive an email with any changes to the Pandemic Influenza status and any actions required as a response.

34.3 Pandemic Influenza Information leaflets will be available in all areas for members of the public.

34.4 Frequent staff briefing sessions will be held as required.

35.0 Public Communication

35.1 Standard Department of Health leaflets will be available across all Trust sites, in various languages.

35.2 Central telephone numbers will be displayed on the Internet and across all Trust sites.

35.3 Regular updates will be provided in conjunction with NHS England and the CCG.
35.4 There will be updated clear signage around the hospital sites to maintain minimum disruption.

36.0 Staff Support

36.1 Chaplaincy and Psychotherapy support will be available for staff during this recognised difficult time where emotive decisions may need to be taken outside of normal working practice.

36.2 The psychotherapy team will contact Silver Command to let them know availability and to confirm what areas they need to support individuals.

36.3 If there is a large number of deaths the Chaplaincy and Psychotherapy teams may be required to undertake a more active role in informing families and will be available to support their work with staff. Staff welfare and needs will be highlighted as necessary.

37.0 Staff Transport

37.1 Staff will be encouraged to car share where possible or seek other forms of transport to attend for duties.

37.2 In the event of fuel shortages Silver Command will invoke the Trusts 'Fuel Disruption Plan' which will involve local authority and national fuel shortage plans to access identified emergency fuel procedures in line with plans.

37.3 Taxi and private car services may be accessed following authorisation according to the Trusts 'Fuel Disruption Plans'.

37.4 Accommodation will be coordinated for key staff living outside of the Mid Essex area in extreme circumstances.

38.0 Security and Traffic Management

38.1 There are four stages for security deployment:

- Access control (partial lockdown) which will involve access control for certain entrances only and will be manned by in house security porters;
- Additional security operatives brought in to assist;
- Full lockdown as required which can be completed by in house security porters;

- Where breaches of the peace or disturbance occur, assistance will be requested from the police.

39.0 Recovery of Services

39.1 At the end of the Pandemic a full evaluation and review of services will be undertaken. This will identify the need for a staged return to re-establish recovery of key services. Lead nurses, service and department managers within those areas affected will manage the return of their services to normal in line with the time frame agreed with Silver Command and in turn NHS England / CCG.

39.2 Staff will continue to be supported during the recovery phase as outlined in the Human Resources protocol with assistance from Human Resources, Chaplaincy and Psychotherapy services as required.

39.3 In line with the Business Continuity Plan the need for resources will be identified during the recovery phase and the distribution of resources will be identified according to area need. This is to promote a seamless return to normal services in line with Key Performance Indicators. Restoration of normal services will be implemented without unnecessary delay.

39.4 This will include feedback from all local agencies with regard to the effectiveness of communications activity within the wave one period. The Pandemic Influenza Planning Team will seek to identify good practice and other lessons learnt.

40.0 Equality Impact Assessment

40.1 In accordance with DH guidance, the Trust will endeavor to apply its Equality and Diversity policy and ensure that during a pandemic, all patients and staff will be treated fairly, and where possible meet the needs of individuals.
(Refer to Appendix 13)

41.0 Review

41.1 When the Department of Health declares the pandemic over, NHS England will prepare a report reviewing the effectiveness of and lessons learned from the response in the East of England. MEHT will undertake its own formal debrief and review of the effectiveness of the Trusts response.

41.2 This plan will be reviewed every two years if a pandemic has not occurred, and submitted to the DRAG for approval as required.

42.0 References

Department of Health and Social Care (2011) Responding to a UK flu pandemic Available at https://www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic

Department of Health (2009) Pandemic influenza: surge capacity and prioritisation in health services - provisional UK guidance

The Control of Major Accident Hazards Regulations (2015)
Available at : http://www.hse.gov.uk/comah/background/index.htm

Department of Health (2012) Seasonal Flu Plan, winter 2012/13

Essex Local Resilience Forum Pandemic Influenza, Preparation and Response Plan (2018)

Public Health England, Operating Framework for Managing the Response to Pandemic Influenza (2017)
https://www.england.nhs.uk/wp-content/uploads/2013/12/framework-pandemic-flu.pdf

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Appendix 1
Pandemic Influenza Decision Log Gold/Silver (delete as appropriate)

Entry No.	Date	Time	Information / Message	From	Contact Details	Action / Decision Taken	Contact Details	Time	Initials

Appendix 2 - WHO Preparedness Levels for Flu Pandemic Planning

WHO Preparedness Levels for Flu Pandemic Linked to Trust Phased Response				
Phase	**Description**	**Clinical Action**	**Laboratory Action**	**Trust Flu Plan Action**
Phase 1 (Inter-Pandemic Period)	No new influenza subtypes in humans		Prepare assays for detection of Influenza A pandemic strain Investigate those cases who fit WHO definition, in particular patients with respiratory symptoms returning from areas where Avian flu prevalent	Trust Flu Plan prepared (this document) Flu Co-ordinator identified : Infection Control Doctor (supported by Head of Emergency Planning & Consultant Virologist) Exercise Flu Plan (table-top)
Phase 2 Inter-Pandemic Period	No new influenza subtypes in humans. But circulating animal influenza poses risk of human disease	Case returning from area endemic for Avian Flu or who have had contact with sick birds with Avian flu Admit patient to high level containment unit or negative pressure room. Treat with Oseltamivir until diagnosis known. Oseltamivir prophylaxis to contacts (Healthcare workers who were not wearing protective masks, household and work colleagues if applicable).		
Phase 3 Pandemic Alert Period	Human infections with new subtype but no new human to human transmission			Trust Flu Plan ready to be activated depending upon locality of outbreak and guidance from Infection Control Doctor/DH, NHS Commissioning
Phase 4 Pandemic Alert Period	Small clusters highly localised suggesting that virus is not well adapted to humans	As above Clinical Identification of cases fitting WHO case definition Prophylaxis and treatment of cases fulfilling NICE guidelines. Treat all cases of influenza-like infections admitted to hospitals until diagnosis known	Type all Influenza A for H5N1: For those fitting case definition i.e. with flu like symptoms who have returned from countries with spread of pandemic strain or who have had contact with case of pandemic strain As phase 4 evolves, investigate all cases of Influenza-like infection even those who do not give a history of contact with known cases /travel	
Phase 5 Pandemic Alert Period	Large clusters but human to human spread still localised substantial pandemic risk	As above	Resp PCR including H5N1 for hospitalised cases only	
Phase 6 Pandemic Period	Pandemic	Assuming outbreaks in UK Encourage patients to remain at home Prophylaxis and treatment of cases fulfilling NICE guidelines. Treat all cases of influenza-like infections admitted to hospitals until diagnosis known		Trust Flu Plan fully activated
Post Pandemic	Return to Inter pandemic Period			Review effectiveness of Trust Flu Plan & revise

Appendix 3 – Inclusion and Exclusion Criteria for Care

Criteria for admission from secondary care to critical care

Inclusion Criteria	Exclusion Criteria
The patient must have one of the following: • requirement for invasive ventilatory support - refractory hypoxemia SaO2 <90% on non-re-breathe mask or FiO2 >0.85 - respiratory acidosis (pH <7.2) – clinical evidence of impending respiratory failure - inability to protect or maintain airway • hypotension (systolic blood pressure <90mmHg or relative hypotension) with clinical evidence of shock (altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure) SOFA score ≥7 or single organ failure	Severe Trauma Severe burns with any two of the following: age >60, >40% of total surface area affected, inhalational injury Cardiac arrest – un-witnessed, witnessed but not responsive to electrical therapy, recurrent cardiac arrest Known, severe, progressive baseline cognitive impairment Known, advanced, untreatable neuromuscular disease Known, advanced, metastatic malignant disease Known, advanced and irreversible Immunocompromise Severe and irreversible neurological event or condition End-stage organ failure meeting the following criteria: ***Heart*** • New York Heart Association (NYHA) class III or IV ***Lungs*** • Chronic obstructive pulmonary disease with FEV1 <25% predicted, baseline PaO2 <7.33k pascal, or secondary pulmonary hypertension • Cystic fibrosis with post-bronchodilator FEV1 <30% or baseline PaO2 <7.33k pascal • Pulmonary fibrosis with VC or TLC <60% predicted, baseline PaO2 <7.33k pascal • Primary pulmonary hypertension with NYHA class III or IV heart failure, right atrial pressure >10mmHg, or mean pulmonary arterial pressure >50mmHg ***Liver*** Child – Pugh score >7 SOFA score >11

Any acute trauma not amenable to treatment in primary care, eg suspected fractures, major lacerations	Any acute trauma amenable to treatment in primary and community care eg minor lacerations, grazes, sprains, strains
Any acute surgical emergency where the cause or a co-morbidity is not within the exclusion criteria and where acute surgical intervention is required, eg suspected appendicitis, bowel obstruction	Admission for 'social' issues
Any acute medical emergency where the cause or a co-morbidity is not within the exclusion criteria, eg acute myocardial infarction, sepsis, gastro-intestinal bleeds	Cardiac arrest – un-witnessed, witnessed but not responsive to electrical therapy, recurrent cardiac arrest
	Known, severe, progressive baseline cognitive impairment requiring respiratory support
	Known, advanced, untreatable neuromuscular disease requiring respiratory support
	Known, advanced metastatic malignant disease
	Known, advanced and irreversible immunocompromise requiring respiratory support
	Severe and irreversible neurological event or condition
	Elective palliative surgery

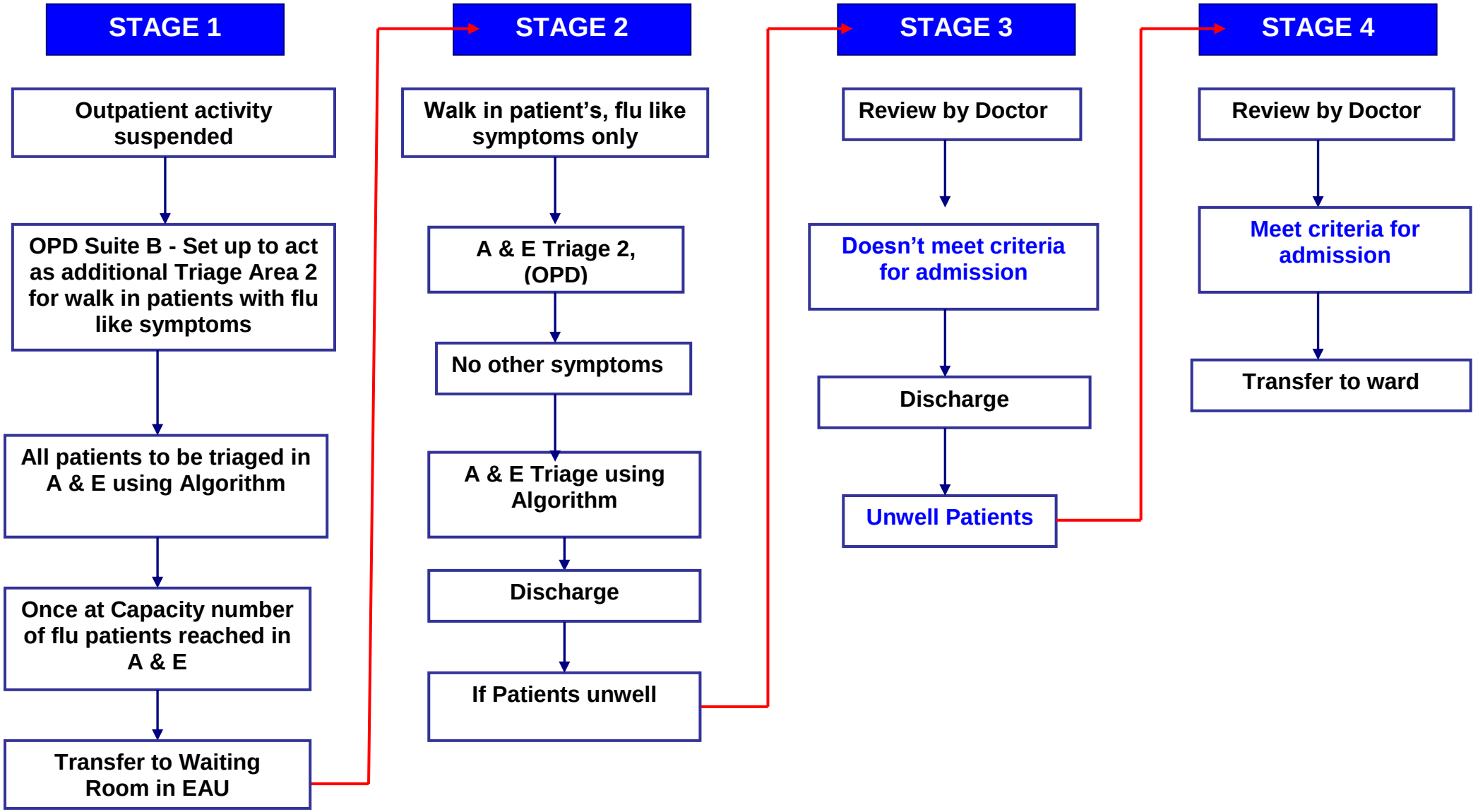
Criteria for admission from A&E to secondary care

Inclusion criteria	Exclusion criteria
Any acute trauma not amenable to treatment in A&E or where conservative management would compromise the outcome, eg compound fracture, fractured neck of femur, ruptured spleen	Acute trauma amenable to conservative treatment in the A&E department, eg manipulation of Colles' fracture and splintage in A&E rather than pinning
Any acute surgical emergency where the cause or a co-morbidity is not within the exclusion criteria and where acute surgical intervention is required, eg suspected appendicitis, 'acute abdomen', gynaecological emergencies	Admissions for 'social' issues
Any acute medical emergency where the cause or a co-morbidity is not within the exclusion criteria, eg acute myocardial infarction, sepsis, gastro-intestinal bleeds	Cardiac arrest – unwitnessed, witnessed but not responsive to electrical therapy, recurrent cardiac arrest
	Known, progressive, severe baseline cognitive impairment requiring respiratory support
	Known, advanced, untreatable neuromuscular disease requiring respiratory support
	Known, advanced, metastatic malignant disease
	Known, advanced and irreversible immunocompromise requiring respiratory support
	Severe and irreversible neurological event or condition
	Elective palliative surgery

Appendix 4

Overflow Flu Plan for Extended A & E For Patients with Flu Like Symptoms Only

NHS Mid and South Essex University Hospitals Group



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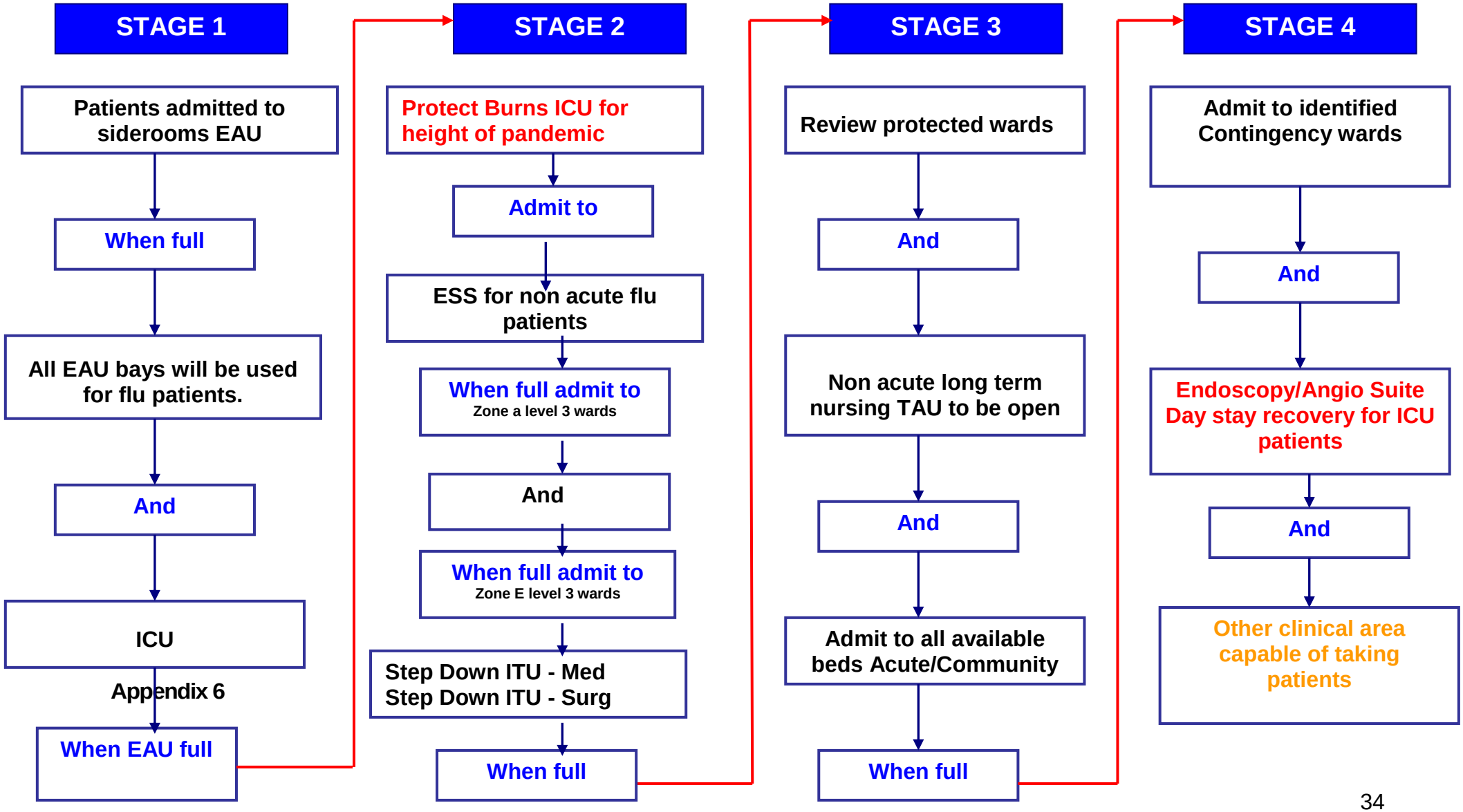
Admission Plan for Pandemic Flu



Post Flu Pandemic – Action and Risk Log

Directorate:

RISKS/THREATS THAT WILL/MIGHT OCCUR	CONSEQUENCES	DEGREE OF SEVERITY (1= LOW, 5 = HIGH)	SECONDARD HAZARDS E.G. DEPENDENCIES	CONTINGENCY PLAN (what will be done)	LEAD (person & directorate)	LIKELY ESCALATION & ACTION REQUIRED

Appendix 7:
Management of Children during Pandemic Influenza

Introduction

This document describes how Mid Essex NHS Trust proposes to manage the demand for Assessment and Children's High Dependency and Intensive care and to cope with sustained increased demand as a result of H1N1, infection. This plan is subject to change and will be reviewed frequently.
The current capacity at MEHT is:

- 20 Children's Medical Beds including 4 HDU rooms on the Broomfield site.
- 16 neonatal beds including 1 NICU and 2HDU on the Broomfield site.
- All Paediatric Intensive Care (PIC) activity is managed by the stabilisation of the patient and referral to the Children's Acute Transport Service (CATS).
- The CATS team will normally mobilize a team within 30 minutes, retrieve the child and transport to the most appropriate PIC bed.
- It is possible that there will be insufficient PIC beds available to manage the demand for PIC and children will need to be cared for locally.
- The current process for management of these patients means that local teams do not have the experience and skills normally required to care for this group of patients.

It is proposed that MEHT will manage this activity by:

The Assessment facility normally manages the flow of GP referrals into Children's Services within Phoenix ward; the 8 bedded bay may need to convert back into 4 beds for inpatient use. It is proposed that if either

a) The flow of children increases above 20 per day or

b) The inpatient numbers increase above 20

The OPD area on Phoenix ward will cease activity and children will be seen and assessed in the OPD area will either be admitted to the ward or discharged home.

The attached flow chart appendix 10 will support decision making by the teams caring for children across the Trust.

- Children requiring medical care including HDU would be admitted to Phoenix Ward at Broomfield Hospital, managed by the children's team and supported by the on site anaesthetic team, with consultation with the ICU team and CATS.
- All children who require PIC will be treated on Phoenix ward, contingency of the Childrens burns ward, final stage will be for children over 10 kg to be transferred to an adult Intensive Care (IC) bed if a suitable bed is available. Children under 10 kg will be managed with the use of non invasive airway support whenever possible and CATS will be consulted to provide ongoing support.
- The staffing of this bed would require partnership working between the Adult Intensive Care team and Children's Services. There would need to be Senior Paediatric medical staff and children's nursing staff available on site 24 hours a day. To allow this to happen all planned care will need to stop.

Medical Staff.

A rota of senior paediatric medical staff will be planned to provide 24 hour a day cover on the Broomfield site.

Admission Plan, Pandemic Flu for maternity patients FOR REVIEW BY DEPARTMENT/SERVICE

Mid and South Essex University Hospitals Group

Appendix 8:

STAGE 1

One patient admitted to room 9 on Labour ward.

More than one patient to cohort nurse in rooms 12 13 and 14. Unless bereaved woman using one of these rooms, then escalate straight to ANW

All patients to be assessed using PAR scoring/

Anaesthetic/ obstetric review which will determine if transfer to Broomfield required

STAGE 2

Close Antenatal ward (DAU) – DAU transferred to Antenatal clinic. Antenatal and triage to be transferred to Mary Munnion.

Stop Parent Craft Classes. Reduce Antenatal Clinics to primigravida and high risk women.
Midwife Antenatal checks via phone for Low Risk Women.

Divert Low Risk births to other agreed community facilities depending on relevant geographical area.

Post Natal women to be discharged home as soon as is possible following N96 check.

STAGE 3

Lead Midwife for Infant Feeding will give telephone support to post natal women to encourage/support breastfeeding.
Use peer support groups to support breastfeeding mothers and involve NCT.

Community Midwives to stop doing post Natal home visits.
Start a clinic for day 5 New Born Spot Screening and 10th day discharge in the ANC at St Johns, St Peters and WJC.

Open ANW for Swine flu patients to be cohort Nursed, caring for Ante Natal and Post Natal women.
Staffing of all units to include Community Midwives.

Appendix 9

PANDEMIC INFLUENZA
EMERGENCY STAFFING PROTOCOLS
HR/ MANAGEMENT ACTION PLANS

1. INTRODUCTION

These guidelines are to help both managers and staff with the implications and issues that may arise during a flu pandemic.

During the pandemic, the Trust will seek to operate within its existing employment principles, although it is acknowledged that there could be a period when this will not be possible due to an increase in patient activity at a time when staff numbers could be depleted due to staff contracting the flu virus. Some staff may also not be available due to carer responsibilities as these staff may be caring for a child or relative who has contracted the virus or because normal care arrangements are not available. If the pressure on the service is such that normal working arrangements can no longer apply (e.g. a major incident is declared) then this approach will have to be reviewed and emergency working arrangements put in place. If this is the case, the Trust would ask for co-operation and flexibility from employees and an understanding and appreciation from the managers in handling this situation.

Set out below are emergency staffing protocols that have been agreed by the Trust in partnership with staff representatives and are designed to assist managers with decision making on staffing issues during a flu pandemic. More importantly, the detail of what each of these protocols means for various services and in specific locations needs to be considered by managers and, where possible, decisions made in advance regarding their implementation (see paragraph 2 below).

These emergency staff protocols will be implemented upon direction from the Trust Pandemic Flu lead and the Director of Workforce or their respective deputies.

2. PREPARATIONS TO BE UNDERTAKEN BY MANAGERS AND HUMAN RESOURCES

Action cards for line managers and HR, setting out key actions and responsibilities for the inter-pandemic, pandemic and post pandemic phases are attached to these protocols and should be referred to upon receipt of this document and the relevant actions to be undertaken.

The Trust has been preparing for a flu pandemic for some time now as part of its major emergency planning. Managers will be aware of the importance of preparing for a potential flu pandemic and should have in place if needed minimum service and staffing requirements to ensure business continuity. Consideration also needs to be given as to the impact these plans may have on their team should only essential services are functioning. For example, consideration must be given to backfilling so that staff may be able to be deployed to critical areas.

HR will undertake an annual audit of staffing information held on ESR to ensure this information is up to date as well as complying with the Data Protection Act.

HR also collates the following information from staff which is kept securely in a separate database held in HR and only used when the emergency staffing protocols are to be implemented:

- Staff out of hours contact details
- Skills audit - names of those staff who have additional skills/qualifications that would enable the Trust to redeploy them to an essential service.
- Travel arrangements to work – this information will be helpful if the public transport system is affected or if staff are reliant on car share arrangements.
- Caring responsibilities – this information will assist managers in their planning as those staff with caring responsibilities of either young children and/or a relative may find it more difficult to attend work as normal if the person they care for becomes unwell or if the usual care arrangements are not available.

This database enables HR to quickly provide reports that will facilitate the appropriate staff to be redeployed to support the delivery of priority services.

The Trust bank office will co-ordinate all staff redeployment if required during the peak of a pandemic. The Director of HR and/or the Pandemic Flu lead will confirm with managers when this arrangement is to commence and the process to be applied.

3. EMERGENCY STAFFING PROTOCOLS DURING AN INFLUENZA PANDEMIC

3.1 Sickness Absence Management.

In the event of staff sickness, normal absence reporting procedures will apply.

Staff who experience flu like symptoms must not attend work and must remain at home whilst they are still presenting symptoms. They should be advised to contact the National Pandemic Flu Line that has been set up by the government.

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If staff are still not fit to return to work following the normal 7 day self certification period, a GP certificate will still be required (as per normal sickness reporting arrangements). If the pandemic is such that a decision is taken centrally that GP surgeries are not able to issue sick certificates, then the Trust may consider extending the period of self certification. The Director of Workforce, in consultation with Occupational Health service, will issue an instruction if this current arrangement is to change and for what length of time the change in arrangement would be acceptable.

Where appropriate and upon the advice of HR, non clinical staff may be asked to contact staff who remain absent following the expected period of sickness (e.g. the worried well) to discuss with them arrangements that may help them return to work. Return to work interviews must be held for all staff who have been absent due to sickness in line with the normal policy to consider the reasons for absence and fitness to return. Where flu like symptoms have been the cause of absence this must be recorded on the personal file and it should be established that all symptoms have disappeared prior to a return to work.

Occupational Health have issued a form that is to be completed for all staff reporting absence due to flu symptoms. This form is available on the staff intranet.

It is recommended that return to work interviews are also held for staff who have been absent for other reasons; to check their own position and update them on the situation, changes or contingency measures required to deal with the effects of the outbreak. This is particularly important if the emergency staffing protocols are being applied and the person returning to work may be required to return to a different work arrangement.

3.1 Non-attendance at Work

The guiding principle is that where possible, the Trust will expect staff to attend work in the normal way but also acknowledges that its staff will share the same worries and concerns as all members of the general public for their own wellbeing and that of their children and other family members. The Trust understands some staff will be concerned about attending work during the pandemic due to fear of infection and putting themselves and their families at risk.

If a member of staff does not appear for work, does not report sickness or make contact to explain the reasons for absenteeism and cannot be contacted, they may be deemed to be on unauthorised unpaid leave. Whilst encouraging our managers to be sympathetic to individual circumstances, in some cases of abstention from work or other failure to attend or report, use of the Trust disciplinary processes may be appropriate. Managers are to seek HR advice before taking disciplinary action.

3.2 Occupational Health and Staff Counselling

Where possible, OH want to be able to continue to provide its normal range of services, including counselling for staff who are distressed or experiencing stress. However an increase in flu cases will mean that the Trust's occupational health service is going to be experience a major increase in demand for its services. For example, OH could be involved in swabbing staff for proof of diagnosis, collating of flu absence forms, as well as being heavily involved in providing a vaccination programme for staff once the vaccine is available. Therefore, the Occupational Health service and staff counselling service may not be as readily available to provide advice and support as required. The OH team will publish alternative arrangements at the appropriate time and this may include access to Trust Psychotherapy services.

3.3 Chaplaincy Service

Depending upon the severity of the outbreak and the impact on staff, it is likely that there will be an increased demand on the chaplaincy service to provide support to staff, patients and relatives.

Staff whom are concerned about the potential impact of a pandemic may seek support from the chaplaincy service, either instead of or as well as that available through occupational health.

Managers therefore need to be aware of the potential for staff asking to be released to access this service during all phases of a pandemic and that these requests should be considered sympathetically and on an individual basis.

3.4 Pregnant Women and Immuno-comprised Workers

The current advice from the Department of Health is that this group of workers should continue to attend work as normal. Where their role brings them into contact with

patients that are presenting flu symptoms or have been diagnosed with flu, managers need to undertake a risk assessment and consider the options available to redeploying these staff to another area. The Trust understands the concerns of this group of staff but also stresses the importance of a common sense approach and based on the risk of infection, e.g. the risk of infection of the H1N1 virus during 2009 within the hospital was considered similar to that when out in public places.

3.5 Acting Up

Managers will have the responsibility to decide on temporary acting up arrangements where this is necessary to cover gaps in essential service delivery or loss of key priority skills. Staff will not be asked or expected to undertake tasks outside their level of competence.

3.6 Working Flexibly and Caring for Patients that Present Flu Type Symptoms

The Trust will expect staff to continue working in the normal way with patients that present flu type symptoms unless they are pregnant or are immuno-compromised (see paragraph 3.4 above). Staff who may be concerned should refer to their professional code of conduct for guidance as well as discuss their concerns with their manager. Where a member of staff does not follow their professional code of conduct, the Trust will consider invoking the formal disciplinary policy.

This same expectation will apply should the Trust need staff to work flexibly to offset the impact of staff absences and redirect staff to caring for patients in priority/critical areas. Working flexibly will require managers to consider:

- relocating staff to work at other locations,
- staff working different hours (including those on fixed hours),
- staff undertaking different duties
- Roles that can be undertaken from home or another remote location

Managers need to ensure that such changes do not compromise infection control, health and safety or other risk management controls.

The Trust will initially request changes to normal working arrangements on a voluntary basis but will, if necessary, direct staff to attend at other locations. The redeployment of staff to be managed via the Trust bank office and managers will be notified when this service will be available and how it is to be managed.

It is expected that as with all major incidents, staff will reasonably co-operate to help ensure the Trust can continue to provide patient services.

3.7 Extended hours for Part-time staff

Part time staff may be asked to increase their hours of work during the peak of the pandemic outbreak and will be paid for any additional hours of work they are required to complete over and above their normal contracted hours in line with their contracts of employment and Agenda for Change provisions. (see also 3.13 below).

3.8 Annual leave

It is not the Trust's intention to cancel pre-booked annual leave unless exceptional circumstances arise and only then will this decision be reviewed. If absolutely necessary and as part of the Trust's response to covering services during a major

incident, and on direction from the Trust Executive Team, all advance annual leave booked by staff may need to be rearranged for a later date. Staff already on leave will be allowed to continue with their leave.

Where reasonably practicable and in the interests of continuity of patient services, additional leave will be allowed to be carried over to the following year in individual circumstances which will assist the Trust in retaining key skills during the pandemic outbreak. However, it must be recognised that staff with key skills working extended hours during the peak of the pandemic will need to rest and may benefit from taking leave when events allow for this to happen.

At the peak of the pandemic, it is more likely that staff will have to cancel holiday arrangements due to decisions taken nationally by holiday or transport companies or because they or their families have contracted the virus and not able to travel. If this is the case then staff are more likely to be able to seek compensation through their holiday insurance. Where it is the Trust that has requested staff to cancel pre-booked annual leave arrangements at short notice and staff suffer a financial loss, then the Trust will compensate the individual member of staff and their immediate family. Managers are to record cancelled leave and should note the potential additional costs to the Trust of cancelling staff annual leave at short notice and avoid this approach where possible.

3.9 Training and Study days

The Trust may need to restrict staff absence for training and study purposes to ensure that services are staffed adequately. Where possible this decision will be taken locally. However, if disruption to services is predicted to be widespread, then the decision will be taken by the Director of HR following consultation with the Pandemic Flu lead.

3.10 Compassionate Leave

If the pandemic were to become severe and causing fatalities, requests for leave/time off to attend funerals is likely to become more commonplace and should be treated sympathetically. Where the bereavement is a close family member then staff will be granted time off in line with current policy. Where the bereavement is a relative, friend or colleague, staff will be granted time off to attend a funeral wherever possible.

3.11 Emergency dependents leave

When the government changes its approach from containment to treatment schools are unlikely to take a decision to close due to pupils contracting the virus. However, if this approach was to change and schools decide to close, then staff who have childcare responsibilities may need emergency dependents leave to make alternative arrangements. Similarly, nurseries or dependent care facilities may close. Managers should seek HR advice if unsure of appropriate response or if multiple requests are made by individual staff.

Advice on alternative care arrangements may be available through Essex County Council website.

3.12 Carer's leave

The Trust current entitlement of 5 days will still apply where staff have to take time off to care for their children either because their children are unwell or because normal

care arrangements are not available. Managers do have the discretion to increase this entitlement in exceptional circumstances.

3.13 Working time Directive

For the duration of the pandemic outbreak the Trust will seek to ensure that staff will generally not be required to work more than an average of 48 hours in any one week. Staff with essential skills or expertise may exceptionally be requested to work extended hours beyond this and will be expected not to unreasonably refuse. Staff that do work in addition to their contracted hours will be paid for these additional hours in accordance with their current terms and conditions of employment.

Managers need to take account of the additional pressure on staff and their families when asked to work above their normal contracted hours and give as much notice as possible as well as endeavouring to keep these requests to a minimum. Managers will be responsible for ensuring that an average of 48 hours per week is maintained when measured over a 17 week period.

3.14 Transport and accommodation

There is the potential for public transport systems to be affected at the peak of a pandemic. Staff who drive to work will be asked to co-operate with the Trust in providing lifts to staff without transport where possible. If by co-operating with this request a member of staff incurs additional home to work mileage, they can claim reimbursement at the normal business mileage rate.

In exceptional circumstances where staff are required to attend work and no other form of transport is available, the Trust may provide taxi transport to work. In the event of key staff being required to remain at work, or be at work for long periods of time, the Trust will seek to make accommodation available to those who require it. The cost of such accommodation will be borne by the Trust.

3.15 Employment checks

It is the Trust's intention to continue to only employ staff that meet the current employment checks required. However, if the absence of staff is such that services are severely affected, the Trust will consider employing staff awaiting DBS and other necessary checks although it is important that anyone placed to work in roles that should be subject to a DBS check is not assigned to duties that would mean working directly and in an unsupervised capacity with vulnerable groups. The Director of HR in consultation with the Pandemic Flu lead will communicate this decision when considered appropriate.

3.16 HR policies and procedures

All current HR policies and Procedures will remain in force unless otherwise advised by the Director of HR.

Staff will have the right to invoke the Trust's Grievance Policy if they feel that emergency measures put in place to safeguard the services provided by the Trust has an unreasonable detrimental effect on them.

The Trust reserves the right to use its Disciplinary Policy in cases where it is deemed appropriate to do so. This decision will be taken in discussion with the Director of HR.

3.17 Immunisation

There will be a decision made nationally regarding which individuals are to be prioritised for immunisation and a timescale determined for this as and when a vaccine is developed and becomes available for the particular strain of flu.

Immunisation of Trust staff will be managed within the Trust.

3.18 Communication/employee records

The Trust will provide as much information as possible to assist staff in protecting their own health and safety, and that of others who may be affected by their actions. The staff intranet will be kept up to date with the latest information.

Staff will be briefed as appropriate about the key facts of pandemic flu, how it spreads, risks of infection and infection control methods together with the role of antivirals and vaccines.

Under the guidance of the Executive Team, all line managers should attend appropriate communications or debriefing sessions that may be held during and following the outbreak, or otherwise ensure that a deputy attends in order to feedback to colleagues.

Line managers should provide staff with timely information as officially provided for internal dissemination regarding any outbreak as appropriate.

Each directorate must have in place up to date staff contact and next of kin details for all staff. Where staff offer up personal mobile numbers, these are to be kept securely and only used as a means of contact when absolutely necessary. HR are to be informed of any changes so that the central ESR system remains up to date.

3.19 Recruitment

HR aim to continue with a normal recruitment service for as long as is possible. If the capacity of the HR team is affected by the pandemic or if managers are not available to attend interviews, etc. then a decision will be made by the Director of HR as to whether some or all of the recruitment service will need to be suspended until capacity allows a return to a basic or normal service. HR will use a variety of media to communicate this decision to applicants and managers.

Sourcing of additional staff will be sought through the staff bank (Trust bank team) and approved agencies to ensure that these staff have fulfilled current employment checks. If this resource is not sufficiently available, the Director of HR will instruct when staff who have recently retired from the Trust are to be contacted to seek their return to work during the pandemic period.

The Director of HR will also consider when to seek advice from the NHS England as to the co-ordinating of staff from the local health economy, including private providers of healthcare.

3.20 Staff working in the Trust that are not directly employed by the Trust

There are staff working in the Trust that may be on secondment from another organisation. Managers need to be aware that the employing organisation will have

priority over the use of these staff and may be recalled to their substantive post to provide support in own organisation's business continuity planning.

The Trust also employs contractors on a temporary basis. Managers should be discussing and agreeing with contractors in their teams as to their continued employment during the pandemic, particularly if they are employed in delivering key services.

3.21 Use of Volunteers

As part of the HR function's pandemic flu preparations, the Voluntary Services Manager has drawn up a list of roles that could be undertaken by volunteers. It is not the Trust's intention to use volunteers to provide patient services as the required employment checks would not have been undertaken. However, there may be support/admin type roles that are key to helping critical services running.

If the situation becomes such that the Trust has to reconsider the types of roles that can be undertaken by volunteers, a directive will be given by the Director of HR in consultation with the Pandemic Flu lead but will only involve those roles that do not involve direct contact with vulnerable groups.

Managers who accept volunteers must ensure that they have the necessary basic training and induction to the department.

4. POST PANDEMIC PHASE/RECOVERY

Returning to normality needs to be planned from the start of the Pandemic as reversal of altered procedures will not be straight forward.

After the first wave, there should be a brief respite during which strategies can be reassessed and the plan revised accordingly.

Managers should also use this time to provide support to staff and ensure that those who have not had a break from work are able to do so. Staff are to be reminded of the counselling services available to them through Occupational Health and other sources of support such as the Chaplaincy service and Psychotherapy services.

Mid and South Essex University Hospitals Group

Appendix 10

FLOWCHART TO DEMONSTRATE PROCESS FOR REDEPLOYMENT OF STAFF VIA THE STAFF BANK OFFICE

Request for staff or movement of staff
Authorised by Gold or Silver command

⇩

Bank Office team contacted by switchboard or on ex 6062 (between 07.00 to 20.00)

⇩

Bank to check data base for available staff

⇩

Bank check staff availability and match staff to shifts

⇩

Bank cold call all staff with relevant competencies for wards

⇩

Bank cold call all the rest of the bank staff

⇩

If unable to cover, Bank staff call wards and ask if the wards are able to down grade from RN to HCA

⇩

Authorisation to go to agency to be sought for Gold or silver command

⇩

Bank to contact agencies

Appendix 11: National to Local reporting and coordination arrangements

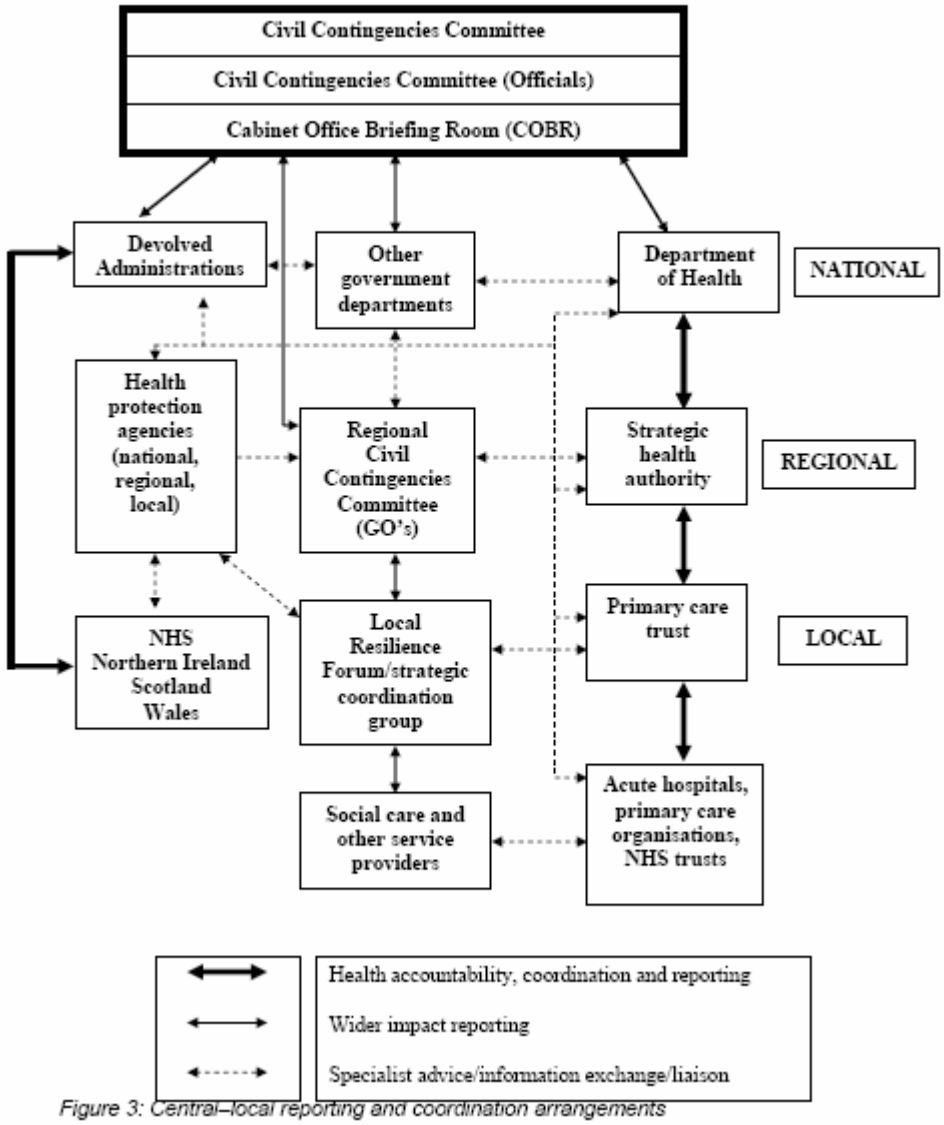
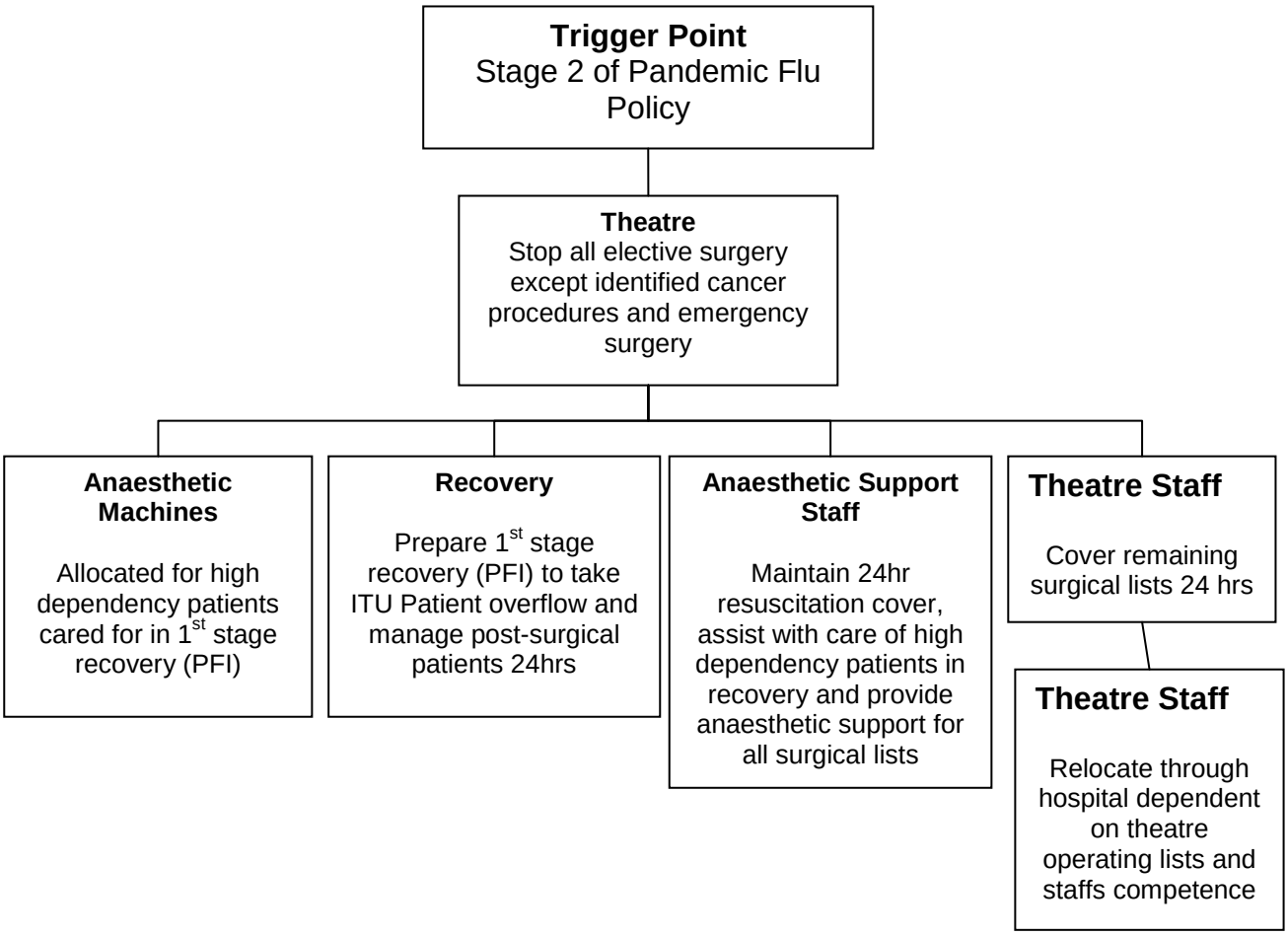


Figure 3: Central–local reporting and coordination arrangements

Appendix 12 – Theatre Pandemic Influenza Process Chart


Trigger Point
Stage 2 of Pandemic Flu Policy
Theatre
Stop all elective surgery except identified cancer procedures and emergency surgery
Anaesthetic Machines
Allocated for high dependency patients cared for in 1st stage recovery (PFI)
Recovery
Prepare 1st stage recovery (PFI) to take ITU Patient overflow and manage post-surgical patients 24hrs
Anaesthetic Support Staff
Maintain 24hr resuscitation cover, assist with care of high dependency patients in recovery and provide anaesthetic support for all surgical lists
Theatre Staff
Cover remaining surgical lists 24 hrs
Theatre Staff
Relocate through hospital dependent on theatre operating lists and staffs competence

NHS
Mid and South Essex
University Hospitals Group

Appendix 13: Preliminary Equality Analysis

This assessment relates to: Pandemic Influenza Policy (06060)

A change in a service to patients		A change to an existing policy	X	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Judith Holdsworth	**Job Title**	IPC Lead	**Date**	May 2019