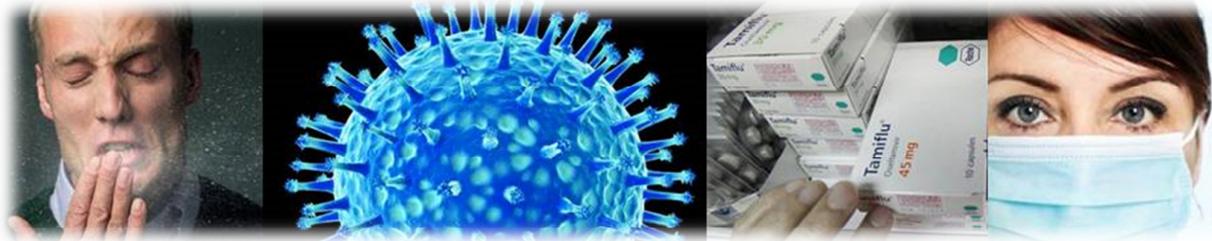


UHL Pandemic Influenza Plan

Management of Surges and Demands on the Trust during a Pandemic



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ASSOCIATED PLANS (Plans / Policies that are likely to be used in conjunction with this plan)	
UHL Major Incident Plan	LRF Management of Excess Deaths due to Pandemic Influenza Plan
LRF Major Incident Plan Annex H - CONOPS for the Management of Pandemic Influenza	UHL Blood Shortage Plan
LRF Mass Treatment Plan	NHS Mutual Aid Agreement
LRF TCG / SCG Set Up Procedures	

Table of Contents

1	Introduction	3
2	Aim & Objectives	3
3	Scope	4
4	Planning Assumptions	4
5	Roles and Responsibilities	6
6	Activation & Notification	7
7	Command and Control	9
8	Patient Management	12
8.6	Patient Testing	13
8.7	Patients with 'Influenza like Illness' but no laboratory diagnosis	14
8.8	Cohorting patients with Laboratory confirmed Influenza	14
8.9	Cohorting different Flu Strains	15
8.10	National priority pandemic research studies	16
9	Surge Planning in Key services	17
9.1	Cancer and Haematology	21
9.2	Critical Care – Adults and Paediatric	21
9.3	Pandemic Surge – General Admission	22
9.4	Renal & Dialysis Patients	22
9.5	Renal & Dialysis Patients	23
9.6	Excess deaths – mortuary resilience	24
10	Personal Protective Equipment & Infection Prevention and Control	26
11	Staff Vaccinations	27
12	Inpatient Vaccination	30
13	Patient Visitors	31
14	Staffing Considerations	32
15	Other Considerations	34
16	Recovery	35
17	Action Cards	35
	ACTION CARD PIP 1- Incident Director (Chief Operating Officer)	36
	Annex A - Priority List for Allocation of Side Rooms	38
	Annex B – Detailed Planning Assumptions	39
	Annex C - Inpatient Vaccination Pack	43
	Annex D– Vaccination Training	49
	Annex E – PPE Requirements for Care of Patients with Pandemic Influenza	50
	ANNEX F - PLAN ADMINISTRATION	Error! Bookmark not defined.

1 INTRODUCTION

- 1.1 Pandemic Influenza is currently considered one of the biggest risks faced by the UK and has the potential to place considerable strain on the health care economy. All sections of the population are likely to be affected, although influenza in the frail and chronically ill can be serious and even lead to death however most people are usually less seriously affected. Routine vaccination policies are designed to minimise the impact of this normal pattern of influenza activity. Periodically, however a completely new and virulent strain of influenza emerges, with new disease characteristics. The population will not have been exposed to this viral strain before and immunological protection is minimal. This new virus can spread causing worldwide epidemics (pandemics) leading to widespread illness and higher rates of mortality.
- 1.2 Influenza pandemics have occurred at irregular intervals throughout history and a further pandemic is thought to be inevitable in the near future. There may be little advance warning therefore, advanced contingency planning is essential for an effective, well-managed and smooth response. The last pandemic was H1N1 during 2009, whilst mild impact it was a useful test of NHS response arrangements.
- 1.3 In the event of an Influenza Pandemic, hospitals are likely to be working to maximum capacity, even in the absence of 'winter pressures'. The increased demand upon services will be further compounded by staff sickness and the absence of staff caring for members of their family. Lack of staff is likely to impact the number of beds and level of service that the Trust can maintain. Therefore it is imperative that there should be contingency plans in place to deal with these eventualities.
- 1.4 This plan has been developed to facilitate an appropriate and effective Trust response to a pandemic outbreak, whilst ensuring that vital UHL services are maintained. Close cooperation with multi agency partners and stakeholders is essential to effectively manage and mitigate the effects on the local population of Leicester, Leicestershire and Rutland.

2 AIM & OBJECTIVES

- 2.1 The Aim of the plan is;

To provide a flexible and appropriate response to a Pandemic Influenza or other communicable disease that threatens the routine operations of Trust services. This will be achieved through the following objectives;

- a. Identify the roles and responsibilities of UHL and other partner organisations
- b. Identify the roles and responsibilities of individuals and service areas with UHL

- c. Identify command and control arrangements and ensure cooperation with other stakeholders
- d. To ensure continued operation of critical services
- e. Identify additional specialist arrangements and considerations
- f. To ensure communication with relevant stakeholders
- g. To manage the recovery and restoration of disrupted services

3 SCOPE

- 3.1 This plan will contribute and supplement the multi-agency response arrangements defined for an influenza pandemic and should be read in conjunction with the [LRF Major Incident Response Framework Plan and LRF Major Incident Framework – Annex H Pandemic Influenza CONOPS](#).
- 3.2 The three main principles that underpin planning and response are;
 - a. **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 about the scale, severity of the level of impact
 - b. **Proportionality** – plan to be able to scale up or down in response to the emergency epidemiological, clinical and virological characteristics of the virus and its impact at the time.
 - c. **Flexibility** – plan for the capacity to adapt to local circumstances that may be different from the overall UK picture – for instance in hotspot areas.
- 3.3 Whilst this plan has been developed specifically for influenza pandemic, the response arrangements and principles are applicable to other types of communicable diseases.

4 PLANNING ASSUMPTIONS

- 4.1 A pandemic is most likely to be caused by a new subtype of the Influenza virus but plans could be appropriately adapted and deployed for any epidemic infectious disease.
- 4.2 An influenza pandemic could emerge at any time of the year anywhere in the world, including 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 or two weeks until sporadic cases and small clusters are occurring across the country.

- 4.3 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.
- 4.4 Whilst a significant amount of focus and effort will be on treating patients with influenza the main challenge to the Trust will be how to maintain services with increased pressures and decreased resources from staff absences.
- 4.5 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.
- 4.6 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 World Health Organisation has declared the pandemic to be over.
- 4.7 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.
- 4.8 Influenza pandemic planning in the UK is based on the worst case scenario up to 50% of the population could experience symptoms over a 15 week period although the nature and severity of the symptoms would vary from person to person. For deaths, the assumptions suggest that up to 2.5% of those with symptoms could die if no treatment proved effective. These figures might be reduced by the impact of countermeasures but the effectiveness of such mitigation is not certain. The combination of particularly high attack rates (circa 50%) and a severe case-severity is relatively improbable but not quantifiable.
- 4.9 Between 1-4% of symptomatic patients could require hospital care, depending on the severity of illness caused by the virus. Of these, up to 25% may require critical care. Table 1 outlines the totals for 3 levels of planning assumptions. Weekly profile data is available in Annex B

Table 1 Pandemic Flu Planning Assumptions (based on a population of 1,017,697 from the 2011 Census)

Clinical Attack Rate (CAR)	Total Affected	Additional Hospital Admissions (4% of CAR)	Additional Deaths (2.5% of CAR)
50%	509,357	20,374	12,734
35%	356,550	14,262	8,914
25%	254,679	10,187	6,367

- 4.10 Staff absence is likely to follow the wider community profile. In a widespread and severe influenza pandemic affecting 50% of the population, between 15-20% of the staff might be absent on any given day during peak weeks. However, these figures may be reduced by the impact of antiviral and antibiotic countermeasures depending on the effectiveness of these measures.

5 ROLES AND RESPONSIBILITIES

5.1 University Hospitals of Leicester NHS Trust

5.1.1 **Role;** to provide hospital care for those most severely affected by the Pandemic Influenza

5.1.2 Responsibilities;

- a. To ensure communications with staff, public and key stakeholders where necessary and participate wider vaccination campaign
- b. Implement appropriate infection, prevention and control measures to limit the spread of infection to staff and other patients including the isolation of infected patients
- c. Where necessary make arrangements to vaccinate at risk, long stay patients who may not be able to receive the vaccination in the community setting
- d. Set up processes to cohort patients to ensure they receive appropriate care for example the setup of a flu ED
- e. Prepare storage and distribution of antivirals and personal protective equipment (PPE)
- f. Undertake vaccination of staff where appropriate to reduce the impact of staff sickness
- g. Reduce services to manage increase capacity where lives will not be put at risk
- h. Maintain essential services
- i. Discharge patients into the community where safe to do so
- j. Increase capacity of critical care and high dependency beds by potentially 100% (double capacity) where required
- k. Participation in National Institute for Health Research (NIHR) priority pandemic research studies

5.2 **Public Health England**

5.2.1 **Role;** to provide specialist advice and monitoring of the spread of Pandemic Influenza or other communicable disease

5.2.2 **Responsibilities;**

- a. To investigate initial pandemic cases to inform real-time monitoring
- b. Implement appropriate surveillance systems on all influenza-like illness
- c. To provide appropriate, accurate and timely information about the clinical effects of the infection to the Trust
- d. To support accelerated vaccine development
- e. Monitor and measure the uptake, safety and effectiveness of any pandemic influenza vaccination programme
- f. To provide guidance when to cease the use of control measures where they have been implemented
- g. Continue to monitor the virus during the recovery phase

5.3 **NHS England Area Team**

5.3.1 **Role;** to coordinate the efforts of local NHS organisations during a Pandemic Influenza Phase

5.3.2 **Responsibilities;**

- a. To lead on antiviral and if necessary vaccination programmes in the community setting
- b. To lead on communication and advice messages to the public and other responders.
- c. To collate and disseminate information to and from local, regional and national stakeholders

6 **ACTIVATION & NOTIFICATION**

6.1 **Flu Pandemic Phases**

6.1.1 The World Health Organisation (WHO) has a series of phases to describe and monitor the progress of a pandemic at global level which is not sensitive enough to direct the pace and scope of the response within individual countries. The UK was affected by H1N1 (2009) before the WHO declared a global pandemic.

6.1.2 The UK now adopts a new approach of indicators; **Detection, Assessment, Treatment, Escalation** and **Recovery** which are not linked to the WHO global phases. The progression between the phases is not linear and it is possible to move back, forward, overlap and jump phases.

6.2 Notification

6.2.1 When the detection of a pandemic flu virus is confirmed in the UK, NHS England will alert the Trust. The Trust should then work to the advice given by NHS England and make appropriate arrangements and where necessary stockpiles of PPE. It is essential that all CAS alerts are disseminated to all staff via the CMG Quality and Safety Managers and CMG Directors. Treatment advice is likely to change throughout the pandemic so must be kept up to date. Table 2 outlines some suggested response escalation levels and appropriate actions to undertake.

Table 2 UHL Pandemic Response Alert Levels

National Response Level	UHL Impact	Actions (Indicative)
Detection and Assessment	<p>Human to human transmission of a novel influenza virus – impact is likely to be unknown</p> <p>ED may face increased demands Rapid increase in referrals of more severely ill patients to intensive care</p>	<p>Outbreak Control Group Preparatory staff training. LRF – SCG / TCG active. Staff vaccination planning/implementation. Staff Awareness campaign Joint meetings between UHL and CCGs & Social Services. Review of Corporate and CMG flu plans. Swabbing of all new patients with flu like symptoms Review PPE – Infection Prevention to manage the distribution of PPE. Review staffing Stocking of antivirals and vaccines</p>
Treatment and Escalation	<p>Low impact pandemic there may be no significant deferral of normal activity however some specialist services – intensive care, ECMO and ED may still come under pressure.</p> <p>Moderate impact pandemic, increasing referrals of respiratory. Increasing staff absence</p>	<p>Outbreak Control Group (increased frequency) Limited non-vital service curtailment. Admission avoidance & avoid hospital messages through CCG/EMAS. Coordination between in and out of hours services Cohort arrangements Consideration for further escalation and reductions of services. Consider Respiratory Consultant/Medic triage at the LRI. Making best use of all available capacity</p>
Treatment and Escalation	<p>High impact pandemic will have a major impact upon Trust. High levels of staff absence & admissions. Multiple services under pressure.</p>	<p>Operational focus at Trust level – Major Incident activated. UHL Gold Team meetings. Silver and Bronze Control Rooms activated. Resources and staff re-deployed between CMGs Widespread non-vital service curtailment.</p>
Recovery	<p>Reducing numbers of admissions. Some pockets of high pressure may remain. Continue to review for cases in case of resurgence of influenza. Multiple waves are not uncommon.</p>	<p>Establishment of a recovery group (internal) Re-normalisation and reinstatement of disrupted services Catch up with delays in activity i.e. rescheduling procedures Post incident review Preparing for post-pandemic seasonal influenza</p>

7 **COMMAND AND CONTROL**

7.1 During the response to any incident it is imperative that suitable command and control arrangements are established and maintained. This will ensure close collaboration at an appropriate level with other organisations, focus on a coordinated response, protection of critical services and clear communications with staff and stakeholders.

7.2 The roles and responsibilities defined in the Major Incident plan are unlikely to be suitable for a protracted pandemic influenza, but the framework and command and control principles should still be adopted. They are outlined below.

7.3 The executive lead for Pandemic Influenza is the Chief Operating Officer.

7.4 **Gold Command**

7.4.1 Gold Command will initially be hosted within routine daily Gold Command Meetings chaired by the Chief Operating Officer, with appropriate updates as necessary. The primary roles of this group is to;

- a. Oversee the response of the Trust to the Pandemic
- b. Set the aims and objective from which the response will be implemented from
- c. Provide strategic direction and support to the Outbreak Control Group

7.4.2 It may become necessary to increase the frequency in which the group meets but it should limit its response to the roles outlined in the Trust Major Incident Plan.

7.5 **Silver Command – Outbreak Control Group**

7.5.1 Silver will establish once it is confirmed that there are confirmed cases in the UK. The primary role of this group is to manage and implement an appropriate response in line with the strategic aims and objectives and the roles and responsibilities outlined in section 6.1.

7.5.2 The group should be chaired by the Chief Operating Officer or suitable deputy and should meet as frequently as required to ensure that appropriate measures are in place and to monitor and respond to the impact on the Trust. The group should;

- a. Meet at least weekly in the initial stages of any pandemic with the expectation that the frequency will increase in line with the pressures within the system.
- b. Receive updates from key areas on current pressures and take any remedial action as necessary (staffing shortages, bed pressures etc).

- c. Make decisions on service prioritisation and curtailment.
- d. Adjustments to the criteria for the transfer of care between primary and secondary care may be required depending on the nature of the pandemic; based on protecting acute hospital beds
- e. Provide advice on clinical & ethical issues, epidemiology, infection control
- f. Ensure regular and consistent advice to staff is provided
- g. Oversee the staff and inpatient vaccinations programme Ensure that horizon scanning takes place.
- h. Receive updates from external agencies.
- i. Be a problem solving group to enable the Trust to respond as appropriate to the situation.
- j. Will manage the recovery phase of a pandemic.

An initial agenda for the group can be found in with action card PIP 1 – Incident Director.

7.5.3 Membership

- a. Chief Operating Officer (Chair)
- b. Chief Nurse/DIPAC (or Deputy)
- c. Deputy Director of Operations (or Deputy)
- d. Senior Site Manager
- e. Emergency Planning Officer
- f. Infection Prevention
- g. Clinical Microbiology/Lead Infection Prevention Doctor
- h. CMG Representatives
- i. Infectious Diseases Clinical Lead
- j. Communications lead
- k. HR lead/Occupational Health
- l. Supplies lead
- m. Interserve
- n. Loggists
- o. Research & Innovation

Other members will be co-opted as required.

7.6 **Communications Group**

7.6.1 As in any incident, communication is critical to ensure a successful response. This group will ensure that communication to staff, public and stakeholders is maintained. This sub group will consist of:

- a. Communications lead (chair)
- b. Infection Prevention
- c. Microbiology
- d. Occupational Health
- e. Representation from infectious diseases and/or a Intensivist.

7.6.2 The group will advise on and oversee the publication of communications to staff. This may include:

- a. Staff newsletters
- b. Creation of dedicated pages on INsite.
- c. Posters
- d. Information cards
- e. Presentations to existing staff meeting (Ward rounds, ward meetings etc)
- f. Information on NIHR priority pandemic research studies

7.7 **Multi Agency Coordination**

7.7.1 NHS England has the responsibility for ensuring a coordinated response across the NHS and health care providers during a Pandemic. NHS England will authorise the activation of the multi-agency response arrangements in line with the [Local Resilience Forum Major Incident Plan Annex H Concept of Operations for the Management of Pandemic Influenza](#). UHL will be expected to participate fully with the multi-agency response and provide suitable representation at the subsequent meetings which are likely to include;

- a. Strategic Coordinating Group – Director level representation
- b. Tactical Coordinating Group – Senior Manager representation
- c. Communications Cell – Communications Manager
- d. Vaccination Cell*
- e. Antiviral Cell*

f. Excess Death Cell*

**NHS England will provide further guidance on suitable representation if required*

8 PATIENT MANAGEMENT

- 8.1 It is essential that **any** new patient admitted to hospital with an influenza-like illness must have a viral swab taken from the nose and throat as soon as possible after admission for influenza testing. This should be sent to the Virology laboratory immediately. Check iLab for the result so that any patient found to be negative can be moved out of the side room.

Patient Flu Status	Cohort Arrangements
Influenza like illness – not confirmed	Immediate treatment with antivirals until conclusive test results Swabbing Allocate to side room
General Medical Patients Laboratory confirmed Influenza	Allocate to side room Cohort on ward 23 LRI or ward 17 or 33a GGH. Treatment with Antiviral Treatments
Cancer Haematology Patients Laboratory confirmed Influenza	Allocate to side room IDU (up to 4 patients) Cohort on 42 or 43 Treatment with Antiviral Treatments
Cystic Fibrosis and Respiratory Patients Laboratory confirmed Influenza	Allocate to side room Cohort on ward 17 or 33a GGH. Treatment with Antiviral Treatments
Maternity Patients Laboratory confirmed Influenza	Allocate to side room IDU (up to 4 patients)
Influenza Negative	Treated within normal arrangements

- 8.2 The fundamental principles of managing patients during a pandemic are meticulous use of infection control requiring segregation, isolation and cohort nursing including stringent attention to hand and respiratory hygiene. The use of surgical masks and respirators has a role to protect staff, provided they are used correctly in conjunction with other infection control measures. Requiring patients to wear mask will offer little to no protection to others and is not necessary.
- 8.3 Patients with confirmed influenza or influenza like illness should preferably be discharged or, if this is not possible, isolated in a single room during their period of infectivity, until they are 24 hours afebrile and free of symptoms wherever possible. Some patients may require longer lengths of stay, for example ITU or Oncology.
- 8.4 Side room use must be reviewed at least a daily basis by a nominated person within the Clinical Management Group to ensure that any patient who does

not require a side room can be moved out. Patients may be required to move to a different ward if this occurs and the medical staff must ensure that these are followed up.

8.5 Where the number of patients exceeds the number of side rooms then cohorting may be considered. In the first instance it may only require the cohort of individual bays but for more prolonged cohort arrangements Ward 23 LRI should be used as it can provide cohort isolation however it will require decanting and extra staffing. This will require Infection Prevention team permission and advice. The cohorted areas will be restricted to admissions. Maintenance of same sex accommodation should be strived for but if this is not possible then the options must be carefully considered by the CMG with input from the Chief Nurse.

8.6 Patient Testing

8.6.1 Patients that require testing will include

- a. Any patient requiring admission to the BMTU who are overtly symptomatic with ILI (influenza-like illness), but who can be side-room isolated. Even if given empirical antivirals on the basis of symptoms only, these patients may continue to shed influenza for some time – see note below*.
- b. Any patient requiring admission to BMTU who will go to an open bay (e.g. 4-bedded, 6-bedded, etc.) with other patients – this will screen for any asymptomatic shedding.
- c. For practical reasons, a patient who is asymptomatic who is being admitted to a side-room for some other reason does not require immediate screening for influenza and other respiratory viruses – but this patient could also be shedding virus, and ideally should be tested at some point.

8.6.2 **Point of Care Testing machines (where available)** - Each test will consist of **TWO** nasal/throat or naso-/oro-pharyngeal swabs. One test can be undertaken on the Point of Care Testing machines (Enigma MiniLabs), which will quickly identify Influenza A, B and RSV, but will not subtype of the infection. These results will be available within 90 minutes. The Second sample is to be sent to the lab to confirm the POCT results but also to test for other respiratory viruses (parainfluenza - PIV, respiratory syncytial - RSV, adenoviruses - AdV, etc.) not covered by the POCT. The lab test will take approximately 6 hours from the start of the test so should be quickly sent to the labs for testing to avoid prolonged delays.

8.6.3 All results from the POCT should be recorded in the patient's notes, or locally agreed procedure, for analysis and comparison with the in-house laboratory results periodically, to check that the performance is satisfactory.

8.6.4 **Testing via Microbiology Labs (Point of Care Testing unavailable)**

8.6.5 Each test will consist of a nasal/throat or naso-/oro-pharyngeal swabs. The sample is to be sent to the lab to test for Influenza and respiratory viruses (parainfluenza - PIV, respiratory syncytial - RSV, adenoviruses - AdV, etc.). The lab test will take approximately 6 hours from the start of the test so should be quickly sent to the labs for testing to avoid prolonged delays.

8.7 **Patients with 'Influenza like Illness' but no laboratory diagnosis**

8.7.1 Any patients with an influenza-like illness should be treated with antiviral medication immediately, tested as quickly as possible while waiting for results the patient should be isolated in a side room. See Annex A for side room allocation priorities. If a side room is not available the patients should be placed in a bay. Surveillance and increased monitoring of other patients should be undertaken and if, where considered appropriate the bay should be treated with antivirals.

8.7.2 However, note that empirical treatment with antivirals does not stop viral shedding immediately. The antiviral drugs only prevent further viral replication – any existing virus can still be shed for several days until the host immune response clears this. Thus, in immunocompromised patients, this period of viral shedding may be prolonged as a weakened immune response slowly clears any existing virus from the respiratory tract.

8.8 **Cohorting patients with Laboratory confirmed Influenza**

- a. Patients with a laboratory confirmed diagnosis of Influenza may be cohorted together – see section 8.9 for more information.
- b. If patients with laboratory confirmed influenza have other infectious conditions such as Clostridium difficile or MRSA then they should not be cohorted with other patients but placed in a side room.
- c. A ward will be allocated for cohorting of patients. Information will be displayed at the ward entrances that will state what precautions are required on entering the ward.
- d. Dedicated staff should be allocated to the cohort area and they must follow correct infection control procedures, including the use of PPE and hand hygiene.
- e. The ward should have side room facilities and aerosol generating procedures should take place within a side room. Aerosol generating procedures must only be carried out if absolutely necessary. Examples of aerosol generating procedures include intubation, CPR, bronchoscopy and non-invasive ventilation.
- f. An area should be allocated outside the ward so that Personal Protective Equipment (PPE) can be donned before entering. PPE should also be available at bay entrances.

- g. Gloves and apron must be changed and hands decontaminated before and after contact with different patients in the cohort bay. Surgical masks must be removed when leaving the cohort area but can be kept on between patients.
 - h. Visitors entering the area should wear aprons and gloves, and clean their hands before leaving the area. The use of a mask is dependent upon the level of contact with the patient and should be advised by staff.
 - i. Uniforms should be transported home in a tied plastic bag and laundered separately at the highest temperature possible as per uniform policy.
 - j. Appropriate cleaning staff resources will be allocated to the cohort area paying close attention to surfaces that staff and patients frequently touch such as door handles and cot sides.
 - k. Patients in high risk areas (ITU, Haematology, Oncology and pregnant women) should remain in the area until discharged. Patients in all other areas should remain in the designated area until deemed non-infectious (apyrexial and asymptomatic). If infectious patients need to visit other departments then they must wear a surgical mask and the department must be informed prior to the patient attending. If patients leave a side room or cohort area then they must be asked to clean their hands.
 - l. Patients with confirmed or suspected influenza must not visit communal parts of the hospital such as the canteen.
 - m. Teams of staff visiting cohort wards should limit their number to the minimum required to provide safe care.
- 8.8.1 Segregation of patients in some specialist areas may be difficult. Examples of this may include areas such as critical care. In this instance side rooms in the area may be required for the protective isolation of patients without flu symptoms and patients with flu may be cohorted in the bays.
- 8.8.2 The decision to cohort is made by the Infection Prevention team or Microbiologist. The Duty Manager must be informed. The decision must be reviewed at the next outbreak control group.

8.9 Cohorting different Flu Strains

- 8.9.1 Ideally, immunocompromised patients (adults and children) infected with different respiratory viruses should not be cohorted together, as there is some evidence that multiple respiratory virus coinfections (if these patients transmit their viruses to each other) may be detrimental and produce more severe disease in immunocompromised patients. At the least, if it can be avoided, patients infected with influenza A should not be cohorted with patients infected with influenza B.

8.9.2 Empirical therapy with the NAI antiviral drugs will treat both influenza A and B, but there is no specific treatment for the other seasonal respiratory viruses (RSV, PIV, AdV, etc.).

8.9.3 If patients are masked (using a surgical mask) during the cohorting, the risk of them transmitting their viruses to others will be reduced. For more advice consult the consultant virologist.

8.10 **National priority pandemic research studies**

8.10.1 In the event of an urgent public health outbreak the National Institute for Health research (NIHR) with the support of the Chief Medical Officer will designate relevant research studies as high priority. These studies will have prior regulatory and ethical approval and will be activated on declaration of a pandemic. Expedited initiation and delivery is expected to ensure the findings can inform on-going care of patients during the outbreak. The R&I Department will co-ordinate research staff and resources and work with clinical teams to ensure the studies are successfully conducted.

Service Area	Service Level Increase			
	25%	50%	75%	100%
ED	<p>Alert 'Gold command'/IP increasing surge of patients Implement ED Profroma for assessment and treatment of Influenza Signage and Posters to be displayed All walking patients suspected to be deflected to UCC Create a Flu Assessment area and identify relevant teams of staff to operate this. Review all ED, MDT staffing for the next 7 working days ensuring all shifts out to temporary staffing. Work with relevant CMG's to 'pull' patients out of ED/specialty inreach Continue Safety huddles and maintain triage times.</p>	<p>Continue as before Daily review of all staffing and continued forward planning (consideration of overtime, bank and agency) Matrons all working clinically with non-essential meetings cancelled. Consider cancelling Study leave and redistribution of tasks to non-clinical staff (operational/ service management teams- all staff groups. Review equipment levels and ensure adequate supplies in place Regular communication to all teams Work with CMG nursing colleagues to staff areas of clinical risk in priority with movement of staff cross site/ consider redeploying non-clinical staff into clinical roles to work clinically Work with CMG colleagues to move medical staff to support ED admissions.</p>	<p>Continue as Before All Study leave / training to be cancelled across staff groups Ask staff on leave to consider cancelling if possible Cancel all non-essential meetings with staff redeployed to areas of need. Increase locum and agency staff to meet demand.</p>	<p>Continue as before</p>
UCC	<p>Increase by 1 GP and 1 Practitioner</p>	<p>Increase by 2 GPs and 2 Practitioners 2 triage Nurses</p>	<p>Need to implement a separate service 3 GPs 1 Practitioner 2 triage Nurses 1 receptionist</p>	<p>Increase staffing to separate service and would probably have to move off UHL sight as this will cause traffic congestion</p>
AMU	<p>Create s/room list and transfer to medical wards. Ensure AMC if fully staffed. Direct patients to AMC where</p>	<p>Request IP review s/room patients. Redirect Bed Bureau patients through to ED. Review need for decant bay on</p>	<p>Review staffing and look to cancel essential training if increased sick leave, Pull staff from specialist nursing</p>	<p>Look to ask staff to cancel A/leave Increase use of Bank and Agency</p>

Service Area	Service Level Increase			
	25%	50%	75%	100%
	<p>appropriate Identify patients suitable to move to d/lounge to await transport. Identify patients who can “sit out” in day areas. Ensure all ward beds are filled</p>	<p>AMU/Decant ward in medicine. Review Entrance routes. Review staffing and any non-essential training if increased levels of staff sickness. Work with other specialities to look at outlying capacity. Daily update of SR list.</p>	<p>and OPD roles. Continue to work with other specialities re: outlying and community partners re- use of community hospital beds.</p>	
CAU	<p>Increase Consultants by 1 and nurses by 2 per shift. review all elective admissions review opportunities to cohort patients cancel all study leave book bank and agency shifts</p>	<p>as before set up 2nd admissions area to review non flu type illness in children’s second smaller outpatients CDC cancel clinics unless essential stages of treatments redeploy staff to key clinical areas cancel all elective admissions implement coms plan to deflect referrals</p>	<p>review current admissions to CAU and second unit review staffing – all grades, cancel annual leave close outpatients unless critical to on-going treatment cancel everything that is elective look to transfer children’s to other areas who may not have same level of activity (non- flu patients) work with GP’s to deflect referrals work with community teams to keep children out of hospital or to support early discharge redeploy non clinical staff to clinical areas to support transport, answering telephones, and other non-clinical duties</p>	<p>If in the winter may need to close unit and to transfer patients to other centres move second assessment centre to Children’s outpatients fully utilise all staff groups for maximum effect Hire additional equipment</p>
CDU	<p>Undertake regular staffing review and ensure that CDU is appropriately staffed Create side room availability list and ensure that affected patients are transferred to isolation rooms Ensure that senior reviews are undertaken in all areas and expedite</p>	<p>As before Maintain IP advice and regular patient review Closely review referrals and redirect any inappropriate referrals to ED Consider creating cohort bay on respiratory ward(s) Review staffing and cancel any non-</p>	<p>As before Review staffing and consider cancelling essential training, study leave, special leave, Consider reducing OPD activity and redeploy staff from Specialist/OPD Roles Consider creating a cohort bay on</p>	<p>As before Cancel all training, study leave, special leave and any annual leave where staff are willing. Increase staffing – consider Agency staff Consider re-deploying</p>

Service Area	Service Level Increase			
	25%	50%	75%	100%
	discharges to maintain capacity/flow from CDU Ensure that the Discharge Lounge is effectively utilised to expedite discharges Source IP advice as appropriate Normal staffing	essential training and redeploy staff as appropriate Consider, overtime, bank etc Work with other specialities to explore any outlying capacity	CDU Work with external partners to explore utilising Community beds	non clinical staff to low level clinical duties Cancel elective activity and reconfigure beds to accommodate Flu patients
Critical Care (LRI)	All ICU beds will be utilised 22 beds regardless of funding. Able to ventilate 19 + 2 ventilators in PACU=21 level 3 beds. Non urgent none cancer elective cases to be cancelled Move staff from LGH unless they are affected	Utilise PACU beds and redeploy PDN team and utilise both ICU and recovery/ ODP's staff. 40 beds . NOTE not all level 3 beds due to lack of ventilators. Explore moving ventilators from LGH ICU. Cancel non urgent theatre lists	Utilise anaesthetic rooms 15 so total 55 with the emergency theatre still available. Cancel all elective surgery. Re deploy nurses with ICU experience from other areas i.e. research and registered staff in management roles.	
PICU (GGH)	Open additional 2 beds on unit. Call in staff from home; cancel A/L & Study leave and Admin time. Move "beds" from CICU LRI if appropriate. Cancel elective activity	Open additional 2 beds on unit. Redeploy anyone currently employed by UHL with PICU experience to the unit. Utilise ward 30 staff and agency staff.	Utilise 2 side rooms on AICU at Glenfield. Utilise Adult ITU staff with Paediatric experience and ODP's with paediatric experience to staff beds	Hire additional equipment, utilise space on ward 34 as can be utilised as ITU space. Utilise management staff and non-specialist clinical staff
CICU (LRI)	Keep open all beds on CICU open additional beds using bank, agency and overtime	Space only for 9 beds. Open ward 12 HDU as second unit. Cancel all elective surgery and urgent surgery Increase HCA and ward clerk support to unit. Have second on-call consultant on site Open additional beds using bank, agency and overtime. Redeploy all trained staff to work clinically	Hire additional equipment Check to see if there is capacity on adult ITU review capacity in theatres to open additional capacity Increase all staffing levels.	use all additional suitable space Hire equipment Increase staff at all grades Cancel all s leave use bank, agency, overtime non-clinical staff who are trained nurses to be re-deployed to nursing duties Cancel Consultant SPR time

Service Area	Service Level Increase			
	25%	50%	75%	100%
Critical Care (GGH)	Empty ITU beds would be utilized – that is, any empty cardiac/ECMO beds. This would be followed by the three 'unfunded' bed spaces.	Cancellation of elective cardiac cases, using any spaces made available by discharges for either emergency/urgent cardiac cases or more flu patients. 22 bed spaces in use	Extend into recovery, utilising up to four bed spaces and theatre/recovery staff. 26 bed spaces in use	
ECMO	Staff to flex between both units – increase in capacity by one additional patient. (5 beds). May impact on planned cardiac surgery. Normal staffing applies.	Staff to flex between both units – increase in capacity by two additional patients (6 patients). May impact on planned cardiac surgery.	Increase capacity by three additional patients (7 patients). Manage patients across the network. Redeployment of all theatre staff / ITU staff / ECMO Specialists within UHL.	Increase capacity by four additional patients (8 patients). ECMO cases triaged to one dedicated area. All nursing, medical & perfusion staff required to work with ECMO patients.
Critical Care (LGH)	12 beds to be utilised. Use theatre ventilators. None urgent none cancer elective cases	Utilise advanced recovery bay in theatre 4 beds and recovery = 6 beds so total 18 beds. Utilise advanced recovery staff.	Utilise the 8 Orthopaedic recovery beds. Cancel all elective surgery. Redeploy PDN nurses and registered management staff. Total 26 beds.	
Dialysis Unit	Fully utilise isolation rooms Create cohort bays Consider increasing nights shift Additional staff may be required Source IP advice In the case of a single case of Flu consider using the negative pressure rooms at Northampton & Kettering Units	Continue as before Review staffing and withdraw staff from any non-essential training to meet demand or if increased levels of staff sickness. Consider using Renal Community Staff, Education Team & Specialist Nurses Work with other units to explore outlying capacity. Increase HCA and ward clerk support to unit. Cohort affected patients in bay/shifts as required Consider increasing night shift Additional staff will be required Source IP advice	Continue as before Increase staffing at all levels Consider cancelling essential training, study leave, etc Utilise capacity across the dialysis network Manage patients across the network Cohort affected patients in bays/shifts/days or consider dedicated unit Source IP advice	Continue as before Cancel all training, study leave, special leave and any annual leave where staff are willing. Increase staffing – consider using bank, overtime, agency Consider re-deploying non clinical staff to low level clinical duties Put in place a dedicated unit in place for Flu patients Consider patients suitable for x2 week dialysis Source IP advice

9.1 Cancer and Haematology

- 9.1.1 All patients on admission in Cancer and Haematology will be “paper screened” for symptoms of influenza and respiratory illness between October and March. If they have flu like symptoms they will be isolated, screened and treated. The screening process will involve; near patient test and samples sent to the labs – please see section 8.6.
- 9.1.2 Isolation will take place in side rooms for all symptomatic and confirmed flu patients, any side room in ward 39 or 40 can be used however only the negative pressure side rooms on ward 41 can be used. If demand outstrips sideroom availability on 39,40 and 41 an additional 4 patients can be isolated on the Infectious Diseases Unit. If demand continues to exceed the available side rooms on 39, 40, 41 and IDU then cohorting arrangements should be implemented on wards 42 or 43. To manage the spread of infections, all bay doors and corridor doors will be kept closed and the air conditioning flow rate within the bays will be adjusted to create a relative negative pressure area within the bays and positive pressure within the corridors.
- 9.1.3 Once the cohorting threshold has been reached an outbreak incident management meeting must be convened. Patients that are being cohorted should where possible remain in their bed space (with in the curtain track). If a patient leaves the bed space they must wear a surgical mask.
- 9.1.4 All staff and visitors coming into contact with symptomatic flu patients must wear a surgical mask whilst they are in the bay. All staff working in cancer and Haematology should be vaccinated once the seasonal vaccine is available.

9.2 Critical Care – Adults and Paediatric

- 9.2.1 There may be a requirement to increase the Trust’s ability to provide additional Level 3 Critical Care capacity. Planning assumptions dictate that this could potentially be a 100% (double capacity) increase. This will have a negative impact on elective theatre capacity across all CMGs with elective surgical services.
- 9.2.2 When demand for critical care services threatens to exceed capacity, pressure on healthcare services can be mitigated initially by careful selection of patients for hospital assessment and admission, and subsequently by a coordinated approach to patient pathways to higher levels of care. Provision should also be made for interim, respite or step down for patients who are less likely to benefit from critical care, or who have received critical care but now require a lower level of care.
- 9.2.3 In order to manage the demand on adult and paediatric critical care and ECMO, admission criteria to each unit may be adjusted to overspill adults into paediatric ICU or vice versa, size rather than age may be used to identify suitable patients for movement. It will be for the clinical team to discuss each case on a case by case basis and will require the approval of the teams involved to ensure patient safety. This will apply when **either** unit is unable to

safely manage its patients with the resources available. Staffing levels will need to flex and be reallocated between adults and paediatrics to meet current national guidelines on minimum levels of staff based on the clinical dependency of the patients.

9.2.4 In order to effectively manage patients in critical care during a pandemic all ECMO activity will be undertaken at the Glenfield site whilst level 3 and 2 critical care patients will be managed from the Leicester Royal and Leicester General Sites. Capacity of all critical care beds will be closely monitored and coordinated by Children's and ITAPS CMG management teams.

9.2.5 Where additional capacity is created this must be coordinated with other supporting services to ensure that they are able to meet the new service requirements.

9.3 **Pandemic Surge – General Admission**

9.3.1 It is expected within Leicestershire that there will be a surge of patients attending ED, CDU and Admissions Units across the Trust. Protocols have been developed in conjunction with the Urgent Care Centre (UCC) to divert patients attending with flu like symptoms to the UCC. The UCC will absorb all patients Monday to Friday but may not be able to manage a surge at the weekend. The UCC and / or ED may become overwhelmed with patients that are deemed to require reviewing by doctors within ED. In this situation a separate Flu Assessment Area will need to be opened to enable the separation of patients with flu like symptoms and other patients attending UCC/ED. This will require close collaboration with the UCC as there will be benefits to both the Commissioners and UHL to joint staffing off this area and patients being signposted to this area from both ED and UCC. UHL will only be asked to provide non-qualified staff to support an administration function.

9.4 **Renal & Dialysis Patients**

9.4.1 Patients receiving dialysis treatment will need to continue to receive dialysis throughout a pandemic, regardless whether they are infected or not. UHL operates a number of dialysis units across Leicestershire, Northamptonshire, Lincolnshire and Peterborough, 10 in total as well as supporting patients in their own homes. In the initial stages of the pandemic each dialysis unit will identify isolation areas where patients can receive dialysis. Isolation of Flu patients takes priority over all other indications for isolation **except known Hepatitis B carriers**. If the pandemic escalates it may become necessary to designate one or more units specifically for flu patients. Many patients rely on patient transport so consideration must be given to ensure that patient transport is prepared to transport infected patients.

9.4.2 To ensure continued delivery of dialysis the following actions should be considered:-

- a. To keep nephrology and ESRD patients at home as much as possible by ensuring that the Renal Community Team is maintained. (Identify

staff with the skills to join team if required also assign medical cover for this team)

- b. Combine all emergency admission activity for the service (nephrology, transplant and ESRD) to single area
- c. Close ward 10 (approximately 33% of the service bed base). Use staff from these areas to support activity on wards 17, 15A and 15N. The estimated allocation of beds for activity in the scaled back service is outlined below. Ward 17 will be reduced until such time as the ward can be closed and/or the immunosuppressed patients can be safely cared for in another area.
- d. Combine urgent outpatient activity for Transplant review/ESRD and acute nephrology.

Table 3 Renal scaled back service allocation of beds (establishment = 56)

Related Activity	Estimated Number of Beds Required
ESRD, acute nephrology/urology	20
Emergency Activity	18
Total	38

9.4.3 Satellite Units

9.4.4 Haemodialysis patients may need to have treatments reduced and be maintained on twice weekly dialysis. It is anticipated that each dialysis unit will manage their own patient population but in extreme situation where insufficient staff are available to maintain services it may be necessary to combine units by geography;

- a. Lincoln/Boston/Skegness/Grantham
- b. Peterborough
- c. Northampton/Kettering
- d. LGH/Loughborough/Hamilton

9.5 Renal & Dialysis Patients

9.5.1 Patients receiving dialysis treatment will need to continue to receive dialysis throughout a pandemic, regardless whether they are infected or not. UHL operates a number of dialysis units across Leicestershire, Northamptonshire, Lincolnshire and Peterborough, 11 in total as well as supporting patients in their own homes. In the initial stages of the pandemic each dialysis unit will identify isolation areas where patients can receive dialysis. Isolation of Flu patients takes priority over all other indications for isolation **except known Hepatitis B carriers**. If the pandemic escalates it may become necessary to designate one or more units specifically for flu patients. Many patients rely on

patient transport so consideration must be given to ensure that patient transport is prepared to transport infected patients.

9.5.2 To ensure continued delivery of dialysis the following actions should be considered;

- a. To keep nephrology and ESRD patients at home as much as possible by ensuring that the Home Care Team is maintained. (Identify staff with the skills to join team if required also assign medical cover for this team)
- b. Combine all emergency admission activity for the service (urology, nephrology, transplant and ESRD) to single area (Ward 29 admissions area – extended to 18 beds)
- c. Close ward 10 and 28 (approximately 50% of the service bed base). Use staff from these areas to support activity on ward 29, 15A and 15N. The estimated allocation of beds for activity in the scaled back service is outlined below. Ward 29 can be expanded to include part of 28 if required. Ward 17 will be reduced until such time as the ward can be closed and/or the immunosuppressed patients can be safely cared for in another area.
- d. Combine urgent outpatient activity for Transplant review/ESRD, acute nephrology and urology.

9.5.3 **Satellite Units**

9.5.4 Haemodialysis patients may need to have treatments reduced and be maintained on twice weekly dialysis. It is anticipated that each dialysis unit will manage their own patient population but in extreme situation where insufficient staff are available to maintain services it may be necessary to combine units by geography;

- a. Lincoln/Boston/Skegness
- b. Peterborough
- c. Harborough Lodge/Kettering/Corby
- d. LGH/Belgrave/Grace Road

9.6 **Excess deaths – mortuary resilience**

9.6.1 There is likely to be additional deaths during a pandemic. Where excess deaths involve children it is likely to cause significant pressures in the mortuary as there are only a small number of Pathologist that are able to perform post mortems on Paediatric and Neonatal patients. These staff may be required to travel to other sites around the country due to their specialist skills. This may be further compounded by requirements of containment and

management of the patients during their post mortems and limited equipment and resources available.

- 9.6.2 The ability of the Mortuary to provide its services depends on continued operation and cooperation with undertakers and the Coroners. Where excess deaths threaten the ability of the mortuary to operate the Mortuary Manager will inform the Coroner who, at their discretion, may make special arrangements to assist the management of excess deaths. Any issues with capacity should also be escalated to the Outbreak Control Team. UHL Mortuary capacity is summarised in Table 4. It may become necessary to request activation of the Excess Death Cell to effectively manage situation. This is achieved through the multi-agency Strategic Coordinating Group. See the [LRF Management of Excess Deaths due to Pandemic Influenza Plan](#).

Table 4 UHL Mortuary Capacity

Site	Capacity	Comments
Leicester Royal Infirmary	152	Including 10 deep freeze
Glenfield	27	
Leicester General	68	Post Mortem facilities not in commission but body storage available
Total	247	

- 9.6.3 The Coroner may decide to implement measures to assist the management of those that have recently died. They could include;
- a. Ease/suspend reporting of deaths that occur within 24hours of admission
 - b. The Medical Certificate Cause of Death (MCCD) could be emailed or faxed to the Registrar if relatives are unable to collect, in order to enable death registration and issue of certificate for burial or cremation. Registration within 5 days of death is unlikely to be suspended.
 - c. Reduce the number of post mortems commissioned because of sufficient alternative evidence is available about the cause of death.
- 9.6.4 These may be supplemented by legislative changes to allow greater flexibility in managing excess deaths. These will be communicated to the Outbreak Control Team via the Mortuary Manager, or representatives at multi agency meetings.
- 9.6.5 In order to support the Mortuary in their ability to manage their work load it is imperative that processes to provide patient information, death certification, medical records and any other requests are accelerated to allow early release of the body to support continued operation.

- 9.6.6 Multi agency cooperation is likely to be coordinated through the LRF Excess Deaths Cell for which UHL will need to be represented. See the [LRF Management of Excess Deaths due to Pandemic Influenza Plan](#).

10 PERSONAL PROTECTIVE EQUIPMENT & INFECTION PREVENTION AND CONTROL

- 10.1 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 sneezes, for up to five days (longer in children). Generally, people become less infectious as their symptoms subside. Once the symptoms are gone they can be considered no longer infectious to others. People who have been infected with a particular strain of the virus will become immune to that strain.
- 10.2 In the initial stages of any pandemic a vaccine will not be available to protect staff and vaccination will be undertaken as soon as the vaccine is available. To protect staff from a virus it is vital that PPE is readily available and appropriate training is given in its use particularly for Filtering Face Piece (FFP3) masks. CMGs must ensure that staff in high risk areas and are involved in aerosol generating procedures are provided with adequate training and instruction of the use of the FFP3 mask. To manage the stocks of PPE effectively Infection Control will manage the distribution of PPE once order requests have been made. Training for both mask fit testing and how to put on and take off PPE will be provided by Infection Control. Annex E outlines the current guidance on the use of appropriate PPE.
- 10.3 Good infection prevention and control will be one of the key action staff can take to prevent the spread of infection. All staff need to have a good awareness of principles of;
- a. Segregation
 - b. Isolation
 - c. Cohorting
 - d. Infection control
 - e. Hand/respiratory hygiene
 - f. Uniform
 - g. Outbreak control
- 10.4 **Environmental Cleaning**
- 10.4.1 During a pandemic it essential that appropriate cleaning of clinical areas is increased to reduce the spread of pandemic influenza. The following principles should be applied;

- a. Areas must be cleaned with Chlorclean.
- b. Areas used for cohorted patients should be cleaned at least daily.
- c. Clinical rooms should be cleaned at least daily and after clinical sessions for patients with influenza
- d. Frequently touched surfaces such as medical equipment and door handles should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.
- e. Domestic staff should be allocated to specific areas and not moved between influenza and non-influenza areas.
- f. Domestic staff should be trained in which PPE to use and the correct methods of wearing and removing. In addition to gloves and an apron, a surgical mask should be worn for cleaning in cohorted areas.

11 STAFF VACCINATIONS

- 11.1 Staff vaccinations will occur once a vaccine becomes available to the Trust. A vaccine will only be available once the pandemic viral strain has been isolated. It may be four to six months from the emergence and establishment of a new virus before a population-wide vaccination campaign can commence. Initial vaccine deliveries will be in limited quantities so prioritisation will be essential. Front line health and social care staff will be a priority group nationally.
- 11.2 Specific guidance on administering the vaccine will be finalised by Occupational Health on receipt of the vaccine. The vaccination programme will be based on ensuring that essential front line staff in critical areas of the Trust are offered the vaccination in order to reduce the likelihood of staff sickness.
- 11.3 The Trust will have access to seasonal flu vaccine which will continue to play an important part in providing some protection to staff against other strains. Consideration must be given to ensure that staff are encouraged to receive the vaccination.
- 11.4 **Priority Areas**
 - 11.4.1 The Trust will liaise with NHS England, Public Health England and local partners to ensure appropriate delivery of vaccination to priority areas. It is likely that the high priority areas will be;
 - a. Intensive Care Areas. (Including Respiratory Physio's and ECMO)
 - b. Emergency Department
 - c. Clinical Admissions areas (AMU, CDU, EDU, IDU)

d. Paediatrics (Intensive and Admissions areas)

e. Midwifery

11.4.2 Within these areas there will need to be a risk assessment carried out to highlight the staff in most clinical contact for the prolonged time period. Consideration will also need to be given to the procedures likely to generate Aerosols.

11.5 **Vaccine Administration**

11.5.1 Vaccination of staff will be undertaken by Occupational Health. Occupational Health will manage the stocks of vaccine to ensure that, in the event of a double dose vaccine being required, that stocks are not depleted in the initial phases of the vaccination programme, to ensure successful delivery of the 2nd dose. Until supplies are guaranteed half of the vaccine should be held back to ensure the 2nd dose is delivered within the required time frame. All staff vaccinations must be recorded on the Staff Vaccination Form. The form will be published based on criteria set by the Department of Health at the time of the pandemic.

11.5.2 Administration of the vaccine will occur in one of two stages either as a Restricted Supply, to targeted groups of staff or via a Mass Vaccination available to wider staff. Principles of the delivery are outlined below.

11.6 **Restricted Supply Plan**

11.6.1 The Occupational Health Service will visit each nominated clinical area within the Trust to ensure that there are suitable clinical areas/rooms for the vaccine to be given.

11.6.2 As soon as the amount of vaccine to be delivered to the trust has been confirmed the information will be relayed to the divisional managers. A list of names and clinical areas will need to be supplied to the OH Department on that site and the OH nurses will arrange to visit and administer the vaccine.

11.6.3 All named staff should be on the unit or area concerned at the time advised by Occupational Health in order to administer the vaccine in a timely fashion.

11.6.4 The OH Team will also follow this up with one clinic on each hospital site to be held in the Occupational Health Department to vaccinate any staff who could not get to their allocated time slot in their own clinical area. A suitable time for this will be given to the divisional managers in order to arrange for the staff to attend.

11.6.5 If necessary for a 2 dose vaccine, the OH staff will return to the clinical area after the required interval to complete the vaccination programme for those staff.

11.7 Mass Vaccination Plan

11.7.1 Mass vaccinations will focus around staff visiting vaccination clinics across the Trust. Vaccination areas are:

Table 5 Mass Vaccination Clinics

Site	Location of Clinic	Opening Times
LRI	Ward 8 or Ward 36 to be confirmed	09.00 -12.00 12.30-15.30
LGH	R&D Clinical Area	
GH	Ward 36	

11.7.2 These areas will be staffed by Occupational Health between the hours of 9am to 12pm and 12.30pm to 3.30pm. Consideration will need to be given to permanent night staff and weekend workers. Each CMG will be assigned a 3 hour slot per week in order to arrange for their staff to be released for vaccination.

11.7.3 There will be multiple OH teams assigned to the vaccination areas in order to ensure clinical staff are not kept away from the area. There will be approximately 3 – 4 teams of OH Nurses for each hospital site with a senior member of the medical team in attendance to ensure that clinical decisions on whether to vaccinate can be made at the time of administration. OH will also train vaccinators to administer the vaccine in their areas to their colleagues.

11.7.4 To administer the vaccination as either a mass vaccination or restricted supply programme the following equipment needs to be available in the vaccination clinics;

- a. Treatment Couch – (Ideal but not essential)
- b. Hand-washing facilities
- c. Desks x 4
- d. Chairs x 8
- e. Telephone
- f. Oxygen
- g. Suction
- h. Portable screens
- i. Lockable filing cabinet
- j. Lockable Vaccination Fridge

11.8 Challenges for Management

- 11.8.1 Due to media portrayal of the safety of the swine flu vaccine in 2009, recent surveys show there is reluctance amongst health care workers to have flu vaccinations. It is suggested that managers will need to encourage not coerce staff to participate in a vaccination programme for the benefit of their patients and themselves. The ways in which this can be achieved are by timely and informative communications and by senior Trust's staff leading by example.

12 **INPATIENT VACCINATION**

- 12.1 It may become necessary and in the best interest of long term patients to offer them the flu vaccination during their stay. Patients should be offered the vaccination if they fall into the high risk category, the length of stay and/or type of treatment they are receiving is likely to prevent them attending their GP or vaccination clinic themselves. Vaccinations should be carried out by a nurse or doctor. The priority of Occupational Health staff will be to ensure staff vaccinations. Staff administering the vaccination should ensure that they complete the training course outlined in Annex D

- 12.2 From the H1N1 outbreak in 2009 the following criteria for inpatient vaccination was applied;

1a. have been in the trust for greater than 30 days,

OR,

1b. Are admitted and are in a high risk group and are likely to have a prolonged stay. (This will require clinical judgement).

AND

2. Fit one or more of the criteria below; (see also Annex C part 4)

- a. Individuals aged six months and up to 65 years in the current seasonal flu vaccine clinical at-risk groups. i.e.
- b. chronic respiratory disease
- c. heart disease
- d. renal disease and chronic liver disease
- e. diabetes requiring insulin or oral hypoglycaemic drugs
- f. Immunosuppressed
- g. Multiple sclerosis, or conditions of the nervous system, or those having had a stroke
- h. HIV patients (this cohort of patients will be vaccinated by the HIV nurses in GU medicine as part of the rolling Seasonal Flu vaccine strategy.
- i. All pregnant women who are in-patients for more than 30 days

- 12.3 Further information for prescribing doctors is contained in Annex C part 5, and will be made available via insite – this information is only provided as a guide further detailed information will become available during a pandemic.
- 12.4 Patients should be assessed as to whether they are able to consent to the vaccine (translation offered if required) and are clinically suitable to be vaccinated. Some patients will already have received the vaccine and this should be recorded in the patients' notes. If the patient does not consent to be vaccinated then record this in the patient notes. Patients meeting the criteria should be offered the vaccine as soon as possible.
- 12.5 The vaccine should be prescribed in the usual way by a doctor or non-medical prescriber. The vaccine should be administered by a suitably trained member of staff. All vaccinations should be reported to the CMG in-patient vaccination clinical lead using the form Pandemrix Reconstitution and Administration Record (see annex C part 1).
- 12.6 After vaccination a letter should be immediately sent to the patients GP to confirm vaccination details (annex c part 2). The patient should also be given a letter stating that they have received vaccination (annex c part 3). This should be in addition and prior to the patients discharge letter. It is the responsibility of the doctor completing the discharge letter to include the fact that the vaccination has been given.
- 12.7 Each CMG will need to identify a Clinical / registered member of staff to take on the role as CMG in-patient vaccination clinical lead. The in-patient vaccination clinical lead will work with each ward and clinicians to identify those patients who meet the criteria for in-patient vaccination and are able to consent. Once all patient information has been gathered then a timetable for vaccination will need to be created. This will need to be completed by the CMG pharmacist, Nursing CMG Flu lead and directorate lead for in-patient vaccination. Consideration needs to be given to ensuring maximum use from each vial of vaccination (10 doses per vial). Pharmacy will then issue enough vaccine needed. Once the timetable has been agreed, the ward staff will be informed when the patient will be vaccinated.
- 12.8 Should a patient suffer a side effect of the vaccine then this should be reported to the Medicines and Healthcare products Regulatory Agency ([MHRA Pandemic Flu Portal](#)). This is a parallel site to the yellow card scheme. The ward pharmacist should also be informed.

13 PATIENT VISITORS

- 13.1 During a pandemic outbreak of infection, visitors to all areas of the hospital will be kept to a minimum. The maximum number is 2 per patient per hour of visiting.

- 13.2 Wards must adopt reduced visiting hours. Visiting hours will be reduced to two one hourly slots per day. Reduced visiting times allow staff who may be in short supply during a pandemic to concentrate on caring for patients, and reduces opportunity for the spread of infection.
- 13.3 There may be certain situations such as, parents caring for sick children, and relatives visiting critically ill or dying patients where visiting times would need to be altered to meet the needs of the family and patient. This should be done by consulting the nurse in charge of the ward.
- 13.4 Visitors with influenza symptoms must not visit clinical areas until they have recovered. Wards that are cohorting patients with influenza will display information at their entrances. All side rooms that accommodate patients with known or suspected influenza will have information displayed on the doors entering the rooms.
- 13.5 If visitors wish to visit patients with flu who is nursed in single room or cohort isolation on a ward, they must first report to the ward reception desk. They must then be instructed on the correct infection prevention and control precautions required, including hand hygiene and the use of protective clothing.
- a. Visitors who sit by a patient's bed side but do not give personal care must wear a surgical mask whilst in the bed space or side room.
 - b. Visitors must not stay in the side room when aerosol generating procedures are being performed as this increases the risk of transmission.
 - c. If visitors are involved in personal care then they must wear disposable gloves and a plastic apron in addition to a surgical mask.
 - d. Visitors should use the foam hand sanitiser on entering the ward area.
 - e. Visitors must wash hands with soap and water before leaving side room or cohort area and use the foam hand sanitiser on exiting the ward.

14 STAFFING CONSIDERATIONS

14.1 Absence management

- 14.1.1 Staff may 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.
- 14.1.2 Staff with caring responsibilities may be adversely affected by local measures, such as closure of schools. As a result, these staff may need to stay at home to care for dependent children or elderly dependants. Therefore, staff should

discuss whether Carers leave may be appropriate in line with the current policy and guidelines.

14.1.3 Staff who display symptoms should be sent home and advised not to work until fully recovered. Normal sick pay arrangements will apply. CMGs must ensure absences related to Pandemic Flu are reported to HR using the Flu Pandemic reporting mechanisms that will be put into operation during a Pandemic situation.

14.1.4 Employees will have no right to refuse to attend work during a pandemic, unless there is a clear health and safety risk. Refusal to do so may put them in breach of their contracts.

14.2 **Reserve workforce / Volunteer sector**

14.2.1 When a pandemic is declared Human Resources the Directorate of Nursing and Medical Directors will work together to identify and contact recently retired staff and ascertain whether they would be willing to work on the bank for the duration of the pandemic to assist with expected staff shortages. Contact will also be made with the volunteer sector for assistance. Contact should also be made with De-Montfort University with regards to Nursing Students joining the staff bank as un-qualified staff.

14.3 **Flexible Staffing**

14.3.1 Staff could be rotated and reallocated to other roles to make best use of the skills and competencies available. Examples include;

- a. Senior managers with a clinical background could be allocated to work clinically
- b. Cancellation of all study leave staff brought back into the workforce
- c. Pharmacists and nurse prescribers could play an important role in prescribing medicines
- d. Clinical Pharmacists can play a role in supporting other clinicians in areas such as adults and paediatric intensive care units
- e. Specialist nurses, clinical educators, service improvement team and outpatient clinic staff would be brought back into front line clinical service
- f. Use bank and agency staff if in extreme need, according to the Infection Control Guidelines only.
- g. Consideration would be given to asking newly retired staff to return to work on a short term contract or in a bank post capacity.

- h. It may be necessary to transfer staff across sites to ensure that their expertise is best utilised
- i. As a general principle, healthcare workers who care for pandemic influenza patient areas **should not** care for other patients; however, exceptions may be necessary

14.4 **Resilience arrangements for key staff**

- 14.4.1 There is a risk that high sickness rates will result in the absence of staff performing key roles. UHL clinical teams and management teams at every level must ensure that key leadership & decision making rolls have clearly identified deputies to provide cover for sickness absence.

15 **OTHER CONSIDERATIONS**

15.1 **Financial Implications**

- 15.1.1 Finance will play a key role in ensuring that staff and contractors continue to be paid and that the costs incurred in response to the pandemic are monitored and accounted for as per their Business Continuity Plan.
- 15.1.2 The Finance department will allocate a specific cost code for pandemic influenza, to be used by all departments for all major non-routine purchases during the response to the pandemic. This will help monitor costs incurred and will be useful for ongoing preparations. Recording of all flu related costs within CMGs is essential.

15.2 **Contractual implications**

- 15.2.1 The business continuity plans of all suppliers of key goods, equipment and services to UHL should be reviewed. Implications of UHL flu contingency measures upon UHL performance against CCG contracts should be assessed and discussed with CCGs at the earliest opportunity.

15.3 **Mutual Aid and links with external agencies**

- 15.3.1 All NHS organisations in Leicester, Leicestershire and Rutland have agreed to provide mutual aid where possible on request. It is also important to ensure links with appropriate Operational Delivery Network are maintained. For more information consult the UHL Major Incident Plan – Section A Para 14.3.

15.4 **Independent Sector**

- 15.4.1 The independent sector can provide a resource for urgent operative procedures. CMGs anticipating elective surgery capacity pressures should consider this option. Use of independent sector should be ratified by the Incident Director.

15.5 **Stock / supplies management**

15.5.1 CMGs will need to order sufficient supplies of essential goods and equipment. This will require close links with supplies and procurement staff. CMGs need to have a good awareness of which supply chains provide key goods and services.

15.6 **Antiviral Collection Centres**

15.6.1 In an extreme pandemic it may become necessary to support the Local Area Team/CCG distribution of antivirals by establishing an Antiviral Collection Centre. UHL Antibiotic Collection Centre plans should be activated and followed. A request to set up an Antiviral Collection Centre within the Trust will only come from either NHS England or the Clinical Commissioning Groups.

16 **RECOVERY**

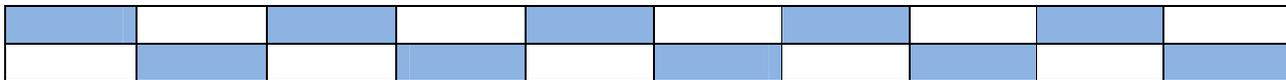
16.1 The UHL aims to return to pre-pandemic levels of service provision as quickly as possible. During the initial phase of an influenza pandemic the Trust will have undertaken actions to ensure its core activity and responsibilities have continued where possible. The pace of this recovery will be dependent on the residual impact of the pandemic, on-going demands, staff and organisational fatigue and supply difficulties. Please consult the UHL Major Incident Plan for further information.

16.2 It is likely that there will be persistent secondary effects as a result of the pandemic including:

- a. Those patients whose existing conditions have been exacerbated
- b. Those new patients likely to suffer medium and long-term health complications
- c. The backlog of patients whose treatment has been postponed for the treatment of more urgent conditions

16.3 With the possibility of a significant reduction in the number of staff available to work it must be recognised that a phased return to normal services may become necessary. For some staff it may become necessary to alter their work patterns to allow for return to normal services. Where staff who are normally employed in a function which, under the circumstances is deemed as 'non-essential', they could be redeployed to assist in departments which are more critical to the core business of the organisation.

17 **ACTION CARDS**



ACTION CARD PIP 1- INCIDENT DIRECTOR (CHIEF OPERATING OFFICER)

SUMMARY: The Pandemic Influenza Plan has been activated due to the detection of Influenza Pandemic within the UK. There may already be patients within the Trust that are infected with the virus. It is essential that appropriate processes are put in place to reduce the spread of the virus between patients, staff and visitors. An Influenza Pandemic is likely to place extreme pressure on the Trust as a result of increased patient admissions, longer length of stays and increased staff sickness and unexpected leave.

Role: To provide the **strategic** management and coordination of Trust activities to the response of the pandemic.

ACTIONS:

		Time
1.	Identify suitable representatives for the Outbreak Control Group	
2.	Chair a meeting of the Outbreak Control Group, initial agenda overleaf.	
3.	Set the strategic aims and objectives for the response	
4.	Set the policy regarding continuation of elective and outpatient activity and critical front line services	
5.	Lead on communications messages within the Trust with the support of the Communications Team	
6.	Liaise with partner organisations and be prepared to attend any relevant external meetings with partners	
7.	Ensure that latest clinical guidance is available to clinicians	
8.	Ensure that appropriate processes are developed and communicated for the use of;	
a.	PPE	
b.	Staff Vaccinations	
c.	Isolation/Side Rooms	
d.	Inpatient Vaccinations	
9.	Assess the need to call on mutual aid arrangements	
10.	Review frequency of meetings	

PANDEMIC STAND DOWN. – Note; pandemics can occur over multiple phases as the virus develops and mutates. Be prepared to continue surveillance and if necessary escalate and initiate response arrangements for a 2nd phase.

1.	Convene the recovery group – see UHL Major Incident Plan	
2.	Collate all documents relating to the command and management of the outbreak – including expenditure	
3.	Debrief with staff and ensure suitable incident review processes are instigated	

PLEASE KEEP AND FILE THIS ACTION CARD AS THIS PROVIDES THE START OF YOUR LEGALLY REQUIRED DOCUMENTATION OF AN INCIDENT
ENSURE ALL ACTIONS AND DECISIONS ARE ‘LOGGED’ AND RECORDED

OUTBREAK CONTROL GROUP

AGENDA (proposed)

Item	Description	Lead		
1	Situation update a. ED attendances b. Admissions (Lab confirmed cases/Influenza like illness not diagnosed) c. Staff Absence d. Current Bed State	Duty Manager		
2	Declaration of urgent issues (anyone with urgent issues should declare them and once all issues are declared then discussions and actions can be assigned)	All		
3	Breakaway (5mins) to action urgent issues	All		
4	Actions from previous meeting	Chair		
5	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> CMG Updates a. CHUGS b. CSI – including mortuary capacity c. E&SM d. ITAPS </td> <td style="width: 50%; vertical-align: top;"> e. MSK & SS f. RRC g. Infection, Prevention and Control/Microbiology h. Interserve i. Finance and Procurement </td> </tr> </table>	CMG Updates a. CHUGS b. CSI – including mortuary capacity c. E&SM d. ITAPS	e. MSK & SS f. RRC g. Infection, Prevention and Control/Microbiology h. Interserve i. Finance and Procurement	CMG Leads
CMG Updates a. CHUGS b. CSI – including mortuary capacity c. E&SM d. ITAPS	e. MSK & SS f. RRC g. Infection, Prevention and Control/Microbiology h. Interserve i. Finance and Procurement			
6	Urgent Care Centre Update	UCC		
7	CCG/NHS England/PHE Update	CCG/LAT		
8	EMAS Update	EMAS		
9	Vaccination Programmes a. Staff Vaccination b. Inpatient Vaccination	Occupational Health		
10	PPE/Fit Testing/Staff Training	Occupational Health		
11	Discharge Problems	Chair		
12	Potential Future Problems	Chair		
13	Communications	Comms Lead		
14	Summary of Agreed Actions	Chair		
15	Any other Business	Chair		
16	Time and Date of Next Meeting	Chair		

ANNEX A - PRIORITY LIST FOR ALLOCATION OF SIDE ROOMS

A.1. There are always competing priorities for side rooms. During periods of increased seasonal influenza activity this demand will increase. The following list should be considered as the priority list for side rooms, with number 1 being the top priority and then in descending order. A list of conditions that may require source isolation can be found in Appendix 3 of the Preventing Transmission of infection DMS No 47699. For advice relating to risk assessing need for side rooms please contact Infection Prevention & Control Team.

1. Any patient as defined in source isolation policy requiring Strict isolation precautions (apart from seasonal influenza)
2. Multi-drug resistant Tuberculosis – Should be in a negative pressure side room
3. Patient requiring nebulised Ribovarin or Pentamidine
4. Smear Positive Tuberculosis
5. Chicken pox
6. *Clostridium difficile* associated diarrhoea
7. Influenza like illness requiring aerosol generating procedure
8. Diarrhoea caused by other micro-organisms
9. MRSA Positive with risk factors i.e. Productive cough, leaky wound exfoliating skin condition
10. Measles/Rubella/Pertussis
11. Bacterial Meningitis (confirmed or suspected) – Until 24 hours of appropriate treatment
12. Necrotising fasciitis – Until 24 hours appropriate treatment

A.2. A risk assessment should be made where patients require protective isolation relative to the numbers of patients with known or suspected infections that may also be on the ward. Examples of patient who require protective isolation include;

13. Infants who have not been immunised
14. Children with Cystic Fibrosis
15. Immunocompromised patients requiring protective isolation

ANNEX B – DETAILED PLANNING ASSUMPTIONS

Table 6 Pandemic Influenza Planning Scenarios - Weekly Profile Leicester, Leicestershire and Rutland Population 1,017,697 (2013)

Week	% total cases	Clinical Attack Rate (CAR) 50%	Clinical Attack Rate (CAR) 35%	Clinical Attack (CAR) 25%	Additional hospital admissions (CAR 50%)	Additional hospital admissions (CAR 35%)	Additional hospital admissions (CAR 25%)	Additional Deaths (CAR 50%)	Additional Deaths (CAR 35%)	Additional Deaths (CAR 25%)
1	0.1	509	356	254	20	14	10	13	9	6
2	0.2	1,018	712	509	41	28	20	25	18	13
3	0.8	4,071	2,850	2,035	163	114	81	102	71	51
4	3.1	15,774	11,042	7,887	631	442	315	394	276	197
5	10.6	53,938	37,757	26,969	2158	1510	1079	1348	944	674
6	21.6	109,911	76,938	54,956	4396	3078	2198	2748	1923	1374
7	21.2	107,876	75,513	53,938	4315	3021	2158	2697	1888	1348
8	14.3	72,765	50,936	36,383	2911	2037	1455	1819	1273	910
9	9.7	49,358	34,551	24,679	1974	1382	987	1234	864	617
10	7.5	38,164	26,715	19,082	1527	1069	763	954	668	477
11	5.2	26,460	18,522	13,230	1058	741	529	662	463	331
12	2.6	13,230	9,261	6,615	529	370	265	331	232	165
13	1.6	8,142	5,699	4,071	326	228	163	204	142	102
14	0.9	4,580	3,206	2,290	183	128	92	114	80	57
15	0.7	3,562	2,493	1,781	142	100	71	89	62	45
Total	100.1	50,9357	35,6550	25,4679	20,374	14,262	10,187	12,734	8,914	6,367

Clinical Cases in Leicester, Leicestershire and Rutland

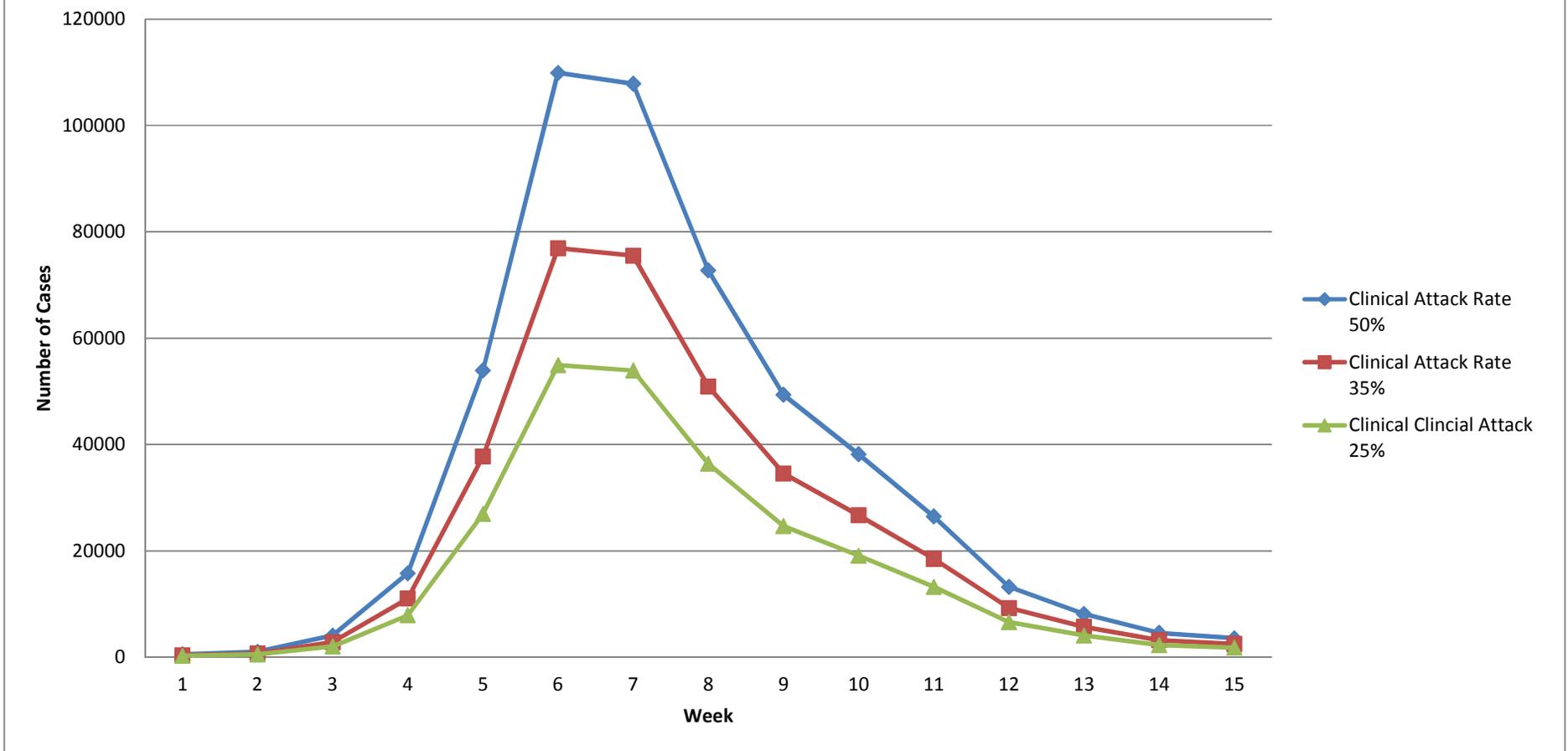


Figure 1 Planning Assumptions of Clinical Cases weekly in LLR (2013)

Hospital Admissions 4% of Clinical Attack Rate (CAR)

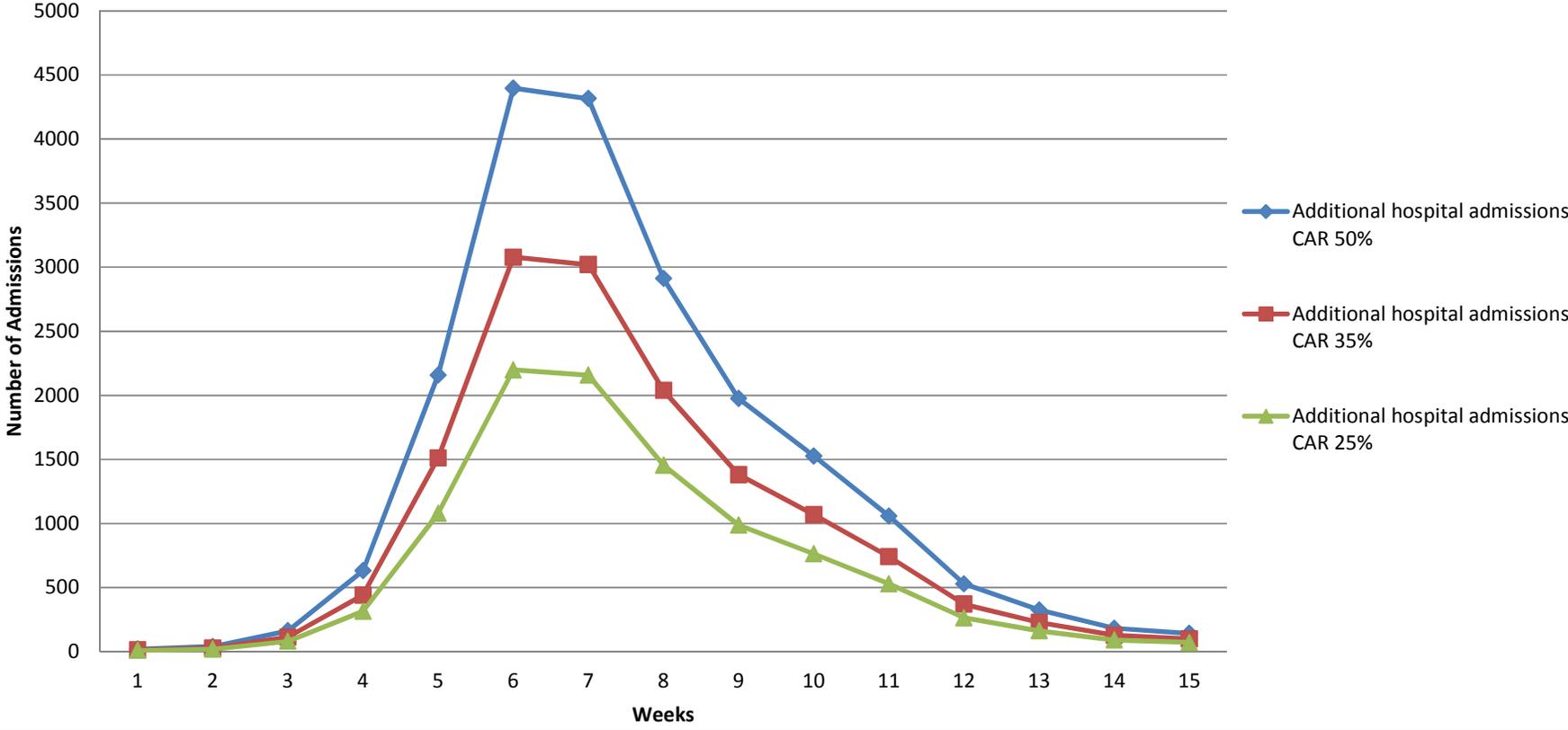


Figure 2 Planning Assumptions of Hospital Admissions weekly in LLR (2013)

Additional Deaths 2.5% Case Fatality Rate

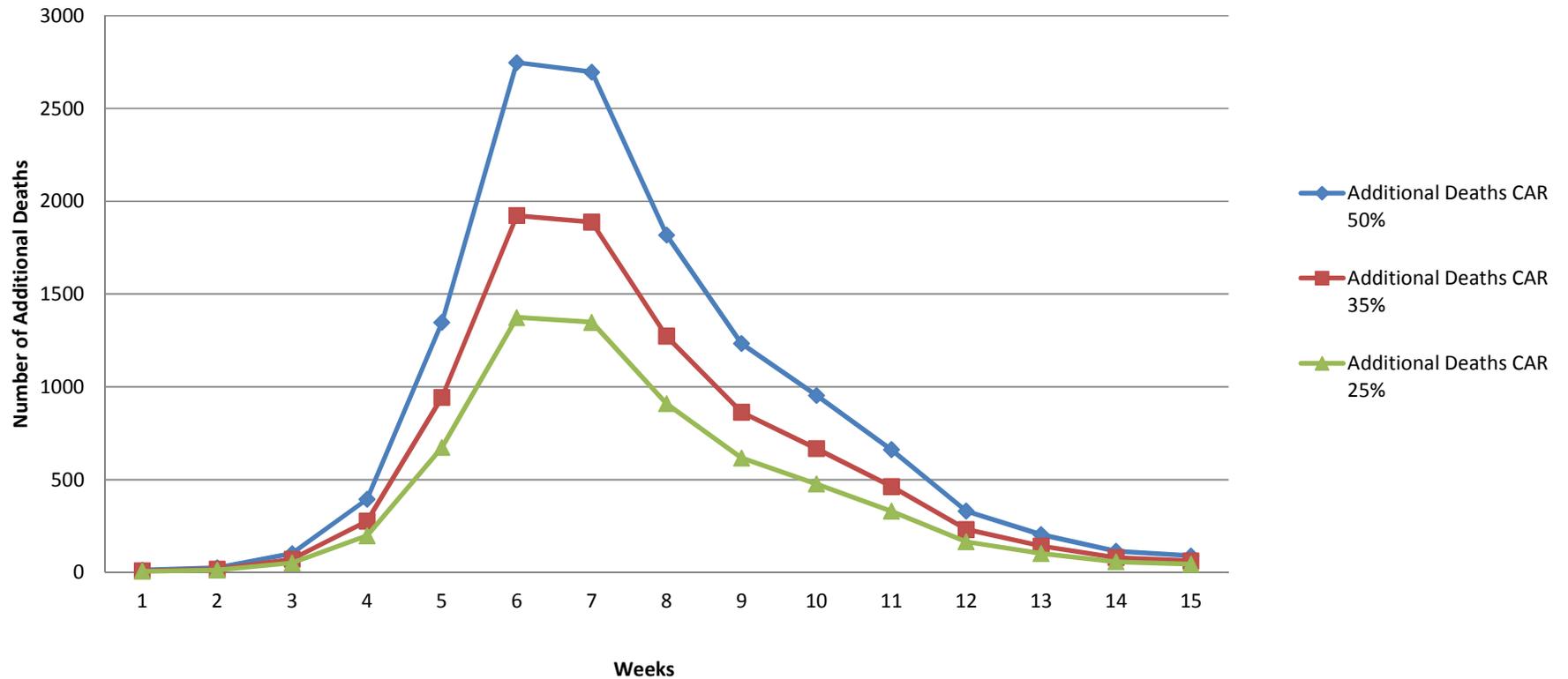


Figure 3 Planning Assumptions of Additional Deaths weekly in LLR (2013)

ANNEX C - INPATIENT VACCINATION PACK

Note: Please check that all the details contained within Annex C are correct for the particular strain of influenza being vaccinated for before using this documentation.

To be completed for each inpatient vaccinated with a specific influenza vaccine

Contents

1. Vaccination Reconstitution and Administration Record
2. Letter to GPs where Specific Influenza Vaccine has been offered
3. Letter to Patient
4. Clinical risk groups who should receive the influenza immunisation
5. Guidance for Prescribing Doctors

Vaccination Reconstitution and Administration Record

Valid for single vial – Use contents of one vial before reconstituting another vial

Reconstitution record

Date prepared		Time prepared	
	Batch No	Expiry Date	Overall Lot No:
Antigen			
Emulsion			
	Name	Signature	
Prepared By:			
Checked By			
Expiry Date		Expiry Time (24 hours)	

Patient Administration Record

Date given	Time given	Hospital Number	Patient name	Patient DoB	Dose 1	Signature 1	Signature 2
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Letter to GPs where Specific Influenza Vaccine has been offered

Dear [GPs Name],

I have today assessed [Patient Name] against the Department of Health's criteria for vaccination against Influenza and consider them to require vaccination.

I have offered the vaccine to the patients and they have accepted this. The vaccine therefore has been administered.

The vaccine used was a single dose of [vaccine name].

I would appreciate it if you could update your records accordingly.

Many thanks

[Consultants Name]

Dear [patient name],

As part of our ongoing response to the Influenza virus we have been asked by the Department of Health to identify patients who are considered to be at particular risk from the virus and its effects.

We therefore offered you the vaccine, which you accepted and a single dose of [Vaccine name] was administered by our staff on [Date]

A letter has been sent to your GP to inform them of this and no further action is required on your part.

If you have any further questions you should contact your GP in the first instance.

Yours sincerely

[Consultants Name]

Clinical risk groups who should receive the influenza immunisation

Check for the latest information against the Green Book

Clinical risk category	Examples (decision based on clinical judgement)
Chronic respiratory disease	Chronic obstructive pulmonary including asthma disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Children who have previously been admitted to hospital for lower respiratory tract disease.
Chronic heart disease	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease.
Chronic renal disease transplantation.	Chronic renal failure, nephrotic syndrome, renal
Chronic liver disease	Cirrhosis, biliary atresia, chronic hepatitis.
Chronic neurological disease	Stroke, transient ischaemic attack (TIA).
Diabetes requiring insulin or oral drugs	Type 1 diabetes, type 2 diabetes requiring oral hypoglycaemic, and diet controlled diabetes.
Immunosuppression	Immunosuppression due to disease or treatment. Patients undergoing chemotherapy leading to immunosuppression. Asplenia or splenic dysfunction. HIV infection at all stages. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kg a dose of 1mg or more per kg per day. However, some immunocompromised patients may have a suboptimal immunological response to the vaccine

Guidance for Prescribing Doctors – to be completed for each pandemic

Dosage	
Precautions	
Exclusion criteria	
Adverse effects	

ANNEX D– VACCINATION TRAINING

- D.1. In order to administer vaccinations you must complete the relevant training course. The following details how to access an online training course to ensure that you receive the relevant training.
- D.2. The training can be access via the following link;
<https://corelearning.skillsforhealth.org.uk/local/sfadmin/login/index.php>
- D.3. You will need to register for the site if you have never used it before. Once you have registered and logged in, click on **Immunisation and Vaccination** and you will be taken to the course. It will take approximately ½ a day to complete. It may be longer or shorter depending on your progress. You can come and go at it as you please. You must complete all modules and complete all assessments. Once you have completed the course it will generate a certificate for you to print off. Please print off your certificate and inform Occupational Health.

ANNEX E – PPE REQUIREMENTS FOR CARE OF PATIENTS WITH PANDEMIC INFLUENZA

PPE Measure	Entry to cohorted area but no patient contact	Close patient contact (within one metre) ^a	Aerosol-generating procedures ^b
Hand hygiene	✓	✓	✓
Gloves	x ^c	✓ ^d	✓
Plastic apron	x	✓	x
Gown	x	x ^{e,f}	✓ ^f
Surgical mask	✓ ^g	✓	x
FFP3 respirator	x	x	✓
Eye protection ^h	x	✓	✓

- a. PPE for close patient contact (within one metre) also applies to the collection of nasal or nasopharyngeal swabs.
- b. Wherever possible, aerosol-generating procedures should be performed in side rooms or other closed single-patient areas with only essential staff present.
- c. Gloves and an apron should be worn during environmental cleaning procedures
- d. Gloves should be worn in accordance with standard infection control precautions. If glove supplies become limited or come under pressure, this recommendation may need to be relaxed. Glove use should be prioritised for contact with blood and body fluids, invasive procedures and contact with sterile sites.
- e. Consider a gown in place of an apron if extensive soiling of clothing or contact of skin with blood and other body fluids is anticipated (for example, during intubation or caring for babies).
- f. If non-fluid repellent gowns are used, a plastic apron should be worn underneath.
- g. Surgical masks are recommended for use at all times in cohorted areas for practical purposes. This should include non-clinical staff in healthcare facilities, e.g. reception staff working in an influenza clinic in primary care. If surgical mask supplies become limited or come under pressure, then their use in cohorted areas should be limited to close contact with a symptomatic patient (within one metre).
- h. Eye protection is required to be work as part of standard infection control precautions when there is a risk of blood, body fluids or secretions splashing into the eyes. Surgical masks with integrated visors are an option for eye protection.

ANNEX F – PLAN ADMINISTRATION

References

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University Hospitals of Leicester (2013) *Business Continuity Policy, Delivering Resilient Health Care* [online] available from <http://moss.xuhl-tr.nhs.uk/together/Documents/Corporate%20and%20Clinical%20Policies/Business%20Continuity%20Management%20Policy.pdf> [1st November 2013]

Legal and Supportive Advice

Legal and supportive advice with regards to this plan, the Civil Contingencies Act 2004, Health and Social Care Act 2012 (in relation to EPRR) can be sought from the Trust's Emergency Planning Officer on ext. 6486/ aaron.vogel@uhl-tr.nhs.uk or the Trust's Operations Team via the Chief Operating Officer.

Training, Exercising and Plan Activation

Training and Exercises are provided by the Trust's Emergency Planning Officer and is delivered in line with a training needs analysis and training programme. Training is delivered in line with current national occupational standards. Further details can be obtained from the Emergency Planning Officer.

Plan Development and Validation

This plan has been developed in conjunction with the service areas within the Trust. This was overseen by the Trust's Emergency Planning and Business Continuity Committee as described in their roles and responsibilities in the Trust's Business Continuity, Delivering Resilient Health Care Policy.

The following amendments have been made to this document since it was first developed;

Date	Version	Paragraph Changed	Brief Details of Alterations	Approved by
02-08-10	6	Whole document	Remove reference to directorate/s and replace with Division/al	RJ
11-10-12	7	Front page	Change to executive lead	RJ
May 2013	8	Whole Document	Update to bring into line with new national guidance and structures	AV
July 2015	9	Whole Document	Updated to bring into line with new national requirements	AV
Sept 2016	10	Whole document	New sections added including, outbreak in cancer and haematology, patient testing and PPE	AV