Livewell Southwest

Pandemic Influenza Policy

Deputy Head of Health Improvement / Head of Corporate Risk and Compliance

Version 1
Review: December 2018

Notice to staff using a paper copy of this guidance.

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Associated documentation	• Risk Management Strategy • LSW Major Incident Plan • LSW Business Continuity Plan and Business Impact Analysis
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0.1	New Policy	12/10/15	Deputy Head of Health Improvement / Head of Corporate Risk and Compliance	New Policy
1	Ratified	December 2015	Policy Ratification Group	Ratified

LSW PANDEMIC INFLUENZA RESPONSE OVERVIEW

PHASE	TRIGGER	ACTION BY	ACTION
DETECTION	**WHO declare a pandemic phase 4 OR A Public Health Emergency of International Concern**	**PCH Director of Operations**	• **Inform PCH Senior Management** • **Convene a Pandemic Management Group (see page 19)** • **Initiate actions for Initial Phase - Pandemic Impact Unknown (page 16)**
		Local Authority Director of Public Health	• **Convenes Influenza Pandemic Committee (IPC) to lead and co-ordinate local multi-agency response to the pandemic**
ASSESSMENT	**Identification of the novel influenza virus in patients in the UK**	**Pandemic Management Group**	• **Continue implementation of Initial Phase actions** • **Provide support to HPU/ Public Health England Outbreak Teams if requested**
TREATMENT	**Evidence of sustained community transmission**	**Pandemic Management Group**	• **Implement actions appropriate for a LOW IMPACT Pandemic (Page 17)**
	National Pandemic Flu Line may be activated	**Influenza Pandemic Committee**	• **Decision on need for Anti-viral Collection Points (ACPs) – use of community pharmacies etc.**
ESCALATION	**Demand for services starts to exceed available capacity**	**Pandemic Management Group**	• **Implement the actions for a MODERATE IMPACT Pandemic (see page 18) and, if appropriate, a HIGH IMPACT Pandemic (see page 19)**
		Influenza Pandemic Committee	• **Identifies need to set-up larger scale Anti-viral Collection Points**
		Pandemic Management Group	• **If required, undertake actions to set-up ACP(s) using guidance in appendices A – H (pages 31 – 46)** • **Adapt response as per any national guidance at the time**
RECOVERY	**Flu activity reduced and within acceptable parameters**	**Pandemic Management Group**	• **Undertake Recovery Actions as per Section 21, Recovery Phase, of this plan (see page 24)**

Pandemic Influenza Policy

1.0 Introduction

1.1 The potential for a new influenza pandemic remains one of the greatest threats facing the UK[1]. While the timing and severity of a future pandemic is unpredictable, the Organisation has a responsibility to the community to be prepared to respond to such an event, whenever it should arise.

1.2 A pandemic will require an integrated response across the health economy and through-out government; consequently, LSW will need to work closely with our partners in Public Health England, NHS England, local Directors of Public Health, local Acute Organisations and Local Authorities.

1.3 This plan provides a framework to guide LSW in supporting the community as part of the wider health response.

2.0 Aim and objectives

2.1 Aim

- To enable LSW to support the community through effective participation in an integrated, multi-agency, response to an influenza pandemic.

2.2 Objectives

- to maintain the LSW's essential services through-out the duration of the pandemic
- to protect the health of staff and patients through-out the pandemic
- to effectively implement regional and national health guidance on responding to the pandemic
- to integrate the Organisation's response with that of local responder partners
- to provide additional services in support of the community as required by the pandemic response

3.0 Scope

3.1 This plan provides a framework to support LSW's response to a pandemic in line with the UK Influenza Pandemic Preparedness Strategy 2011; the operational implementation of it will be subject to change dependent upon the circumstances and nature of the threat faced by LSW and the community.

3.2 This is not a stand-alone plan; it is to enable LSW to contribute to the integrated pandemic response managed through the Major Incident Multi Agency Response Command and Control structure.

[1] UK Influenza Pandemic Preparedness Strategy 2011 (updated 5th June 2014)

3.3 This plan is heavily dependent upon information regarding the Influenza virus and its treatment from external sources such as Public Health England, NHS England (NHSE) and local Directors of Public Health.

3.4 The implementation of this plan will require close co-ordination and co-operation with the NHSE, Acute Organisations, Social Care and other local health economy partners.

4.0 Duties and Responsibilities

4.1 The **Chief Executive** is ultimately responsible for LSW Emergency Planning Resilience and Response Policies and Plans.

4.2 The **Head of Corporate Risk and Compliance** is responsible for ensuring that this policy is reviewed and updated according to current legislation, best practice and guidance. Also for ensuring that appropriate training is developed and delivered to appropriate staff in order to facilitate the implementation of this policy.

4.3 All **Directors** are responsible for ensuring that this policy is implemented within their area of leadership.

4.4 All **Locality Managers** are responsible for implementing this policy throughout all of their services and ensuring that staff are released to attend relevant training.

4.5 All **Line Managers** are responsible for:

- Ensuring that this policy is communicated to, understood and followed by staff, including any identified training needs.

5.0 Activation Process

5.1 The plan will be activated in response to the receipt of an alert to a pandemic threat to the UK or arising from within the UK.

5.2 The alert may be received from Public Health England itself, via NHS England or via local Directors of Public Health.

5.3 Upon receipt of the alert the Director of Operations should inform the Executive Team and convene a Pandemic Management Group to co-ordinate the LSW's response.

5.4 Actions should then be undertaken in line with the 'LSW Actions' set out in Section 9 of this plan and co-ordinated with local health economy partners.

6.0 Background - Summary

6.1 Historically, the UK's pandemic planning had been based upon an assessment of the "reasonable worst case"[1]. After the Swine Flu pandemic of 2009, it was recognised that this approach had been widely misunderstood as being the 'likely' scenario. The unpredictability of an influenza pandemic means that pandemic

plans should be flexible and adaptable for a wide range of scenarios, rather than just the 'reasonable worst case' scenario.

6.2 The UK Influenza Pandemic Preparedness Strategy 2011 outlines three principles that should underpin all pandemic preparedness and response activity:

- Precautionary: the response to any pandemic should take into account the risk that it could be severe in nature.
- Proportionality: the response to the pandemic should be no more and no less than that necessary in relation to the known risks.
- Flexibility: there should be a consistent, UK-wide, approach to the response to a new pandemic but with local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection.

6.3 Based upon these three principles, the strategy advocates planning for scenarios with a Low, Moderate and High impact. Section 9 of this plan sets out actions for LSW in line with these principles; covering an Initial Phase, followed by a graduated response to a Low, Moderate or High impact pandemic.

6.4 Further information on influenza and pandemics is available in Section 22, the Supporting Information section of this plan.

7.0 Planning Assumptions[2]

7.1 A pandemic is most likely to be caused by a new subtype of the Influenza A virus but this plan may be appropriately adapted and deployed for any epidemic infectious disease.

7.2 An influenza pandemic could emerge at any time of the year anywhere in the world, including in the UK. Regardless of where or when it emerges, it is likely to reach the UK very rapidly and, from arrival, it will probably be a further one to two weeks until sporadic cases and small clusters of cases are occurring across the country.

7.3 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.

7.4 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.

7.5 Initially, pandemic influenza activity in the UK may last for up to three to five months, depending on the season. There may be subsequent waves of activity of the pandemic virus weeks or months apart, even after the WHO has declared the pandemic to be over.

7.6 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

[2] Health and Social Care Influenza Pandemic Preparedness and Response (DH 2012)

pandemics, subsequent winters are likely to see increased seasonal flu activity compared to pre-pandemic winters.

7.7 In a worst case scenario, up to 50% of the population could experience symptoms spread of one or more pandemic waves each lasting 15 weeks, although the nature and severity of symptoms would vary from person to person.

7.8 Deaths

7.8.1 Analysis suggests that, if no treatment proved effective, up to 2.5% of those with symptoms could die.

7.8.2 The combination of particularly high attack rates (circa 50%) and a severe case-severity is relatively improbable but not quantifiable.

7.9 Health Planning Assumptions

7.9.1 Health services should prepare to provide advice and treatment for up to 30% of all symptomatic people in the usual pathways of primary care;

7.9.2 Between 1-4% of symptomatic patients could require hospital care, depending upon the severity of illness caused by the virus; of these, up to 25% may require critical care;

7.9.3 Staff absence is likely to mirror the wider community profile. In a widespread and severe pandemic affecting 50% of the population, between 15-20% may be absent on any given day during peak weeks;

7.9.4 The above figures may be reduced by the impact of antiviral and antibiotic countermeasures, dependent upon their effectiveness.

8.0. Stages Of Pandemic Response - UK Approach (DATER)

8.1 The World Health Organisation (WHO) is responsible for identifying and declaring an influenza pandemic based on the global situation; however the WHO has recognised that its alert system is unsuitable as a basis for planning within individual countries. Consequently, the Department of Health has developed a UK-specific approach to the phases of a pandemic response.

8.2 The UK approach takes the form of the following phases (referred to as DATER):

8.2.1 **Detection**

This phase will commence either when the WHO issue an alert that a new sub-type has been identified in humans, or earlier on the basis of reliable intelligence, or if an influenza-related 'Public Health Emergency of International Concern' (PHIEC) is declared by the WHO[3]. The focus in this stage would be:

- Intelligence gathering from countries already affected
- Enhanced surveillance within the UK

[3] See paragraph 7.17 of this plan for description of a PHEIC

- The development of diagnostics specific to the new virus
- Information and communications to the public and professionals

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

8.2.2 **Assessment**

The focus in this stage would be:

- The collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK.

- Reducing the risk of transmission and infection with the virus within the local community by:

    - actively finding cases;
    - self-isolation of cases and suspected cases; and
    - treatment of cases / suspected cases and use of antiviral prophylaxis for close / vulnerable contacts, based on a risk assessment of the possible impact of the disease

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

8.2.3 *These two stages – Detection and Assessment - together form the initial response*. This may be relatively short and the phases may be combined depending on the speed with which the virus spreads, or the severity with which individuals and communities are affected. It will not be possible to halt the spread of a new pandemic influenza virus, and it would be a waste of public health resources and capacity to attempt to do so.

8.2.4 Treatment

The focus in this stage would be:

- Treatment of individual cases and population treatment via the National pandemic Flu service (NPFS), if necessary.
- Enhancement of the health response to deal with increasing numbers of cases.
- Consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localised school closures based on public health risk assessment.
- Depending upon the development of the pandemic, to prepare for targeted vaccinations as the vaccine becomes available.

Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases and deaths.

When demands for services start to exceed the available capacity, additional measures will need to be taken. This decision is likely to be made at a regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity.

8.2.5 Escalation

The focus in this stage would be:

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

Whilst escalation measures may not be needed in mild pandemics, it would be prudent to prepare for the implementation of the Escalation phase at an early stage of the Treatment phase, if not before.

8.2.6 Recovery

The focus in this stage would be:

- Normalisation of services, perhaps to a new definition of what constitutes normal service.
- Restoration of business as usual services, including an element of catching-up with activity that may have been scaled-down as part of the pandemic response e.g. reschedule routine appointments/operations.
- Post-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt.
- Taking steps to address staff exhaustion.
- Planning and preparation for a resurgence of influenza, including activities carried out in the Detection phase.
- Continuing to consider targeted vaccination, when available.
- Preparing for post-pandemic seasonal influenza.

The indicator for this phase would be when influenza activity is either significantly reduced compared to the peak or when the activity is considered to be within acceptable parameters. An overview of how services' capacities are able to meet demand will also inform this decision.

8.3 Operational Use of 'DATER'

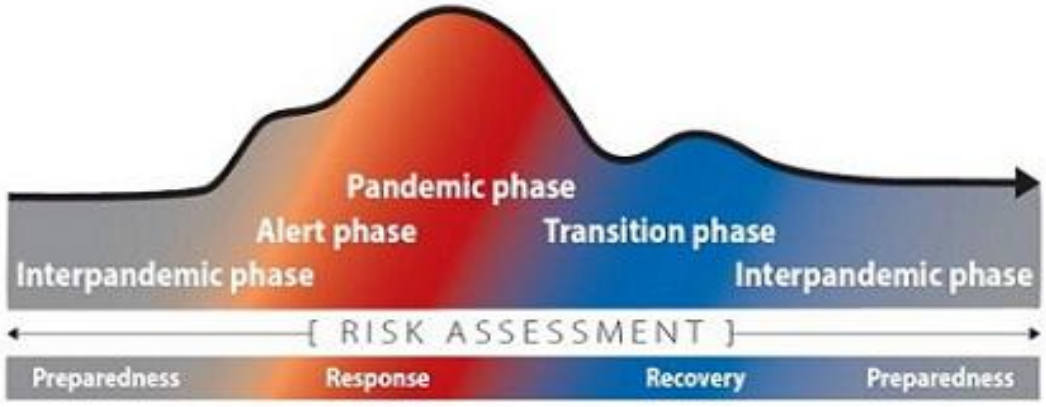
The grouping of Detection and Assessment stages into an 'initial response' phase, and the splitting of the Escalation stage into actions for Moderate impact and High impact pandemics, enables us to focus our planning and preparations.

8.4 WHO Pandemic Influenza Risk Management Continuum[4]

For background information purposes only, a brief description of the WHO Pandemic Influenza Risk Management Continuum is given below.

As pandemic viruses emerge, countries and regions face different risks at different times. For that reason, WHO advised countries to develop their own national risk assessments, based on local circumstances, but taking into consideration the information provided by the global assessments produced by WHO.

This risk-based approach to pandemic influenza phases is represented below as a continuum, which also shows the phases in the context of preparedness, response and recovery, as part of an all-hazards approach to emergency risk management.



Phases in the Continuum

The phases in the continuum shown above are defined in the table below:

Phase	Description
Interpandemic Phase	This is the period between influenza pandemics
Alert Phase	This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur
Pandemic Phase	This is the period of global spread of human influenza caused by a new subtype. Movement between the interpandemic, alert and pandemic phases may occur quickly or gradually as indicated by the global risk assessment, principally based on virological, epidemiological and clinical data
Transition Phase	As the assessed global risk reduces, de-escalation of global actions may occur, and reduction in response activities or movement towards recovery actions by countries may be appropriate, according to their own risk assessments

[4] Pandemic Influenza Risk Management - Interim Guidance (WHO 2013)

8.5 Public Health Emergency of International Concern (PHEIC)

A public health emergency of international concern (PHEIC) is defined as "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response" (WHO 2012). The responsibility for determining and declaring one rests with the WHO Director-General and would lead to the WHO issuing temporary recommendations.

9.0 Initial And Treatment "Dater" Phases - Triggers And Impacts

TRIGGERS \ STAGES	Detection & Assessment Stages Initial Response - Impact Unknown	Treatment Stage – Low Impact	Escalation Stage – Moderate Impact	Escalation Stage – High Impact
Nature & Scale of Illness	• Reports of sporadic influenza cases in the local community • Limited influenza local outbreaks in schools, care homes, prisons, etc. • Increased ratio of influenza cases in critical care	• Similar numbers to moderate or severe seasonal influenza outbreaks • In the vast majority of cases - mild to moderate clinical features	• Higher number of cases than large seasonal epidemic • Young healthy people and those in at-risk groups severely affected • More severe illness	• Widespread disease in the UK • Most age-groups affected • Severe, debilitating illness with or without severe or frequent complications
Healthcare Delivery Impacts	• None – business continuing as usual	• Primary and hospital services coping with increased pressures associated with respiratory illness, with maximum effort • No significant deferral of usual activities • Continued compliance with statistical reporting standards expected • Intensive care units (ICUs) nearing or at maximum pressure	• Health services no longer able to continue all activity • Local and regional decisions to cease some health care activity • Continued compliance with statistical reporting standards expected • ICUs under severe pressure	• GPs, community pharmacies, district nurses and social carers, independent sector, residential homes and voluntary organisations fully-stretched trying to support essential care in the community • Consequential pressure on secondary care • Hospitals can only provide emergency services • Demand outstripping Critical Care services supply even at maximum expansion
Key National Healthcare Response Actions	• Public Health England (PHE) response supported by primary care • Detection and diagnoses of early cases through testing and contact tracing • No activation of the 'National Pandemic Flu Service (NPFS) or Antiviral Collection Points (ACPs); local areas to start preparations to use NPFS and ACPs • Influenza information line may be activated • Continuation of Normal Health Services	• Influenza information line function active • ACPs established in hotspots only • NPFS active depending on pressures in primary care • Use of existing legislation to allow the supply of antiviral medicines at premises that are not a registered pharmacy	• Influenza information line function active • NPFS activated as required • Local areas establish ACPs as required • Contingency plans for supporting care at home and respite care	• Emphasis on maintaining supplies and staffing • Possible implementation of national legislative changes to facilitate changes in working practice (eg death certification, drivers' hours, sickness self-certification requirements, Mental Health Act, benefits payments)

10.0 LSW Actions By "Dater" Stage

DETECTION STAGE & THROUGH THE ASSESSMENT STAGE – Pandemic Impact Unknown		
No.	**Actions**	**Owner/ Responder**
1	Establish a Pandemic Management Group chaired by Director of Operations (or their nominated deputy) - each representative to have a named Deputy	Director of Operations
2	Initiate urgent review of: • Pandemic Influenza Plan • Corporate and Service-level Business Continuity Plans • Capacity Plan • any emerging information and guidance Report findings to Pandemic Management Group	Head of Corporate Risk and Compliance (EPRR Lead)
3	Review the use of infection control procedures and personal protective equipment (PPE) within services	Director of Infection Prevention and Control
4	Review stocks and distribution of personal protective equipment (PPE) across Organisation; include resources needed for non-clinical/ patient facing areas	Director of Infection Prevention and Control
5	Review policy on staff absence and distribute guidance to managers and staff side	Head of Human Resources
6	Executive Team to agree a budget for use by the Pandemic Management Group in preparing the organisation	Executive Team
7	Nominate LSW senior management representative(s) to attend local authority Influenza Pandemic Committees (IPC) with EPRR Lead	Director of Operations
8	Disseminate national advice on the clinical management of patients suffering from influenza like illness (when available)	Director of Operations
9	With Influenza Pandemic Committee partners, exercise pandemic response (if sufficient time available)	Pandemic Management Group
10	Communications Plan to be developed to disseminate: • key public health messages • infection prevention and control messages Based upon information from Public Health England (PHE), local Directors of Public Health (DsPH) and Infection Prevention and Control Lead	Head of Communications
11	If available and directed by national strategy/policy, arrange the provision of anti-viral medications to appropriate staff in consultation with staff Occupational Health and wellbeing	Head of Human Resources
12	Update staff contact details	Head of Human Resources
13	Clinical teams to identify 'at risk' service users	Locality Managers through Team / Service Leads
14	Liaise with Hotel Services regarding enhanced cleaning in line with Infection Prevention and Control policy chapter 24 - Pandemic Flu for: • In-patient wards • Out patient areas • MIU/APMS • Clinics • Offices	Director of Infection Prevention and Control
15	Liaise with contractors and suppliers to ensure that they have robust Pandemic Plans/ Business Continuity Plans in place	Head of Estates / Director of Operations / EPRR Lead
16	Undertake an assessment of critical clinical supplies stock levels; levels of stock held to be increased if necessary	Director of Operations
17	If required, support preparations to set up Anti-Viral collection points across LSW footprint	Pandemic Management Group
18	Increase awareness across all LSW staff of: • The signs, symptoms and epidemiology of pandemic influenza • Infection control measures (i.e. catch it, bin it, kill it) Using posters, intranet/intranet and LSW news	Director of Infection Prevention and Control & Head of Communications
19	Implement record keeping and surveillance measures for suspected	Head of Human Resources

	and confirmed cases, including staff. As required, report any cases, or suspected cases, of influenza-like illness to Public Health England/ Director of Public Health/ NHSE	Director of Infection Prevention and Control
20	Identify managers and administrative staff with clinical registration and arrange refresher training as required, to enable their clinical deployment if necessary Prepare list of recently retired staff/ volunteers who may be approached to assist the Organisation; review skills & training requirements	Head of Human Resources & Director of Professional Practice
21	Managers and Team Leaders across the Organisation to develop an understanding of their staffs personal/ domestic situation – in respect of school age children and other dependents – to enable impact assessments to be collated for events such as school closures Risks to key staff/ services to be flagged up to the Pandemic Management Group via line management	All Managers & Team Leaders
22	Adapt LSW's Pandemic Plan as information is received from Public Health England/ local Directors of Public Health	EPRR Lead and Pandemic Management Group

The actions outlined in the following stages are in addition to those listed above

TREATMENT STAGE – Low Impact Pandemic		
No.	**Actions**	**Owner/ Responder**
1	Review LSW's membership of pandemic related health and multi-agency groups - ensure appropriate representation from LSW while working with local and pan-Southwest partners to mitigate and minimise the pandemic's impact	Pandemic Management Group
2	Establish internal LSW situation reports- SITREPs for: • staff flu incidence • patient flu incidence • service operational status • essential supplies stock levels Submit SitRep information to NHSE as required	Pandemic Management Group and all service managers
3	Maintain central monitoring of staff flu, patients' flu, service delivery and essential supplies – take action upon identification of risks to service delivery	Pandemic Management Group
4	Services to implement Business Continuity Plans as necessary	Service Managers
5	Co-ordinate communication of Public Health messages with partners	Head of Communications
6	Arrange the distribution of personal protective equipment (PPE) from national stockpiles (eg face masks, FFP3 respirators) as well as locally procured (eg sprays/ gels) across all areas of the LSW	Pandemic Management Group supported by Director of Infection Prevention and Control
7	Liaise with Commissioners regards potential additional service requirements, e.g. • anti-viral distribution points • vaccination centres • changes to admission/discharge arrangements with Acute Organisations	Director of Operations & Director of Finance
8	If required, set-up and manage Anti-viral Collection Points (see Appendix A for guidance) and, if required, make preparations for vaccination of the local population in partnership with GPs	Pandemic Management Group
9	Maintain contact with contractors/ key suppliers to monitor pandemic impact upon their service and horizon scan for problems	Director of Finance
10	Identify all staff qualified to undertake vaccinations and arrange any additional training required as specified by DH	Head of Health and Wellbeing

11	Implement any Pandemic Influenza training as required (i.e. FFP3 Mask Fitting, Infection Control)	Director of Infection Prevention and Control
12	Clinical management to agree co-ordination of flu-related care for patients in the community with Social Care partners/colleagues	Director of Operations
13	Work with Plymouth Hospitals NHS Trust (PHNT) to Integrate the Urgent Care Centre into their pandemic response	Locality Manager for Urgent Care
14	In line with any national advice, provide LSW/PHNT staff with guidance on how to deal with patients with influenza like illness This may require the production of protocols for staff, briefings on PH advice and notices for patients	EPRR Lead and Head of Communications
15	Initiate regular staff updates on: • The pandemic's impact and how this is affecting LSW • LSW's actions and the reasons for them • Actions staff can take to help protect LSW, their colleagues, their patients, visitors and themselves • What psycho-social support is available to them and how to access it	Head of Communications Lead & Pandemic Management Group
16	Convene recovery team to oversee return to business as usual	Pandemic Management Group

ESCALATION STAGE - Moderate Impact Pandemic		
Implement the Treatment Stage actions then supplement them with the actions below		
1	Pandemic Management Group to consider activation of the Major Incident Plan to coordinate: • prioritisation of service delivery • deployment of staff to meet service prioritisation needs	Pandemic Management Group
2	If Major Incident Plan activated, issues to consider are: • redeployment of staff/ resources to support essential functions/ services • use of agency staff to support service delivery	Major Incident Response Team
3	Consider implications of any changes in the duties of staff and provide advice to staff and management across the organisation	Head of Human Resources
4	Communications Team to communicate to patients/ the public the impact of Major Incident Response upon normal service delivery	Head of Communications
5	Director of Operations & Director of Finance to discuss with commissioners/ keep commissioners informed of business continuity actions and any service delivery pressures/ restrictions	Director of Operations and Director of Finance
6	Deploy staff resources to meet Influenza Pandemic Committee agreed programmes of work as required – Major Incident Response Team to support these decisions through the deployment of staff	Pandemic Management Group & Major Incident Response Team
7	Pandemic Management Group to consider use of retired staff/ volunteers If decision made to use them, HR to contact recently retired staff/ volunteers to request their assistance in meeting service delivery priorities	Pandemic Management Group & Head of Human Resources
8	Retirees and Volunteers to be provided with the necessary training to enable them to practice/ assist effectively and lawfully and support to re-register if registration has lapsed.	Head of Human Resources & Director of Professional Practice
9	Clinical teams to monitor 'at risk' patients and ensure support provided or signposted as necessary in line with Public Health England/ local Public Health messages and direction	Locality Managers
10	Work with Acute Providers on discharge planning for peak weeks	Locality Manager for Urgent Care
11	Suspend routine training and limit meetings across the organisation to reduce pressures upon staff and management	Pandemic Management Group supported by Chief Executive

	Implement teleconferences in place of necessary meetings if practical	
12	Incorporate PPE stock monitoring process into the internal service SITREP process	Pandemic Management Group & Director of Infection Prevention and Control
13	Consider staff welfare and attendance issues, identifying solutions for implementation by Pandemic Management Group	Human Resources & Pandemic Management Group
14	Consider whether the LSW Incident Control Centre (ICC) should be activated If decision taken to do so, rotas for each role to be established	Pandemic Management Group
15	Keep staff informed with regular updates and ensure key messages are included in local communication bulletins issued by local Influenza Pandemic Committees	Head of Communications
16	Discuss with suppliers, methods of reducing the impact upon the organisation should they suffer business continuity issues – e.g. increased quantity of supplies in deliveries (where practical) to reduce the frequency deliveries required	Head of Estates and Director of Finance
17	Consider actions that LSW could implement to enable staff with child care responsibilities to attend work in the event of school closures	Pandemic Management Group

ESCALATION STAGE - High Impact Pandemic		
Implement the 'Treatment Stage' and 'Escalation Stage - Moderate Impact Pandemic' actions then supplement them with the actions below		
1	Consider suspending non-essential services across all clinical services, diverting all available resources to supporting LSW and local health partners in meeting the community's needs If implementing this, discuss with commissioners	Pandemic Management Group and Executive Team
2	Consider using non-operations clinically trained staff to support service delivery	Pandemic Management Group & Head of HR
3	Review policy on visitors to LSW Wards/clinical areas during peak weeks	Locality Managers
4	Provide Executive Team with daily SITREP updates on LSW status	Pandemic Management Group
5	Implement any reduced service policies agreed with suppliers and subcontractors	Pandemic Management Group & Director of Finance
6	Determine level of care to be provided in the community for service users in relation to staffing and resource availability - co-ordinate patient visits across all localities	Director of Operations

11.0 Pandemic Management Group

11.1 The LSW Pandemic Management Group will co-ordinate the organisations pandemic response under the leadership of the Director of Operations.

11.2 A suggested membership of the team is:

- Director of Operations
- Locality Managers / Deputies (representation across all localities)
- Director of Professional Practice Safety and Quality
- Director of Infection Prevention and Control
- Head of Corporate Risk and Compliance (EPRR Lead)
- Chief Pharmacist
- Head of Communications
- Head of Human Resources

- Head of Health Improvement
- Head of Estates
- Director / Deputy Director of Finance
- Admin Support (Minutes)

If the Major Incident Response Team has been activated, a representative should also attend the meetings.

11.3 Each member of the group should nominate a deputy who shall attend in their place should they be unavailable; all deputies must be kept informed by their principal and be able to replace them in managing the response should the need arise.

11.4 As the pandemic related workload of group members is likely to be high, consideration should be given to how their business-as-usual workload will be met; this may require:
- delegation of work within their team(s)
- agreeing to temporarily stop areas of work
- funding a temporary promotion post to deputise for areas of work

11.5 The Terms of Reference for the Pandemic Management Group are:
- to lead LSW's response to the pandemic;
- to develop and implement a plan to prepare the organisation and to receive updates on progress;
- to monitor the impact of the pandemic upon LSW's operations;
- to take action to maintain the organisations essential services (activating business continuity plans as necessary);
- to ensure staff are kept fully informed of how LSW is responding to the pandemic;
- to ensure that LSW is fully engaged in local Influenza Pandemic Committees
- to provide SITREPs to commissioners/ NHSE as required;
- to ensure that the costs involved in preparing for and responding to the pandemic are established and a budget allocated;
- to maintain a record of all decisions taken, reasons for those decisions and detail progress made.

12.0 Influenza Pandemic Committee (Response)

12.1 During the pre-pandemic period, the Local Resilience Forum (Devon, Cornwall and IOS) have the responsibility of ensuring that a multi-agency approach to pandemics is planned for. Under the revised NHS structures, there is no longer a nominated NHS lead within each locality and the local responsibility has defaulted to individual providers and the resilience fora.

12.2 The influenza Pandemic Committee (Response) will be chaired by the local Directors of Public Health. The IPC(R) will co-ordinate an integrated multi-agency response to the pandemic across the CCG area.

12.3 The IPC(R) membership will include all health and social care providers within the locality, a representative from the local Public Health England team, the local authority, representatives from the emergency services and the voluntary sector.

12.4 The Pandemic Management Group will nominate suitable Clinical Management representatives to attend each area's IPC(R) with the EPRR Lead.

13.0 Infection Prevention And Control

13.1 LSW Infection Prevention and Control Policy, Chapter 24 Pandemic Flu, provides guidance for the processes and protocols that should be followed to minimise the transmission of the virus and for the management of those staff and patients who have contracted it.
This covers:

- General working
- Infection Control
- Personal Protective Equipment (PPE)
- Cleaning
- Patient management
- Home Visits
- Inpatients Unit specific guidance
- Hand Hygiene

13.2 LSW Director of Infection Prevention and Control will advise the Pandemic Management Group and clinicians on the management of infection control through-out the pandemic.

13.3 The Pandemic Management Group should identify the elements of additional expenditure required to maintain proper infection prevention and control procedures through-out the pandemic. The Executive Team should then allocate an appropriate level of funds to pay for this; the level of funds available should be regularly reviewed through-out the duration of the pandemic and adjusted as necessary.

14.0 Business Continuity

14.1 A significant part of the LSW response to a pandemic will revolve around the maintenance of service delivery; consequently, should the pandemic have an impact upon the staffing, LSW will use its' Corporate and service level Business Continuity Plans to ensure the delivery of essential services.

14.2 Many service's business continuity plans have a role for agency staff in meeting their essential services in times of staff shortages; these costs should be monitored by Directors of Operations and Finance.

14.3 LSW depends upon its suppliers and contractors to enable it to deliver its services. To ensure that they will be able to maintain their services through-out the pandemic, the LSW will require assurance (evidence in the form of effective business continuity plans) from its suppliers and contractors that they have plans in place to ensure the maintenance of their services to LSW.

15.0 Recently Retired Staff and Volunteers

15.1 Should staffing levels be significantly impacted by the pandemic, consideration should be given to the use of recently retired staff and/ or volunteers.

15.2 Head of Human Resources should identify any recently retired staff that may be able to fulfil a required role. Work should be undertaken to establish possible duties and the training required to ensure compliance with legal and professional requirements.

15.3 Where volunteers are to be utilised, the roles that they will undertake should be clearly specified. The LSW volunteer co-ordinator will manage their use within the organisation. This coordinator is responsible for ensuring that volunteer availability and LSW need are matched. Head of Human Resources should ensure that any legal requirements/ background checks are met before volunteers are deployed in support of the organisations operations.

16.0 Anti-Viral Medicines

16.1 During the initial stages of a pandemic, anti-viral medicines may be used for the prevention of pandemic influenza (prophylaxis), as a way of limiting the spread of disease from person to person, as well as for treating suspected and /or confirmed cases.

16.2 When used to treat influenza, anti-viral medicines such as oseltamivir (Tamiflu™) and zanamivir (Relenza™) can reduce the length of symptoms and, usually, their severity. Evidence suggests that when anti-virals are taken within 48 hours of the onset of symptoms, the total duration of illness is reduced by around half to one full day; the greatest benefit is derived when the medication is taken within 12 hours of the onset of symptoms.

16.3 As a vaccine is unlikely to be available for some time, more wide-spread deployment of anti-viral medicines may be recommended by Public Health England, to help reduce pressure on health services. Should this decision be taken nationally, the organisation may be asked to support the distribution of anti-viral medications through setting up Anti-viral Collection Points (ACP).

17.0 Anti-Viral Collection Points (ACP)

17.1 Should the government decide to deploy anti-viral medicines during the initial response phase, LSW will work with the Local Authority (Office of the department of Public Health-ODPH)/ NHSE to establish Anti-viral Collection Points (ACPs) as necessary.

17.2 The purpose of an ACP is to:

- to enable symptomatic patients to remain at home but still gain access to anti-virals;
- to help prevent people burdening hospitals and GPs unnecessarily during a pandemic (standard cases will be directed to the Flu Line and then to collection points);
- to enable GPs and other healthcare staff to access anti-virals for people with no access to the Flu Line (where appropriate).

17.3 The locations of ACPs may be different depending upon the impact of the pandemic. During the Swine Flu pandemic in 2009 - a low impact pandemic - community pharmacies were used for this purpose; however in the event of a moderate or high impact pandemic, this may not be sufficient and other, larger, more centralised, collection points may be required as well.

17.4 Should such larger ACPs be required, an outline of the requirements is set out in Appendices A and G.

18.0 Vaccination

18.1 Preparations for vaccinating the population in the local area, and patient facing healthcare staff, should begin early in the pandemic response. As vaccines will initially only be available in limited amounts[5], the priorities will be to get patients within the high risk groups and patient/public facing staff vaccinated first.

18.1.1 Staff

Once a vaccination has been developed for the pandemic strain and is available, occupational health and wellbeing (OH&WB) in partnership with LSW Health Improvement Team, will arrange a vaccination programme for all patient/public facing and on-call staff.

18.1.2 Patients

The identification of patients within the high risk groups will be undertaken by GPs, medical staffing and clinicians. If assistance is requested by GPs, LSW District Nursing lead should negotiate and agree the level of service to be undertaken in vaccinating patients in the community.

Vaccination of people receiving inpatient services within LSW may be undertaken by either GPs or appropriately trained Nursing staff.

18.1.3 General Population

As sufficient vaccines become available to vaccinate the population, a vaccination programme should be established in partnership with GPs and Public Health. Working with these partners, centres for vaccination should be established and staff provided to carry out the inoculations.

18.2 Lessons Learned from Swine Flu Pandemic - Vaccination

Successful initiatives included:

- training additional staff to administer vaccine to their colleagues in support of Occupational Health departments (e.g. ward nurses);
- using private providers to inoculate staff;
- local leadership to promote vaccination by having the vaccine on first day available;
- using roving clinics to take the vaccine to staff;

[5] It is expected that initial supplies of vaccine will not be available until after the first pandemic wave; it may be 4 to 6 months before a population-wide vaccination campaign can commence

- engaging with staff side to support the campaign and promote its importance
- holding clinics outside normal hours.

19.0 Outbreak Teams

19.1 During the Assessment and Treatment phases of the pandemic, Public Health England (PHE) may ask LSW to support them in their management of an outbreak in a school or other environment; they may request the support of nursing staff. PHE or NHSE will contact LSW should this assistance be needed.

20.0 Cross-Border Issues

20.1 The need for close co-operation and communication with our partners in NEW Devon CCG and across the county borders is fundamental to the success of the plan. Areas to be discussed with partners include:

- patients living the beyond the LSW footprint but receiving services from the organisation;
- schools with catchment areas that cross the borders of our operational area requiring the support of a School Outbreak Team led by Public Health England;
- ensuring that LSW plans are in line with neighbouring Organisation's and providers, PHNT, Devon and Cornwall.

21.0 Severely ill And Dying Patients In The Community

21.1 During a Moderate or Severe pandemic, there may be a high incidence of patients becoming severely ill and requiring hospital treatment. In the event that hospital services become overwhelmed, then LSW may (if appropriate) need to support these patients in the community until acute care space becomes available, the patient recovers, or they die.

21.2 The organisation will need to work closely with other health and social care providers to manage the care of these severely ill and dying patients.

21.3 The Major Incident Plan may need to be activated to enable staff deployment to be managed on a 'organisational wide' basis in support of these patients.

21.4 Should deaths occur amongst patients on any LSW inpatient Wards during the pandemic, the normal process should be followed. Local undertakers work closely with Local Authorities to plan for excess deaths and the storage of bodies.

22.0 Recovery Phase

22.1 Once the impact and demands of the pandemic recede, LSW should start the recovery process to return to normal operating as soon as possible. This may need to be done both internally and for the community with multi-agency partners. The community recovery will be led by the Local Authority who will establish a multi-agency recovery group.

22.2 The Pandemic Management Group should start considering and implementing recovery actions as soon as the impact and demand has begun to recede. Should

it be thought necessary, a separate Recovery Group may be established to manage the organisations recovery to normal operations (see section 30 of the Major Incident Plan).

22.3 A pandemic may occur in more than one wave, therefore it is important as part of recovery to ensure readiness for a future wave of cases; this could manifest as increased winter pressures.

22.4 The recovery should cover the following areas:

Recovery Planning Process
Understanding Losses and Impacts
Undertake gap analyses for • Staffing - numbers and core skills available v's needed • Service delivery - current levels of delivery v's commissioned levels • Resources - current v's required (e.g. clinical consumables, equipment etc.)
Undertake an impact assessment based upon the gaps identified
Identify staff affected by: • illness • bereavement • stress/ anxiety/ fear
Assess (with partners) the impact upon community health
Assess the impact upon performance and financial targets
Assess the impacts upon budgets across the organisation
Impact Management
Staffing: • co-ordinate redeployment of staff/ recruitment of staff to fill gaps identified in numbers/ core skills • arrange staff training where appropriate to fill skill gaps • ensure sufficient availability of and access to Occupational Health/ counselling services for all staff that need it; publicise it widely • ensure service managers/ team leaders provide what support that can be provided to staff in their teams • ensure support for line managers is put in place
Resources: • replenish stock of clinical supplies • identify premises/ areas within premises requiring deep-cleaning/ decontamination • undertake routine/ required maintenance of equipment and replace as necessary • plan the return of facilities used for pandemic response to normal use

Service delivery:
• establish a prioritised list of services/ functions to be recovered – the priorities listed in Business Continuity Plans may form the basis of this
• re-establish core functions first then work outwards to peripheral functions
• service managers/ team leaders to draw up plans for re-establishing functions within their services/ teams in line with the prioritised list:
  ○ manage flow of patients
  ○ review appointments/ waiting lists for services – establish priorities
  ○ manage the backlog
• ensure resources are managed across services towards re-establishment of the priority functions
• Group Managers to provide regular updates to the Pandemic Management Group on progress against plan

Community Health: • participate in multi-agency recovery group led by Local Authority (if established)

• agree joint priorities and develop action plans to meet required outcomes • integrate requirements of multi-agency community recovery with internal service delivery recovery planning • deploy staff and resources to undertake agreed actions
Management and Finance: • ensure rigorous financial controls are/ remain in place • negotiate reduction in targets/ performance indicators for current business year with commissioners • assess expenditure required based upon revised targets/ performance • identify income streams to meet anticipated expenditure • identify any shortfall between income and expenditure due to pandemic response • identify actions to be taken to remedy any shortfalls in finance
Identification of Opportunities
Collate lessons learned from debriefs
Consideration to be given to the possibility of improving upon what was in place previously. Service/ senior managers to consider: • procedures • processes • resilience • redundancy • cost effectiveness • value for money

23.0 Supporting Information[6]

23.1 Pandemic Influenza

An influenza pandemic occurs when a novel influenza virus emerges against which the human population has little or no immunity; global spread is thus considered inevitable. A future pandemic could occur at any time. Intervals between the recent pandemics have varied from 10 to 40 years with no recognisable pattern.

A future pandemic could originate anywhere in the world although South East Asia, the Middle East and Africa are widely considered to be the most likely potential sources. The virus could rapidly reach the UK and it could then take only one to two weeks until sporadic cases and small clusters acting as initiators of local epidemics are occurring across the whole country. The 2009/10 pandemic proved that the virus could reach the UK more rapidly than this, but internal spread could be slower. The measures put in place by regions where the first cases were reported, meant that spread across the UK to major population centres was slower than this (see later).

As most people will have no immunity to the pandemic virus, infection and illness rates may be higher than during seasonal influenza epidemics. Modelling based on previous pandemics indicates that a substantial percentage of the world's population could require some form of medical care during a pandemic. Influenza poses a serious danger for high-risk groups (such as the very young, the elderly and the chronically ill and some disabled people). However, in previous pandemics hospitalisation and deaths have also occurred in healthy younger people.

[6] Local Resilience Pandemic Influenza Response Plan: Influenza Pandemic Framework Version 12.3 – Mar 14

The clinical attack rate of the illness will only become evident as person-to-person transmission develops, but response plans should recognise the possibility of up to 50% in a single wave pandemic. Up to 4% of those who are symptomatic may require hospital admission if sufficient capacity were to be available.

Without intervention, and with no significant immunity in the population, historical evidence suggests that one person infects about 1.4 to 1.8 people on average. This number is likely to be higher in closed communities such as prisons, residential homes or boarding schools.

All ages are likely to be affected but children and otherwise fit adults could be at relatively greater risk as older people may have some residual immunity from possible previous exposure to a similar virus earlier in their lifetime.

Although the potential for age-specific differences in the clinical attack rate should be noted, they are impossible to predict, and a uniform attack rate across all age groups is assumed for planning purposes. More severe illness than seen with seasonal influenza is possible in all population groups, rather than predominantly in high risk groups as with seasonal influenza. A higher number of people than usual may develop severe prostration and/or rapidly fatal viraemia, viral pneumonia or secondary complications. It is not possible to predict these numbers in advance.

Past pandemics have varied in scale, severity and consequence, although in general their impact has been much greater than that of even the most severe winter 'epidemic'. Although little information is available on earlier pandemics, the three that occurred in the 20th century are well documented. The worst (often referred to as 'Spanish flu') occurred in 1918/19. It caused serious illness, an estimated 20–40 million deaths worldwide (with peak mortality rates in people aged 20–45) and major disruption. Whilst the pandemics in 1957 and 1968 (often referred to as Asian and Hong Kong flu respectively) were much less severe, they also caused significant illness levels and an estimated 1–4 million deaths between them. The 2009/10 pandemic is reported to have caused around 19,500 confirmed deaths globally, however there is no published estimate of the overall number of cases.

In addition to their potential to cause serious harm to human health, pandemics threaten wider social and economic damage and disruption. Social disruption may be greatest when rates of absenteeism impair essential services.

A pandemic may occur over one or more waves of around 15 weeks, each some weeks or months apart of which the second or a subsequent wave could be more severe than the first. Previous pandemics have had up to three waves that occurred over two years; the 2009/10 pandemic had two waves in the UK before the virus became one of the circulating seasonal viruses.

23.2 Avian Influenza

Avian influenza ('bird flu') is an infectious disease of birds caused by influenza A viruses. It is spread between birds (and occasionally to humans) mainly through contact with contaminated faeces but also via respiratory secretions or contaminated blood. Although they do not readily infect species other than birds

and pigs, scientists believe that human-adapted avian viruses were the most likely origin of at least two of the last four human influenza pandemics.

The highly pathogenic avian influenza A/H5N1 virus has caused concern for over a decade, due to its highly contagious nature amongst domestic poultry species. Whilst the virus has also infected humans, such infections have only been detected in a small proportion of those who have been exposed to infected birds. To date, there has only been limited evidence of person-to-person transmission and, even where that has occurred; it has been with difficulty and has not been sustained.

A growing reservoir of infection in birds (for example the virus is recognised as being endemic in Egypt, India, Bangladesh, Vietnam, China, and Indonesia), combined with transmission to more people over time, increases the opportunities for the A/H5N1 virus either to adapt to give it greater affinity to humans or to exchange genes with a human influenza virus to produce a completely novel virus capable of spreading easily between people and causing a pandemic. However, the likelihood and time span required for such mutations are not possible to predict.

Experts agree that A/H5N1 is not necessarily the most likely virus to develop pandemic potential. However, due to the potential severity of a pandemic originating from an A/H5N1 virus, this possibility cannot be discounted and the virus remains a key concern.

23.3 Influenza A/H1N1v (Swine Influenza)

The world first became aware of cases caused by a novel influenza virus, influenza A/H1N1v, at the end of April 2009. The World Health Organisation (WHO) raised the global pandemic alert level from WHO Phase 3 to WHO Phase 5 over five days in late April 2009. Phase 6 was declared by WHO on 11 June 2009 and signalled the start of the first pandemic of the 21st century.

The first UK cases were reported in Scotland on 27 April 2009, the first London case on 30 April 2009 and the first Plymouth case on 12th June 2009. Initially the pandemic was managed through containment measures such as treating cases and some school closures. As case numbers increased, this was followed by outbreak management (limited prophylaxis and contact tracing) before the UK entered the treatment phase (no prophylaxis or contact tracing).

Most people who contracted the swine flu virus were mildly affected and were treated with antivirals, over the counter medicines, bed rest and fluids. However some cases were more serious and required acute hospital care.

The majority of swine flu cases were in younger age groups than those usually affected by seasonal flu. Pregnant women and morbidly obese people were unanticipated risk groups. A number of cases and deaths were of people with no previously identified underlying condition.

The 2010/11 winter season in the UK was dominated by the A/H1N1v virus as part of the range of influenza viruses circulating that winter. It is likely to continue to circulate and cause seasonal outbreaks until replaced by another dominant strain.

23.4 Public Gatherings

Large public gatherings or crowded events where people may be in close proximity are an important indicator of 'normality' and can help maintain public morale during a pandemic. Whilst close contact with others – especially in a crowded confined space – accelerates the spread of an influenza virus, there is little direct evidence of the benefits or effects of cancelling such gatherings or events. Individuals may benefit from reduced exposure by not attending such events, but there would be very little benefit to the overall community. Reduction in travel to such events may also reduce spread, although the benefits of even major reductions in all travel are small.

23.5 School closures

Influenza transmits readily wherever people are in close contact and is likely to spread particularly rapidly in schools. As children are particularly unlikely to have any residual immunity, they could be amongst the groups worst affected and can be 'super spreaders'.

The Government will take decisions on whether or not to advise closures on the basis of an assessment of the emerging characteristics and impact as the pandemic develops. The trigger for advice to close would be confirmation of initial cases in the area. The decision to close schools would have an impact on not only the education of children, but also services and businesses dependent on working parents.

Once the Government has issued advice, Local Authorities are responsible for communicating this advice to school Head teachers. The final decision rests with schools and child care providers as to whether or not to close the school. Local Authorities have a legal duty to provide education "at school or otherwise" for children who for any reason may not for any period receive suitable education unless such arrangements are made for them. Therefore, while it might not be possible to provide the usual full service, Local Authorities must provide a reasonable level of education for all children in their area if pupils are unable to attend school due to closure.

Once the pandemic virus is spreading freely in the community there is little public health benefit of closing schools, and they would only be advised to do so for operational reasons (e.g. insufficient teaching staff).

Guidance has been provided by the Departments for Children, Schools and Families for schools and providers of childcare services advising them of operating procedures during a pandemic.

24.0 Monitoring Compliance

The Deputy Head of Health Improvement and Head of Corporate Risk and Compliance will monitor this policy and review bi-annually or if a major change to LSW services occurs;

The LSW Board will also receive a report at least once a year on Emergency Preparedness Response and resilience as required by the Department of Health Emergency Planning Guidelines 2005[7].

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

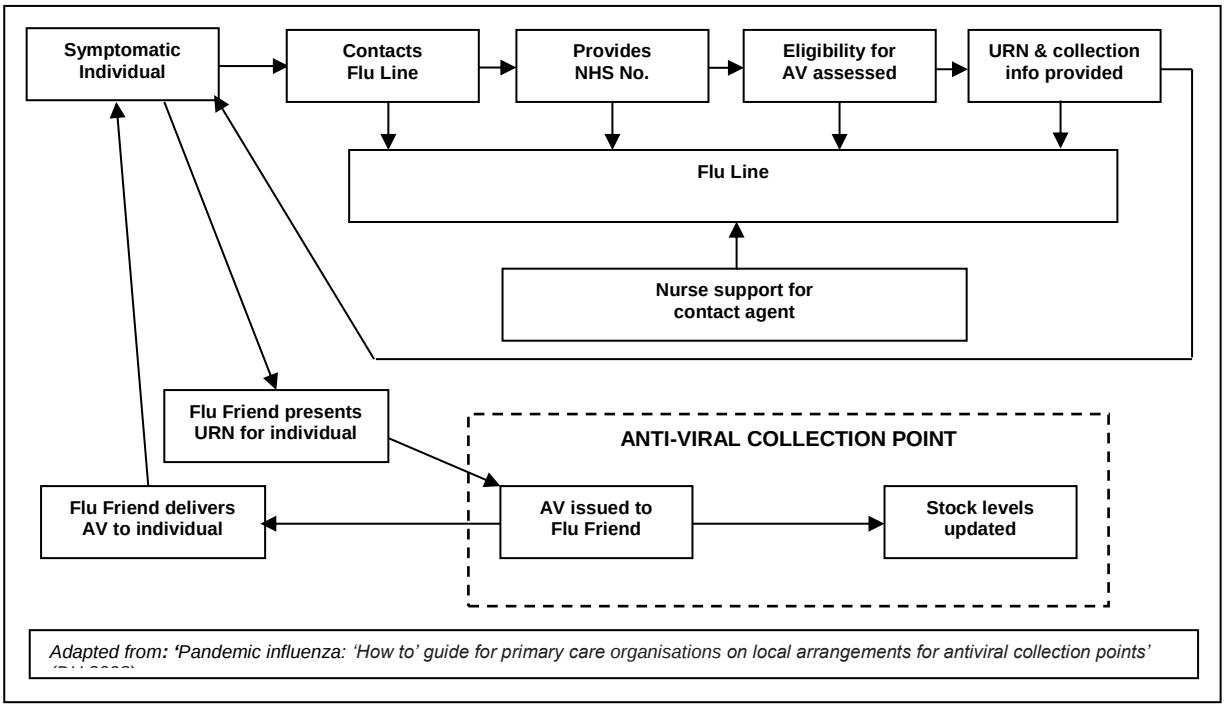
Signed: Director of Operations

Date: 11th December 2015

[7] **NHS emergency planning guidance 2005**

ANTIVIRAL COLLECTION POINTS **Appendix A**

How the Anti-Viral Distribution Process will Operate during a Pandemic



A1. The above diagram illustrates how the distribution of anti-viral medications was managed during the Swine Flu pandemic of 2009/10. During Swine Flu, Primary Care Organisations (PCT) were responsible for establishing Anti-viral Collection Points (ACPs). As the pandemic was a mild one, they utilised community pharmacies. With the demise of PCTs, the burden of establishing and staffing larger ACPs is likely fall upon community providers.

A2. Should the Organisation be asked to establish ACPs, it is likely that the process for individuals will be the same as it was for Swine Flu, i.e. as in the above diagram.

A3. To set up an ACP, use the information below to ensure that all necessary areas are covered.

NOTE: this information is to provide a framework upon which to base ACP planning, it is likely that DH will issue further guidance to support Organisations in the event of a pandemic.

The Purpose of Antiviral Collection Points (ACPs)

A4. The purpose of ACPs is to enable a symptomatic person's 'flu friend' to collect anti-viral medication for them.

A4. There will also be a requirement to provide clinicians with access to anti-viral medications for patients that they are providing care for in the community. It is recommended that this ACP be separate from the public collection points.

The Flu Line

A6. The Flu Line is a nationally operated service that will offer self-service assessment, care advice and antiviral authorisation during a flu pandemic. The service will be available by web, automated telephony or through call centres.

A7. To maximise accessibility the Flu Line will be available across the UK and will be contactable 24 hours a day, 7 days a week.

A8. In providing an assessment and antiviral authorisation service the Flu Line will be focused on all routine cases of pandemic flu and in doing so will enable frontline NHS staff to concentrate on those with the greatest needs.

Possible Anti-viral Collection Point Locations[8]

A9. Possible options for the Organisation to use as collection points could include one, some or a mixture of:

- Health Centres or clinics
- non-healthcare secure facilities such as libraries, community halls and leisure centres
- partner agency facilities
- retail sites
- private healthcare facilities

A10. Any facility outside the Organisation's control would require the support of our IPC partners, in particular Local Authorities.

Basic Requirements for an ACP[1]

Category	Requirement
Technical	Computers (PCs)
	Internet connection (current supported Internet Explorer version) – where an N3 connection is available it should be used
	Telephones
	Fax
	Printer
	Access to local IT support. E.g. for password resets
Physical (including storage and security)	Lockable building
	Lockable storage area to prevent unauthorised people accessing anti-virals
	Space to accommodate demand for ~1,600* transactions per 100,000 population, per day pro rata
	Ability to store cases of antiviral
	Space for queues in times of high demand
	Ability to receive a delivery from a 17.5 tonne lorry
Location	Location not on a red route
	Accessibility by public transport where possible
Resources	Availability of appropriately trained staff for roles listed below
Communication	Appropriate signage to ensure ease of access to collection points – design to be provided centrally at time of ACP requirement

Collection Point Functions[1]

A11. Collection points will vary in size and location depending on the local population to be served. However, all collection points will have 5 key functions:

[8] Pandemic influenza: 'How to' guide for primary care organisations on local arrangements for antiviral collection points (Draft – not published)

- verifying patient URNs and checking them against the collection point issuing system
- issuing anti-virals to flu friends and confirming their identity
- issuing information leaflets to flu friends
- receiving and securely storing supplies of anti-virals
- signing off deliveries of supplies

Staff Resource

A12. A fundamental principle is that there must be enough staff issuing the anti-virals to be able to meet demand, i.e. to ensure that flu friends do not have to wait for an unreasonable amount of time (e.g. no longer than 15 minutes) and that lengthy queues do not develop.

Roles

A13. There will be a need in larger ACPs to have the following roles:

- Meeter and Greeter
- Queue Manager
- Issuer
- Security Manager
- ACP Manager

Action Cards for these roles are attached at Appendices B to F.

Staff Type

A14. The staff issuing anti-viral medications need not be clinicians or pharmacists. Competent administrative staff should be able to undertake the work involved in the distribution of medication.

Staff Numbers

A15. The following calculation may be used to assess the numbers required to staff collection points. This assessment of time per distribution and that of effective hours of work operates on the assumption that no-one is 100% effective during the working day:

Time estimate per anti-viral distribution*****	7½ min
Effective hours of work during 7½ hour working day (80% effective)	6 hours
No. of distributions per issuer per 7½ hour working day	48

*** This time includes the provision of information as well as the anti-viral medication**

A16. The above calculation may be used to calculate how many staff/ collection points are required to meet the distribution needs of the local community.

A17. A further consideration should be to provide sufficient staffing to cope with staff sickness within the ACP to a level equivalent to the levels of sickness in the local community.

Collection Point Process

A18. When a flu friend presents a URN, the member of staff should:

1. enter the URN into the computer system
2. validate the URN and the patient's details using the system

If the system confirms the details, they should:

3. collect the anti-viral medication from the locked storage unit
4. take the flu friend's details
5. check a form of identification (e.g. utility bill, passport or driving licence)
6. give the anti-virals with an information leaflet to the flu friend
7. confirm on the system that the anti-virals have been collected

Staff will not be required to provide clinical advice to flu friends collecting anti-virals.

A19. Members of the public who go to collection points to request advice should be provided with the Flu Line information number.

ACP IT System

A20. Access to the online IT system to be used by ACPs will be provided when a pandemic hits. Full instructions on its use will be provided at that time.

Security

A21. In the event of a pandemic, the public could become anxious and collection points may be visited both by the 'worried well' and symptomatic patients, in addition to flu friends. To manage this situation, it is recommended that additional staff are provided to:

- check that people have a URN when entering collection points
- manage queues and demand
- safeguard staff and anti-virals

Queuing systems

A22. As a pandemic moves towards its peak, ACPs should expect increased demand at collection points. To manage this demand, the ACP Manager should put in place a queuing system. This system should be efficient enough to ensure that the service remains acceptable to customers and to minimise stress to staff. The ACP should have sufficient space to accommodate possible queues.

Stock Management

A23. A robust system for the ordering, storage and monitoring of anti-viral medication will need to be put in place at each ACP.

A24. It will be the responsibility of the ACP Manager to ensure that these systems are in place.

A25. The processes to be used to order and re-order anti-viral medications will be provided by the DH once the decision to distribute them has been taken.

ACP MANAGER - ACTION CARD

Key responsibilities and accountabilities:

- Mobilise and manage the ACP (physical premises, procedures and staff) in order to deliver antiviral treatment to the public
- Provide guidance, support and leadership to ACP staff
- Direct and control the anti-viral stockpile supply to ensure fulfilment of local demand
- Ensure that the ACP building meets safety and security requirements
- Co-ordinate communications and reporting to all relevant stakeholders (messages to flu friends on site, Pandemic Management Group, local authorities)
- Liaise with the pharmacist who has oversight of the arrangements

Key tasks and activities:

1. Mobilisation

- Mobilise the ACP. Refer to Key Requirements checklist - Appendix G of Pandemic Plan
- Ensure all action cards and templates are received and ready for use
- Ensure the clinical algorithm is on site and ready for use by assessors
- Ensure staff are identified and trained accordingly before operation of the ACP

2. Facilities and operations

- Ensure that the building remains operational and that entry and exit points are clearly signposted (using signage design provided by NHS England/ Public Health England) and clear of obstruction
- Ensure that there is an adequate stock of stationery, cleaning equipment, etc
- Ensure facilities are clean and tidy, employing cleaning staff as necessary
- Ensure the ACP provides a professional health care environment and has adequate cleaning arrangements

3. Stock management

- Liaise with Stock controller to ensure storage and supply issues are managed
- Check deliveries to the ACP on receipt to ensure everything expected has arrived
- Ensure that stocks and supplies are stored appropriately and securely
- Set a threshold at which to request a re-supply, and monitor stock levels accordingly
- Consider delivery lead times when making requests for supply or re-supply

4. Staff

- Ensure staff register is maintained, attendance is recorded on sign-in sheet and staff availability forecast for the next three days
- Ensure that a list of assessors and issuers is maintained on a daily basis
- Create and manage staff rota
- Ensure sufficient staff are available
- Ensure new staff are trained and given information packs (including action cards)
- Hold daily briefing meeting to update staff of any changes to policy and procedure
- Organise staff to ensure security and queue management are in place if required

5. Security and safety

- Carry out an initial risk assessment of the site to identify hazards and implement any measures required to reduce risk
- Liaise with the Organisation's Local Security Management Specialist and Fire Officer for advice on security arrangements and fire marshalling/exits and crowd control issues
- Check that security arrangements are in place and working every day (personnel, alarm systems, lockable storage for stockpile, CCTV where available)
- Ensure staff are in place to manage queues and conflicts or aggressive behaviour, providing support as and when required
- Ensure all staff are aware of fire exits, are signed in and know the fire marshalling point for the treatment centre they are working in
- Notify the Manager on-Call and LSMS immediately of any security breaches and incidents including harm to any member of ACP staff or any individuals acting suspiciously
- Ensure compliance with standard Organisation health & safety policy and procedures and that all efforts are taken to provide a safe environment for staff and attendees at the ACP
- Assess and mitigate the risk to staff from cross-infection
- Ensure staff have adequate breaks throughout their shift

6. Communications

- Notify the Manager on-Call of any emergencies or issues (e.g. staff requirements, problems with access to systems)
- Notify the Manager on-Call of any anomalies such as sudden and consistent rise in demand or increase of people at ACP who do not require anti-virals
- Ensure appropriate signage in place and visible at all times (opening / closing times, directions, general information)

7. Reporting

- Complete reporting requirements, including daily stock usage reports

ACP ISSUER - ACTION CARD

Issuing an antiviral medicine authorised by the National Pandemic Flu Service (1)

Instructions – Issuing an Antiviral medicine Authorised by the National Pandemic Flu Service for Tamiflu® (oselta mivir) 30mg, 45mg, 2 x 30mg (60mg) or 75mg, or Relenza® (zanamivir)	
Step	**Task**
1	The flu friend will attend the ACP: • Enter the authorisation number in the collection point issuing system – if it is valid, ask for the symptomatic individual's ID and review details (name, age, gender, postcode, dosage) against those displayed on screen. These details will have been provided during the National Pandemic Flu Service assessment. **Note:** If the authorisation number is invalid, confirm and re-enter the authorisation number. If the authorisation number is not recognised, ask the flu friend to leave the ACP and inform the symptomatic individual that they need to be re-assessed and authorised for anti-virals **Note:** If the collection point issuing system is down, refer to action card AC11 for guidance on how to manually validate the authorisation number
2	**Visually validate ID** • Visually validate the symptomatic individual's ID • For invalid ID, ask the flu friend to return with valid ID, press cancel and return to the start screen • If the ID provided matches the details on the system, press continue • Select ID from the drop-down list • Ask for the flu friend's ID, visually validate it and enter their name, address • and postcode on the system **Note:** If the ID is invalid, ask the flu friend to return with valid ID, press cancel and return to the start screen
3	**Collect correct antiviral** • The authorisation number will provide the correct antiviral medicine and correct dose required • Collect the required antiviral medicine from storage **Note:** Refer to the overview of anti-virals action card to familiarise yourself with the antiviral medicines issued from the ACP and the correct dosage requirements according to the symptomatic individual's situation • Ask another ACP staff member to check that you have picked the correct antiviral medicine and correct dose
4	**Select and complete label** • Select the appropriate label as per the dosage of product • Complete the label with the: o name of the symptomatic individual o date of issue o ACP address • Stick the label on the antiviral medicine package **Note:** Ideally, have another ACP staff member verify that the correct dosage instructions have been included on the label • Record the issue on the system

Instructions – Issuing an Antiviral medicine Authorised by the National Pandemic Flu Service for Tamiflu® (oselta mivir) 30mg, 45mg, 2 x 30mg (60mg) or 75mg, or Relenza® (zanamivir)	
Step	**Task**
5	• Record the issue on the 'AV Issue Record – ACP Level v1.0' template, including the: o type antiviral medicine issued, including dose o authorisation number o date of issue • Provide the 'AV Issue Record – ACP Level v1.0' template to the ACP stock controller
6	**Hand over the antiviral medicine and information leaflet to the flu friend** • Advise the flu friend that the symptomatic individual should start taking the • antiviral medicine as soon as possible **Note:** The flu friend will need to deliver the antiviral medicine to the symptomatic individual as soon as possible
7	• Advise the flu friend that they should leave the ACP via the exit point

If the flu friend requests any kind of clinical advice, please refer them to the information leaflet issued with the antiviral treatment for further instruction/ input. Do not attempt to give advice if you are not a qualified pharmacist or healthcare professional.

ACP QUEUE MANAGER - ACTION CARD

Key responsibilities and accountabilities:

- Planning for queues, including floor plans and staffing
- Managing queues
- Informing flu friends of site arrangements at all times

Role requirements:

- Crowd management
- Ideally a background in security services

Planning and managing queues:

- Queues may form inside the ACP. This will usually be due to a surge in new arrivals or a decrease in staff due to illness or inability to attend the ACP. This scenario will result in an increase in processing time. It will be essential to manage queues effectively to ensure that disruption is kept to a minimum.

Key Tasks and Activities:

- Ensure that the floor plan accounts for the possibility that queues will form at each station as part of the natural variation in arrivals, staffing and processing times
- Ensure that staff are not taken away from essential roles for unnecessary reasons when there are large queues
- Work with security to manage any disruption
- Plan the best way to manage separate queues
- Work closely with the meet and greeter to ensure that only individuals eligible for the issuance process enter the ACP. This should also be evaluated and planned closely with security to help speed the flow of eligible patients and minimise the numbers of ‘worried well’
- Consideration should be given to vulnerable groups and suitable arrangements made as required:
    - Supporting individuals with special needs from the outset to minimise the time that any individual spends at the ACP

- It is important to consider disabled access and special arrangements required to accommodate people unable to stand for long periods. Adequate seating should be available at each step of the process
- Ensuring that any symptomatic individuals are kept away from flu friends and non-symptomatic individuals

Relevant action cards:

- Meet and greeter role description
- Security manager role description
- Handling difficult flu friends

ACP SECURITY MANAGER - ACTION CARD

Key responsibilities and accountabilities:

- Formally assess security needs and incorporate these into the specific site selected depending on the community setting
- Ensure protection of antiviral medicines
- Ensure that fire exits are clear at all times
- Manage crowds, ensure the safety of staff and protect the infrastructure
- Manage flu friends in a way that ensures an even and orderly flow
- Ensure that flu friends are communicated with at all times to reduce confusion and tension where possible

Role requirements:

- Knowledge/experience of security management desired. Ideally the primary care organisation (PCT) will have at least consulted local security management services

KEY TASKS AND ACTIVITIES

1. Facilities

- Carry out an initial risk assessment to identify hazards and implement any measures required to reduce risk
- Identify areas in the ACP where security may be required, for example entrance, exit, queuing area and storage area
- Identify any security equipment requirements, for example measures such as access control, alarms and CCTV, and ensure that staff are issued with and wear ACP/PCT identification at all times in order to control movement of people to restricted areas
- Refer to the NHS Security Management Service's lockdown guidance for instructions regarding how to undertake a proportionate lockdown of a site in response to a threat or hazard
- Carry out a daily check to ensure that security arrangements are in place (personnel, alarm systems, lockable storage for stockpile)
- Ensure that health and safety policy and procedures are adhered to
- Ensure that fi re exits are clear at all times

2. Staff

- Identify staff to patrol security areas within the ACPs. Suitably trained security staff must be assigned
- Assign staff to security points, outlining their shift patterns, roles and responsibilities
- Brief staff on the functions and objectives of the ACP
- Ensure that all staff are aware of fire exits. Ensure that they sign in and know the fire marshalling point for the ACP
- Notify the PCT immediately of any security breaches or harm to any member of the ACP staff

3. Queue management

- Liaise with the queue manager to:
    - assist with managing disturbances and ensure the safety of staff and the general public in the ACP
    - maintain order and move people through the defined queue system as efficiently as possible
    - refer to the queue manager action card

4. Stock security

- Ensure that the storage facility remains secure while the ACP is operational and when it is closed
- Assist the stock controller to ensure that antiviral deliveries are securely received
- Refer to the ACP stock controller action card

Relevant action cards:

- Meet and greeter role description
- Queue manager role description
- Handling difficult flu friends
- ACP stock controller role description

ACP MEETER AND GREETER - ACTION CARD

Key responsibilities and accountabilities:

- Directing people attending the ACP
- Ensuring that entry and exit points are clearly signposted
- The role may also act as support for a queue manager or security manager

Role requirements:

- Crowd management skills
- Experience in security an advantage

Note: This role is not mandatory but is recommended.

Directing People Attending the ACP

- Clearly identified meet and greeters (or traffic and crowd marshals) need to be in place at the entry points to the ACP to assess eligibility of flu friends attending the ACP and to direct them appropriately
- Meet and greeters should be vigilant for symptomatic individuals who turn up against advice to collect their own anti-virals and ensure they are kept well away from flu friends and non-symptomatic individuals

ACP KEY REQUIREMENTS CHECKLIST

No.	Task	Done?
IT requirements		
	Computers with: • an anti-virus package with up-to-date signature and patches • Microsoft (MS) Office - minimum - MS Excel and MS Word	
	Internet connection (a current, supported version of Internet Explorer) - Broadband, Dial up or N3	
	Access to email - e.g. MS Outlook	
	Printers that can print labels	
	Photocopier plus paper	
	Tables and chairs for assessor, Issuer	
	Telephones	
	Fax	
Physical (including storage and security)		
	Entry	
	Large reception area where patients can be marshalled and registered in an orderly fashion prior to control entry	
	Meet and Greet area to divert into respective queues	
	Queuing	
	Disability/ Special needs access	
	Queuing for holding area	
	Separate access and exit if possible	
	Space for queues	
	Overspill holding area for attendees	
	Security and storage	
	Security personnel for crowd control, traffic movement, the safety of clinical staff and infrastructure protection	
	Secure stock delivery points	
	Lockable building	
	Lockable storage for stock and associated consumables	
	Consider the outer perimeter of the building - fencing, natural barriers , i.e. planting	
	Consider the building perimeter – parking area, locking devices for external doors and windows, defensive planting, CCTV and fencing	
	Consider the interior of the building – entire ACP interior, internal windows and doors, ability to be locked, access and intrusion alarms, CCTV and adequate lighting, ability for natural surveillance by staff, movement of people from public to private space, ability to detect intruders	
Location		
	Accessible to public by public transport	
	On-site parking and drop-off site for public	
	Free from red route/ restrictions	
	Adequate Staffing requirements	
	Guidance/ instructions for safe systems of operation at the ACP for the safe supply of medicines	
	Staff for the following roles:	

	Centre Manager	
	Stock Manager/ Controller and staff	
	Security Manager and staff	
	Assessor	
	Issuer	
	Meet and Greet	
Command and control area		
	An area from which centre managers and the team can: • Oversee the operation of the whole centre including the clinical and non-clinical support activities • Oversee the regular collection and collation of performance data for the centre, and provide regular Situation Reports to commissioners • Communicate with Organisation management, the Police (via the onsite Police Bronze Commander (if deployed)) and Local Site Manager if required	
Standard Organisation Health and Safety procedures		
	Fire alarms, certification and clear evacuation instructions	
Communications		
	Space for signage and leaflets	

ACCEPTABLE FORMS OF ID FOR PROOF OF IDENTITY

Forms of ID

The following forms of ID could be used at an ACP:

- Full Driving Licence
- Paid Utility Bill or (Not older than 6 months)
- Building Society /National Saving Book
- Cheque Guarantee/Credit/Debit Card
- Cheque Book
- Credit Card Statement (Not older than 6 months)
- Council Tax Payment book
- Birth/Marriage Certificate
- Passport / European ID Card
- Military ID
- Trade Union Card
- A Standard Acknowledgment Letter (SAL) issued by The Home Office for Asylum/ Seekers.
- Child benefit letter
- Parent held record (red book)
- NHS Card
- Healthcare Professional Registration Number and ID card
- Pension / Benefit book
- Store charge card, but not loyalty card