Pandemic Influenza:

Draft

Guidance on preparing NHS Trusts in Wales

Version 1.1
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1 Introduction and aims

This planning document is designed to assist NHS Trusts in Wales (hereafter referred to as Trusts) develop their plans for responding to an influenza pandemic. This document should be considered in addition to the Wales Framework for Managing Infectious Disease Emergencies, which can be found at:


and guidance already published by the National Public Health Service (NPHS), which can be found at:

http://nww2.nphs.wales.nhs.uk/flu/page.cfm?pid=1389

Planners should be aware that the information available on pandemic influenza changes rapidly. Guidance is therefore continually being revised. It is important that planners ensure they work to the latest versions of text, including any guidance referred to within this document.

1.1 Scope

The arrangements described relate specifically to an influenza pandemic. They do not cover planning for, or the response to, seasonal influenza outbreaks or any incidents involving the prevention or control of avian (e.g. A/H5N1) influenza or other animal influenza infection in birds or humans, which remain the responsibility of the relevant government department, public health, animal health and local authority bodies in accordance with normal procedures.

Trusts contribute to the influenza pandemic preparedness planning undertaken by members of Local Resilience Fora (LRFs). This guidance sets out the planning elements that Trusts should be considering as their contribution to developing local resilience.

Whilst not intended to provide detailed operational guidance on those aspects, this document provides general information to support operational responses in an influenza pandemic. The guidance is aimed at helping Trusts to plan for an influenza pandemic in inter-pandemic (World Health Organization (WHO) Phases 1 and 2) and pandemic alert periods (WHO Phases 3 to 5) and then to respond in the actual pandemic period (WHO Phase 6, UK alert levels 1 to 4) and the post-pandemic recovery period.

1.2 Audience

This guidance is primarily intended for those preparing NHS Trusts in Wales for an influenza pandemic. However, it will have relevance to other stakeholders including Local Health Boards (LHBs), the Welsh Ambulance Services NHS Trust and Local Authorities. It will be of interest to independent and private sector providers and may be of interest to those seeking general information or an overview of the general preparations for and planned response to a pandemic in Wales.
2 The current context of influenza pandemic planning for Trusts

As Category 1 responders under the terms of the Civil Contingencies Act 2004, Trusts have a responsibility to prepare for emergencies, which include infectious disease emergencies such as an influenza pandemic.

Trusts have a responsibility as Category 1 responders to cooperate with other local responders to enhance coordination and efficiency of plans and response. It is essential that Trusts work within the framework of their Local Resilience Forum and health community emergency planning arrangements.

An emergency as defined by the Civil Contingencies Act is: 'An event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.'

To constitute an emergency, this event or situation must require the implementation of special arrangements by one or more Category 1 responders.

The Wales Framework for Managing Major Infectious Disease Emergencies 2005 sets out national arrangements for managing major infectious disease emergencies, including national co-ordination, operational responsibilities of NHS organisations and the role of partner agencies.

The Framework establishes widely understood arrangements for responding to a major infectious disease emergency, sets out the additional measures needed to mitigate the effects of a major infectious disease outbreak and integrates those arrangements with existing emergency planning structures for dealing with major emergencies. It sets out the planning needed to manage the health response to any major infectious disease emergency and includes more detailed information on management of pandemic influenza.

The framework also provides clear guidance to the NHS and partner organisations to assist them to develop and enhance integrated response arrangements and detailed operational plans. Trust plans should link with their arrangements for ensuring business continuity as required by the Civil Contingencies Act. Trusts and LHBs need to ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances.

Trusts will come under significant pressure during an influenza pandemic. They will be faced initially with small numbers of people infected, or potentially infected, with a new influenza virus type and will need to treat them and contain any spread within the context of their normal services. As the pandemic develops (this transition may be very rapid),
Trusts will need to deal with large numbers of individuals infected with pandemic influenza and as a result face very high demands for admission of pandemic influenza emergency cases for treatment, including critical care. This will occur at a time when Trusts’ own resources in terms of staff, consumables and utilities will be compromised. Modelling suggests that, at the peak of a pandemic wave, demand will exceed hospital and other healthcare capacity to respond.

2.1 The potential impact of an influenza pandemic on Trusts

The impact of an influenza pandemic on Trusts is likely to be intense, sustained and nationwide. Services may quickly become overwhelmed as a result of:

- the increased workload of patients with influenza and its direct complications
- the particular needs for critical care (levels 2 and 3) and infection control facilities and equipment
- a secondary burden on health caused by anxiety and bereavement
- depletion of the workforce and of numbers of informal carers, due to the direct or indirect effects of influenza on staff and their families
- logistical problems due to possible disruption of supplies, utilities and transport as part of the general disruption caused by an influenza pandemic
- delays in dealing with other medical conditions
- the longer term macroeconomic effects of an influenza pandemic on the national (and world) economy
- pressure on mortuary facilities (possibly exacerbated by delays in death registration and funerals).

In order to allow sufficient lead time to finalise and implement operational response arrangements, the Welsh Assembly Government’s Department for Health and Social Services will need to make decisions to reduce NHS services to the provision of essential care.

In response to the increased demands and to maintain an effective response, Trusts will also have to find innovative approaches for many aspects of healthcare, including staffing, triaging of patients and coping with those patients needing more complex care than is normally possible at home but who may not be able to be admitted to hospital.

2.2 Trust influenza pandemic preparedness planning

Planning should be based on and use the range of possible attack rates, clinical impact and mortality assumptions set out in the UK guidance *Pandemic Influenza: A national framework for responding to an influenza pandemic* and on the latest additional business contingency planning guidance issued by the Cabinet Office. However, Trusts should be
aware that the epidemiology of an emergent influenza pandemic virus and its clinical behaviour cannot be predicted with certainty. Plans will have to be adjusted as new information becomes apparent.

Uncertainty about the nature and impact of the pandemic virus means that planning across all sectors, including Trusts, needs, for prudence, to be sufficiently flexible to cope with a range of possible impacts, including those arising from an influenza pandemic virus with a clinical attack rate and case fatality rate in the upper ranges of the planning assumptions set out in national guidance.

Most emergency plans are based on short-term escalation of services; however, an influenza pandemic will have a sustained impact on demand, affecting most areas simultaneously, which therefore will require different planning responses. Additionally, Trusts need to be aware that a pandemic may occur over more than one wave. Planning will need to take account of this possibility and use the recovery period after a wave to restock and prepare for possible subsequent waves.

Cabinet Office guidance on contingency planning for a possible influenza pandemic is available at: www.ukresilience.info/publications/060710_revised_pandemic.pdf

Trusts will need to consider the UK Governments’ key aims in preparing for and responding to an influenza pandemic. These are to:

- protect citizens and visitors against the adverse health consequences as far as this is possible
- prepare proportionately to the risk, taking into account both the likelihood of a new (or re-emerging) influenza A virus subtype emerging with potential to cause a pandemic and the likely severity of the impact of such an event
- support international efforts to prevent and detect its emergence and prevent, slow or limit its spread
- minimise the potential health, social and economic impact
- organise and adapt the health and social care systems to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care
- cope with the possibility of significant numbers of additional deaths
- support the continuity of essential services and protect critical national infrastructure as far as possible
- support the continuation of everyday activities as far as practical
- uphold the rule of law and the democratic process
• instil and maintain trust and confidence by ensuring that the public and the media are engaged and well informed in advance of and throughout the pandemic period

• promote a return to normality and the restoration of disrupted services at the earliest opportunity.

There are some specific health and social care responses that will be required, most of which will apply to Trusts. These are as follows:

• maintaining surveillance to detect the emergence of a novel virus strain or any illness attributable to it, monitor its spread and health impact, describe the illness and inform the response

• providing prompt access to rapid and reliable diagnostic tests

• reducing disease transmission and rates of illness by applying individual and community infection control measures

• reducing the severity of illness and incidence of complications in infected individuals

• adjusting responses to reflect emerging epidemiological data

• developing surge capacity to respond to the increased demands as efficiently as possible – recognising that this will require the reactive redefinition of boundaries between primary and secondary care

• making targeted and effective use of potentially scarce healthcare skills, facilities and resources

• reducing or ceasing non-essential activity as demand increases but maintaining essential care for emergencies or patients with chronic or other illness

• assessing symptomatic patients rapidly and treating promptly with antiviral and other medicines if indicated

• providing effective treatment for those suffering complications

• educating the community and providing public advice and information

• vaccination if and when suitable vaccines are available

• providing data to monitor the impact and effectiveness of interventions.
2.3 Principles underlying planning and response

Health and social care organisations should apply the following general principles to their planning and response:

- Response arrangements should be based on strengthening and supplementing normal delivery mechanisms as far as practical.
- Interventions will be applied where they achieve maximum health benefit, but may also be required to help maintain essential services – political decisions will be necessary if there is conflict.
- Plans should be developed on an integrated multi-agency basis with risk pooling and cross-cover between all organisations.
- Plans should encourage pan-organisational working, seeking to mobilise the capacity and skills of all public and private sector healthcare staff (including students and those who are retired), contractors and volunteers.
- Antiviral medicines should initially be available to all patients who have been symptomatic for less than 48 hours preferably within 12 - 24 hours of reporting symptoms.
- Response measures should maintain public confidence and ‘feel fair’.
- Treatment and admission criteria should be transparent and applied in a consistent and equitable way that utilises the capacity available for the seriously ill.
- Plans should recognise the need to respond to psychosocial issues and concerns such as anxiety, grief and distress and for sympathetic arrangements to manage additional fatalities.
- Individual care should be balanced with the priority to reduce illness and save most lives in a way that is fair The Ethical framework for the response to pandemic influenza can be found at:
  

2.4 Planning sensitive to local needs

Planning for an influenza pandemic should reflect the needs of the local population, including the population demographics, ethnic structure and geographic dispersion of the residents. This will be particularly important for communications and access to services and treatment.
3 Minimising disruption to health and other essential services

In developing plans to minimise disruption to health and other services from an influenza pandemic, it would be advisable for Trusts to consider the following elements of planning:

- Programme – influenza pandemic preparedness programme of planning – proactively leading and managing the process.
- Processes – organising and adapting health systems to provide treatment and support for large numbers suffering from pandemic influenza, maintaining essential care and supporting essential services.
- Premises – buildings and facilities.
- Providers – supply chain, including outsourcing.
- People – roles and responsibilities, awareness and education.
- Trusts’ responsibilities in limiting illness and death arising from infection and in reducing further spread of pandemic influenza.
- Providing treatment and care for those who become ill.
- Service image and reputation.
- Performance – benchmarking, evaluation and audit.
- Reducing disruption to society as far as possible.

Each of these is covered in more detail below.
3.1 Programme

3.1.1 Partnership working

In developing plans to prepare for and respond to an influenza pandemic, Trusts should ensure there are good partnership/multi-agency working and communication arrangements between different healthcare services and other local stakeholders in order to ensure that responses are structured and cohesive. Trusts should ensure that during plan development the views of these stakeholders have been taken into account, otherwise there may be a danger of making planning assumptions that will not be sustainable in the event.

The Civil Contingencies Act 2004 recognises the requirement for Local Resilience Forums. This is the ideal multi-agency forum for Trusts to participate in at this level of planning.

Stakeholders in plan development should include:

- primary care commissioners and providers
- other secondary care providers in the locality
- Welsh Ambulance Trust
- local authorities/social care
- other emergency services (e.g. police)
- business and voluntary sector
- private providers of care – hospitals/care and nursing homes
- community pharmacy
- education
- Local Resilience Forum
- suppliers/contractors.

3.1.2 Command and control

An influenza pandemic will place considerable demands on the co-ordination of responses to the emergency. It is vital, therefore, that Trusts have clear arrangements for command and control.

Command and control systems should include representation from senior management (including operational delivery), medical and nursing, infection control and security.
Command and control systems will need to integrate and communicate with external stakeholder command and control systems, in particular, the LRF, other Trusts and local authorities.

Trust plans should identify clearly how these links will be made and who will be responsible.

3.1.3 Influenza pandemic plan activation

The decision to declare a pandemic will be taken by the Minister for Health and Social Services on receipt of advice from the WHO. The decision will be cascaded at this point to Trusts.

Trusts should ensure that they have robust systems capable of receiving and acting on a decision to declare an influenza pandemic. In their planning for an influenza pandemic, Trusts should ensure that there are nominated individuals in charge who can trigger activation of the hospital's influenza pandemic response. Trusts should ensure that these individuals can be readily contacted and that there are means of communicating the decision to frontline/other hospital staff, to activate the plan and respond.

In practice, it is likely that escalation of the planned response will evolve in steps over a number of weeks, as the pandemic threat and case presentation increases.

3.1.4 Decision-recording systems

Clear recording of decisions taken will help avoid confusion and ensure consistency at a time of significant disruption. It is also important for Trusts to have an audit trail of their command and control judgements.

As a minimum, these should include:

- the nature of the decision
- the reason for the decision
- date and time of decision
- who has taken the decision/authority designation
- extent of consultation/advice from external stakeholders/who notified
- any review date set for revocation of the decision(s) where relevant. (Where decisions may have a major impact, Trusts may wish to ensure that they are shared by at least two appropriate personnel.)

This list is not exhaustive. Trusts will wish to supplement it.
3.1.5 Information requirements

Trusts’ command and control systems will need to be aware of the current pandemic phase and the local, national and international situation.

In order to maintain an effective response, the command and control system will need to collect a number of data streams. These will include:

- staff availability/illness in staff/volunteers (by hospital unit/specialty)
- number/rates of patients admitted/discharged
- case demographics/other underlying disease profiles
- triage level of admitted patients
- bed capacity/occupancy including critical care and also length of stay
- general responses to treatment of pandemic influenza cases
- deaths
- core facilities status
- consumables – stocks remaining/utilities availability/supply chain issues
- utilities
- financial impact.

This list is not exhaustive and Trusts will wish to supplement it depending on their local circumstances.

The Welsh Assembly Government will in due course be issuing further guidance on the information that Trusts will be required to supply centrally in the event of an influenza pandemic, and will also make recommendations on data streams that Trusts may optionally collect to optimise their own response to the event.

Trusts should endeavour to get real-time data in order to inform timely responses. Data collection on the first few hundred cases of pandemic influenza will be crucial. The lessons learned from these may have a significant impact on the subsequent management of infected patients. Most of the data collected will be for local use; however, some streams will be required centrally.

3.1.6 Risk communication

Risk communication is an area that may warrant particular attention. Risk can be a difficult concept for many to understand and therefore effective explanation of the risks faced is particularly important. Trusts should endeavour to convey risk in a manner that
does not create undue fear but provides sufficient information to allow individuals to prepare.

Disease outbreaks are inevitable and often unpredictable events. They are frequently marked by uncertainty, confusion and a sense of urgency or even panic.

WHO has produced outbreak communication guidance, which, if implemented effectively, may result in greater public resilience and participation to support the rapid containment of an outbreak.

Important goals for outbreak communications can be summarised as:

- **trust** – communicate to build, maintain or restore public trust
- **announcing early** – to prevent potentially frightening rumours and misinformation. Please note that the timing of announcements in the event of a pandemic will be determined at national level by the Welsh Assembly Government and Trusts will be alerted via their Regional Office.
- **transparency** – helps inspire trust; communication must be honest, easily understood, complete and factually accurate
- **allaying the concerns of the public** – accurate and timely information helps the public overcome concerns and understand what they can do to protect themselves and their families
- **planning** – be prepared. Answer questions such as:
  - What needs to be done?
  - Who needs to know?
  - Who is the spokesperson?
  - Which agency has the lead?
  - Who needs to act?

### 3.1.7 Communications

A Pandemic Flu Communications Toolkit was developed in consultation with the Service and the latest version was issued to the NHS and LA Communication Officers in January 2007. The toolkit:

- explains the challenges of a pandemic;
- sets out roles and responsibilities of communications personnel in key national, regional and local organisations; and
- outlines the national communication strategy as it applies to Wales.

Three workshops were organised in April 2007 for Communication Officers and Emergency Planning Officers in the NHS and Local Authorities, to discuss pandemic flu communication issues. During these workshops there was a review of the arrangements in place relating to the communication aspects of pandemic flu planning.
A working group comprising NHS, Local Government, NPHS and Welsh Assembly Government was established to develop a media handling protocol. The protocol provides a useful framework of who is responsible for what, how we work together across organisational and sectoral boundaries and case studies of issues which we may have to deal with.

It is particularly important that the OOH database is accurate and regularly maintained. To this end the DHSS issues details to the Communication Officers on a quarterly basis.

A range of communications material is being prepared on a UK wide basis. The Department of Health in London is leading on health aspects with the Cabinet Office coordinating across Government. The Welsh Assembly Government is part of this process. Planned materials include TV and Radio adverts and fillers, a public information, a national door drop leaflet, travel advice leaflet, information leaflet on antivirals, and information on caring for your family. A range of web activity is also planned.

The Department of Health are carrying out further communications research to refine messages and further work will be carried out on all of the main materials as a result and to reflect changes in policy and advances in preparations.

Utilising available national communication materials where possible, Trusts should be developing plans now for providing information to staff and to the public before, during and after the pandemic. Communication materials should be prepared and customised to meet the needs of the local situation. Trusts should also identify mechanisms by which these communications can be cascaded. Frequency of delivery should be determined. This should be done in conjunction with national, local and regional stakeholders, including the Welsh Assembly Government, NPHS, LHBs, emergency services, local authorities and LRFs.

3.1.8 Social responsibility

Social responsibility is another area requiring careful communication both to the public and staff members. If services are to remain as functional as possible, the public will need to observe advice on protecting themselves and their families, complying with public health measures and when and how to seek medical advice or care.

3.2 Processes

3.2.1 Useful guidance documents

The documents below are the current versions and may be subject to change or revision.

Trusts should always ensure they are working to the latest guidance available.

• Business contingency planning guidance for pandemic influenza from the Cabinet Office:
  www.ukresilience.info/publications/060710_revised_pandemic.pdf

• Business Continuity Institute/British Standards Institute Publicly Available Specification (PAS 56) Guide to business continuity management:
  www.thebci.org/pas56.htm or
  www.bsi-global.com/Risk/BusinessContinuity/PAS56.xalter

• Emergency planning – a whole suite of documents provided by the Welsh Assembly Government:

3.2.2 Risk assessment-based planning

As part of the influenza pandemic planning process, Trusts should take a risk assessment-based approach in order to understand each of the risks faced, to set them into priority order, to act on them accordingly and evaluate progress towards achieving optimum preparedness.

A risk assessment grid framework tool will be a helpful way forward in developing this work. This should assess the likelihood of occurrence against severity of impact to produce an overall risk score.

3.2.3 Key essential functions

An influenza pandemic will compromise the ability of hospitals to continue to provide normal services. As the threat of an influenza pandemic escalates, it will be necessary for Trusts to be capable of diverting resources to respond effectively to the emergency. Trusts will need to put in place measures to maintain core business activities for several weeks at high levels of staff absenteeism.

Understanding the key essential functions of a hospital in a prolonged emergency is key to planning for an effective response. Prior to an influenza pandemic, Trusts should develop an understanding of their life-saving, critical and important functions and non-essential/non-lifesaving functions. At WHO Phase 5, and WHO Phase 6, UK alert levels 1 and 2, activities may need to be scaled back in anticipation of pandemic influenza cases occurring in the UK. At WHO Phase 6, UK alert levels 3 and 4 (where there are outbreaks/epidemics or widespread influenza activity in the country), it is anticipated that even life-saving activities will be difficult to sustain and others will have to be discontinued.

A graded response to an increasing threat would be appropriate. It may help if Trusts map out which activities will be continued or stopped against the relevant influenza pandemic phases/alert levels, so that decisions on which functions to continue or cease are decided before an influenza pandemic and thus changes readily enacted.

To provide clarity, it is suggested that the functions are split into clinical and non-clinical support functions.
3.2.4 Clinical functions

As the emergency escalates, there will be elective and routine clinical functions that will have to be withheld as demands increase elsewhere (including some laboratory services). For example, at the earlier stages of the pandemic, it will be appropriate to cease some routine surgery and outpatient services. At later phases of an influenza pandemic where there is widespread disease, it may be necessary to cancel all routine clinical functions and concentrate on expanding management of influenza emergency and non-influenza emergency cases.

A clear plan of which activities will be suspended/expanded at varying stages of an influenza pandemic should be developed and subject to appropriate consultation with relevant stakeholders. Trusts will need to review and disseminate these decisions dependent on their own circumstances.

3.2.5 Non-clinical functions

Non-clinical activities will be similarly affected by an influenza pandemic. A plan for suspension/expansion should again be developed and subject to appropriate consultation with relevant stakeholders.

Examples of the functions to review and for which plans will need to be made regarding how they will change during a pandemic include:

- maintenance/renovation
- catering
- cleaning
- records management
- information technology services
- waste handling
- mortuary.

3.2.6 Working practices

Working practices will need to be flexible during a pandemic in order to minimise the spread of disease and also to mount an effective response despite potential staffing shortages.

Trusts will wish to enable staff to work in different ways from usual such as by remote working or the use of flexible rotas.
The Welsh Assembly Government will in due course be issuing guidance on the human resource management of an influenza pandemic. It would be advisable for Trusts to consult now with their human resources advisers, staff associations and unions about the need for additional flexibility during an influenza pandemic. In many cases, redeployed staff will require additional education and training to take on different roles. Please see section 3.5.19 on education and training for further information.

It should be possible for some functions to be provided by staff working remotely. This will be particularly relevant to the business units of Trusts that do not require direct patient contact, such as finance, logistics and supplies procurement and other management aspects.

3.2.7 Impact of legal issues on processes

There are potential legal issues that may impinge on Trusts’ influenza plans. These range from regulatory matters through to concerns about staff undertaking different roles from usual to the level of treatment that it may be possible to sustain.

The Welsh Assembly Government is in discussion with the stakeholders concerned on how these may be dealt with.

3.2.8 Hospital surveillance

The Welsh Assembly Government is working with the other UK countries to develop guidance on surveillance activity that health organisations including Trusts should undertake in an influenza pandemic. More details will be available in due course. However, in the interim, Trusts will need to assess their surveillance capabilities as detailed below.

An influenza pandemic may arise from an avian influenza virus developing into a pandemic virus. Trusts should ensure that their systems are capable of rapid clinical diagnosis of possible first/early cases of avian influenza in humans according to the HPA algorithm, available at: www.hpa.org.uk/infections/topics_az/influenza/avian/algorith.htm

If an influenza pandemic arises, Trusts should ensure they have robust systems capable of rapid identification of potential first/new pandemic influenza cases in hospital, e.g. within the cohort of non-influenza cases/staff. This capability is particularly important in the early stages of an influenza pandemic so that initial cases can be rapidly identified and isolated from other individuals in order to prevent further spread. Hospital surveillance will also assist in bed and staff planning and may help detect subsequent influenza pandemic waves.

Trusts will need to ensure that their surveillance systems work effectively for pandemic influenza case identification in all units from emergency department through to all clinical and non-clinical departments in the hospital. Surveillance systems will also need to be capable of detecting pandemic influenza cases in staff, reserve staff and volunteers.

If a Trust decides to adopt the BTS guidelines for managing patients during a pandemic, it should ensure that they are approved by the internal Trust clinical guidelines group.

Trusts should also have systems in place for referral of test samples to NPHS laboratories. The NPHS will be collecting detailed information on the first 100 to 200 cases. Trusts will need to be able to provide the appropriate surveillance data for this.

If hospitals identify a possible case, they should ensure that the individual is treated in isolation and staff are provided with appropriate protection.

Trusts should consult with their local NPHS and public health colleagues on planning their surveillance activity.

3.2.9 Blood and associated services

Blood supplies
The supply of blood and blood components may become compromised as the pandemic threat escalates until after the wave passes. Blood donation rates will be lower than usual and will not meet normal demand. However, in partnership with the NHS, the Blood Services in Wales have developed arrangements for shortages which will be escalated as required in a flu pandemic dependent on actual and projected available supply (further details are available below). The plans require medical and surgical activity to be tailored to match supply. Trusts should ensure that they have management arrangements in place to ensure these plans can be escalated as required.

NHS Trusts should refer to the joint CMO/Director NHS letter of 4 November 2004 enclosing Contingency Planning – An Integrated Plan for the Management of Blood Shortages. The letter and plan is available at:


Tissue supplies
The supply of tissue products (e.g. skin, bone, amnion, corneas) used as life-saving or significantly life-enhancing grafts may become compromised due to the potentially reduced donation rates associated with a pandemic threat. Trusts should continue to have in place their arrangements for the referral and retrieval of tissues. Plans should support the continued practice of potential donor referral from the deceased and maintain access arrangements to mortuaries for retrieval teams. In addition, where there are living donor programmes in place and where elective surgery continues, bone donation should also continue.

WHO has also provided guidance on maintaining blood supply in a pandemic, available at www.who.int/bloodproducts/quality_safety/WHO_Guidelines_on_Pandemic_Influenza_and_Blood_Supply.pdf
**Stem cell and diagnostic services**

The Welsh Blood Service, National Blood Service and others provide stem cell and specialist diagnostic services to hospitals. Wherever possible, these services will continue uninterrupted. Advice from the service provider should be sought and careful decisions taken before treating new patients to ensure there is confidence that these services plus adequate transfusion support is available, in order to minimise the risk that patients might be compromised mid-treatment. Where a normal service is not possible, these services will need to be prioritised according to clinical need.

### 3.2.10 Independent sector

Whilst this document is primarily aimed at NHS Trusts, the information will also have relevance to private hospitals and independent sector treatment centres.

The private and independent sector and the NHS should, where possible, provide assistance to each other in the event of an influenza pandemic. Trusts should include local independent sector providers (e.g. private hospitals/independent treatment centres) in their planning and exercise arrangements.

Independent sector hospitals should have a role in providing capacity, for example for emergency operative procedures or obstetric care at the peak of an influenza pandemic. The logistical, human resources and financial implications should be planned for now.

### 3.2.11 Operational feasibility, contract and Service Level Agreements

An influenza pandemic will place considerable strain on the capacity to deliver emergency and routine functions. Trusts should be realistic about what will be achievable and adjust their plans and responses as the pandemic threat increases or knowledge improves.

Prior to a pandemic occurring, Trusts should consider which contracts will need to be suspended or renegotiated. Trusts should not however destabilise other organisations they have contracts with. It would also be sensible to build into any new contract/service level negotiations contingencies for emergencies in general and pandemic influenza in particular. In addition, there may be new contracts/service level agreements that will be necessary in an influenza pandemic and, therefore, where possible or relevant, these should be negotiated in advance.

### 3.2.12 Medical records

Trusts should ensure that medical records systems and processes continue to function as normally as possible during an influenza pandemic in order to ensure patient safety, quality of care, the development of a care audit trail and the fulfillment of legal obligations.
3.2.13 Finance/Annual National Targets

The Welsh Assembly Government is fully aware that an influenza pandemic will have a considerable impact on normal operational functioning of hospitals at a time when there will be additional calls on financial resources thus affecting cash flows. The Welsh Assembly Government will in due course be issuing guidance for NHS Wales organisations on financial duties during an influenza pandemic, and guidance for Trusts on the management of annual national targets during a pandemic.

3.3 Premises

Physical hospital capacity will be severely pressurised during an influenza pandemic, especially at the peak stages.

3.3.1 Emergency departments

Trusts need to plan for and be capable of responding to a sustained surge in pandemic influenza cases attending emergency departments. Trusts should plan how they will provide for large numbers of individuals arriving (self-presenting, referred or by ambulance), waiting to be seen and triaged and then assessed for further management. Reception and triage areas will need to be designed to minimise the exposure of staff to risks from a pandemic influenza virus, for example by the use of screens or telephone systems. There will also be an impact on other services, so Trusts will need to consider halting non-critical services early to cope with the influx of pandemic influenza patients.

It is possible that individuals will present to emergency departments but would be more appropriately cared for by primary care or in the community. Trusts will need to plan with their primary care stakeholders on how individuals will be redirected.

In the interests of infection control and efficiency of patient flows, Trusts will need to separate emergency cases immediately into influenza and non-influenza patients as far as is practical. At WHO Phases 3 to 5, individuals presenting with possible pandemic influenza will need isolating. In the pandemic period (WHO Phase 6), the large numbers presenting will preclude isolation at the level of the individual patient. Trusts will instead need to cohort influenza and non-influenza patients into separate management streams to minimise the risk of cross-infection. It is paramount that this separation occurs as rapidly as possible on presentation to hospital to prevent the two groups mixing and cross-infection occurring. Plans therefore need to make provision for space to deal with these groups separately, from access (including for ambulances) through to assessment and admission. There may also be a need for space to ensure that individuals exposed to pandemic influenza, but otherwise well, do not come into contact with unexposed individuals. The separate areas will need appropriate equipment provision for the tasks required.

The need to handle large numbers of emergencies separated into influenza and non-influenza cases will be logistically difficult for many Trusts and therefore needs detailed planning now in order to achieve as practical a solution as possible, based on a range of potential clinical attack rates. Trusts will need to model the range of patients they will need to receive and handle through emergency departments and plan accordingly.
Trusts will need to ensure that where planning necessitates alternative facilities, these are capable of providing the function required (e.g. medical gas supplies, power supplies, and ambulance access).

The Welsh Assembly Government Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings can be found at:

http://www2.nphs.wales.nhs.uk:8080/flupandemicdocs.nsf/61c1e930f9121fd080256f2a04937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Gover
nment%20%20Infection%20Control%20Guidelines%20-%20May%202006.doc

3.3.2 Other accommodation requirements

Apart from handling emergency cases, hospitals will need to plan and make accommodation provision for the following:

- **Management command and control.** These facilities will need to provide space for meetings, including tele or video-conferencing, with IT and telecommunications links. Trusts should be aware that telephone, internet and email communications may be compromised. Plans should take account of this possibility.

- **Call handling.** Although the Welsh Assembly Government is working in conjunction with the Department of Health and other Devolved Administrations to optimise telecommunications systems to direct the public effectively, it is nonetheless possible that not all callers will use or comply with these systems. Hospitals will probably receive greater numbers of calls than usual seeking advice or with other enquiries. Trusts will need to ensure their telecommunications systems are capable of dealing with call surges and that there are physical facilities in place for staff to operate call centre phones.

- **Communications.** There will be considerable media interest in influenza pandemic cases, particularly at the early stages. Trusts will need to ensure they have physical facilities for enabling these communications with the media to take place and also to accommodate their needs.

- **Rest areas for staff.** Staff and volunteers are likely to be working under considerable pressure and will need areas for rest and to obtain refreshments. Trusts will need to consider the accommodation, rest and refreshment needs of staff or volunteers who are unable to return home, for example due to disruption to transport links or movement restrictions or work responsibilities. Staff are also likely to be relocated from their usual places of work, and volunteers will need receiving and directing. Facilities for providing for these staff and volunteers and for organising their deployment to where the work is needed will therefore be required.

- **Mortuary facilities.** There is a high risk that existing mortuary facilities will be overwhelmed by an excess number of deaths. Simultaneous delays in funeral arrangements are also likely. Trusts need to ensure that their mass casualties plans are capable of handling large numbers of bodies over a prolonged period, and that these plans take account of the differing cultural, religious and spiritual needs of the
population. Allied to the possible increased numbers of deaths there are likely to be many distressed relatives who will need help. Facilities should be made available for handling them. There may be some anti-social responses from some people. Trusts should ensure there is provision for dealing with such instances.

Trusts should in advance of an influenza pandemic:

- review national guidance on handling mass casualties and modify this appropriately in accordance with local circumstances. In the light of this knowledge they should have discussions with local stakeholders as to how the eventuality might be handled in operational terms, for example with local authorities, coroners, death registration and undertakers

- assess how existing capacity for refrigeration of the deceased will be expanded and identify other local facilities that may be accessed in difficult circumstances. Trusts should work closely with local and regional authorities on this issue.

- The Home Office Document *A Framework for Planners Preparing to Manage Deaths* is available at:

  (Link to Home Office Guidance will be included when available.)

- *Ambulance decontamination.* Ambulances will need decontamination after having brought in patients infected with pandemic influenza. Trusts will need to make space and equipment available to facilitate this.

### 3.3.3 New premises development/refurbishment

In any new development work (either new build or refurbishment), Trusts should consider the need for handling future emergencies such as a pandemic, and the need for reallocation of physical facilities. Therefore, Trusts should consider at the design stage how the new or refurbished facility could fit into, or be reallocated for, emergency use. As an example this might include providing additional power, medical gas and suction supplies, to allow an area to be reassigned as an extra critical care unit in an emergency.

### 3.3.4 Security considerations

An influenza pandemic may result in some civil disturbance. Trusts need to consider how they can continue to provide services whilst keeping patients and staff safe. Particular issues that need addressing are:

- keeping influenza and non-influenza cases separate for as long as possible

- redirecting cases more suited to assessment and treatment away from hospital to the community

- security of limited supplies – especially medications and vaccines
• public order issues when faced with potential overcrowding or population panic
• violence (threatened or actual against staff )
• security issues over access to the hospital for treatment
• security issues over access to personal protective equipment
• general hospital security.

Trusts will need to work with local authorities, police and security providers in developing their security plans.

Security staff will also have their own specific needs for personal protective equipment (i.e. protection against violence and also infection).

### 3.3.5 Ambulance services

The Welsh Assembly Government will be issuing separate guidance for ambulance Trusts on influenza pandemic preparedness.

Trusts will need to work closely with ambulance Trusts to ensure their influenza pandemic preparedness plans are coherent and cohesive.

There are a number of specific issues that will need to be considered, however. These include:

- criteria for admission to hospital and handling of those not fitting the criteria
- logistics of admission to hospital, for influenza and non-influenza emergency cases, including direct admission to wards
- criteria for commencement of advanced respiratory support prior to admission to hospital in the event of influenza pandemic (taking account of the consultation document on the provision of critical care facilities)
- contingency plans if hospital facilities (especially critical care) are not available
- transport out of hospital of recovered cases or other patients no longer requiring hospital care
- decontamination of ambulances following transport of a pandemic influenza case.

This list is not exhaustive and is intended as a guide only. There will be other local issues on which Trusts will need to consult with the Welsh Ambulance Trust.
3.3.6 Transport

Trusts will need to plan for the transport needs of patients during an influenza pandemic. These plans will need to cover safe internal hospital transport arrangements whilst maintaining isolation or cohorting of patient groups into those infected and non-infected. They will also need to cover the external transport of patients coming into and being discharged from hospital, whilst again maintaining separation of influenza cases from non-influenza patients as far as possible. In particular, hospitals will need to consider the transport arrangements for patients being discharged to other accommodation or healthcare provision to make space available for handling influenza pandemic patients.

It would be advisable for Trusts to develop clear guidance on transport arrangements during an influenza pandemic, broken down by patient group, including for whom, how and in what circumstances it should be provided. Trusts will also need to provide safe transport for pandemic influenza laboratory specimens.

Trusts should work with the Welsh Ambulance Trust in developing their transport arrangements. They should consult the guidance on Ambulance Trust preparation and response to an influenza pandemic that the Welsh Assembly Government will issue in due course.

3.4 Providers

An influenza pandemic will result in increased demand for supplies and other consumables at a time when the ability of suppliers to maintain deliveries will be compromised. Most businesses (including hospitals) do not now hold large inventories of stocks, instead relying on timely deliveries. Small stock reserves have implications for how a hospital can continue to function with a prolonged emergency, when the (re)supply chain is disrupted.

Trusts will need to plan for how they will cope under these circumstances and what they can do to mitigate such an event. There are a number of key groups of supplies that should be considered (however, this list is not exhaustive, and it will need to be supplemented by the Trusts according to their own local needs). These are:
<table>
<thead>
<tr>
<th>Supply grouping</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilities</td>
<td>Water, fuel (for heating and vehicles), electricity, telecommunications (including emergency back-ups)</td>
</tr>
<tr>
<td>Food supplies</td>
<td>General food supplies, special foods – e.g. baby food/milks/specialist milks/food replacements such as parenteral nutrition</td>
</tr>
<tr>
<td>Linen</td>
<td>Bed linen/gowns/uniforms/shrouds</td>
</tr>
<tr>
<td>Consumable medical items</td>
<td>Dressings, ventilator tubing, endotracheal tubes, syringes, intravenous catheters, surgical stitches, imaging consumables, masks, personal protective equipment</td>
</tr>
<tr>
<td>Non-consumable medical items</td>
<td>Ventilators/monitors/imaging equipment</td>
</tr>
<tr>
<td>Consumable non-medical items</td>
<td>Hand washing soaps, cleaning liquids, essential maintenance items, vehicle parts, waste disposal bags, air filters</td>
</tr>
<tr>
<td>Non-consumable, non-medical items</td>
<td>Cleaning equipment, bedding, vehicles</td>
</tr>
<tr>
<td>Sterile supplies</td>
<td>Surgical operating packs, sterile gowns</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>Including oxygen and anaesthetic gases, anaesthetics, antibiotics, other essential medications. The Department of Health is separately considering how to maintain these supplies in a pandemic and also the development of additional stocks of critical medications including antibiotics</td>
</tr>
<tr>
<td>Blood supplies/blood product supplies/ tissue supplies</td>
<td>Plasma, red cell packs</td>
</tr>
<tr>
<td>Record keeping/information supply and handling</td>
<td>Including paper notes supplies, prescription and monitoring sheets, hospital information technology systems – back-up and support</td>
</tr>
<tr>
<td>Laboratories</td>
<td>Test reagents, sampling devices/tubes, test request forms</td>
</tr>
</tbody>
</table>

It is likely that suppliers’ staff absences will be at their maximum during and just after the peak of an influenza pandemic wave and therefore supplies will be most compromised around this time.

Trust planners in collaboration with internal stakeholders will need to identify what supplies are essential to sustain hospital core services during the peak phase of a pandemic wave. Trusts will need to model specific inventories according to local requirements (based on a range of influenza pandemic attack rates). Trusts will also need to determine at what point they will begin ordering these additional reserves.

Trusts will need to discuss with their suppliers how such inventories can be most cost-effectively developed and stored. Provided suppliers can provide robust business continuity reassurances, it may be appropriate to negotiate with suppliers that they develop and hold these stocks, as they may have greater storage capacity than most
Trusts and may be more able to ensure stock rotation to comply with expiry dates. However, where a supplier is unable to provide such assurances, Trusts will have to decide to store the inventory, or negotiate with an alternative supplier able to provide a business continuity guarantee. Nonetheless, suppliers are unlikely to be able to accurately predict the effect of an influenza pandemic on their ability to sustain supplies, so Trusts should interpret their business continuity assurances with caution and plan accordingly.

Trusts should ensure that they have robust supply (medical and non-medical) tracking systems to enable deteriorating stock positions to be readily highlighted. It would be advisable for Trusts to have contingency plans in place for managing the situation when the availability of specific supplies becomes limited.

Contracts with suppliers should include specification on the level of service to be maintained in the event of an emergency of any sort, in particular a prolonged emergency such as an influenza pandemic. This will necessitate revisiting existing contracts and renegotiating them where necessary to include specifications for continued supply in an emergency, and also ensuring that, where relevant, all new contracts take emergency supply maintenance into account. Specifications should allow for surge provision. Trusts should also consider the risk of using sole suppliers and the use of local sleeping clauses within existing contracts.

Trusts should ensure that their systems are capable of receiving, storing and distributing any share of national stockpiles they may be allocated.

### 3.4.1 Mutual aid

An influenza pandemic is likely to affect many areas simultaneously and so the ability to provide and receive mutual aid from other providers will be limited. Hospitals should establish dialogue with other local/regional healthcare providers (NHS and independent sector) about providing mutual aid and support.

Elements of mutual aid provision that Trusts will need to consider include:

- staff sharing (especially those with specific expertise, for example outreach specialist support for paediatrics)
- reserve staff allocation
- financial aid
- material resource sharing (clinical and non-clinical) and pharmaceuticals
- bed sharing (especially critical care beds)
- transport
- other accommodation needs.
3.5 People

The Welsh Assembly Government is working with the Department of Health and NHS Employers to produce guidance for human resource management during a pandemic, which will become available in due course. In the interim, the following issues need to be considered.

3.5.1 Staffing

The availability of sufficient human resources is critical to the maintenance of any hospital service. Therefore, planning for optimum staffing levels should be a key focus for influenza pandemic preparedness.

Planning should focus on the following groups of staff:

- those performing tasks that would be essential during a pandemic (clinical and non-clinical)
- those performing tasks that would be non-essential during a pandemic (clinical and non-clinical)
- managerial
- voluntary
- external contractors
- other reserve staff pools.

Key elements to consider in relation to planning for these staff groups are:

- mapping directly employed staff groups
- mapping reserve staff, including volunteer and externally contracted staff
- staff location audit
- normal operational staffing levels
- minimal staffing levels
- staffing situation representation
- skills audit
- roles during a pandemic/redeployment including sharing of health professionals between organisations (within and outside the NHS)
• staff absence from work – including the management of sickness, in and out of work, and staff absence for other reasons
• ethical and professional obligations of staff during an influenza pandemic
• staff discipline, including the handling of suspended staff
• supporting staff and the provision of support to relatives and dependants of staff
• payment of reserve staff and volunteers
• contracted hours and the European Working Time Directive
• occupational health
• restriction of deployment of potentially infected staff, reserve staff and volunteers
• health and safety/risk mitigation
• regulatory issues
• indemnity
• certification
• Criminal Records Bureau assessment of staff, reserve staff and volunteers
• education and training.

3.5.2 Mapping directly employed staff groups

It is suggested that Trusts develop a database (within the constraints of the Data Protection Act 1998 and in collaboration with staff and their representative bodies) that maps out the strengths of the workforce (including the individual's identity, dependents, current employment role, routine location and contact details, current and potentially transferable skills, redeployment training needs). Trusts need also to consult staff about employment in other NHS organisations or involvement in voluntary activities, e.g. St John's Ambulance, to ensure that there is no double-counting of resources by organisations.

This database should be regularly updated to take account of staffing changes. In combination with an understanding of the key essential functions of a hospital, this database would help map where staff could be located/redeployed during an influenza pandemic and ensure they are mobilised to where there are best needed.

It may also be useful for Trusts to map the usual modes of transport to work of these staff and whether they can walk or cycle if transport links are disrupted.
3.5.3 Mapping reserve, volunteer and externally contracted staff

Many influenza pandemic plans have included the use of volunteer and other reserve staff. A clear understanding of the availability and skill sets of these groups will be necessary in order to supplement the employed workforce. Therefore, again within the constraints of the Data Protection Act 1998, it may be appropriate for Trusts to develop a similar database to those of the employed staff. Similarly, this should be regularly updated.

In order to provide these reserve, volunteer and externally contracted staff with legal protection, Trusts should ensure that they can be rapidly provided with contracts of employment.

There may be external contractors working directly for a Trust or supplying services to it. Understanding the impact of any disruption to the services provided by these contractors is important. Where the service supplied by the external contractor is deemed important or critical to the hospital’s continuing functioning, it should seek assurances that the external contractor has developed its own business continuity plan to cover the impact of an influenza pandemic on its staff.

3.5.4 Staff location audit

As part of the staff mapping work, prior to an influenza pandemic, it is suggested that Trusts audit the usual locations of staff, reserve staff and volunteers. Understanding the usual siting of staff should help in any redeployment required during an influenza pandemic.

3.5.5 Normal/minimum acceptable staffing levels/staffing situation representation

The normal and minimum acceptable staffing levels required to maintain life-saving, critical, important and non-essential functions should be mapped. Trusts should have a staffing availability situation representation system, so that it is clear which staff are available.

Both of these will then allow decisions to be made about redeployment should this be necessary. (Redeployment will need to be managed by the command and control systems of the Trust. It will need to be able to facilitate timely decisions.)

3.5.6 Skills audit

In preparation for an influenza pandemic, Trusts will want to know what pool of skills they have at their disposal from their employed, reserve and volunteer staff. It is likely that from a clinical perspective, key skills required for handling influenza pandemic cases will include (although this list is not exhaustive):

- emergency care
- critical care skills
• basic nursing care
• medication handling
• infection control
• venous access
• basic respiratory care/monitoring
• advanced respiratory support/monitoring
• care of the elderly/paediatric care
• advanced nursing care
• anaesthesia
• neurology
• gastroenterology
• basic imaging
• laboratory (biochemistry/haematology/microbiology/virology)
• pharmacy
• counselling.

Trusts will, according to their local circumstances, need to supplement this list with the skill sets needed to treat non-influenza emergency cases.

Non-clinical key skills required during an influenza pandemic include:

• catering
• food handling
• maintenance and engineering
• transport
• records handling
• information technology
• logistics/stores handling/requisitions
• finance
• security
• linen handling
• waste disposal – clinical and non-clinical
• telephony/call handling
• chaplaincy and other religious support facilities
• mortuary.

Understanding what skills staff have over and above their usual functions will help in redeployment during an influenza pandemic. It will also help to develop training programmes prior to and as an influenza pandemic develops in order to maximise staff preparedness. Competence assessment will be a necessary part of the process.

3.5.7 Roles during a pandemic/redeployment

Prior to an influenza pandemic, it is suggested that Trusts should plan what roles they will require redeployed, reserve and volunteer staff to undertake should an influenza pandemic occur and take steps to meet any training needs. Clarity to this process will be facilitated by mapping what roles these groups of staff will need to undertake, according to the stage of the emergency and the epidemiology of the emergent influenza pandemic virus. These plans will need to be flexible to take account of changing circumstances.

3.5.8 Staff absence from work

The Cabinet Office has issued guidance on the likely levels of staff absence during an influenza pandemic. Trusts are advised to consult the guidance in order to understand the levels of absence they will need to plan for. The current guidance is available at www.ukresilience.info/publications/060710_revised_pandemic.pdf

3.5.9 Ethical and professional obligations of staff during an influenza pandemic

An influenza pandemic will put staff under considerable pressure. There are likely to be conflicts between staff’s professional or contractual obligations, their own personal or family responsibilities and concerns about the risks they are exposed to by caring for patients suffering from pandemic influenza.

The Welsh Assembly Government, in conjunction with the Department of Health and NHS Employers, are developing guidance on human resource issues that will have relevance to the ethical and professional obligations of staff during an influenza pandemic, and will release this in due course. However, once this guidance is released, Trusts will need to work with staff to explain what will be considered appropriate professional practice during an influenza pandemic.
It is acknowledged that at the height of a pandemic the ability to provide care to usual standards will be affected. The Welsh Assembly Government will in due course issue guidance on the prioritisation of care, which will help staff meet their ethical and professional obligations during a pandemic.

3.5.10 Staff discipline and handling suspended staff

Staff discipline during an influenza pandemic will need to be considered by Trusts. There may be instances during an influenza pandemic where the conduct of some staff might warrant a disciplinary intervention. The Welsh Assembly Government, in conjunction with the Department of Health and NHS Employers, will be issuing further guidance on the handling of human resource issues in due course, which will include how disciplinary issues should be managed during an influenza pandemic. However, Trusts should begin to consider how these issues may be handled locally.

Policies should not disadvantage staff who (as instructed) have been advised to stay at home when ill.

3.5.11 Supporting staff and the provision of support to relatives and dependants of staff

Trusts should make services available that can enable their staff, reserve staff and volunteers to work effectively, by providing support for them and their families or dependants. These plans would be best made in conjunction with staff liaison groups/unions.

Services that might be needed include:

- general child care facilities, including for babies (24 hours) (taking into account that school closures may preclude the use of such facilities, for reasons of cross-infection)
- transport arrangements for children of staff
- communication facilities between staff and their children/families
- support for bereaved staff.

3.5.12 Payment of reserve staff and volunteers

Reserve staff may require payment and volunteer staff may have out-of-pocket expenses. Trusts will need to ensure they have systems in place for payment of these staff, and have agreed prior to a pandemic the criteria for and scale of payment that will be made.
3.5.13 Contracted hours and the European Working Time Directive

During an influenza pandemic, it is possible that due to absence from work, there will be a need to increase the hours worked by staff still able to attend work. Normally, the hours worked would be controlled by the contractual agreement entered into between the employer and staff member and also the European Working Time Directive.

Within the European Working Time Directive there are provisions that deal with the need for longer working hours than usual where the circumstances are unforeseen, unusual and beyond the control of the employer, or exceptional and could not have been avoided by the employer (subject to ensuring adequate rest, protection and health and safety of the employee).

The Welsh Assembly Government, in conjunction with the Department of Health and NHS Employers are examining the implications of the Working Time Directive during an influenza pandemic on the ability to increase hours of work and will be issuing guidance as part of the human resource work in due course.

However, Trusts’ attention is drawn to the regulations as they stand, and they are advised to begin to plan for how they might respond to the need to increase hours of work. Details of the regulations are available at:
www.opsi.gov.uk/si/si1998/19981833.htm#21

3.5.14 Occupational health considerations for pandemic influenza planning and response

In carrying out business continuity planning, Trusts will wish to consider how best to support the Government’s efforts to reduce the impact of an influenza pandemic by taking all reasonable steps to ensure that employees who are ill or think they are ill during an influenza pandemic are positively encouraged not to come into work. Trusts will therefore need to have systems in place for detecting staff that have or may have pandemic influenza before they arrive at work. They will also need arrangements in place for handling staff that become ill with possible pandemic influenza whilst at work. Personnel policies may need to be reviewed to achieve this aim and Trusts should consider issuing guidance to staff ahead of pandemic.

Once staff have recovered from pandemic influenza it may be appropriate to use these staff to look after the cohort of patients with pandemic influenza. However, there may be risks other than influenza to which staff would be exposed such as secondary bacterial infections. Trusts will need to consider how they will use these staff safely without putting them at additional risk.

Ensuring that employers and employees are made aware of government advice on how to reduce the risk of infection during an influenza pandemic is important. The Welsh Assembly Government Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings can be found at:
http://www2.nphs.wales.nhs.uk:8080/fluandpandemicdocs.nsf/61c1e930f9121fd080256f2a04937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Guidelines%20-%20May%202006.doc
Employers should:

- ensure that adequate hygiene (e.g. hand washing) facilities are routinely available to all business areas, not just clinical areas
- ensure that health and safety responsibilities to employees continue to be fully discharged in order to protect staff, reduce the risks they face and avoid unnecessary staff exposure to risk from pandemic influenza
- factor into their planning that medical counter-measures will not solve staff absence issues for Trusts, their suppliers and other significant stakeholders, because antiviral drugs for treatment will only lessen the severity of the illness. They will neither cure it nor significantly reduce absenteeism.

In addition, Trusts will need (as necessary) to be aware of, and plan for, the consequences of measures that the Government may conclude are necessary to control or delay the spread of the disease, which may result in additional staff absence from work (in addition to increased parent-worker absences arising from possible school closures). (Further information from the Cabinet Office is available at [www.ukresilience.info/publications/060710_revised_pandemic.pdf](http://www.ukresilience.info/publications/060710_revised_pandemic.pdf))

As part of the preparation towards an influenza pandemic, Trusts should ensure that they can:

- monitor and optimise the uptake of seasonal influenza vaccine by staff
- monitor and optimise the uptake of pneumococcal vaccine by staff deemed to be at particular risk of pneumococcal infection.

The Welsh Assembly Government has a stockpile of H5N1 vaccine, which may be used to protect health service staff if appropriate (this will depend on the emergent influenza pandemic virus type). Similarly, it is also making efforts to procure pandemic-specific vaccine. It is likely, however, that there will need to be some prioritisation of staff groups provided with vaccination, given the likely available quantities, logistics of delivery and dosing regimens. Trusts should therefore develop plans for how they will prioritise their staff for vaccination (using national guidance in appropriate local contexts). The Welsh Assembly Government will issue guidance in due course to help Trusts to prioritise who amongst their staff should receive vaccination.

3.5.15 Restriction of deployment of potentially infected staff, reserve staff and volunteers

It is likely that staff, reserve staff or volunteers will be exposed to patients suffering from pandemic influenza. There may be circumstances where these staff will need to have their deployment restricted, either because of personal risks from contracting influenza, risks to family members particularly vulnerable to influenza or risks to vulnerable patients. An example is where staff would normally work with patient groups such as bone marrow transplant patients who would be particularly at risk of complications from influenza. Under these circumstances it would not be appropriate to expose these
patients to a staff member known to have been exposed to patients infected with influenza.

Trusts should plan for dealing with such circumstances. Trusts should consult the Welsh Assembly Government Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings.

3.5.16 Health and safety and risk mitigation

In an influenza pandemic, it is possible that staff could be adversely affected. Trusts will be expected to consider and mitigate these risks where possible.

Patients could also be put at risk by using staff/treatment locations not usually used for the types of care required in an influenza pandemic. Again, Trusts will be expected to consider and mitigate these risks where possible. Examples of such risks include the following:

- **Staff at high personal risk of influenza complications (e.g. those who have pre-existing respiratory disease or other chronic disease likely to be exacerbated by influenza).** Consideration should be given to reallocating such staff to work where they are less likely to be exposed.

- **Exposure risk from clinical activity.** Personal protective equipment measures will need to be considered, particularly for staff exposed to high-risk aerosol generating procedures such as intubation. The Health and Safety Executive has issued guidance on the use of personal protective equipment in an influenza pandemic. This is available at [www.hse.gov.uk/biosafety/diseases/pandemic.pdf](http://www.hse.gov.uk/biosafety/diseases/pandemic.pdf). Additionally the Welsh Assembly Government has previously issued guidance on infection control in hospitals and primary care settings. Further statements and guidance on the provision of personal protective equipment will be available later. This will include advice on the provision of masks.

- **Risks of infection.** Appropriate training will need to be provided on infection control and the handling of potentially infected patients. Again, Trusts will need to consider the infection control guidance already issued, and the training they will need to implement.

- **Risks of working in a different environment or in a different role from usual.** Appropriate training for working in settings or roles different from usual will be required. The use of staff in settings other than their usual specialty/skill set or of volunteer/other reserve staff has potential risks to both the staff member, patients and the Trust. Plans will need to be developed to ensure that reallocated staff are not working beyond their competence limits, that their professional registration (where relevant) allows them to do so and that insurance arrangements cover their work. Arrangements will need to be made prior to a pandemic for ensuring that other potential staff identified (such as those recently retired) can be provided with certification to work in an emergency.

- **Risks from general security issues.** Security provision and training in handling confrontational situations will be required.
3.5.17 Indemnity and regulatory issues

Indemnity
Staff, reserve staff and volunteers must be provided with appropriate indemnity. Responsibility for this lies with the Welsh Risk Pool and this will not change should payment be required as a result of a pandemic influenza outbreak.

Certification
Some staff – especially reserve or volunteer staff – will require rapid recertification with their professional body. Trusts should identify who will need this urgently and should have systems in place to provide it. Further guidance on human resource issues, including those of certification, will be issued by the Welsh Assembly Government, in conjunction with the Department of Health and NHS Employers, in due course.

3.5.18 Criminal Records Bureau assessment of staff, reserve staff and volunteers

Under normal circumstances, healthcare workers are subject to Criminal Records Bureau checks prior to commencing employment. Reserve and voluntary staff would also be required to undergo such checks. During an influenza pandemic, the timely recruitment of reserve and volunteer staff would be constrained by the need to check previous criminal history. The Welsh Assembly Government, in conjunction with the Department of Health and NHS Employers, are examining how to deal with this and will issue advice within the human resource guidance in due course.

3.5.19 Education and training

Pandemic-specific/emergency preparedness education
Trusts should already have detailed programmes of education in place on emergency planning for all key staff groups. Trust emergency planners should take the opportunity in preparing for an influenza pandemic to revise these plans and check that sufficient resources are committed to enable adequate training for staff to ensure a sustainable response. All training needs should be tailored to the hospital’s specific requirements.

For pandemic influenza there are a number of key elements of training that need to be covered (depending on which staff group the education is being delivered to), in particular:

- general awareness of the implications of pandemic influenza for hospitals and staff
- duties of staff during a pandemic
- training specific to roles when redeployed
- occupational health of staff during an influenza pandemic
- triage and containment of possible cases
• isolation/cohorting of influenza patients

• treatment (in particular the role and limitations of antiviral drugs and vaccination and psychological support for patients and relatives)

• case reporting (for influenza pandemic surveillance and response purposes)

• safe handling of laboratory samples

• prevention and control of influenza, including infection control/awareness of biohazard risks and how to reduce risks of transmission to self/other staff and patients/other hospital visitors

• waste disposal

• visiting restriction policies in an influenza pandemic

• staff safety, in particular the use of personal protective equipment and handling conflict and violence

• steps to avoid transmission from staff to non-work personal contacts including family

• staff annual influenza vaccine benefits.

Training should be delivered in a staff-group specific way. Staff should receive the level of training they need for the tasks they will be expected to undertake during an influenza pandemic. Trusts should ensure that back-up staff are also included in training activities.

Much of this education will need to refer to and be based on the Welsh Assembly Government Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings, which can be found at:

http://www2.nphs.wales.nhs.uk:8080/flupandemicdocs.nsf/61c1e930f9121fd080256f2a004937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Gover nment%20Infection%20Control%20Guidelines%20-%20May%202006.doc

Service expansion in areas required to respond to an influenza pandemic, especially critical care, will be dependent upon redeploying staff from other clinical areas. These staff will require specific training. This will require resource allocation and backfill of the posts during training sessions, and will need to be agreed and planned in advance and regularly updated to ensure that reserve staff retain the core competencies required to support their new roles, in particular in critical care.

**Standardised operating procedures and training**
Each Trust should have standard operating procedures for emergencies (SOPs)/hospital emergency plans. In preparing for an influenza pandemic, it would be opportune for Trusts to examine whether their SOPs/emergency plans are fit for purpose.
Guidelines and protocols should be readily available at the point of care. They should be regularly updated to keep abreast of new developments.

Staff all need basic knowledge and training in the SOPs, with further specific training and scenario experience being provided according to their functional group.

**Training delivery**
Where possible, Trusts should use published national training sources in responding to emergencies and pandemic influenza. Training should be adapted to suit staff group needs and contexts.

**Self-protection**
Staff should be advised on how to avoid catching influenza and the action they should take if they develop influenza. Guidance has been issued from the Cabinet Office in the form of *Contingency planning for a possible influenza pandemic*, available at [www.ukresilience.info/publications/060710_revised_pandemic.pdf](http://www.ukresilience.info/publications/060710_revised_pandemic.pdf).

More specific guidance on self-protection has been issued by the Welsh Assembly Government in *Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings*.

**Seeking medical care**
Staff, reserve staff and volunteers may themselves become ill during the course of an influenza pandemic. Trusts should develop systems for enabling these staff to obtain medical care and should ensure staff are educated as to how to access care if they become ill, either during or out of work hours. Trusts should emphasise to staff the importance of registering with a general practitioner, as primary care will be the main route for staff to obtain assessment and treatment.

**Business continuity training**
It is important to ensure that relevant people across the Trust are confident and competent concerning the business continuity plans. Training should be supplied for those directly involved in the execution of the business continuity plan should it be invoked. More information on this is available at [www.ukresilience.info/preparedness/businesscontinuity/index.shtm](http://www.ukresilience.info/preparedness/businesscontinuity/index.shtm).

### 3.6 Trusts’ responsibilities in limiting illness and death arising from infection and in reducing further spread of pandemic influenza

#### 3.6.1 Providing education and training to the public in the locality (Category 1 responsibility)

Trusts as Category 1 responders under the terms of the Civil Contingencies Act 2004 have warning and informing duties. The Act requires Category 1 responders to engage in pre-emergency awareness-raising work, and to warn and inform the public during emergencies.
3.6.2 Advice for members of the public

Trusts should be developing communication and information campaigns for their population on self-protection in an influenza pandemic situation. All guidance should where possible be based on nationally available guidance and then modified where necessary to the local situation.

3.6.3 Education resources for patients, relatives and hospital visitors

Leaflets and other education material about influenza pandemics should be made available to patients, their relatives and hospital visitors. Where possible, these should use nationally available resources, adjusted to local circumstances, where necessary and should be available in suitable languages for the local population.

3.6.4 Trusts’ responsibilities for wider control measures

In addition to instructing staff and patients to exercise personal responsibility in terms of self-protection, Trusts will need to exercise their responsibilities to reduce the spread of an influenza pandemic by the use of social measures and travel restrictions.

3.6.5 Social and hygiene measures

Reducing social mixing is one strand of civil contingencies planning and aims to reduce exposure to a pandemic influenza virus from social interaction.

Good hygiene measures need to be in routine use now, in particular coughing and sneezing etiquette and hand washing.

Trusts need to consider in their planning the fact that routinely large numbers of patients and staff pass through their doors daily. Trusts should therefore consider the following:

- How they will reduce the risks of droplet spread in seated areas. This is clearly relevant in waiting areas, for example in emergency departments and outpatients, but also in large collection areas, such as restaurants or rest areas.

- The availability and adequacy of hand washing facilities. Adequate hand washing practice and facilities are fundamental to good infection control practice. As part of their general response to infection control, Trusts should be reviewing the availability of hand washing facilities and hand washing practice in staff. They should also be providing guidance to patients and relatives on hand washing (using national guidance where possible).

- The adequacy of, and standards set for, cleaning facilities before and after use. Infection control standards at all times are important regardless of the presence of an influenza pandemic. However, Trusts will need to ensure that high-quality cleaning standards are maintained during a pandemic, with particular attention given to places affected by droplet spread.
The most appropriate management of areas of close person-to-person contact on entering, within or leaving the site. Trusts will need to plan for how they will minimise mixing in areas of high contact. (For example reception areas, triage stations, cohorting patients and staff streams for entry and exit.)

Trusts will need to consider and plan for their own duty of care to their staff in how they will continue to provide their services, whilst minimising social exposure where possible. For example, they may consider using screens between reception staff and patients or telephone interaction systems.

Trusts should consult the guidance issued by the Welsh Assembly Government 
Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings available at:

http://www2.nphs.wales.nhs.uk:8080/flupandemicdocs.nsf/61c1e930f9121fd080256f2a04937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Government%20Infection%20Control%20Guidelines%20-%20May%202006.doc

3.6.6 Travel restrictions

Trusts should examine ways of reducing the amount of travelling their patients need to do in an influenza pandemic. Undoubtedly, many patients will continue to need to attend hospital, but there will be some who could be followed up by alternative means, such as telephone review, or blood tests being taken in the community instead of at the hospital. Additionally, Trusts should plan to minimise the number of patient movements within the hospital to reduce the risks of cross-infection.

Trusts should plan for and enable staff where possible to work remotely so that exposure to others is minimised. This should be considered and planned for before an influenza pandemic, so that functions that can be provided and sustained remotely without the physical presence of staff on site can be organised and tested prior to the event.

Where staff have to work at the Trust site, Trusts should consider and plan for enabling the staggering of journeys to work using public transport. For example, it may be possible to stagger starting times on rotas. For more information on this see www.ukresilience.info/publications/060710_revised_pandemic.pdf

3.6.7 Partnership working/working with stakeholders on prevention

Trusts do not exist in isolation. There are programmes to provide seasonal influenza vaccination and pneumococcal vaccination to qualifying at-risk individuals in the community. Trusts should be working with their community partners to monitor and improve uptake of these vaccines.

3.6.8 Managing staff and community expectations

The heightened media interest has fuelled public concern about a possible influenza pandemic. Public and staff concern is likely to increase as the pandemic threat
escalates. There will be a large amount of pressure on all sectors of the health community for assistance, including vaccination and treatment. Trusts, in conjunction with their stakeholders, need to plan for and begin to manage these expectations immediately.

3.6.9 Infection control

Each Trust should have an infection control committee. The committee should be part of the Trust’s pandemic planning activity and also should be represented in the command and control of an actual influenza pandemic. The infection control committee should be using the Welsh Assembly Government Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings.

Infection control committees should be considering the personal protective equipment needs of the hospital and advising the Trust on this.

3.6.10 Special precautions for highly pathogenic organisms

Trusts should use the pandemic influenza infection control guidance to ensure that they have standard procedures in place for handling patients infected with highly pathogenic influenza (or indeed other highly pathogenic organisms). Particular attention should be paid to patients and staff at higher risk, such as those on immunosuppressive medication or suffering from immunocompromising conditions.

These precautions should cover at least:

- identification and isolation of cases infected with avian or pandemic influenza
- possible modes of transmission/carriers and how the pathway may be interrupted
- identification of particularly vulnerable potential recipients in order to apply additional precautions.

Trusts should ensure that staff, patients and visitors are made aware of the precautions to be taken.

Trusts will need to pay particular attention to the standards of cleaning, disinfection and waste management during an influenza pandemic. Although these standards should already be uniformly high, there will be some additional needs over and above those considered to be routine. The infection control committee should contribute actively to this aspect of plan development. They will need to be guided by the infection control guidance already issued by the Welsh Assembly Government, available at:

http://www2.nphs.wales.nhs.uk:8080/flupandemicdocs.nsf/61c1e930f9121fd080256f2a04937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Government%20Infection%20Control%20Guidelines%20-%2020May%202006.doc
3.7 Providing treatment and care for those who become ill

3.7.1 Triaging/admission criteria/bed management

It is likely that during an influenza pandemic the need for hospital beds will increase and at times this will be a substantial increase. Even at the early stages of an influenza pandemic, where numbers of affected cases are few, there will still be a case for managing bed use carefully to minimise the risks to staff and other patients.

Effective triage, admission criteria and bed management should help hospitals to provide optimal care to as many patients as possible whilst taking into account limited resources. Triaging development should be undertaken with all care providers in the local area, in particular primary and community care and the Welsh Ambulance Trust but also including private and voluntary care providers, hospices, and mental health and social care providers.

This guidance is designed to offer generic advice and may not address issues specific to individual specialties.

Triage, admission criteria and bed management will have to be capable of rapid change, taking into account the dynamics of the emergency in terms of the behaviour of the virus and severity of patients’ illnesses or other emergencies and the availability of care facilities, staffing and other resources. Some triaging assessments will need to take place outside of hospital at the patient’s home or other places of healthcare delivery. Triage development should take account of this. Triage development will also need to take account of the specific needs of children, in particular concerning critical care provision.

Decisions on access to care should take into account the ethical framework developed by the Committee on Ethical Aspects of Pandemic Influenza (CEAPI) (see Ethical framework for the response to pandemic influenza). Advice on prioritisation for treatment is being developed currently and will be issued once available.

Trusts should consult the guidelines issued for the management of pandemic influenza cases from the British Thoracic Society in the development of their triage criteria. These are available at www.brit-thoracic.org.uk/c2/uploads/pandemicflu.pdf

If a Trust decides to adopt the British Thoracic Society guidelines for managing patients during a pandemic, they should ensure that they are approved by the internal Trust clinical guidelines group.

Additionally for triage to critical care facilities, Trusts should in the first instance consult the consultation document on Critical Care Contingency Planning in the event of an emergency where the number of patients substantially exceeds normal critical care capacity. This is available at www.dh.gov.uk/assetRoot/04/13/76/19/04137619.pdf

The following are issues to consider and plan for when dealing with triage and admissions:
• As an influenza pandemic threat escalates, specific triage for pandemic influenza symptoms will need to be activated with direct questioning to identify possible cases. Trusts should define when this would commence and terminate.

• Triage criteria (adults and children). Trusts should ensure that they can triage influenza and non-influenza emergency cases effectively, in order to ensure that patients are appropriately categorised according to their need for care.

• Thresholds for admission and admission criteria for influenza emergency cases to hospital (adults and children). Admission processes should minimise the amount of contact with staff and other patients where possible, such as by use of direct admission wards for referred patients.

• Thresholds for admission and admission criteria for non-influenza emergency cases to hospital (adults and children). Guidelines need to be developed on routine case admissions to hospital and other routine activity such as outpatients.

• Thresholds for admission/admission criteria for influenza emergency cases to critical care (adults and children) need to be developed.

• Thresholds for admission/admission criteria for non-influenza emergency cases to critical care (adults and children) need to be developed.

• Guidelines on routine cases admissions that will require critical care services (adults and children) need to be developed.

• Facilitation of the early discharge of patients who no longer need hospital care. Plans will need to be made in conjunction with primary care providers to ensure continuing care, and also social care services. Out of hospital, care providers will also need to be consulted in developing these plans, including the nursing and residential home sector and other temporary accommodation sites such as rest centres. Within these plans, transport arrangements will also need consideration.

• Facilitating the timely discharge of patients who have recovered will be important in freeing up bed capacity in the hospital. Trusts should plan immediately with social care services and liaison teams how they will achieve this during a pandemic. Discharge planning will need to start early following admission.

• Cohorting of patients. Bed management may require that in localities with more than one hospital, one of the hospitals is designated an influenza hospital whilst another is designated for other emergency patients. This would help in keeping the patient cohorts separate. However, Trusts should recognise that it is doubtful whether the non-influenza hospital could be kept free of influenza, due to asymptomatic infected patients, relatives and staff spreading the virus. This approach would also depend on the number of expected cases for a given area and so would have to be carefully planned. Additionally, the separation of hospital roles would have to be carefully communicated to the local population and other stakeholders, so that it was clear where patients should go. Where such separation is not feasible, Trusts should consider designating specific areas of the hospital for cohorting influenza and non-influenza cases (including for critical care services and obstetric and paediatric services). Trusts may need to
consider how they can use the independent sector in making these provisions, for example for the provision of maternity services to non-infected antenatal patients.

- Developing new or supplementing existing plans for tracking bed availability. Any system developed should be capable of rapid, real-time updating and of being communicated to the LHBs and Trusts. Systems should also be capable of tracking ventilated and non-invasive respiratory support beds.

- During the pandemic, there will be situations where facilities become overwhelmed (in particular ventilated critical care beds). Trusts should plan for such events and how to handle them.

- Some Trusts will have inpatient psychiatry beds. Trusts are advised to consider the particular needs of this group of patients. For example, there will be issues around the cohorting of such patients and the facility to provide secure accommodation where needed.

- Some Trusts will have patients enrolled on drug trials. Planners are advised to consider how the needs of the patients will continue to be met during an influenza pandemic, in particular with respect to the continued supply of trial medications and monitoring of the patients.

- Trusts will need to ensure that the needs of children can be met, taking into account the need to cohort infected and non-infected cases. There will be specific intensive care needs to be addressed for children.

- The Department of Health has consulted on the handling of critical care issues during an influenza pandemic. Definitive guidance will be issued in due course. However, the consultation guidance *NHS Emergency Planning Guidance 2005: Critical Care Contingency Planning in the event of an emergency where the number of patients substantially exceeds normal critical care capacity – A consultation* is available at [www.dh.gov.uk/assetRoot/04/13/76/19/04137619.pdf](http://www.dh.gov.uk/assetRoot/04/13/76/19/04137619.pdf)

### 3.7.2 Management of cases and contacts

In accordance with the clinical guidelines issued to date, the Welsh Assembly Government will expect all Trusts to have:

- developed and cascaded protocols for the treatment of adult, paediatric and critical care cases to clinical staff (antiviral drug treatment should be provided as rapidly as possible)

- developed and cascaded triage protocols for adults and children presenting with an influenza-like illness during an influenza pandemic. Within these triage criteria there should be criteria for access to pandemic-specific medication, including antivirals and antibiotics
• developed and cascaded triage protocols for handling non-influenza emergencies in a pandemic.


Trusts should ensure their medical directors, clinical leads and critical care leads are conversant with the document, keep abreast of any changes and cascade the knowledge to frontline staff as appropriate. Trusts should summarise the guidance into posters with algorithms to help frontline staff make rapid, consistent decisions so as to improve efficiency and quality of care.

If a Trust decides to adopt the British Thoracic Society guidelines for managing patients during a pandemic, it should ensure they are approved by the internal Trust clinical guidelines group.

### 3.7.3 Hospital supplies of antivirals for inpatient treatment

Systems for supplying antivirals for inpatient treatment are being considered. Further information will be decided in due course.

### 3.7.4 Home and community care

The effectiveness of response to pandemic influenza will depend heavily on the provision of care in the community for most individuals. Trusts should engage with their community care providers (general practitioners, primary care, social care services, local authorities, local population and volunteers) on how provision in the community and hospital will work together in the event of a pandemic.

Trusts should consider the provision of innovative approaches to providing care outside the hospital setting. Home hospital care may be possible if staff are redeployed from other areas.

Trusts should be guided by the document *Pandemic influenza contingency planning: Guidance for the provision of health care in a community in Wales.*

Trusts should work with local stakeholders to identify potential alternative community accommodation resources for providing medical and non-medical care, for example for recuperation of patients or accommodation of relatives. Examples include community centres or hotels.

### 3.7.5 Vulnerable groups

It is likely that there will be individuals presenting at hospital who will not meet the criteria for admission, but nonetheless are from a vulnerable group and will therefore need additional support if they are not to deteriorate further and require admission. Trusts
should be planning now with stakeholders how they will support these groups of individuals.

Vulnerable groups include, amongst others, children (especially those without a carer), elderly people, disabled people, asylum seekers and homeless people.

### 3.7.6 Ethical basis of decision making

The Welsh Assembly Government is aware that an influenza pandemic will pose considerable ethical difficulties for decision makers with regard to the delivery of clinical care.

However, the priority is to reduce illness and save the most lives, in a way that is fair. The ethical framework will assist Trusts in the ethical provision of clinical care.

### 3.7.7 Maintenance of services to non-influenza cases

Trusts should ensure for as far and as long as possible that they have robust plans for continuing services to those with acute, chronic or life-threatening non-influenza cases (e.g. heart attacks, parenteral nutrition or chemotherapy/radiotherapy).

The Department of Health will ask all Royal Colleges to review all pandemic influenza guidelines in the light of these requirements.

### 3.7.8 Reporting of the effectiveness of treatment

It is unclear at this stage how well antiviral drug treatment will work in an influenza pandemic. Information on effectiveness of the medication for treated cases will be important. Trusts should therefore develop systems to be able to collect this information, so that it can be analysed. This will help inform practice during the pandemic.

### 3.7.9 Isolation and cohorting of cases

During the pre-pandemic WHO Phases 3 to 5, possible cases of avian or pandemic influenza should be identified and isolated rapidly and their contacts followed up for possible post-exposure prophylaxis with antiviral drugs if appropriate. Once WHO pandemic Phase 6 has been declared, it is likely that health services will still try to identify the first few individuals infected with the pandemic virus and control the spread in the same way as in the pre-pandemic phases. However, it is acknowledged that this approach is likely to fail and become rapidly unsustainable as the pandemic unfolds. Therefore, in order to buy time, Trusts can anticipate the need to continue isolating, in the early stages of WHO Phase 6, UK alert levels 1 and into 2, the first few individuals suspected of being infected. However, it is equally clear that there will be a stage at which this will have to stop, and hospitals will then need to change to cohorting of care.

Trusts should now be planning with local stakeholders how this will actually be done when the time comes to respond.
Trusts should consult the guidance issued by the Welsh Assembly Government Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings available at:

http://www2.nphs.wales.nhs.uk:8080/flupandemicdocs.nsf/61c1e930f9121fd080256f2a04937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Government%20Infection%20Control%20Guidelines%20-%20May%202006.doc

3.7.10 Special situations

Some Trusts will have within their community prisons, ports (air and sea), mental health Trusts, military bases and other ‘closed communities’. Most Trusts will also have within their catchments nursing and residential homes. In order to try to contain the spread of the disease, where relevant, Trusts should work with these stakeholders, including the Local Resilience Forum, to plan for how they will respond to:

- prison cases and asylum detention centres
- mental health and learning disability unit cases
- cases (and contacts) presenting through ports, or immigrants
- cases in other closed communities such as military bases, schools, and nursing and residential homes.

Where possible, if treatment can be safely provided in the patient’s usual locality, transfer to hospital should be avoided. Therefore, protocols for handling these patient groups will need to be drawn up and shared with these relevant stakeholders, taking account of national guidance on clinical care and infection control already issued. Clearly, if the patient’s condition does not allow this then admission may be necessary. Again, arrangements will need to be developed to handle this.

The British Thoracic Society Guidelines for the clinical management of patients with an influenza-like illness during an influenza pandemic should be consulted when developing these plans. These are available at www.brit-thoracic.org.uk/c2/uploads/pandemicflu.pdf

If a Trust decides to adopt the British Thoracic Society guidelines for managing patients during a pandemic it should ensure they are approved by the internal Trust clinical guidelines group.

Guidance for Pandemic Influenza: Infection Control in Hospitals and Primary Care Settings should also be consulted. This is available at

http://www2.nphs.wales.nhs.uk:8080/flupandemicdocs.nsf/61c1e930f9121fd080256f2a04937ed/db0e619f03aab0098025717800461395/$FILE/Welsh%20Assembly%20Government%20Infection%20Control%20Guidelines%20-%20May%202006.doc
3.7.11 Surge in clinical demand

Modelling suggests that during an influenza pandemic there will be peaks in demand that either threaten or overwhelm capacity to respond, in particular for more specialised treatments or scarce resources such as critical care. Under these circumstances, it will be impossible for Trusts to provide the usual standards of medical care.

Available resources will therefore limit the standard of care that can be provided in the emergency, and decisions will need to be made prior to the event on how to provide care in a manner that is ethically appropriate.

Decisions on access to care should take into account the ethical framework developed by the Committee on Ethical Aspects of Pandemic Influenza. Decisions should also take account of the critical care guidance already issued, which is available at www.dh.gov.uk/assetRoot/04/13/76/19/04137619.pdf

Trusts should be aware of the possibility of restricted availability of resources and plan for how they will respond; however, this element of planning should not be limited to critical care provision only but should also cover more general clinical care.

3.7.12 Deaths

Modelling has predicted that there may be large numbers of individuals dying during an influenza pandemic from the disease or its complications. Mortuary handling issues are discussed separately in section 3.3.2. However, there are likely to be some clinical issues that need to be considered:

- The death of a patient is difficult at the best of times for most staff and for the patient’s relatives in particular. During an influenza pandemic it is likely to be an even more stressful and emotional issue, particularly if deaths occur which might have been preventable in normal circumstances. Trusts should be considering and planning for how they will respond to this in terms of providing support to the staff and relatives affected.

- Patient deaths will in some cases leave vulnerable individuals without a carer. Trusts should have procedures for dealing with such an eventuality; however, these systems will come under more pressure than usual during a pandemic. Trusts should therefore be planning with stakeholders how they will deal with this eventuality.

3.7.13 Communicating with partners and relatives

Clinical staff in the course of their routine work should have been trained in delivering bad news. However, there will be some additional training needs for staff communicating bad news in an influenza pandemic setting, particularly where it involves informing patients, partners or relatives about restricted access to critical care and other specialist treatment.

Staff, patients and their relatives may be assisted by the provision of verbal or written information that has been developed prior to an influenza pandemic occurring. This
would also help achieve consistency of messages and therefore help to reduce distress due to perceived inequities of management.

### 3.7.14 Hospital visits

Trusts should ensure they have visiting policies that help to contain the spread of a pandemic. Trusts should ensure during an influenza pandemic that visiting is reduced as much as possible, other than for those for whom a visit is essential. Trusts should therefore define which groups of visitors are considered essential, for example parents of sick children and spouses or partners of ill adults.

### 3.7.15 Outpatient arrangements for non-influenza cases

The Welsh Assembly Government is developing guidance on the management of outpatient cases during an influenza pandemic and will issue further details in due course.

### 3.8 Service image and reputation

The public will expect a coherent, effective response to an influenza pandemic across government. However, public perception is likely to be influenced by the response of the health service. The NHS will be the cornerstone of successful management of an influenza pandemic, and it will need to ensure public confidence in its operational delivery during the event.

It is therefore critical that Trusts plan for an influenza pandemic and test their influenza pandemic preparedness plans, so that the response can be as smooth as possible in the actual event. In particular, planning will need to ensure that for example:

- access to care and treatment is uniform according to clinical need and availability and within the constraints that the pandemic imposes
- wherever a patient presents in Wales, as far as possible and according to their clinical need the treatment and management they receive will be same as any other patient, subject to the limitations imposed by an influenza pandemic and available resources
- dependent on the exposure risks, healthcare workers are all given the same degree of protection for the tasks they are undertaking.

Healthcare communities and the NHS cannot afford for there to be any variation in provision that would damage the reputation of the service, not least because robust public confidence will help optimise compliance with plans and therefore enhance the response to the emergency.
3.9 Performance

3.9.1 Benchmarking, evaluation and quality assurance

Trusts are advised to benchmark their preparedness plans against those of similar Trusts to provide a measure of assessment of the quality of readiness. This should allow examples of good practice to be disseminated and incorporated where appropriate.

Trusts should regularly evaluate and quality assure the state of their influenza pandemic preparedness plans.

3.9.2 Audit and evaluation of exercises and training

It is vital that the learning points from any exercises and training are evaluated and plans modified accordingly. Trusts should seek evidence of the quality of education imparted to staff, their acquired knowledge and how that understanding is being applied. Similarly, learning points from handling an actual influenza emergency should be taken into account when revising plans.

Emergency planners in Trusts should be clear about what they will assess prior to any exercises, including measures and performance targets.

3.10 Reducing disruption to society as far as possible

3.10.1 End of the first wave: preparing for subsequent waves

A single wave pandemic profile with a sharp peak provides the most prudent basis for planning, as that would put a greater strain on services than a lower level but more sustained wave or the first wave of a multi-wave pandemic. However, second or subsequent waves have occurred in some previous pandemics, weeks or months after the first. Whilst the first priority at the end of the first wave will be to develop recovery plans and restore supplies, services and activities depleted or curtailed during the pandemic, plans must assume that some regrouping may be necessary in anticipation of a future wave.

Trust plans should assume that heightened monitoring and surveillance will be required for some time beyond the first wave and that their plans will require review and revision in the light of lessons learnt. In particular, the likelihood of ongoing constraints on supplies and services and continuing pressures on health and social services should be taken into account.

Updated information on the epidemiology of the virus, effectiveness of treatment, availability of countermeasures and lessons learnt from the first wave will help inform and shape the response measures that Trusts will need to undertake to respond to second or subsequent waves.
3.10.2 Second or subsequent waves

Second or subsequent waves may be more or less severe than the first: UK alert levels 1–4 will come into play again, informed by epidemiological and mathematical modeling following the first wave. The Welsh Assembly Government will issue guidance to inform health plans following review of the first wave and the availability of countermeasures.

3.10.3 Recovery phase – returning to normality

As the impact of the pandemic subsides and it is considered that there is no threat of further waves occurring, Wales will move into the recovery phase. Although the objective is to return to pre-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisational fatigue and continuing supply difficulties in most organisations, including Trusts. Therefore, a gradual return to normality should be anticipated and expectations shaped accordingly. Trust plans should recognise the potential need to prioritise the restoration of services and to phase the return to normal in a managed and sustainable way.

Trusts are likely to experience persistent secondary effects for some time, with increased demand for continuing care from:

- patients whose existing illnesses have been exacerbated by influenza
- those who may continue to suffer potential medium- or long-term health complications (such as encephalitis lethargica, which may have been linked to the 1918 pandemic)
- a backlog of work resulting from the postponement of treatment for less urgent conditions.

The reintroduction of normal care standards will need to recognise loss of staff and their experience and that most others will have been working under acute pressure for prolonged periods and are likely to require rest and continuing support. Trusts’ facilities and essential supplies may also be depleted, resupply difficulties might persist and critical physical assets are likely to be in need of backlog maintenance, refurbishment or replacement. Impact assessments may therefore be required.

Other sectors and services are likely to face similar problems and may also experience difficulties associated with income loss, changes in competitive position, loss of customer base, lack of raw materials, the potential need for plant start-up, etc.
Annex A
WHO international phases and UK alert levels

WHO has defined phases in the evolution of a pandemic (see table below) that allow for a step-wise escalation in planning and response that is proportionate to the risk from first emergence of a novel influenza virus. WHO will inform its member states of any change in the alert phase, and this classification is used internationally. If a pandemic were declared, action would depend on whether cases had been identified in the UK, and the extent of spread. For UK purposes, four additional alert levels have therefore been included within WHO Phase 6; these are consistent with those used for other communicable disease emergencies.

<table>
<thead>
<tr>
<th>WHO international phases</th>
<th>UK impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inter-pandemic period</strong></td>
<td></td>
</tr>
<tr>
<td>1 No new influenza virus subtypes detected in humans</td>
<td>UK not affected unless it has strong travel and trade connections with affected country</td>
</tr>
<tr>
<td>2 Animal influenza virus subtype poses substantial risk</td>
<td></td>
</tr>
<tr>
<td><strong>Pandemic alert period</strong></td>
<td></td>
</tr>
<tr>
<td>3 Human infection(s) with a new subtype, but no (or rare) person-to-person spread to a close contact</td>
<td></td>
</tr>
<tr>
<td>4 Small cluster(s) with limited person-to-person transmission but spread is highly localised, suggesting that the virus is not well adapted to humans</td>
<td>UK not affected unless infection starts in the UK or it has strong travel and trade connections with affected country</td>
</tr>
<tr>
<td>5 Large cluster(s) but person-to-person spread still localised, suggesting that the virus is becoming increasingly better adapted to humans</td>
<td></td>
</tr>
<tr>
<td><strong>Pandemic period</strong></td>
<td></td>
</tr>
<tr>
<td>6 Increased and sustained transmission in general population</td>
<td>UK alert levels</td>
</tr>
<tr>
<td></td>
<td>1 Virus/cases only outside the UK</td>
</tr>
<tr>
<td></td>
<td>2 Virus isolated in the UK</td>
</tr>
<tr>
<td></td>
<td>3 Outbreak(s) in the UK</td>
</tr>
<tr>
<td></td>
<td>4 Widespread activity across the UK</td>
</tr>
</tbody>
</table>

Return to post-pandemic period
Welsh Assembly Government

Request for Comments

Draft Pandemic Influenza Guidance for Preparing NHS Trusts in Wales

Response Proforma

Closing date for responses: 1 October 2007
Respondent Details (Please provide the details of a single point of co-ordination for your response)

<table>
<thead>
<tr>
<th>Title</th>
<th>Mr / Mrs / Miss / Ms / Dr / Professor / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name</td>
<td></td>
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<tr>
<td>Organisation</td>
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<tr>
<td>Your Role</td>
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<tr>
<td>Address (including postcode)</td>
<td></td>
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<tr>
<td>Email Address</td>
<td></td>
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<tr>
<td>Phone Contact</td>
<td></td>
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</tbody>
</table>

If you are replying on behalf of a group of respondents or a number of organisations, please complete the following information:

<table>
<thead>
<tr>
<th>Organisations represented within this response</th>
<th></th>
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</table>

Response details

<table>
<thead>
<tr>
<th>Date of response:</th>
<th>Closing date: 1 October 2007</th>
</tr>
</thead>
</table>

Confidentiality: Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information that you have provided to be confidential. If we receive a request for disclosure of the information we will take full account of your request, but we cannot give an assurance that confidentiality can be maintained. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Welsh Assembly Government.

The Welsh assembly Government will process your personal data in accordance with the DPA and, in the majority of circumstances, this will mean that your personal data will not be disclosed to third parties.
<table>
<thead>
<tr>
<th>Consultation Question</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Did you find the structure and layout of the guidance user friendly? If not how could this be improved?</td>
<td></td>
</tr>
<tr>
<td>2 Are there any general comments you would like to make about part 3 of the guidance?</td>
<td></td>
</tr>
<tr>
<td>3 Are there any specific comments you would like to make about the following sections in part 3?</td>
<td></td>
</tr>
<tr>
<td>3.1 Programme</td>
<td></td>
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<tr>
<td>3.2 Processes</td>
<td></td>
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<tr>
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<tr>
<td>3.4 Providers</td>
<td></td>
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</tbody>
</table>
3.5 People

3.6 Trusts’ responsibilities in limiting illness and death arising from infection and in reducing further spread of pandemic influenza

3.7 Providing treatment and care for those who become ill

3.8 Service image and reputation

3.9 Performance

3.10 Reducing disruption to society as far as possible

4 | Does the guidance, in conjunction with other guidance cited within, appropriately support the planning needs of Trusts and more generally the NHS? If not, why not?

5 | Have you identified any gaps where you feel Trusts and the NHS in Wales would benefit from further guidance?

6 | Are there any specific planning points contained in the guidance that are a cause of major concern for your organisation?

7 | Any further comments.
If you have any comments not relating to the consultation itself, these should be directed to:

Mr William Whiteley  
Welsh Assembly Government  
Cathays Parks  
Cardiff  
CF10 3NQ

Email: william.whiteley@wales.gsi.gov.uk  
Tel: 02920823972  
Fax: 02920823823