THE LEEDS TEACHING HOSPITALS NHS TRUST

PANDEMIC INFLUENZA PLAN (DRAFT)

Publication Level A - RESTRICTED

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<th>Version No.</th>
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<th>Date</th>
<th>Review Date</th>
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<tr>
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<td>Full review and update of 2009/10 plan against updated national guidance</td>
<td>Sharon Scott</td>
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<td>Sharon Scott</td>
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Associated Documentation:

Trust Controlled Documents
Major Incident Plan
Winter Plan 2014/15 (and all future updated)
Infection Prevention and Control Policy August 2013
Control of Outbreak of Infection in Hospital January 2014
Critical Care Bed Escalation Plan

External Documentation
Leeds City Council: Draft Leeds Local Pandemic Influenza Response Plan V0.6 01.09.15
Yorkshire and the Humber Adult Critical Care Escalation Framework May 2014 V2 (Under Development)
NHS Core Standards for Emergency Preparedness, Response and Resilience 2015
NHS England Command and Control Framework for the NHS During Significant Incidents and Emergencies 2013
NHS England Operating Framework for Managing the Response to Pandemic Influenza 2013
Clinical guidelines for patients with an Influenza like illness during an Influenza pandemic (DH, 2006)
Guidance on the Roles and Responsibilities of Clinical Commissioning Groups (CCGs) in preparing for and responding to an influenza pandemic (NHS England 2013)
Health and Social Care Influenza Pandemic Preparedness and Response (DH 2012)
Influenza Pandemic Contingency Planning: Operational Guidance for Health Service Planners (DH 2005)
Pandemic Influenza: A national framework for responding to an Influenza pandemic (DH, 2007)
Pandemic Influenza: Guidance for acute hospitals in England (DH, 2007)
Pandemic Influenza: Guidance for infection control in hospitals and primary care settings (DH, 2007)
Pandemic Influenza: Guidance on Infection Control in Critical Care (DH 2008)
Pandemic Influenza: Guidance on meeting the needs of those who are or may become vulnerable during the pandemic (DH 2009)
Pandemic Influenza: Guidance on preparing maternity services in England (DH, 2008)
Pandemic Influenza: Guidance on the Management of Death Certification and Cremation Certification (DH 2012)
Pandemic Influenza: Human resources guidance for the NHS (DH, 2008)
Pandemic Influenza: recommendations on the use of antiviral medicines for pregnant women, women who are breastfeeding and children under the age of one year (DH 2009)
Preparing for Pandemic Influenza: Guidance for Local Planners (Cabinet Office 2013)
Responding to Pandemic Influenza – the ethical framework for policy and planning (DH, 2007)
Scientific Pandemic Influenza Advisory Committee – Subgroup on Modelling: Modelling Summary (DH 2013)
Swine Flu: UK Planning Assumptions (Department of Health/Cabinet Office, 2009)
UK Influenza Pandemic Preparedness Strategy 2011 (DH 2011)
UK Pandemic Influenza Communications Strategy 2012 (DH 2012)
Pandemic (H1N1) 2009 Influenza: A summary of guidance for infection control in healthcare settings (DH 2009)

Legal Framework
Civil Contingencies Act 2004
Equality Act 2010
Health and Social Care Act 2012

For more information on this document please contact:
Sharon Scott
Resilience Manager
0113 20 64576
Sharon.scott10@nhs.net
## Executive Summary

### Influenza Pandemic Plan

<table>
<thead>
<tr>
<th>Document Objectives:</th>
<th>To set out how Leeds Teaching Hospitals NHS Trust will respond to pandemic influenza.</th>
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| **Group/Persons Consulted:** | Emergency Preparedness Coordinating Group 11 December 2014  
Infection Prevention and Control Committee February 2015  
Leeds City Council Public Health 19 October 2015  
Leeds Outbreak/Pandemic Influenza Task & Finish Group 19 October 2015 |
| **Ratified and signed off by:** | Executive Team Meeting 9 November 2015  
Trust Board (CE report) 26 November 2015 |
| **Monitoring Arrangements and Indicators:** | Post incident reports  
Training and validation exercises  
Review by Emergency Preparedness Coordinating Group and Infection Prevention and Control Committee |
| **Training Implications:** | General Managers will be advised to include this plan in training for emergency preparedness at a local level. |
| **Equality Impact Assessment:** | To be assessed. |
| **Resource implications:** | Training and testing of this and individual CSU surge plans |
| **Intended Recipients:** | Trust Executive Directors  
Clinical Directors  
General Managers  
Heads of Nursing  
Matrons  
Members of the Emergency Planning Coordinating Group  
Members of the Infection Prevention and Control Committee  
On call management teams |

### Who should:

- **Be aware of the document and where to access it**
  - All staff

- **Understand the document**
  - All staff who would be required to undertake a role during a pandemic influenza

- **Have a good working knowledge of the document**
  - Trust Executive Directors  
    Clinical Directors  
    General Managers  
    Heads of Nursing  
    Matrons  
    Members of the Emergency Planning Coordinating Group  
    Members of the Infection Prevention and Control Committee  
    On call management teams
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1. Introduction

This plan describes the procedures used by Leeds Teaching Hospitals NHS Trust (LTHT) to respond to an outbreak of pandemic influenza. It covers all main and peripheral sites.

It is impossible to forecast the exact characteristics, spread and impact of a new influenza virus strain. Modelling suggests that from the time it begins in the country of origin it may take as little as two to four weeks to build from a few to around 1,000 cases and could reach the UK within another two to four weeks.

An influenza pandemic can occur in one wave, or in a series of waves, weeks to months apart. Once in the UK, it is likely to spread to all major population centres within one to two weeks, with its peak possibly only 50 days from initial entry.

The Trust can anticipate up to a three and a half fold increase in admissions during the peak of the pandemic wave due to acute respiratory and related conditions.

Influenza spread will impact on the whole community and may therefore lead to the closure of nurseries, schools, day care centres and other social facilities. It is therefore anticipated that staff will be absent during a pandemic due to the need to look after relatives or children.

It is estimated that 50% of the workforce may require time off over the entire period of the pandemic. Modelling suggests absenteeism may be as high as 15 – 20% of the workforce during the peak of the pandemic wave.

The plan has been prepared in consultation with appropriate parties within, and outside the Trust. It contains links to the other organisations in the Leeds health and social care community to ensure a comprehensive and co-ordinated response.

2. Influenza Background

A pandemic is the world-wide spread of a disease, with outbreaks or epidemics occurring in many countries and in most regions of the world.

An influenza pandemic occurs when a new influenza virus emerges which is markedly different from recently circulating strains, and has the ability to:

- Infect people (rather than, or in addition to, other mammals or birds);
- Spread easily from person to person;
- Cause clinical illness in a high proportion of the population infected;
- Spread widely due to the population having little or no immunity.

Influenza pandemics are natural phenomena that tend to occur two or three times each century. Pandemic influenza spreads rapidly to affect most countries and regions around the world. Unlike the ordinary ‘seasonal’ flu that occurs every winter, a pandemic can occur any time of year, and it is likely to affect different age groups than typical seasonal strains e.g. children or elderly rather than adults.

It cannot be predicted exactly when a pandemic will happen. When it does, it may come in one or more waves several months apart, with each wave lasting 14 – 15 weeks. A second or subsequent wave, if they occur, could possibly be more severe than the first.

The World Health Organisation (WHO) and other international organisations have warned that an influenza pandemic is both ‘inevitable’ and ‘imminent’. Such warnings have been driven by a highly virulent strain of ‘bird’ (avian) flu (A/H5N1) in Asia and the virulent strain of ‘swine’ flu (A/H1N1) that caused infections in 2009.

People with influenza are highly infectious for four to five days from the onset of symptoms. Some people may be infectious before any symptoms become apparent (up to 6 days).
Some groups, such as children and those with compromised immune systems, may remain infectious for longer periods (up to 21 days or longer from the onset of symptoms).

Pandemic influenza is likely to cause the same symptoms as seasonal flu, such as episodes of high fever, severe muscle aches and pains, cough, blocked or runny nose and sore throat. Pandemic influenza symptoms may be more severe. A pandemic is also highly likely to cause deaths, disrupt daily life and put intense pressure on health and other services. Each pandemic is different, and until the virus starts circulating, it is impossible to predict its full effects.

Diagnosis may be made clinically or through the laboratory by obtaining viral throat swabs – it is anticipated that appropriate diagnostic reagents will be made available to all NHS laboratories, though this may change following guidance from PHE. PHE will advise on the surveillance requirements for index and contact cases.

Antivirals can be used to treat influenza, however their effectiveness in treating a pandemic strain will not be known until the pandemic virus is circulating.

There is no vaccine ready to protect against pandemic flu. A vaccine can only be developed once the new virus is identified, even with preparatory work underway; it will be 4 to 6 months after that before a vaccine is available, possibly longer. Broad range Influenza A vaccines are in development but currently not yet licensed. National policy decisions will have to lead local actions.

2.1. **Aim and Objectives**

2.1.1. **Aim**

To enable LTHT to respond appropriately to an outbreak of pandemic influenza.

2.1.2. **Objectives**

- To establish clear command, control and communications procedures to ensure the safe and effective response to an influenza pandemic.
- To highlight resources available.
- To enable the maintenance of critical services during an influenza pandemic.
- To enable the Trust to discharge its responsibilities under the appropriate legislation.
- To ensure a return to normal operations as soon as is practicable.
- The plan is based on the Trust’s procedures for responding to an influenza pandemic.

2.1.3. **National Objectives and Principles**

To minimise the potential health impact of a future influenza pandemic on society and the economy and to instil and maintain trust and confidence this plan will reflect the strategic objectives and principles contained within:

- Department of Health UK Influenza Pandemic Preparedness Strategy 2011.
- Cabinet Officer - Preparing for Pandemic Influenza, Guidance for Local Planners. July 3013.
- NHS England Operating Framework for Managing the Response to Pandemic Influenza, 28 October 2013

Given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles should underpin all pandemic preparedness and response activity:
Precautionary: the response to any new virus should take into account the risk that it could be severe in nature. Plans must therefore be in place for an influenza pandemic with the potential to cause severe symptoms in individuals and widespread disruption to society.

Proportionality: the response to a pandemic should be no more and no less than that necessary in relation to the known risks. Plans therefore need to be in place not only for high impact pandemics, but also for milder scenarios, with the ability to adapt them as new evidence emerges.

Flexibility: there should be a consistent, UK-wide approach to the response to a new pandemic but with local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection and the different healthcare systems in the four countries.

3. Policy Statement

3.1. Legal Obligations

Leeds Teaching Hospitals NHS Trust recognises its legal obligation under the Civil Contingencies Act 2004 and the NHS England Emergency Preparedness Framework 2013 to undertake the following during an influenza pandemic:

- Provide a safe and secure environment for the assessment and treatment of patients.
- Provide a clinical response, including the provision of general support and specific/specialist health care to all patients.
- Provide a safe and secure environment for staff that will ensure their health, safety and welfare.
- Liaise with the ambulance service, and other emergency services, NHS England (NHSE), other health organisations, Leeds City Council, independent sector providers, voluntary agencies and other organisations in order to manage the impact of the incident.
- Liaise with activated health emergency control centres and/or on call NHSE/ Clinical Commissioning Group (CCG) Officers as appropriate.
- Continue an essential function throughout the course of the incident (business continuity) as far as is reasonably practicable.
- Maintain communication with patients, their relatives and friends, the local community and the media.
- The Trust will participate within the Local Health Resilience Partnership (LHRP) as required.

The Trust will also take into account the NHS Core Standards for Emergency Preparedness, Response and Resilience 2015.

3.2. Discharge of Trust Responsibilities

In order to discharge its responsibilities, the Trust will:

- Ensure that this Pandemic Influenza plan considers all reasonably foreseeable impacts of an outbreak, and all aspects of the Trust’s response.
- Ensure that staff are trained and equipped for their roles.
- Undertake training exercises to ensure that the plan can be implemented operationally and reflects the potential risks and threats.

3.3. Chief Executive’s Responsibilities

The Chief Executive will be aware of factors within organisations which negatively impact on public protection within the local health community as a result of outbreaks of pandemic influenza and any associated civil contingency events.
The Chief Executive will be aware of their legal duties to ensure preparedness to respond to an outbreak of pandemic influenza or associated civil contingency event within the local health community to maintain the protection of the public and maximise the NHS response.

3.4. The Accountable Emergency Officer

Under the changes to EPRR in the NHS brought in by the Health and Social Care Act (HSCA) (2012) every provider of NHS funded care must have a board level director responsible for ensuring that the organisation complies with the legal and policy requirements regarding EPRR.

The Accountable Emergency Officer is responsible for:

- Ensuring that the organisation is compliant with the EPRR requirements as set out in the CCA, the HSCA, the NHS planning framework, the NHS standard contract as applicable and the EPRR Core Standards.
- Ensuring that the organisation is properly prepared and resourced for dealing with a significant incident or emergency.
- Ensuring their organisation, and any providers they commission, have robust business continuity planning arrangements in place which are aligned to the Framework for Health Services Resilience (PAS 2015) and ISO 22301.
- Ensuring the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and parties in the local community(ies) served.
- Ensuring that the organisation complies with any requirements of the NHSE, or agents thereof, in respect of the monitoring of compliance.
- Providing the NHSE, or agents thereof, with such information as it may require for the purpose of discharging its functions.
- Ensuring that the organisation is appropriately represented at, and effectively contributes to, any governance meetings, subgroups or working groups of the LHRP or Local Resilience Forum (LRF).

Within LTHT, the role of Accountable Emergency Officer is carried out by the Chief Nurse/Deputy Chief Executive.

3.5. Oversight by Chief Nurse / Deputy Chief Executive

The Chief Nurse / Deputy Chief Executive will ensure that this Pandemic Influenza plan is:

- Kept up to date, is known by, and accessible to staff and is tested regularly.
- Flexible enough to deal with all reasonably foreseeable causes of an outbreak.
- Able to address any potential situations which place the Trust at particular risk.

3.6. Delegation

The Trust will discharge its responsibilities through its Emergency Preparedness Coordinating Group (EPCG) in association with individual CSU’s, which will ensure that:

- Staff understand the plan and are competent in their roles.
- The plan provides an effective and timely response to an outbreak.

3.7. Plan Construction
All revisions of the Pandemic Influenza plan will be carried out using the current best practice. The process set out in Chapter 5 of Emergency Preparedness (Cabinet Office 2012) will be followed.

The appropriate elements of the 2015 NHS Core Standards for EPRR will also be used in construction of the plan.

The plan will reflect best practice as indicated by:

- The World Health Organisation
- The Department of Health
- Public Health England
- NHS England

The plan covers the following significant areas and issues:

- A future influenza pandemic remains a threat and may have a more severe impact than in 2009.
- Joint planning between organisations and a cohesive approach for all response phases is essential.
- Exercises and testing are required both for individual organisations and partner organisations to test assumptions and interrelated aspects of plans.
- A coordinated response to any pandemic is key to ensure best use of resources and achieve the best outcome for the area.
- As in other emergency response plans, there is the need for it to be underpinned by appropriate business continuity plans and processes.

3.8. Plan Distribution

The plan will be published on the Trust’s intranet and will be accessible to all staff. Copies will also be provided to those category one and two responders included in the plan that are within the LRF and LHRP areas that the Trust covers.

3.9. Plan Risk Assessment

The plan has been based on the advice and guidance from the Department of Health and other key health bodies regarding the risks presented to the Trust by an outbreak of pandemic influenza. The reasonable worst case scenario has been used as recommended in the national EPRR standards.

The Trust’s EPRR risk register has been consulted and informs this plan and the Trust’s business continuity planning processes that support the implementation of the plan. This risk assessment will be revisited every time the plan is reviewed.

4. Planning Assumptions

A pandemic is most likely to be caused by a new subtype of the Influenza A virus. An influenza pandemic could emerge at anytime, anywhere in the world, including in the UK. It could emerge at any time of the year. Regardless of where or when it emerges, it is likely to reach the UK very quickly.

The West Yorkshire Resilience Forum Public Community Risk Register 2013 has categorised the likelihood of an Influenza Type Disease (Pandemic) as Very High.

The UK Influenza Preparedness Strategy 2011\(^1\) provides the key planning assumptions identified in table 1 below. The summary table has been derived from a combination of

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\(^1\) Department of Health 2011: The UK Influenza Preparedness Strategy 2011.
current virological and clinical knowledge, expert analysis, conclusions drawn from previous pandemics and mathematical modelling, and follow from the reasonable worst case scenario.

**Table 1. DoH - The UK Influenza Preparedness Strategy (2011)**

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<table>
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<tbody>
<tr>
<td><strong>Clinical attack rate</strong></td>
<td>Cumulative clinical attack rates of up to 50% of the population in total, spread over one or more waves each of around 12 - 15 weeks, each some weeks or months apart. If they occur, a second or subsequent wave could possibly be more severe than the first.</td>
</tr>
<tr>
<td><strong>Peak clinical attack rate</strong></td>
<td>Locally, 10% - 12% of population per week.</td>
</tr>
<tr>
<td><strong>Hospitalisation rate</strong></td>
<td>Between 1% - 4% of those who are symptomatic may require hospital admission.</td>
</tr>
<tr>
<td><strong>Case fatality rate</strong></td>
<td>Up to 2.5% of clinical cases. Local level planning target of excess deaths in the range of 210,000 - 315,000 nationally (approximately 0.4% - 0.5% of the population).</td>
</tr>
<tr>
<td><strong>Peak absence rate</strong></td>
<td>Up to 15% - 20% of workforce (large organisations). Up to 30% - 35% of workforce (small organisations).</td>
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**Responding to an Influenza Pandemic**

- Health services should continue to prepare for up to 30% of symptomatic patients requiring assessment and treatment in usual pathways of primary care, assuming the majority of symptomatic cases do not require assistance from health care professionals.
- Between 1% and 4% of symptomatic patients will require hospital care, depending on how severe the illness caused by the virus is, with a likely increase in demand for intensive care services.
- For deaths, the analysis remains that up to 2.5% of those with symptoms would die as a result of influenza if no treatment proves effective.
- Local planners should prepare to extend capacity on a precautionary but reasonably practicable basis and aim to cope with a population mortality rate of up to 210,000 – 315,000 additional deaths [nationally].

**4.1. Leeds Data**

Pandemics are based on new flu viruses which can vary in many ways. Figures in table 2 below are dependent on a range of factors including: strain of virus, severity, infection rate and behaviours, and adopt 2.5% as the case fatality rate. The 4% figure represents the worst case scenario, assuming that half of the population in Leeds catch the pandemic strain of flu, however in practice this number might be lower. A milder pandemic may affect less individuals, or have less severe effects.

Table 2. Leeds Data

<table>
<thead>
<tr>
<th>Year</th>
<th>Area</th>
<th>Population</th>
<th>Symptomatic (50%)</th>
<th>GP Consultations (30%)</th>
<th>Hospital Care (4%)</th>
<th>Hospital Care (1%)</th>
<th>Excess Deaths (2.5%)</th>
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<tbody>
<tr>
<td>2014</td>
<td>West Yorkshire</td>
<td>2.2 million</td>
<td>1.1 million</td>
<td>330,000</td>
<td>44,000</td>
<td>11,000</td>
<td>27,500</td>
</tr>
<tr>
<td>2014</td>
<td>Leeds</td>
<td>770,100</td>
<td>385,050</td>
<td>115,515</td>
<td>15,402</td>
<td>3,850</td>
<td>9,626</td>
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<tr>
<td>2015</td>
<td>Leeds</td>
<td>775,000</td>
<td>387,850</td>
<td>116,355</td>
<td>16,514</td>
<td>3,878</td>
<td>9,696</td>
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4.2. Treatment

Current national policy is to use community pharmacies as Antiviral Collection Points (ACPs). It is the responsibility of NHS England to establish ACPs which will be based in community pharmacies across the Leeds district. The Local Authority will be asked to review the list of proposed ACPs and provide feedback to NHS England to ensure adequate access for the local population.

A national agreement is being negotiated between NHS England and the Pharmaceutical Services Negotiating Committee, however NHS England have undertaken work locally to gather expressions of interest from pharmacies in order to understand what an ACP network might look like. This process will also determine whether this is likely to be sufficient to meet demand generally across the area and in areas of greater population density and higher need.

4.3. Infectivity and Spread

Influenza is spread by droplets of infected respiratory secretions which are produced when an infected person talks, coughs or sneezes. It may also be spread by hand-to-face contact after a person or surface contaminated with infectious droplets has been touched.

The incubation period will be in the range of 1-4 days (typically 2-3). Adults are infectious for up to 5 days from the onset of symptoms. Longer periods may be experienced, particularly in those who are immunosuppressed. Children may be infectious for up to 7 days. Some people can be infected, develop immunity and have minimal or no symptoms, but may still be able to pass on the virus. Most people will return to normal activity within 7-10 days.

All ages are likely to be affected, but those with certain underlying medical conditions such as pregnant women, children and otherwise fit younger adults could be at relatively greater risk, as older people may have some residual immunity from previous exposure to a similar virus in earlier life.

4.4. Staff Absence

Up to 50% of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic affecting 35%-50% of the population this could be even higher, as some with caring responsibilities may need additional time off.

Some small organisational units (5-15 staff), or small teams within larger organisations where staff work in close proximity are likely to suffer higher percentages of staff absences. In a widespread and severe pandemic, affecting 50% of the population, 30%-35% of staff in small organisations may be absent on any given day.
Additional staff absences may occur due to other reasons such as illnesses, providing care for dependants, childcare in the event of schools and nurseries closing, family bereavement, practical difficulties in getting to work and/or other psychosocial impacts.

5. Ethical Considerations

5.1. Overarching Principles

The Trust will follow the principle of equal concern and respect as set out in Responding to Pandemic Influenza – the ethical framework for policy and planning published by The Department of Health.

This means that:
- Everyone matters
- Everyone matters equally – but this does not mean that everyone is treated the same
- The interests of each person as the concern of all of us, and society
- The harm that might be suffered by every person matters, and so minimising the harm that a pandemic might cause is a central concern.

There are eight individual principles:
- Respect
- Minimising the harm that a pandemic could cause
- Fairness
- Working together
- Reciprocity
- Keeping things in proportion
- Flexibility
- Good decision making

5.1.1. Respect

This principle means that:
- People should be kept as informed as possible
- People should have the chance to express their views on matters that affect them
- People’s personal choices about their treatment and care should be respected as much as possible
- When people are not able to decide, those who have to decide for them should take decisions based on the best interests of the person as a whole rather than just based on their health needs.

5.1.2. Minimising the harm that a pandemic could cause

During a pandemic, some harm is likely to be unavoidable. This principle means that there is a need to:
- Help other countries to fight a pandemic if it starts abroad, to stop it developing further and reaching this country
- Try to minimise the spread of a pandemic if it reaches this country. Everyone has a role to play, for example by covering the face when sneezing, or staying at home when ill
• Minimise the risk of complications if someone is ill, for example by the appropriate use of antiviral treatment
• Learn from experience both at home and abroad about the best way to fight the pandemic and to treat people who are ill
• Minimise the disruption to society caused by a pandemic.

5.1.3. Fairness

The principle of fairness means that:

• Everyone matters equally.
• People with an equal chance of benefiting from health or social care resources should have an equal chance of receiving them; however, it will not be unfair to ask people who could get the same benefit from an intervention at a later date to wait.

5.1.4. Working together

This principle means:

• Working together to plan for, and respond to, a pandemic
• Helping one another
• Taking responsibility for our own behaviour, for example by not exposing others to risk
• Being prepared to share information (for example on the effects of treatment) that will help others.

5.1.5. Reciprocity

The principle of reciprocity is based on the concept of mutual exchange. Therefore:

• If people are asked to take increased risks, or face increased burdens, during a pandemic, they should be supported in doing so, and the risks and burdens should be minimised as far as possible.

5.1.6. Keeping things in proportion

This principle means that:

• Those responsible for providing information will neither exaggerate or minimise the situation and will give people the most accurate information that they can
• Decisions on actions that may affect people’s daily lives, which are taken to protect the public from harm, will be proportionate to the relevant risk and to the benefits that can be gained from the proposed action.

5.1.7. Flexibility

This principle means that:

• Plans will be adapted to take into account new information and changing circumstances
• People will have as much chance as possible to express concerns about or disagreement with decisions that affect them.
5.1.8. Good decision making

Respect for this principle involves the following components:

5.1.9. Openness and transparency

This means that those making decisions will:

- Consult those concerned as much as possible in the time available
- Be open about what decisions need to be made and who is responsible for making them
- Be as open as possible about what decisions have been made and why they were made.

5.1.10. Inclusiveness

This means that those making decisions will:

- Involve people to the greatest extent possible in aspects of planning that affect them
- Take into account all relevant views expressed
- Try to ensure that particular groups are not excluded from becoming involved. Some people may find it harder to access communications or services than others, and decision-makers need to think about how to ensure that they can express their views and have a fair opportunity to get their needs for treatment or care met
- Take into account any disproportionate impact of the decision on particular groups of people.

5.1.11. Accountability

This means that those responsible for making decisions:

- Are answerable for the decisions they do or do not take.

5.1.12. Reasonableness

This means that decisions should be:

- Rational
- Not arbitrary
- Based on appropriate evidence
- The result of an appropriate process, taking into account how quickly a decision has to be made and the circumstances in which a decision is made
- Practical – what is decided should have a reasonable chance of working.

5.2. Ethical Approaches within LTHT

In the event of influenza pandemic being declared, clinicians, healthcare workers and many others involved in caring professions or leadership roles will face difficult decisions and choices that may impact on the freedom, health and, in some cases, prospects of survival of individuals. For LTHT, hard choices and compromises are likely to be particularly necessary, such as:
• Allocation of limited resources – for example, restricting anti-viral medication due to limited supplies, deciding which patients get ventilated beds, or strict admission criteria to ensure only those who need acute care in a hospital environment are admitted;
• The imposition of restrictive measures to prevent the spread of infection e.g. isolating in-patients, or restricting visiting of families and carers to in-patients;
• Staff dilemmas in terms of tensions between personal and professional work obligations in caring for the sick;
• Re-allocating staff out of their normal areas of work or in establishing flexible shift patterns to ensure that the critical functions of the organisation are sustained throughout the episode;
• Staff concerns regarding the use of personal protective equipment, or the potential to contract pandemic influenza themselves, thereby putting their families at risk;
• Issues relating to the ‘death to disposal’ process.

Throughout the process of decisions that will be made during an influenza pandemic, the potential consequences of decisions that might compromise widely held ethical beliefs and values will be systematically considered by those making the decisions. Decisions made and any subsequent plans will:

• Be developed in an open honest way that reflect as proportionately fair as possible given the circumstances at the time of decisions;
• Demonstrate that the Trust does not unlawfully discriminate, and seeks to promote equality and to recognize that everyone matters equally, although not everyone will be treated the same;
• Reflect the guidance in Responding to Pandemic Influenza – the ethical framework for policy and planning published by the Department of Health and any subsequent ethical guidance published
• All decisions made will be rational, not arbitrary, based on the most contemporary evidence available;
• All decisions will be logged or set down in minutes, to ensure transparency in the process of decision-making;
• All decisions will be made in conjunction with partner agencies wherever possible;
• The LTHT Pandemic Influenza Plan will be published on the LTHT Intranet for all staff to view.

6. Pandemic Declaration

6.1. Pandemic Phases

The WHO has several phases they use for describing the state/spread of a pandemic. It should be remembered that these phases relate to the spread of the pandemic, not its severity, mortality or disruptive impact. These phases are detailed in table 3 below:
Table 3. WHO International Pandemic Phases

<table>
<thead>
<tr>
<th>Phase</th>
<th>WHO international phases</th>
<th>Overarching public health goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-pandemic period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>No new influenza virus subtypes detected in humans</td>
<td>Strengthen influenza pandemic preparedness at global, regional, national and sub-national levels; Minimise the risk of transmission to humans; Detect and report such transmission rapidly if it occurs</td>
</tr>
<tr>
<td>2</td>
<td>Animal influenza virus subtype poses substantial risk</td>
<td></td>
</tr>
<tr>
<td>Pandemic alert period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Human infection(s) with a new subtype, but no (or rare) person-to-person spread to a close contact</td>
<td>Ensure rapid characterisation of the new virus subtype and early detection, notification and response to additional cases; Contain new virus or delay its spread transmission to gain time to implement preparedness measures, including vaccine development; Maximise efforts to contain or delay spread, to possibly avert a pandemic and to gain time to implement response measures</td>
</tr>
<tr>
<td>4</td>
<td>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></td>
</tr>
<tr>
<td>5</td>
<td>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>Pandemic period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Increased and sustained transmission in general population</td>
<td>Minimise the impact of the pandemic</td>
</tr>
<tr>
<td>Post - pandemic period</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Return to inter-pandemic period</td>
<td></td>
</tr>
</tbody>
</table>

6.2. The UK approach to the phases of pandemic response

Following lessons learned from the response to the pandemic influenza (H1N1) outbreak in 2009, the UK moved away from its alert level based response to something more flexible that can reflect that different areas of the country can have different rates of infection. This approach takes the form of a series of phases named: Detection, Assessment, Treatment, Escalation and Recovery (DATER). There are indicators for moving from one phase to another.

These phases are not numbered as they are not linear, may not follow in strict order, and it is possible to move back and forth or jump phases. It should also be recognised that there may not be a clear delineation between phases, particularly when considering regional variation and comparisons. Different areas of the country may be in different phases according to local prevalence and impact.

6.3. Detection
This phase would commence on either the declaration of the current WHO phase 4 or earlier on the basis of reliable intelligence or if an influenza-related “Public Health Emergency of International Concern” (a “PHEIC”) is declared by the WHO. The focus in this stage would be:

- Intelligence gathering from countries already affected.
- Enhanced surveillance within the UK.
- The development of diagnostics specific to the new virus.
- Information and communications to the public and professionals.

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

6.4. Assessment

The focus in this stage would be:

- The collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK.
- Reducing the risk of transmission and infection with the virus within the local community by:
  - Actively finding cases;
  - Self-isolation of cases and suspected cases; and
  - Treatment of cases/suspected cases and use of antiviral prophylaxis for close/vulnerable contacts, based on a risk assessment of the possible impact of the disease.

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

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

6.5. Treatment

The focus in this stage would be:

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

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

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

6.6. Escalation
The focus in this stage would be:

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

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

6.7. Recovery

The focus in this stage would be:

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

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

7. Trust Escalation Triggers

It is important to remember that the WHO phases only refer to the incidence of the infection, not the severity. The triggers for LTHT are based on both prevalence and severity.

There are effectively three stages of pandemic planning and response for LTHT:

- Inter-pandemic periods – This is when planning for and testing the proposed pandemic response takes place. This will also include the period when there are outbreaks elsewhere in the world but not yet at pandemic levels.
- Pandemic periods where the UK is not yet affected – This is when the planning should be refreshed to reflect the current situation and for everyone who may have a role in the Trust’s response to pandemic flu to be reminded of their role.
- Outbreaks in the UK – This is the start of the Assessment phase in the UK response detailed above.

The start of the Trust’s full response will be triggered during the Assessment phase of the UK response based on advice from NHS England and DH, tempered by levels of local impact.

The level of local impact will determine when LTHT will switch between the UK phases of the response. This will be in conjunction with all the local partner agencies involved in the response.
Depending on the course of the pandemic, it is possible for the response to be scaled back and then escalated again.

7.1. The Trust management response to an influenza pandemic

The whole Trust will respond to an outbreak of pandemic influenza and the impact is likely to affect every site. The silver and gold level command and control functions will be based at the St James’s University Hospital site with bronze level commands across all CSUs.

7.2. Command and Control

The Trust will operate using the same command and control structure as set out in the Trust’s Major Incident Plan.

The Trust Gold Command will be set up at the UK Treatment phase or at the same time as the Regional Pandemic Flu Committees are being set up by NHS England (if earlier) subject to the local and national impact.

Gold Command’s primary role is to:

- Ensure that the Trust’s escalation plan is as comprehensive as possible
- Agree to key requirements of the organisation to maintain its core business
- Liaise with local and regional groups to ensure than an effective system is in place across the healthcare system.

The Trust Silver Command will be established at the UK Treatment phase or as Gold deems necessary. Silver command will consider the following on a daily basis:

- Distribution of workforce, redeployment needs, supportive measures required and suitability of rosters
- Tactical decisions regarding the management of resources and activity in line with current REAP (Resource Escalation Action Plan) Levels.

7.3. Capacity Management

Until Silver Command is activated, capacity will be managed as it is during business as usual operations. Information about capacity or lack thereof will be one of the factors to consider when deciding whether to activate the full plan.

Capacity will be managed by the Silver Commander with support from the Chief Nurse/Deputy Chief Executives Team who will regularly update and advise Silver Command on available and potential capacity, and the consequent ability to receive patients.

Discharges will be undertaken in collaboration with Primary and Community Services, Leeds Health and Social Care Trust, Leeds Provider Services and Leeds Social Services.

DOP/CSM will collate available bed capacity in all inpatient areas through the Bronze commands. These will be the definitive bed figures.

Bronze commands must only feed bed state information to the DOP/CSM. This will prevent confusion and the possibility of double counting.

The Trust will initiate some or all of its surge arrangements (REAP) as required.

8. Managing Patient Treatment

8.1. Critical Care

Estimates suggest that up to 25% of the symptomatic patients who would warrant admission to hospital if sufficient capacity is available may require critical care. Demand for critical care could rise up to 110 per 100,000 population per week at the peak, given a 50% clinical
attack rate. Demand, particularly for mechanical ventilatory support, is likely to exceed available resources rapidly as the pandemic develops.

8.2. Adult patients

LTHT service provision for patients with critical care needs is as follows:

**SJUH**
- J53/J54 – ICU/HDU – 23 bed spaces (funded for 21,15 ICU and 6 HDU)
- J81 HDU – 16 bed spaces (14 funded)
- J10H ARCU – acute respiratory care unit 10 beds – this is not considered official level 2/3 capacity
- J84a – 4 Beds - Oncology HDU

**LGI**
- L02 and L03 – General ICU – 14 bed spaces (funded for 10 – 6 ICU/4HDU)
- L04 and L05 – Cardiac ICU – 15 bed spaces –15 funded (9 ICU/6 HDU)
- L06 -Neuro ICU – 7 bed spaces – funded for 7
- L07 Neuro HDU – 7 bed spaces – funded for 7
- L39 – Ortho/Plastics HDU 6 beds – TRS CSU
- L18 - Coronary Care Unit – not considered level 2 or 3
- L08 – mothballed 6 bedded area

In the event of an influenza pandemic where the number of adult patients requiring critical care facilities exceeds the normal critical care capacity the LTHT Critical Care Bed escalation plan will be activated.

In response to increased admissions, the LTHT Critical Care Bed escalation plan outlines the response required to mobilise an increase in adult critical care capacity, identifying the potential effects on the rest of the Trust and also across the regional critical care network.

The LTHT Critical Care escalation plan is based on a phased increase and will be reassessed on a four hourly to six hourly basis throughout the acute period. However, it is anticipated that an influenza pandemic would require a sustained response for a considerable period of time, possibly up to 3 months.

It is highly probable that the demand for critical care beds will result in elective procedures having to be cancelled.

In alignment with the Yorkshire and the Humber (Y&H) critical care escalation approach LTHT will refer to the Yorkshire and Humber adult critical care escalation framework (plan underdevelopment, dated May 2014, Version 2.)

8.3. Neonatal patients

Leeds Children’s Hospital is based in Clarendon Wing, Leeds General Infirmary. LTHT service provision for children with critical care needs is as follows:

**LGI**
- PICU - L47 - 20 bed spaces (16 funded)
- HDU - L48 - 6 bed spaces (4 funded)
- HDU - L51H - 6 bed spaces
- Neonatal ICU - L43 - 12 cots
- Neonatal ICU- J1- 2 cots

It is anticipated that the increase in paediatric critical care beds will be in response to increased demand for neonatal and/or paediatric mechanical ventilatory support via the Leeds Children’s Hospital NHS Trust and/or increased demands within the neonatal/paediatric critical care network.
Any proposed new arrangements to the provision of adult and/or neonatal LTHT Critical Care services will initially be considered by the LTHT Silver Command group on the advice of representatives from both Adult and Neonatology Critical Care. These proposals will then be escalated to the LTHT Gold Command group for approval/authorisation.

8.4. Triage

Alternative approaches to triage and initial assessment will be required to:

- Rapidly screen and identify people who have symptoms of pandemic influenza on their arrival
- Separate symptomatic patients from others to reduce the risk of disease transmission
- Determine as rapidly as possible the type of care patients will receive

The Emergency Department will use the following triage criteria for all ED attendances:

- Fever (pyrexia ≥ 38°C) or a history of fever AND
- Influenza-like illness (two or more of the following symptoms: cough; sore throat; rhinorrhoea; limb or joint pain; headache; vomiting or diarrhoea)

Any patient with a fever and any one of the other criteria will be isolated in an individual cubicle, or if numbers are high, cohorted in a designated ‘flu bay’. Treatment will be expedited to minimise risk. Appropriate isolation/cohorting facilities are side rooms with closed doors or bays with multiple trolleys which have doors which can be closed. These should be identified in advance by the ED team and they will be activated during the Treatment phase of the response.

For people displaying acute symptoms and complications, normal admission procedure should be undertaken. For further guidance please refer to current LTHT seasonal influenza guidance:

- Guidelines for Clinical Management of Adult Patients with Influenza
- Guidelines for Clinical Management of Neonates and Children with Influenza

The above guidelines are available via the seasonal influenza website at the following link: http://lthweb/sites/influenza/antiviral-treatment-and-prophylaxis

As updates are provided by PHE, these will be considered by the LTHT Silver Command group, and appropriate amendments will be made and be circulated to clinicians by the LTHT Emergency Preparedness Team.

9. Surge Response

Managing fluctuating demand and capacity for the NHS is part of normal working activity, especially during winter months and will be managed in accordance with the Trust’s REAP procedures, Full Capacity Protocol and Trolley Wait Escalation process. To provide the best patient care possible under pressure it may be necessary to consider the postponement of certain procedures. This would only be done, if there are large numbers of more urgent cases, and capacity has to be released within the NHS. Continued pressure would mean an increase in numbers of patients who are cared for at home, which is already part of primary care planning for pandemic.

It is anticipated that there will be a requirement for the LTHT to determine the range of patient life-saving/life enhancing services offered, national guidance on managing demand and capacity will be used to determine local priorities. In addition to national guidance CSU escalation plans should be implemented to guide and support staff responsible for the matching of elective and emergency patient admissions and treatment to the available capacity.
The Operating Framework sets down the priorities for the NHS, including exceptional circumstances which NHS England should take into account before deciding whether to suspend national or local NHS targets. As the threat of an influenza pandemic increases, the Department of Health will delegate decisions to reduce NHS services to the provision of essential care only, and around the modification of/or suspension of performance targets to local/regional decision making.

The Department of Health issued an ‘Ethical Framework for responding to an influenza pandemic’ which provides principles that will guide the NHS in implementing the National Framework and in taking decisions about “normal business” such as implementing the Operating Framework. In the event of an influenza pandemic, the decision about whether to suspend these targets is one which will be taken by the NHS in light of the prevailing situation.

10. Roles, Responsibilities and Coordination

10.1. External Partners

Roles and responsibilities of external partners are included in table 4 below:

<table>
<thead>
<tr>
<th>External Partners Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health England</strong></td>
</tr>
<tr>
<td>• Lead agency providing overall multi-agency command, control and coordination during the initial phases (before NHS resources required).</td>
</tr>
<tr>
<td>• Jointly lead with NHS England on warning and informing and the provision of advice to the public.</td>
</tr>
<tr>
<td>• Provide advice on the emerging understanding of the virus and evidence on the effectiveness of counter measures.</td>
</tr>
<tr>
<td>• Ensure ongoing and risk-based surveillance, detection and assessment and provide microbiology laboratory services for the NHS and local authorities.</td>
</tr>
<tr>
<td>• Lead on the investigation and management of hotspot outbreaks and contact tracing.</td>
</tr>
<tr>
<td>• PHE may establish a helpline for healthcare professionals.</td>
</tr>
<tr>
<td>• Activate a Science and Technical Advice Cell if required.</td>
</tr>
<tr>
<td>• Provide advice on the implementation of a pandemic vaccination programme, if and when available.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>NHS England</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lead agency providing overall command, control and coordination (once NHS resources required).</td>
</tr>
<tr>
<td>• Jointly lead with Public Health England on warning and informing and the provision of advice to the public.</td>
</tr>
<tr>
<td>• Co-ordinate adequate staffing for the investigation and management of hotspot outbreaks, contact tracing and ongoing and risk-based surveillance, detection and assessment with Clinical Commissioning Groups.</td>
</tr>
<tr>
<td>• Establish a network of antiviral collection points (ACPs) in community pharmacies for the dispensing of antivirals in line with the National Pandemic Flu Service.</td>
</tr>
<tr>
<td>• Contract with General Practice for the delivery of pandemic vaccination in GP surgeries to target at risk groups and promote high vaccine uptake.</td>
</tr>
<tr>
<td>• Provide leadership on management of surge and escalation at a West Yorkshire level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>x3 Leeds Clinical Commissioning Groups</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Support NHS England in command, control, co-ordination and communication and provide leadership internally.</td>
</tr>
<tr>
<td>• Support PHE\NHS England warning and informing and communicate the effect of the influenza pandemic on services to affected patients and the public.</td>
</tr>
</tbody>
</table>
| • Lead surge and escalation across the health and social care economy at a local level utilising
### External Partners Organisations

- Support NHS England in respect of infection prevention and control and personal protective equipment.
- Support NHS England in contracting with General Practice for the delivery of vaccination in GP surgeries to target at risk groups.
- Provide medicines management expertise.

### Providers of NHS Funded Services

- Establish internal command and control arrangements and ensure these are linked to wider health and multi-agency coordination.
- Support general communications by PHE\NHS England and communicate effects on services to patients and the public.
- Ensure that staff have access to advice and guidance.
- Provision of staff to support the management of outbreaks and administration of countermeasures during the assessment phase (acute hospitals, mental health and community providers).
- Provide information through PHE surveillance programmes.
- Community Pharmacies to dispense in line with contract, or signpost patients to contracted pharmacies.
- Where appropriate prescribe and dispense antibiotics in line with current guidance.
- Ensure staff are appropriately protected for the work they undertake. Manage personal protective equipment stock and maintain infection prevention and control.
- Provide signposting to the National Pandemic Flu Service for patients presenting to NHS facilities.
- Vaccination of staff in occupational at-risk group and vaccination of in-patients and prisoners etc in at-risk groups.
- Manage surge and escalation (REAP) in line with internal and multi-agency plans; System Resilience Plan.

### Leeds City Council Public Health

The Public Health service within LCC, led by the Director of Public Health (DPH) has the following roles in a pandemic:
- Providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of disease
- Ensure plans are in place to protect the public health of Leeds through providing public health advice on health protection to internal and external providers
- Director of Public Health to coordinate the public health input in planning, testing and responding to emergencies in Leeds
- Director of Public Health to ensure all parties (public health teams and commissioned services) are discharging their emergency response roles effectively and to provide visible leadership
- Maintain communication, support and liaison with Public Health England Centre and the NHS England (Yorkshire and The Humber), Clinical Commissioning Groups and the West Yorkshire Strategic Coordinating Group
- To provide updates of the situation to internal departments and services and external partners as required or available
- To act as a central point for contact for any queries or questions from internal and external partners.
- To develop and maintain clear data collection and sharing arrangements with the NHS England (Yorkshire and The Humber), Clinical Commissioning Groups and the LCC Public Health commissioned services to aid an effective response. To assist in the cascade of information and data sharing as required.
- Ensure access to influenza vaccination/antivirals and to improve the uptake by eligible populations (if and when available)
- Implement mass treatment and/or vaccination arrangements which incorporates vulnerable
External Partners Organisations

- groups such as schoolchildren (develop and activate a separate LCC Mass Treatment Plan. (separate plan)
- To implement and manage the Flu Friends Service (if established)
- Provide advice and support to occupational health in the identification of frontline staff and advice on PPE, vaccinations in line with information provided by PHE and the Department of Health etc.
- Provide representation at the LCC Corporate Business Continuity Management Group if requested
- Establishment and operation of a LCC Public Health Control room in order to control the LCC Public Health emergency responses to the pandemic
- Provide representation and advice to the multiagency command and control rooms as required including the NHS England (Yorkshire and The Humber) Strategic Coordinating Group
- Receive information and advice from Public Health England Centre and the Department of Health and assist in the dissemination of key messages in line with the Gold Media Cell operating principles.
- To assist in the dissemination of information to the public including vulnerable groups. Information to include health protection advice, access to support lines, vaccinations and treatments and general information.
- Assist in the LCC recovery response in relation to protecting the public health Leeds
- Undertake a review of the emergency response and prepare for subsequent waves including review of plans and resources
- Implement BCM arrangements to maintain essential services in line with the corporate LCC BCM plan and the LCC public health priority services to protect the ongoing public health needs of Leeds.

111 Service Operator

- Currently the 111 service is provided by YAS. Messages regarding health advice for the general population during an influenza pandemic can be passed to the 111 service via the YAS chain of command. These messages will be agreed by a multi-agency health panel.

10.2. National and Regional Command and Control

NHS England Operating Framework for Managing the Response to Pandemic Influenza, published October 2013 identifies that:

Upon initiation of a pandemic response in the UK, NHS England Incident Management Teams (IMTs) will convene and meet as appropriate to the level of response to coordinate and support the response of NHS organisations. NHS England National, Regional and Area Teams will ensure that capacity to respond to a concurrent major incident or emergency is maintained; in terms of personnel, facilities and capacity.

Local Health Resilience Partnerships (LHRPs) provide a strategic forum to facilitate health sector preparedness and planning for emergencies. The LHRP has a role in ensuring integrated plans are in place across the health economy to enable the health sector to respond to a pandemic.

NHS England, Public Health England (PHE) and Directors of Public Health (DsPH) in local authorities have important roles at all levels to ensure a coordinated health and social care response that provides the services needed by members of the public throughout a pandemic.

Local Resilience Fora (LRFs) will coordinate multi-agency planning for pandemic influenza. During the response, NHS England will represent the NHS at any Strategic Coordinating
Groups (SCGs), and ensure close collaboration with all NHS funded organisations through the LHRP and relevant sub-group structures as part of the planning process.

The NHS incident coordination process is set out in the diagram below:
*Figure 1: Central-local reporting and coordination groups in England and Wales*

10.3. Local Coordination

The Leeds District Pandemic Influenza Group will be established in the event of a pandemic to ensure there is a coordinated approach and that effective arrangements are developed in responding to a pandemic.

Where required and where appropriate, the Pandemic Influenza Group may invite multi-agency partners in the Leeds District to ensure plans and arrangements are co-ordinated effectively. The Pandemic Influenza Group will be chaired by the Director of Public Health.
11. Human Resources Strategy and Response

The level of staff absence from work during a pandemic will depend significantly on the nature of the pandemic virus when it emerges. The planning assumptions set out below are based on current knowledge, analysis of past pandemics, published evidence and scientific modelling. Given the inevitable uncertainties, a range of figures is given in some areas.

During a pandemic, staff will be absent from work if:

a) they are ill with flu. Numbers in this category will depend on the clinical attack rate. If the attack rate is the 50% figure given in the reasonable worst case, half of staff in total will be sick (and hence absent from work for a period) at some point during the course of the pandemic. This could give absence rates of 15-20% in the peak weeks of the pandemic assuming it occurs in one wave over a period of 12-15 weeks. But there may well be more than one wave, with absence from work being spread across those waves. Absence is likely to be 7 working days for those without complications, and 10 for those if;

b) they need to care for children or other family members who are ill with flu;

c) they need to care for (well) children because of the closure of schools and group early years and childcare settings;

d) they have non-flu medical problems; or

e) their employers have advised them to work from home and therefore unable to carry out tasks required in the work place itself.

Business continuity planning against an influenza pandemic will have at its heart an estimate, through aggregation of data in each of the categories above, of the number of staff likely to be absent from work at the peak of the pandemic.

In order to manage in an influenza pandemic, it will be necessary for the Trust command and control groups to make some practical decisions if essential and critical services are to be sustained. These may include:

- Non-essential/non-critical services are discontinued.
- Staff redeployment to address acute staff shortages in critical services.
- Staff no longer in clinical practice will be redeployed to support clinical areas (both professional/registered and non-registered, and includes those who are no longer registered).

In general, the Trust will seek to operate within existing LTHT human resource strategies, however some principle actions will need to be taken, categorised in three phases:

- Pre-pandemic – developing preparedness
- During a pandemic – managing and modifying the human resources strategy
- Post pandemic – recovery for staff

11.1. Pre-pandemic – Developing Preparedness

11.1.1. Mapping staff skills
Information relating to the workforce will be held within a combination of systems. Absence recording and rostering for Nursing and Midwifery staff will be held within the e-rostering system.

The following details will be entered onto the Electronic Staff Record (ESR):

- Contact details for all staff
- Staff development details including training records

11.2. During a Pandemic

During an influenza pandemic, staffing levels within services are likely to be most compromised, and the key requirement for the Trust will be the utilisation of all staff to sustain critical services.

11.2.1. Recruitment Processes

It is anticipated that during an influenza pandemic, LTHT will maintain processes that serve to uphold patient safety, and will therefore need to adhere to relevant checks, including:

- Health clearances
- References and identity checks
- Qualification confirmation
- Right to work in the UK
- DBS where appropriate

11.2.2. Working Time Directives

During an influenza pandemic, LTHT will be mindful of the Working Time Directives and adherence to these principles. Any new arrangements to these directives will be reported by the Human Resources Department to the LTHT Gold Command group.

11.2.3. Disciplinary and Grievance Procedures

The Trust’s Disciplinary and Grievance policies will continue to be followed by all Trust employees throughout the pandemic period.

During the peak phase of the pandemic when the Trust is at the highest level of command and control processes to maintain critical services, the timescales and processes identified within the policy will become extended to allow staff to focus on maintaining critical functions.

These timescales cannot be pre-determined as they are dependent on the unpredictable nature of the pandemic. However, the decision to extend strategy timescales will be considered by the LTHT Gold Command group on the advice of the Director of Human Resources.

11.2.4. Sickness Reporting Arrangements

It is anticipated that agreed LTHT sickness reporting arrangements will be maintained during an influenza pandemic. However, it is expected that self-certification arrangements will be increased from seven to fourteen days before a medical certificate is required from a general practitioner. Any new arrangements will be reported by the Human Resources Department to the LTHT Gold Command group.
11.2.5. Rostering

To ensure that staff have appropriate rest times the principles of good rostering will be observed during a pandemic.

11.2.6. Annual Leave

Pre-pandemic booked annual leave will be honoured where possible, however during the peak phase of the pandemic, LTHT may need to consider that new annual leave booking will be limited or even discontinued, unless the individual staff member can identify special circumstances. Requests for annual leave should be considered on their merits, as it is important to allow staff to recuperate from the intense pressure of a pandemic.

Any annual leave that is requested at the time of the peak phase will be given at the discretion of matrons, department or service managers, based on the individual’s special circumstances, an assessment of the current situation within the service/CSU and the Trust service provision as a whole.

11.2.7. Working from Home

LTHT recognises that it may be appropriate for some staff to work from home if it can be accommodated within the individual’s role, and their contribution to the Trust’s emergency response is not compromised.

11.2.8. Study Leave

All study leave, across all disciplines, both internal and external, will stop during the peak phase of a pandemic. The LTHT Gold Command group will identify when study leave can recommence once the Trust is recovering from a pandemic. Consideration will have to be given to reimbursing staff for any losses due them being unable to attend pre-booked and paid for training as a result of the cancellation of study leave.

11.2.9. Taking time back

The Trust recognises that during an influenza pandemic, staff may work over contracted hours to ensure that services are delivered. All hours worked beyond contracted hours will be dealt with in accordance with LTHT/agenda for change guidance, taking into account nationally agreed terms and conditions such as those for medics and dentists. For those staff who would prefer to negotiate taking time equivalent hours worked over contract as time off, this can be considered and negotiated with matrons, department or service managers; however, service provision should not be compromised.

12. Infection Control

During a pandemic, healthcare workers can be exposed to people with influenza both in their normal daily lives (outside work) and in healthcare settings. Limiting the transmission of influenza in the healthcare setting requires:

- Timely recognition of influenza cases
- Instructing staff members with respiratory symptoms to stay at home and not come in to work
- Consistently and correctly implementing appropriate infection control precautions i.e. standard infection control principles and droplet precautions to limit transmission using personal protective equipment (PPE) appropriately, according to risk of exposure to the virus
• Maintaining separation between influenza and non-influenza patients – cohorting patients in designated areas within LTHT sites should be carried out from the outset of the pandemic to help contain influenza and reduce the risk to other patients
• Restricting access of ill visitors to the facility and posting pertinent signage in clear and unambiguous language (including in languages other than English)
• Environmental cleaning and disinfection
• Annual fit-testing for staff who are likely to need to wear FFP3 masks
• Staff vaccination as soon as vaccine available
• Appropriate treatment of patients to reduce volume and duration of viral shedding
• Antiviral prophylaxis of exposed patients where appropriate and logging of significant inpatient contacts
• Ensuring adequate and appropriately balanced ventilation
• Ensuring adequate clinical waste disposal
• Adequate hand hygiene in line with the WHO 5 moments
• Reducing patient transport in and out of segregated areas

These requirements are described in more detail on the Trust’s, Infection Prevention and Control intranet http://lthweb/sites/infection-control/infection-control and seasonal influenza intranet http://lthweb/sites/influenza/homepage

13. Supporting Self Care

13.1. Local NHS Responses

Wherever possible, patients should be managed and cared for at home, avoiding acute hospital admission. The Leeds City Council, Leeds Local Pandemic Influenza Response Plan identifies a strategy for supporting and encouraging patients to self-care.

The LTHT response in supporting self-care lies in the giving of basic self-care advice to all patients and visitors to the organisation. Staff training and education (see Section 23) will ensure that Trust staff are aware of the best self-care advice as per national guidance, and this advice will continue to be highlighted via internal communication responses (see Section 20) to ensure that a robust, single message is delivered to all who enquire or require health advice.

Local press releases produced as part of the multi-agency media cell will inform the public on how best to protect themselves and others from the virus and the appropriate use of health services during the pandemic.

13.2. National Pandemic Flu Service

The National Pandemic Flu Service (NPFS) is designed to supplement the response provided by primary care if the pressures during an influenza pandemic means that it is no longer practical for all those with symptoms to be individually assessed by a doctor or other prescribers in order to access antiviral medicines.

The NPFS comprises an online and telephony self-assessment service where individuals are not assessed by a clinician but follow a process of answering questions which have been developed with extensive advice from clinicians, which determine whether the person who is ill is eligible for an antiviral medicine or not. Individuals may also be directed to other health interventions such as home care advice or ambulance response.

13.3. Antiviral Collection Points
A national network of Antiviral Collection Points (ACP) will be set up so that friends or relatives (“Flu friends”) can collect the antiviral medicine on behalf of the person with influenza, enabling them to remain at home and minimise further spread of infection.

Current national policy is to use community pharmacies as Antiviral Collection Points (ACPs). It is the responsibility of NHS England to establish ACPs which will be based in community pharmacies across the Leeds district. The Local Authority will be asked to review the list of proposed ACPs and provide feedback to NHS England to ensure adequate access for the local population.

A national agreement is being negotiated between NHS England and the Pharmaceutical Services Negotiating Committee, however NHS England have undertaken work locally to gather expressions of interest from pharmacies in order to understand what an ACP network might look like. This process will also determine whether this is likely to be sufficient to meet demand generally across the area and in areas of greater population density and higher need.

13.4. Patients who present with symptoms, but do not require hospital care

During a pandemic, LTHT will see a significant increase in demand for services. To reduce this burden, the Trust is not designated as a public antiviral collection point; antivirals will be issued only to inpatients. There is no current intention for LTHT to provide antivirals to out-patient attendees.

A & E’s will not issue antivirals. These departments will be supplied with leaflets giving the National Pandemic Flu Service contact details. Patients presenting with flu symptoms (and no apparent complications) wishing to access antivirals should be directed to the National Pandemic Flu Service. Patients who do not require hospital care but may require assistance with accessing primary care and community based services can be referred, where appropriate, to the LTHT Discharge Liaison Team.

For people displaying acute symptoms and complications, normal admission procedure should be undertaken. For further guidance please refer to current LTHT seasonal influenza guidance:

- Guidelines for Clinical Management of Adult Patients with Influenza
- Guidelines for Clinical Management of Neonates and Children with Influenza

The above guidelines are available via the seasonal influenza website at the following link:


As updates are provided by PHE, these will be considered by the LTHT Silver Command group, and appropriate amendments will be made and be circulated to clinicians by the LTHT Emergency Planning team.


14.1. Take home medications

Medicines for in-patients to take home on discharge are supplied for 14 days. In the event of an influenza pandemic, it is anticipated that the LTHT Pharmacy will continue to supply 14 days of ‘take home’ medication, which is envisaged as adequate time for patients to consult their GP if repeat prescriptions are required.

Specific influenza medication advice will also be supplied to patients receiving take home medication, including:

- Leaflets (produced as part of the joint communications response) in all take home medications packs regarding medication and basic self-care influenza advice.
• For at risk patients, verbal advice delivered by ward staff will be supported with leaflets.
• For patients at most risk, clinical staff to consult with Pharmacy staff regarding the most appropriate medication advice.

14.2. Antiviral Agents

The National Pandemic Flu Service will provide LTHT with antiviral medication for the treatment of in-patients. LTHT will have access to the National Pandemic Flu Service in order to provide updates of the organisation’s antiviral usage and re-supply requirements. Availability will be dependent upon national supply.

Treatment with antiviral agents should be considered in all patients with pandemic influenza. Patients at high risk of severe influenza who have confirmed influenza or an influenza-like illness, or who come into contact with influenza, should be offered antiviral treatment or prophylaxis. The following guidance on antiviral treatment and prophylaxis for seasonal influenza is available via the LTHT seasonal influenza website: [http://lthweb/sites/influenza/antiviral-treatment-and-prophylaxis](http://lthweb/sites/influenza/antiviral-treatment-and-prophylaxis)

• PHE guidance on use of antiviral agents for the treatment and prophylaxis of influenza
• LTHT Medicines Management and Pharmacy Services Information Bulletin Influenza Treatments

It should be noted that the above guidance documents are for seasonal influenza and subject to change. As updates are provided by PHE, these will be considered by the LTHT Silver Command group, and appropriate amendments will be made and be circulated to clinicians by the LTHT Emergency Preparedness Team.

14.3. Antibiotics and other medications

National guidance regarding antibiotics and antivirals will be monitored, reviewed and advised by the Medicines Management Group.

The Trust’s Pharmacy CSU will need to/have considered the stock levels of antibiotics and medications that might be used in the treatment of Pandemic Influenza. The antibiotics and medications that might be used to treat secondary complications that patients might experience as a consequence of the virus have been identified, however it is anticipated that stock levels may need to be raised to ensure adequate supplies for in-patients.

15. Pre-pandemic and Post-pandemic vaccines

Public Health England will monitor the impact of influenza and advise the NHS accordingly. They will assist with briefing local staff and the press.

In the initial phase of the pandemic, the focus will be on using medical/pharmaceutical measures to limit the spread of disease. Immunisation is the most effective counter-measure against influenza, but the influenza vaccine currently in use for seasonal influenza would not be effective against the new strain.

LTHT offers an annual vaccination programme against seasonal influenza which not only protects the workforce and potentially reduces staff sick time but also has a protective effect on patients – particularly patients who are immunocompromised – who are cared for by healthcare workers who have had the flu vaccine. However the seasonal vaccine will not offer protection against a pandemic strain.

The development and availability of a specific pandemic vaccine may take four to six months. The public health response is therefore likely to be in three phases:
• No vaccine available
• Vaccine available in limited supply
• Vaccine available widely

The Department of Health will distribute vaccines according to the estimates of local needs for pre-determined priority groups. As vaccines (when available) will be limited, vaccination will take a tiered approach for key front line staff, considering the following points:

• Degree of potential exposure i.e. those with direct patient contact.
• Those staff essential to the health service response.
• Staff and patients in vulnerable or high risk groups i.e. with underlying predisposing factors e.g. asthma
• Closed communities/environments where influenza may be more rapidly transmitted.

On completion the list of staff who have been immunised against the pandemic strain will be held with the Occupational Health Department

16. Managing Excess Deaths

16.1. General Principles

An influenza pandemic may lead to a substantial increase in the number of cared-for people becoming ill and a subsequent increase in deaths. According to the UK influenza pandemic planning assumptions, local level plans should take into consideration excess deaths in the range of approximately 0.4% - 0.5% of the population. Excess deaths will be managed in accordance with the Leeds City Council Management of Excess Deaths Plan.

For deaths during a pandemic, analysis demonstrates that up to 2.5% of those with symptoms would die as a result of influenza if no treatment proves effective. These figures might be reduced by the impact of countermeasures, but the effectiveness of such mitigation is not certain. When planning for excess deaths local planners should prepare to increase capacity on a precautionary but reasonably practicable basis and aim to cope with a population mortality rate of between 7,250 – 10,880 across West Yorkshire, possibly over as little as a 15 week period. Potentially half of these will occur during the three weeks at the height of the outbreak. More extreme circumstances would require a local response to be combined with facilitation or support from a national level. In a less widespread and lower impact influenza pandemic the number of additional deaths would be lower.

Relevant Council departments such as Parks and Crematoria and Registrars will ensure that service and business continuity plans are up to date in relation to excess deaths. A local agreement is in place with the Leeds Teaching Hospitals NHS Trust Mortuary and Chaplaincy Service in regard to mortuary provision, and discussions have been undertaken with both Leeds University, the Leeds Hospices and local funeral directors in order to scope any additional mortuary capacity which may be required.

16.2. Mortuary Facilities

LTHT (Leeds General Infirmary and St James’ University Hospital) have the following mortuary capacity. It should be noted that these mortuaries operate between 80-90% capacity at all times, and therefore would not provide support in the event of a pandemic.
Table 5. LTHT mortuary capacity

<table>
<thead>
<tr>
<th>Site</th>
<th>Adult Fridges</th>
<th>Bariatric Fridges</th>
<th>Infant Fridges</th>
<th>Adult Freezers</th>
<th>Bariatric/Infant Freezers</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGI</td>
<td>74</td>
<td>4</td>
<td>11</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>SJUH</td>
<td>40</td>
<td>4</td>
<td>26</td>
<td>0</td>
<td>1 (Infant)</td>
</tr>
</tbody>
</table>

Mortuary capacity may become an even greater issue by the potential delay in registering deaths, delay in removal of deceased from the hospital mortuaries and delays with crematoria and funerals services.

Although legal responsibility for the provision of additional mortuary facilities for deaths in the community lies with the Local Authority, it is anticipated that LTHT will be required to significantly increase its mortuary capacity for deaths occurring within the Trust during an influenza pandemic.

Furthermore, it is anticipated that there may be changes to the storage of deceased patients who may have otherwise been taken to the Medico-legal centre. Any new arrangements will be reported by the LTHT Histopathology Department to LTHT Gold Command.

When demand exceeds capacity the Trust will:

1) Seek assistance from Bradford Public Mortuary
2) Seek assistance from Trust’s Contract Funeral Service

Leeds Coroners - community case contingency:

1) Coroner send them director to Bradford Public Mortuary
2) Leeds City Council to provide alternative capacity

16.3. Death Certification

During a pandemic, there will be two distinct stages with regard to death certification. Stage one is where the number of deaths requiring certification is increasing but the rules and regulations remain as they are in a non-pandemic period. The second stage is once the Home Office and Department of Health have approved new working arrangements to manage the increased pressure on services.

16.4. Operating under current arrangements during a pandemic

Under the current arrangements relatives collect the death certificate from Bereavement Services; however increased demand may make this impossible. Consideration should be given to posting the certificates direct to the registrar. In certain circumstances it may be acceptable to fax or e-mail the MCCD to the registrar.

Consideration should be given to holding extra stocks of books of Medical Certificate of Cause of Death (MCCD) and other key paperwork as it may be difficult to obtain supplies during a pandemic.

Additional training may be required for doctors unfamiliar with the processes or who have not practiced for a period.

As this stage continues, it is likely that the pressures will increase and where extra resources are required, any request should be made to senior management or Silver Command (if active) as soon as possible.

16.5. Operating under new arrangements during a pandemic

As the impact of the pandemic increases, the processes surrounding MCCDs may change.
Measures proposed include:

- Pandemic flu specific proforma to assist in certification
- Allowing doctors not currently registered to reregister temporarily
- List of doctors who would be able to support the process will be drawn up
- Emergency powers may be invoked to allow the Registrar to alter the processes to reduce any backlog.

If additional medical practitioners are required to assist with death certification, there should be appropriate indemnity arrangements in place and simple written arrangement for terms and conditions.

16.6. HM Coroner

In the event of a pandemic, Coroners’ offices will:

- With the assistance of Local Authorities, put into operation existing plans to re-deploy staff (including appointing additional assistant deputy coroners)
- Prioritise acute work (i.e. disposal certificates) over inquests
- Liaise with partner agencies
- Maintain surveillance of all reported deaths in order to avoid untoward deaths going undetected.

17. Primary and Community Services

17.1. Services in the Community

Services in the community will be managed in line with the Leeds Local Pandemic Influenza Plan. This plan aims to ensure an effective, collaborative and coordinated approach from Leeds City Council and local health and social care partner organisations in responding to a pandemic.

See also section 13 Supporting self care.

18. Procedures for Support Services

18.1. Supplies and Contracts

Given the scale and complexity of the challenge, supply chain contingency planning will need to be undertaken, collaboratively with a manageable number of critical suppliers. Supply chain planning needs to reflect Trust activity planning, and therefore has to be done consecutively. Demand for some products and services will increase significantly, whereas others will decrease. The planning process will involve:

- Identifying which goods and services are mission-critical for activities during a pandemic;
- Forecasting anticipated quantities and phasing of demand based on standard assumptions;
- Establishing dialogue with the suppliers involved and understanding their supply chains (point of manufacture, distribution network, modes of transport) and any existing business contingency plans;
- Conducting a Risk Assessment;
- Mitigating risks for specific goods/suppliers through various options, including:
Formal Agreements on minimum stockholding levels on suppliers’ premises, as an Addendum to existing contract. For these to be meaningful they will need to specify minimum quantities of individual products.

- Minimum stockholding levels on Trust premises
- Identified pre-approvable substitute products/suppliers
- Contingencies for collecting deliveries using Trust vehicles/couriers etc
- Contingencies for rationing supply across Trust departments
- For Specialty items, contingency for supply from other UK Trusts

Other options are expected to emerge during Risk Assessment activity and dialogue with suppliers.

19. **Business Continuity**

Within LTHT, the responsibility for maintaining services lies primarily with each CSU; however, in the event that an Influenza Pandemic is declared, the effects on the Trust may compromise service delivery throughout the organisation, and ultimately make it impossible to maintain service delivery.

A planned approach that aims to maintain normal services for as long as possible, and that can activate a proportionate response to the pandemic and the managing of services, and that will ensure the organisation is both able to respond to the disruption, and able to maintain and deliver key or critical activities of the organisation, has been identified.

Utilising DH (2008) guidance on business resilience and the Civil Contingencies Act (2004) key areas for service delivery, an assessment of the most likely effects was completed (see table 5 below).

### 19.1. Likely Effects of an Influenza Pandemic upon LTHT Key Areas

**Table 6. Likely effects of an influenza pandemic upon LTHT Key areas**

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Pandemic Declared</th>
<th>Comments and Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>Staff:</td>
<td>Biggest impact in shortest space of time: LTHT would be unable to deliver services without adequate staffing level.</td>
</tr>
<tr>
<td></td>
<td>Depletion of the workforce and number of informal carers due to the direct or indirect effects on influenza on staff and their families.</td>
<td>Redistributed staffing levels caused by the outbreak may reduce the number of critical beds available.</td>
</tr>
<tr>
<td></td>
<td>Increased workload because of patients with influenza</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased exhaustion of staff due to covering extra shifts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vulnerable groups:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase in the number of critical care beds required</td>
<td></td>
</tr>
<tr>
<td>Premises</td>
<td>Locations – buildings</td>
<td>Locations unaffected</td>
</tr>
<tr>
<td></td>
<td>Staffing levels main issue to support the maintenance of equipment</td>
<td>Staffing levels to ensure areas cleaned effectively - training for staff in effective cleaning.</td>
</tr>
<tr>
<td></td>
<td>Facilities - including cleaning</td>
<td></td>
</tr>
</tbody>
</table>
Consideration and planning for recovery should start as soon as possible to minimise the period of disruption after the outbreak.

20. Communications Strategy

20.1. Trust Strategy

The Trust has a statutory requirement to communicate with key stakeholders throughout the period of a flu pandemic. During a pandemic, demands on communications personnel will be high especially as normal day to day activity will remain with potentially fewer staff to manage the workload.

The strategy summarises the communications activity which needs to take place during the pre-pandemic, during a pandemic and post pandemic phases. It takes into account the proposed objectives, activity required, plus the personnel and resources required – note that this is a working document and subject to change.

The lead organisation for communications across West Yorkshire in a pandemic situation is NHS England (Yorkshire and The Humber) The strategy aims to dovetail with the Yorkshire and Humber Communications Plan (YHCP) and works in parallel with the West Yorkshire Communications protocol. The Directors of Public Health within local authorities will also have significant input into the communications process.

20.1.1. Aim

The aim of the communications strategy is to ensure that all key stakeholders have the information they require to mitigate the impact of a flu pandemic. It aims to enhance public confidence in the ability of health services to cope with the surge of activity and to facilitate the Trust’s response to a pandemic situation. Essentially the LTHT Influenza Communications Plan will be delivered by the Trust’s Communications Team with support from other West Yorkshire Communications personnel if required.

In order to fulfil this aim, four objectives have been identified together with action plans.

20.1.2. Objectives
• Provide stakeholders with information according to their requirements
• Convey accurate, timely and consistent advice to the public and health professionals so that individuals can make informed decisions about their own health
• Aid understanding to mitigate the spread of the disease and allay concerns
• Plan for a depleted communications function

20.1.3. Stakeholders

Stakeholders are divided into three main groups – internal, external and partners with distinct messages targeted at each. However it should be recognized that staff are also potential patients and public health messages should be targeted accordingly.

Internal
• Staff
• Patients

External
• Public
• Media
• Contractors/Suppliers

Partners
• Local Authorities (lead)
• NHS Leeds CCGs
• West Yorkshire NHS Organisations
• PHE
• NHSE
• Monitor
• TDA
• Charities
• Members of Parliament
• West Yorkshire Police
• Commissioners

20.1.4. Information Requirements
Pre pandemic – objective – build understanding and awareness among stakeholders.

<table>
<thead>
<tr>
<th>Internal – before pandemic</th>
<th>Aimed at</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>Staff and patients</td>
<td>LTHT Communications Team</td>
</tr>
<tr>
<td>Prepare written materials; fact sheets, online newsletter copy, develop template statements. Utilise catch it, kill it, bin it campaign materials.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reinforce respiratory hand hygiene and general flu information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Self help strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain organisational management strategies using internal mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Media – identify and train key spokespeople</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### External – before pandemic

<table>
<thead>
<tr>
<th>Action</th>
<th>Aimed at</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinforce hygiene and general flu information</td>
<td>Patients and public</td>
<td>LTHT Communications Team/NHSE</td>
</tr>
<tr>
<td>Self help strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publish flu plans on LTHT website</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using online/social media and traditional communications channels</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Partners – before pandemic

<table>
<thead>
<tr>
<th>Action</th>
<th>Aimed at</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative working to coordinate plan</td>
<td>All partners</td>
<td>All partners</td>
</tr>
<tr>
<td>• Regular dialogue and meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Joint planning – West Yorkshire Communications Protocol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 20.1.5. During pandemic – objective – advise, warn and inform

### Internal – during pandemic phase

<table>
<thead>
<tr>
<th>Action</th>
<th>Aimed at</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>In conjunction with Influenza pandemic group plan staff bulletin.</td>
<td>Staff and patients</td>
<td>LTHT Communications Team</td>
</tr>
<tr>
<td>Staff bulletin - Update on national, regional, Leeds and LTHT situation.</td>
<td></td>
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<tr>
<td>WHO status, operational matters – electives, outpatients, chemo patients, cancellations suspension/relocation of regular health services.</td>
<td></td>
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</tr>
<tr>
<td>• The general course of action to be taken by staff/patients in the event of influenza symptoms – reinforce hygiene &amp; self help strategies.</td>
<td></td>
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</tr>
<tr>
<td>• Utilise catch it, kill it, bin it campaign material.</td>
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</tr>
<tr>
<td>• Promote pandemic flu line</td>
<td></td>
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<tr>
<td>Organisational management strategies including status reports, sickness management, access to antivirals &amp; vaccination.</td>
<td></td>
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</tr>
<tr>
<td>Managers should use staff bulletin above as a template for local briefings include potential changes to role, practice or duties.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>LTHT managers and supervisors</td>
<td></td>
</tr>
</tbody>
</table>
### External – during pandemic phase

<table>
<thead>
<tr>
<th>Action</th>
<th>Aimed at</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Yorkshire Communications Protocol activated</td>
<td>Media</td>
<td>LTHT/CCG/West Yorkshire Communications Teams</td>
</tr>
<tr>
<td>Direct staff/patients/public to website</td>
<td>Patients &amp; Public</td>
<td>LTHT Communications Team</td>
</tr>
<tr>
<td>Reinforce hand hygiene and general flu information. Self help strategies</td>
<td>NHS CCGs and NHSE</td>
<td></td>
</tr>
<tr>
<td>Regular status reports plus early warning of potentially high profile media stories</td>
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<td></td>
</tr>
</tbody>
</table>

### Partners – during pandemic phase

<table>
<thead>
<tr>
<th>Action</th>
<th>Aimed at</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative working through local coordinating groups</td>
<td>DH / LTHT / NHSE / CCG / West Yorkshire Communications Teams</td>
<td>DH / LTHT / NHSE / CCG / W Yorkshire Communications Teams (LTHT will be represented by the Associate Director of Communications)</td>
</tr>
<tr>
<td>West Yorkshire Communications Protocol activated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Regular contact via phone/email – virtual office</td>
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<td></td>
</tr>
<tr>
<td>• Upload info to website at least daily</td>
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<td></td>
</tr>
</tbody>
</table>

End of first wave - objective – review and evaluate communications strategy
- Internal/external/partner communications
- Reinforce routine hand hygiene messages

Subsequent waves
- Implement revised communications plans

Post pandemic
- Review and evaluate.

Communications Mechanisms

Internal
- Senior team meetings (Exec Group, Team Brief, DOP)
- CEO online briefing
- Communications Update
- Start the Week/Intouch
- E mail
- Staff/team meetings
- Posters/flyers/patient info leaflets
- Intranet/internet
- Facebook/Twitter/Social Media

External
- TV – Look North, Calendar
- Radio – BBC Radio Leeds,
- Press - Yorkshire Post
- Council information points
- Posters/flyers
- NHS Direct
- LTHT website – public, staff, patients, media information
- Pharmacy touch screens
- National Pandemic Flu Line Service
• Via partner organisations
• Independent health sector

**20.1.6. Communication with NHSE/Department of Health**

Communication and information of the current situation within the Trust will be via already existing situation reporting (SITREP) mechanisms, on the DH website that is also accessed by NHSE.

The SITREPs will also be shared with Leeds CCGs.

The SITREP will be produced by the Silver group, overseen by the Silver Commander to ensure that accurate information is being given.

**20.1.7. Communications personnel and contingency planning**

A senior communications professional is responsible for overseeing all internal /external/partner communications. In the event of senior communications personnel being unavailable, junior communications or general administrative support personnel may be drafted in to provide administrative support. Mutual aid may be requested from West Yorkshire NHS Partners. However, it is essential that any information is approved by the lead executive Director / Associate Director of Communications prior to being released internally or externally.

Internal and partner communications remain the responsibility of individual organisations. The protocol outlines the actions local communications teams will take to ensure that information is provided to the media, the public, NHS staff and patients.

**20.2. Multi Agency Communications**

The West Yorkshire LRF Pandemic Influenza Plan includes a communications plan for the area.

The Department of Health will define and lead on national public health messages to be disseminated. The objectives of these messages will be:

- improve general awareness and understanding of influenza
- help people to recognise the symptoms and what to do if infected
- promote good hygiene and other general precautionary measures
- advise people on how best to look after themselves and others
- the need for self care and availability of a National Pandemic Flu Service (once activated)
- communicate the role of vaccines and antiviral medicines
- minimise impact on GP surgeries and hospitals

Where a Strategic Co-ordinating Group (SCG) is convened, the Chair will be responsible for activating the Gold Media Cell.

Local messages will be co-ordinated and approved by the SCG to enable all organisations to share information and ensure that consistent messages are being communicated. Once agreed, messages will be issued either though the Gold Media Cell or by individual SCG members to their usual West Yorkshire contacts and will be issued frequently to keep the public updated on the latest status and advice.

The Gold Media Cell will:

- ensure messages are consistent with national and regional messages
• provide accurate and timely advice to the public and partner organisations
• monitor media coverage and update SCG on issues
• manage media requirements
• assist recovery and return to normality

Target audiences have been identified and include:

• the public
• the business community of West Yorkshire
• vulnerable people identified by primary healthcare providers and Local Authorities
• staff of Category 1 responders
• others as appropriate and detailed in individual plans

The NHS will provide public information in relation to local treatment arrangements, including:

• clarify that the National Pandemic Flu Service (once activated) will be the prime source for treatment and only patients with complications or children under 3 years should contact a GP or hospital
• provide information on local distribution of antivirals through Pharmacies.
• Promote concept of a ‘Flu Friend’ – friends and relatives of someone with flu who will be able to go and collect antivirals for example, enabling the individual with flu to stay at home minimising spread.
• Provide information to patients and public regarding any changes or reduction to services, including any local disruption to healthcare services including updating the directory of services used by 111 to signpost callers to appropriate services.

It is envisaged that the majority of people who catch a new strain of influenza will be able to care for themselves in their normal environment. There is an expectation that generally health intervention will be unnecessary unless there is either an exacerbation of an existing illness or a complication. The generic public message should be:

• Go home
• Go to bed
• Plenty of fluids
• Paracetamol
• Treat symptoms (sore throat, etc)
• Contact the National Pandemic Flu Service for advice and access to antiviral medicine
• Only seek medical help if the patient has complications

Health and Social Care organisations have included within their plans initiatives for communication with a wide range of vulnerable groups of people.

21. Other Procedures

21.1. Vulnerable People

The guidance relating to the CCA, Emergency Preparedness, sets out the responsibilities placed on Category 1 responders to plan for and meet the needs of those who may be vulnerable in emergency situations.

Other legislation may interact with the Trust responsibilities under the CCA, in particular the Disability Discrimination Act 1995 and 2005, the Equality Act 2010 and the HSCA.
Vulnerable groups and individuals with long-term conditions will need to be identified and supported particularly during the admission and discharge process from hospital (see below). LTHT Discharge Liaison Team has well established links to partner agencies to support home and primary care including:

- Mental Health Teams;
- District Nurses, Community Matrons and Case Managers;
- Local Authority groups;
- Faith groups;
- City-wide equipment stores.

<table>
<thead>
<tr>
<th>Vulnerable Groups</th>
<th>Actions to support by LTHT staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-English speakers</td>
<td>Use of agreed LTHT Interpreters processes to ensure patients have access to effective communication</td>
</tr>
<tr>
<td>Older people</td>
<td>Careful and integrated discharge planning with all partner agencies</td>
</tr>
<tr>
<td>Those living alone</td>
<td>Careful and integrated discharge planning with all partner agencies</td>
</tr>
<tr>
<td>Those who are clinically at risk</td>
<td>Careful and integrated discharge planning with all partner agencies</td>
</tr>
<tr>
<td>Those needing palliative care</td>
<td>Careful and integrated discharge planning with all partner agencies</td>
</tr>
<tr>
<td>Those in residential or nursing institutions</td>
<td>Careful and integrated discharge planning with Homes to ensure patient safety</td>
</tr>
<tr>
<td>Those whose good health is dependent on taking regular medications or on using medical support equipment</td>
<td>Careful and integrated discharge planning with all partner agencies and Pharmacies</td>
</tr>
<tr>
<td>Individuals with a mobility, sensory, or learning impairment or mental health issue</td>
<td>Ensure effective communication with patients and families utilising all available methods. Integrated discharge planning with all partner agencies</td>
</tr>
<tr>
<td>Those not registered with a GP</td>
<td>Integrated discharge planning with CCG</td>
</tr>
<tr>
<td>Homeless people</td>
<td>Integrated discharge planning with Leeds City Council</td>
</tr>
<tr>
<td>Travellers</td>
<td>Integrated discharge planning with Leeds City Council</td>
</tr>
</tbody>
</table>

21.2. Child health

For children brought to A&E or the Minor Injuries Unit (MIU) with flu like illness displaying acute symptoms and complications, normal admission procedure should be undertaken – i.e. child assessed and stabilised before transfer to Leeds Children’s Hospital. Children with flu symptoms and no apparent complications should be directed to the National Pandemic Flu Service or to primary care or other community based services.

21.3. Mental health

Adult patients brought to A & E or the Minor Injuries Unit (MIU) displaying acute symptoms and complications, irrespective of co-existing mental health problems, will be treated as per
current protocol. However, it is not expected that Leeds & York Partnership Foundation Trust will refer any patients with flu symptoms and no apparent complications to LTHT.

Patients with mental health problems presenting to A & E or the MIU with flu symptoms and no apparent complications should be directed, with assistance from, where appropriate, to the Mental Health Liaison Team, the National Pandemic Flu Service or to primary care or other community based services.

21.4. Managing Visitors

Visitors to affected areas should be restricted and any visitor with influenza symptoms should be strongly discouraged from entering clinical areas and asked to return home.

Visitors will follow LTHT Infection Control Guidelines; this includes the promotion of correct hand hygiene practices prior to entering and leaving an affected area; infection control advice will be delivered by LTHT staff in areas.

In some areas, relatives may assist in patient care delivery if staff shortages are extreme – in such circumstances visitors must be instructed in hand hygiene practice and the use of personal protective equipment. Visitors to affected areas will be advised that having contact with vulnerable groups after visiting is to be avoided.

Dependent on national directives, LTHT may have to face the difficult decision to impose further restrictions on visiting patients. If visiting is restricted to essential visits only, the following groups are the ones considered essential:

- Parents of babies
- Spouses or partners of critically ill adults
- Spouses, partners, parents or advocates of in-patients with special needs

21.5. Lockdown Process

When an influenza pandemic is declared, the Trust Command and Control processes will consider the need to restrict access to the Trust, to ensure that visitors and staff access the Trust via a single route/specified routes, and these processes will then be implemented by the LTHT Security teams. Restricting access to main hospital sites will enable the Trust to

- Target resources on supporting and advising visitors as they enter the organisation.
- Target information streams regarding pandemic influenza such as self-care, restricting visiting.
- Free security time to monitor the limited entrances and exits to the Trust.

22. Recovery From the Outbreak

22.1. Recovery Considerations

Depending on the scale of the outbreak, the Gold Command will need to consider the following management priorities:

- Establishing Recovery Time Objectives and manage the return to normal service delivery
- Priority of elective services including the impact on targets and capacity
- Communication with patients affected by the outbreak including the re-booking of cancelled appointments
- Workforce/Staffing levels
- Communication with staff and stakeholders/partner organisations
- Re-stocking of supplies and equipment
• Auditing and reporting of the outbreak including lessons identified.

In the event of a protracted or severe outbreak, the return to normal may be phased with a focus on restoration of critical functions first.

A detailed list of issues to be considered in the recovery phase is included in Appendix 3

22.2. De-brief Issues

General Managers will be responsible for departmental operational ‘hot’ debriefings. Managers should remind staff of the availability of post event psychological support. Staff have to self refer to the service.

Following resolution of the problem and a return to normal working, the Emergency Planning Team on behalf of the Chief Nurse / Deputy Chief Executive will conduct a debriefing exercise as soon as practically possible and produce an Influenza Pandemic report and associated “lessons learned” action plan.

The Influenza Pandemic report and proposed action plan will be signed off by the Quality Committee. Progress against the action plan will be monitored by the Emergency Preparedness Coordinating Group, reporting back to the Quality Committee if required.

23. Training

To ensure that the most effective and efficient response possible is provided by the Trust, it is vital that all staff are familiar with their roles, or potential roles, in an Influenza Pandemic.

All staff shall receive awareness raising training to ensure a common base level of knowledge regarding Influenza Pandemic actions.

Where applicable, the relevant staff will receive more specific training to ensure that they are able to perform the necessary functions required during an Influenza Pandemic.

Educational needs will vary across the workforce, however education and training is essential to ensure quality of care to people with influenza regardless of location for delivery of care, and to ensure patients and staff are safeguarded as much as possible from the transmission of the pandemic virus.

23.1. Raising Awareness

To raise general awareness of pandemic influenza planning and safe precautions that are to be taken, LTHT will develop a strategy that will include:

• The use of message boards, posters and signs
• A specific Pandemic Influenza site on the intranet at the appropriate phase of an outbreak

23.2. Training for High Risk Areas – Personal Protective Equipment

For those areas that perform high risk procedures that cause greater exposure of healthcare workers to the pandemic influenza virus, the correct wearing of FFP3 respirator masks will be required. Anyone using FFP3 respirator masks must be ‘fit tested’ and trained in its use.

LTHT has a number of fit test trainers and staff trained to perform fit tests. A list of those staff able to perform fit testing will be made available by the IPC team. Records are to be kept by the manager of each area of all staff that receive training. This will be actively communicated to all CSUs at the outset of a pandemic. Specific areas for training identified in the plan include (but not exclusively):

• Intensive Therapy staff
• Anaesthetic staff
Theatre Recovery staff
Endoscopy Suite staff
Physiotherapy staff

24. Exercising and Review

24.1. Exercising

The plan shall be exercised as the CCA regulations place a duty on the Trust as a Category 1 Responder to do so. The exercise programme will have the following broad objectives:

- validating plans – to verify that the plan works;
- rehearsing key staff – to familiarise key staff with what is expected of them in a crisis and preparing them for crisis conditions;
- testing systems – to ensure that systems relied upon to deliver resilience (e.g. uninterrupted power supply) function correctly and offer the degree of protection expected;
- identify areas where the plan can be improved and
- Practice the teams in working together.

The requirements for testing and exercising set out in the NHS EPRR Core Standards are:

- a communications exercise every six months;
- a desktop exercise once a year; and
- a major live or simulated exercise every three years

Where possible these exercises should include participation from key stakeholders such as YAS, Police, the Fire & Rescue Service, and other health organisations as appropriate. There will be a full debrief of participants following each exercise and all lessons identified will feed into the next review of the plan and the training programme.

The Resilience Manager will produce a written report after each trust-wide exercise with specific recommendations for:

- changes to the Influenza Pandemic plans and possible investment in preparedness resources
- Further training as appropriate.

The Resilience Manager will take these recommendations to the Emergency Planning Coordinating Group for discussion and to formulate an agreed action plan.

25. Review Process

The CCA requires that plan maintenance procedures must be developed to ensure that plans are kept up to date. The plan shall be reviewed and updated annually. It shall also be reviewed:

- whenever the Trust becomes aware of significant changes that affect the plan;
- following debrief after exercising or invocation of the plan;
- following changes in legislation and
- Following significant changes in Trust policy or structure.
### Appendix 1: Proportionate Response to Pandemic Influenza

<table>
<thead>
<tr>
<th>Impact</th>
<th>Nature and scale of illness</th>
<th>Key healthcare delivery</th>
<th>Impact on wider society</th>
<th>Public Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial phase (pandemic impact unknown at this stage)</strong></td>
<td>Sporadic influenza cases may be reported from the community</td>
<td>Response led by public health services supported by primary care and pharmacy services, and making preparations for extra support should this initial phase be extended</td>
<td>Possible public concern arising from media reporting of cases at home or abroad</td>
<td>Advice on good respiratory and hand hygiene</td>
</tr>
<tr>
<td></td>
<td>Possible limited local outbreaks (schools, care homes)</td>
<td>Detection, diagnosis and reporting of early cases through testing and contact tracing</td>
<td>Possible disruption to international travel and concern among intending / returning travellers</td>
<td>Advice about how to obtain further information e.g. to consult Government and NHS websites and other channels for up to date information</td>
</tr>
<tr>
<td></td>
<td>Possible increased proportion of critical care cases with influenza</td>
<td>National Pandemic Flu Service (NPFS) not activated. Local areas may start initial preparations to use NPFS and Pharmacy Antiviral Collection Points (ACPs)</td>
<td>Possible school closures to disrupt the spread of local disease outbreak, based on public health risk assessment</td>
<td>Establish transparent approach to communicating emerging science, the level of uncertainty about severity and impact, and the likely evolution of the situation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influenza information line may be activated</td>
<td>Review and update of pandemic response plans</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Consider support arrangements for Health Protection Teams</td>
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<td></td>
<td>Normal health services continue</td>
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<tr>
<td><strong>LOW</strong></td>
<td>Similar numbers of cases to moderate or severe seasonal influenza outbreaks AND In the vast majority of cases - mild to moderate clinical features</td>
<td>Primary and hospital services coping with increased pressures associated with respiratory illness, with maximum effort Paediatric/Intensive care units (PICU / ICU) nearing or at maximum pressure No significant deferral of usual activities</td>
<td>Increase in staff absence due to sickness – similar to levels seen in seasonal influenza outbreaks</td>
<td>As above; Information on the pandemic and the clinical effects of infection, and what to do</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influenza information line function active ACPs established in hotspots only – consider using community pharmacies alongside other arrangements NPFS active depending on pressures in primary care Use existing legislation to allow the supply of antiviral medicines at premises that are not a registered pharmacy.</td>
<td>Consider arrangements for sickness absence surveillance No significant or sustained impact on service and business capacity</td>
<td>Information about antiviral medicines and tailored messages for children, pregnant women, elderly and other at risk groups (in liaison with expert bodies and support groups)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>How to use your local health service</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Employers planning in advance for sickness absence, service reprioritisation and alternative</td>
</tr>
</tbody>
</table>
| MODERATE | Higher number of cases than large seasonal epidemic  
Young healthy people and those in at-risk groups severely affected  
AND/OR  
more severe illness | Health services no longer able to continue all activity  
ICUs/PICUs under severe pressure  
Local and regional decisions to cease some health care activity  
Influenza information line function active  
NPFS activated as required in each country  
Local areas establish ACPs as required in each country  
Contingency plans for supporting care at home and respite care  
Continued compliance with statistical reporting standards | Supplies of electricity, gas and fuel will remain at near-normal levels of supply. Routine maintenance afforded a lower level of priority if there are staffing shortfalls, essential repairs expected to continue  
Potential disruption to general supplies if peak staff absence coincides with technical or weather related supply difficulties  
Prepare to implement business continuity arrangements for management of excess deaths, if necessary  
Concern among teachers and parents about infection spread in educational settings may lead to teacher and pupil absence  
Supply chain companies implement business continuity plans  
Possible review of legislation regarding drivers’ hours  
Justice system affected by absence of staff, judiciary and other parties. Maintain essential services in accordance with established business priorities | ways of working  
Information on the pandemic and the clinical effects of the infection  
Advice on seeking medical assessment when not improving or getting worse  
Information on NPFS  
Information on collection of medicines  
Information about antiviral medicines and tailored messages for children, pregnant women, elderly; and other at-risk groups (in liaison with expert bodies and support groups)  
Infection control and business continuity advice for specific occupations. E.g. funeral directors, registrars, cemetery and crematorium managers, police etc as appropriate  
Managing expectations of Critical Care |
| HIGH | Widespread disease in the UK AND/OR most age-groups affected AND/OR severe, debilitating illness with or without severe or frequent complications | GPs, community pharmacies, district nurses, dental practitioners and social carers, independent sector, residential homes and voluntary organisations fully stretched trying to support essential care in the community with consequential pressure on secondary care. Hospitals can only provide emergency services. NPFS working to capacity; ACPs under pressure. Influenza information line function active. Critical Care services: demand outstrips supply, even at maximum expansion. Continued compliance with statistical reporting standards. | Emphasis on maintaining supplies and staffing. Transport, schools, shops affected by sickness and family care absences. Numbers of deaths putting pressure on mortuary and undertaker services. Possible implementation of national legislative changes to facilitate changes in working practice (e.g. death certification, drivers' hours, sickness self certification requirements, Mental Health Act, benefits payments). Justice system affected by absence of staff, judiciary and other parties. Maintain essential services in accordance with established business priorities. | Messages about progress of the pandemic, availability of healthcare and other services. Advice on how to minimise risks of transmission. Information on how to support family members and neighbours. Advice on where to get help for emergencies. Truth about how services are coping and what they are doing to cope. Explanation of triage systems to align demand and capacity. Some civil contingencies advice, including advice to specific occupations such as paramedics, funeral directors, registrars, cemetery and crematorium managers, police etc as appropriate. |
Appendix 2: Outline Gold and Silver Agendas and Checklists

Outline Gold Update Meeting Agenda
- Establishment of the team (first meeting) and succession planning
- Confirm Silver team established (first meeting)
- Status
  - Strategic situation update – from NHS England or multi-agency Strategic Coordinating Group (SCG) if sitting
  - Update from Silver
- Issues
  - Issues from Silver
  - Issues from other agencies
  - Any other issues
- Actions
  - Set out (first meeting) or review strategic aim and objectives for the Trust
  - Set out (first meeting) or review recovery time objectives for returning to normal
  - Agree any other actions to resolve outstanding issues
- Communications
  - Agree messages for staff, the public and partner agencies
  - Updates for Silver Team
- Time of next update meeting

Outline Silver Update Meeting Agenda
- Establishment of the team (first meeting) and succession planning
- Confirm Bronze teams established (first meeting)
- Status
  - Pandemic update – numbers of patients with pandemic influenza and severity
  - Current overall bed state, critical care beds, theatre capacity, burn beds
- Issues
  - Staffing issues – medical, nursing and other staff
  - Estates issues
  - Hotel services – transport, car park management, food, laundry, security
  - Any other issues
    - Actions
      - Agree actions to resolve issues
- Communications
  - Briefing for Gold Team
  - Updates for Bronze Teams
- Time of next update

Silver Team Issue Checklist

Patient/workflow issues
Inpatients (cohort wards, other wards, ventilated patients, deaths)
Triage (more specifically to Critical Care Level 2, 3)
Patients awaiting urgent treatment (unscheduled and elective)
A&E attendances (influenza, non-influenza)
Number of patients admitted/discharged
Bed occupancy/length of stay
Out-patients services
Opening/closing more wards/departments

Staffing issues
- Cohort wards/other wards
- Sickness/absence
Staffing redistribution (Medical, Nursing, PAM/AHP, Porters, Catering, Domestics, SSD, Laboratories, Estates, Secretarial, Medical Records, Transport, Management, Volunteers/relative helpers, Bereavement Services, Mortuary staff)

**Supplies**
- PPE
- Antibiotics/antivirals
- Respiratory Care equipment
- Other – consumable stock/supply chain information

**Support Services**
- Laboratories
- Waste management
- Laundry
- Catering
- Cleaning
- Accommodation
- Transport
- Estates – utilities

**Vaccination**
- Supply
- Administration

**Communication**
- Switchboard
- Internal to the Trust
- External Communications

**Other issues**
- Feed back from health community
- Visitors
- Security
- Financial issues/impact
Appendix 3: Post-pandemic Recovery Items to Consider

**People**
Review availability of staff/critical resources including core skill sets and skill gaps and, if necessary, consider minimum resource requirements
Consider impact on staff caused by work load, stress, illness and bereavement; provide support to staff who have been personally affected by the pandemic
Follow up any outstanding staff related information including Criminal Records Bureau (CRB) checks, qualification, references
Identify resourcing requirements to replace staff who will not return to work
Manage volunteers
Use information on availability and demand to identify gaps in service and take action to redeploy/retarget staff if required
Arrange staff training where necessary
Acknowledge staff contribution including from external partners, contractors, suppliers, volunteers
Provide regular updates via staff meetings, briefings, intranet, etc
Provide opportunities for those staff who wish to de-brief
Provide training in developing psychological resilience prior to pandemic

**Programme/planning**
Review effectiveness of local service delivery strategy and business continuity activities
Assess impact on commissioned services and financial agreements
Review financial business targets and consider the long term financial impacts and implications for the organisation
Consider how income streams will be adjusted after the pandemic
Ensure due income has been received and creditors paid
Re-introduce targets in parallel with restoring services
Monitor impact on levels of need in your service area and recognise opportunities for possible service improvements

**Processes**
Review response activities and identify lessons learned for possible subsequent waves/other wide-scale emergencies
Update Business Continuity Plans/Internal Incident Plans and other relevant procedures (Action Cards)/checklists as required
Share best practice beyond the borders of your organisation as appropriate
Backup/restore core information if necessary including
- Staff records
- Accounting/payroll records
- Service user records
- Other data
- Other IT systems
- Other paper records
Issue regular communication to internal/external stakeholders
Continue to produce and/or contribute to status reports as needed
Review key (emergency) contact information and update details as required

**Premises**
Take stock of local resources including personal protective equipment, medicines, and other essential supplies. (Unused national countermeasure stocks will need to be returned to the national stockpile at the end of the pandemic having been stored appropriately with temperature recordings made available)
Review what was used in the first wave and attempt to re-stock according to usage profile
Check equipment and arrange for routine inspection/service/replacement as necessary
Review security arrangements
Identify areas that require deep clean/decontamination as required
Identify necessary maintenance work on buildings and arrange for maintenance, ensuring that alternative facilities are available if necessary
If any facilities have been used as multi-purpose facilities investigate whether it is secure to revert to original purpose
In case of a partial/total relocation of services investigate whether it is secure to partially/fully restore services

Providers
Inform suppliers/providers/contractors on the restoration actions you are undertaking
Be flexible and supportive in your approach to providers who are struggling to recover
Coordinate the response in collaboration with all other key departments
Continuously monitor availability of suppliers/providers/contractors that are required for key functions and consider their resilience capability
Identify alternative suppliers/providers/contractors that are required for key functions
Identify areas requiring strengthening in future planning
Review emergency information for suppliers/contractors and update as necessary
Review agreements with other organisations regarding staffing, use of facilities, supplies
Establish new agreements with other organisation if previous alternatives have become unavailable

Profile
Keep people informed on the restoration actions that are taking place and provide reassurance of a continuing service including information on expected delays
Maintain communication on risks of infection (respiratory and hand hygiene)
Keep in touch with all internal and external key stakeholders so they are informed about the restoration actions that are taking place as well as preparedness for possible subsequent waves
Identify actions that can be taken to reduce potential reputational damage to your organisation and rebuild the reputation of/trust in the organisation within your area of influence

Performance
Re-establish normal working practice, recovering core services/processes first followed by less critical services
Manage the flow of service users
Review appointment and waiting lists for services
Establish priorities
Manage the backlog
### Appendix 4: Glossary of Terms and Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACP</td>
<td>Antiviral Collection Point</td>
</tr>
<tr>
<td>BCM</td>
<td>Business Continuity Management</td>
</tr>
<tr>
<td>CCA</td>
<td>Civil Contingencies Act 2004</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>COO</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOP</td>
<td>Daily Operational Performance</td>
</tr>
<tr>
<td>EPCG</td>
<td>Emergency Preparedness Coordinating Group</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Response and Recovery</td>
</tr>
<tr>
<td>FOC</td>
<td>First on Call</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
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<tr>
<td>HSCA</td>
<td>Health and Social Care Act 2012</td>
</tr>
<tr>
<td>LGI</td>
<td>Leeds General Infirmary</td>
</tr>
<tr>
<td>LHRP</td>
<td>Local Health Resilience Partnership</td>
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<tr>
<td>LRF</td>
<td>Local Resilience Forum</td>
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<tr>
<td>MIU</td>
<td>Minor Injuries Unit</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
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<tr>
<td>NPFS</td>
<td>National Pandemic Flu Service</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>REAP</td>
<td>Resource Escalation Action Plan</td>
</tr>
<tr>
<td>SAGE</td>
<td>Scientific Advisory Group for Emergencies</td>
</tr>
<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
</tr>
<tr>
<td>SCG</td>
<td>Strategic Coordinating Group – The multi-agency Gold group</td>
</tr>
<tr>
<td>SJUH</td>
<td>St James’s University Hospital</td>
</tr>
<tr>
<td>STAC</td>
<td>Science and Technical Advice Cell</td>
</tr>
<tr>
<td>LTHT</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
</tr>
<tr>
<td>TEG</td>
<td>Trust Executive Group</td>
</tr>
<tr>
<td>TTO</td>
<td>To Take Out</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YAS</td>
<td>Yorkshire Ambulance Service</td>
</tr>
</tbody>
</table>

**Acquired immunity**

Immune defence that develops following exposure to a pathogen (e.g. bacterium or virus) or vaccine. It involves the
production of specific defensive blood cells (lymphocytes) and proteins (antibodies), and provides lasting immunity based on the experience or ‘memory’ of previous exposure.

**Aerosol**
A gaseous suspension of fine solid or liquid particles which remain suspended in the air for prolonged periods of time.

**Airborne**
Carried by or through the air.

**Airborne transmission**
Movement of viral particles through the air either attached to solid particles (such as dust) or suspension in droplets of liquid.

**Antibiotic**
A type of drug that can prevent the growth of bacteria.

**Antiviral medicines**
Used to describe a chemical or drug that inhibits virus replication.

**Antiviral resistance**
The lack of responsiveness of a virus to an antiviral drug, caused by natural variation or as a result of adaptation by the virus.

**‘At risk’ groups**
Groups of people who, through their immune disposition or long-term illness (e.g. diabetes, chronic heart or respiratory disease) are deemed to be especially threatened by infection.

**Case fatality ratio**
The proportion of the population who develop symptoms, ranging from severe to mild during an Influenza and who subsequently go on to die as a result of that infection.

**Clinical attack rate**
The cumulative proportion of people infected and showing symptoms over a specified period of time.

**Cohorting**
Placing patients with the same infection together in order to reduce transmission and to facilitate treatment.

**Community**
The general population, outside of a hospital or clinical environment.

**Confirmed cases**
Cases of illness that have been confirmed by laboratory analysis.

**Countermeasures**
Interventions that attempt to prevent, control or treat an illness or condition.

**Critical Care**
Care of a patient in a life-threatening situation by staff specially trained in recognising and responding to emergencies.

**Diagnosis**
Specific identification of the illness that is causing a disease or set of symptoms.

**Droplet**
Airborne particle which is larger than an aerosol and drops quickly to the ground.

**Epidemic**
The widespread occurrence of significantly more cases of a disease in a community or population than expected over a period of time.

**Epidemiological**
Relating to the study of the patterns, causes and control of disease in groups of people.

**Excess mortality**
The number of deaths that occur during an outbreak and above that expected for the time of year.

**Face mask**
A protective covering for the mouth and nose.
FFP3
A type of facemask capable of filtering out aerosol particles. Comes in valved and unvalved versions. Valved types have a one-way valve to make exhalation easier. Valved masks should not be used by patients with suspected influenza.

H1N1 (2009) influenza
The worldwide community spread of a new H1N1 influenza virus, pandemic originating in pigs and entering the human population in 2009.

H5N1
Highly pathogenic avian influenza virus, enzootic in birds in South East Asia.

Hand hygiene
Thorough, regular hand washing with soap and water, or the use of alcohol-based products containing an emollient that do not require the use of water to remove dirt and germs at critical times, e.g. after touching potentially infected people/objects and before touching others or eating.

Household prophylaxis
Post-exposure prophylaxis of household contacts with antiviral drugs.

Immune
The state of a person that is protected from a specific type of infection.

Immunisation
Manipulation of the immune system to confer, or bolster, its ability to protect.

Immunosuppressed
A state in which the immune system is suppressed by medications during the treatment of other disorders, like cancer, or following an organ transplantation.

Incubation period
The time from the point at which infection occurs until the appearance of signs or symptoms of disease.

Infection
The acquisition and active growth of a foreign microbial agent in a host, such as a human or animal, usually with a detrimental outcome.

Infectious
A disease caused by a micro-organism that can be transmitted from one person to another.

Infectivity
The extent to which a given micro-organism infects people (or animals), i.e. the ability of the organism to enter, survive and multiply in people and cause disease.

Isolation
Separation of individuals infected with a communicable disease from those who are not for the period they are likely to be infectious in order to prevent further spread.

Lockdown
Process of controlling exit, entry, movement and access around a building or site

Mitigation
Strategy to delay of the spread, or moderate the severity or extent, of a pandemic.

Modelling
Use of the mathematical theory of disease dynamics to make a quantitative assessment from available data of the range of possible behaviours of a pandemic and the impact of various responses, most importantly those that are likely to be both effective and robust over the range of uncertainty.
<p>| <strong>Osteltamivir</strong> | Antiviral drug, marketed by Roche Pharmaceuticals under the trade name Tamiflu®, that acts by inhibiting Neuraminidase activity and thus blocking viral spread. |
| <strong>Outbreak</strong> | Sudden appearance of, or increase in, cases of a disease in a specific geographical area or population, e.g. in a village, town or closed institution. |
| <strong>Pandemic</strong> | Worldwide epidemic – an influenza pandemic occurs when a new strain of influenza virus emerges which causes human illness and is able to spread rapidly within and between countries because people have little or no immunity to it. |
| <strong>Pandemic-specific vaccine</strong> | Vaccine developed against the antigens of the specific viral strain responsible for the pandemic. |
| <strong>Pathogenic</strong> | Able to cause disease. |
| <strong>Pre-pandemic vaccine</strong> | Vaccine developed, ahead of a pandemic, against antigens of a viral subtype. |
| <strong>Post-exposure prophylaxis</strong> | Use of antiviral drugs to prevent infection after exposure to infected contacts. |
| <strong>Prognosis</strong> | A prediction of the probable course and outcome of a disease. |
| <strong>Prophylaxis</strong> | Administration of a medicine to prevent disease or a process that can lead to disease – with respect to pandemic influenza, this usually refers to the administration of antiviral medicines to healthy individuals to prevent influenza. |
| <strong>Quarantine</strong> | Separation of those who are thought to have been exposed to a communicable infection, but are well, from others who have not been exposed in order to prevent further spread. |
| <strong>Relenza®</strong> | See ‘Zanamivir’. |
| <strong>Respirator</strong> | A face mask incorporating a filter. In this document, it implies a particulate respirator, usually of a disposable type, often used in hospital to protect against inhaling infectious agents. Particulate respirators are ‘air-purifying’ respirators because they filter particles out of the air as one breathes. |
| <strong>Respiratory</strong> | Relating to the respiratory system (e.g. the nose, throat, trachea and lungs). |
| <strong>Seasonal epidemic</strong> | An epidemic that occurs at a defined time each year, typically in the autumn and winter months in the UK due to climatic or social factors (e.g. the end of school holidays). |
| <strong>Seasonal flu/influenza</strong> | Annual period of widespread respiratory illness, typically occurring during the autumn and winter months in the UK, caused by the circulation of a strain of influenza virus that is slightly altered from the previous season. |
| <strong>Screening</strong> | Institution of special measures at points of exit/entry into a country to detect individuals who have – or may have – been exposed to an infection as a measure to reduce the spread of infection. |
| <strong>Sero-prevalence</strong> | The overall occurrence of a disease within a defined population at one time, as measured by blood tests. |</p>
<table>
<thead>
<tr>
<th><strong>Social distancing</strong></th>
<th>Measures to reduce influenza transmission by limiting the contact frequency between infected and susceptible individuals.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subtype</strong></td>
<td>Viral strain classified by the versions of Haemagglutinin and Neuraminidase that it possesses.</td>
</tr>
<tr>
<td><strong>Surge capacity</strong></td>
<td>The ability to expand provision beyond normal capacity to meet transient increases in demand, e.g. to provide care or services above usual capacity, or to expand manufacturing capacity to meet increased demand.</td>
</tr>
<tr>
<td><strong>Surgical mask</strong></td>
<td>A disposable face mask that provides a physical barrier but no filtration.</td>
</tr>
<tr>
<td><strong>Surveillance</strong></td>
<td>The continuing scrutiny of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action.</td>
</tr>
<tr>
<td><strong>Suspected cases</strong></td>
<td>Cases of illness identified through symptoms but not confirmed by laboratory analysis.</td>
</tr>
<tr>
<td><strong>Swine flu</strong></td>
<td>H1N1 influenza arising in 2009 from pigs and the cause of the 2009 pandemic in humans.</td>
</tr>
<tr>
<td><strong>Symptomatic</strong></td>
<td>Showing symptoms of disease or illness.</td>
</tr>
<tr>
<td><strong>Tamiflu®</strong></td>
<td>See ‘Oseltamivir’.</td>
</tr>
<tr>
<td><strong>Transmission</strong></td>
<td>Any mechanism by which an infectious agent is spread from a source or reservoir (including another person) to a person.</td>
</tr>
<tr>
<td><strong>Triage</strong></td>
<td>Procedure in which treatment is prioritised according to severity of injury or illness. Makes most efficient use of limited resources.</td>
</tr>
<tr>
<td><strong>Vaccine</strong></td>
<td>A substance that is administered in order to generate an immune response, thereby inducing acquired immunological memory that protects against a specific disease.</td>
</tr>
<tr>
<td><strong>Virological</strong></td>
<td>Pertaining to viruses.</td>
</tr>
<tr>
<td><strong>Virulence</strong></td>
<td>The capacity of an infectious agent to infect and cause illness.</td>
</tr>
<tr>
<td><strong>Virus</strong></td>
<td>A micro-organism containing genetic material (DNA or RNA) which reproduces by invading living cells and using their constituent parts to replicate itself.</td>
</tr>
<tr>
<td><strong>Wave</strong></td>
<td>The period during which an outbreak or epidemic occurs either within a community or aggregated across a larger geographical area. The disease wave includes the time during which the disease occurrence increases, peaks and declines back towards baseline.</td>
</tr>
<tr>
<td><strong>Zanamivir</strong></td>
<td>Antiviral drug, marketed by GSK Pharmaceuticals under the trade name Relenza® that inhibits Neuraminidase activity, thus blocking viral spread.</td>
</tr>
</tbody>
</table>