

# ***INFLUENZA PANDEMIC CONTINGENCY PLAN***

**Version1**

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## **1. Introduction**

This document outlines the contingency arrangements within the Health Economy for dealing with an influenza pandemic. The plan deals primarily with issues that have to be decided and acted upon at local level. Areas that will be subject to central guidance are dealt with in less detail, but references to the relevant documents are given where necessary, and local arrangements for implementing this guidance are discussed.

## **2. Background**

Influenza is a viral illness. Worldwide epidemics or “pandemics” of influenza resulting in high morbidity and mortality, occur when influenza A viruses undergo major antigenic shifts. This occurs at unpredictable intervals.

### **2.1 Infectivity**

Influenza viruses are respiratory viruses, primarily spread by aerosol. It is also possible to acquire influenza by direct contact with, for example, contaminated hands. The incubation period is between 24 hours and 5 days, and individuals can transmit infection from the time of acquiring influenza up to 5 to 7 days after the onset of illness. Children can continue to shed the virus for even longer. In addition, many people acquire the infection, but may not have signs of clinical illness. The virus can persist outside the body for up to 24/48 hours on hard surfaces, 8-12 hours on cloth, paper and tissue, and 5 minutes on hands. With these characteristics, it is not surprising that flu is very readily communicable within communities.

### **2.2 Timescale**

There may be several waves of outbreaks during a pandemic, each lasting between 6 to 8 weeks. In previous pandemics, waves have occurred at intervals of between 6 to 9 months.

### **2.3 Complications**

Influenza can affect any age-group, but usually causes the most serious complications in vulnerable groups such as the elderly or the chronically ill. However, pandemic viruses can have serious complications in any age-group – for example, in the 1918 pandemic, young adults were the most severely affected.

The complications of flu are primarily respiratory, but it can affect other organs [see box on next page]. Bacterial pneumonia is the most common pulmonary complication. However, in the 1918 pandemic, many of the victims died rapidly of a viral pneumonitis.

### **2.4 The Planning assumptions: the possible impact of a pandemic**

It is difficult to predict the impact of a flu pandemic with any certainty. The three flu pandemics in the last century differed in overall attack rate, in the age-groups of the population most affected, and in mortality rate.

**Table 1:** Possible serious complications of influenza

Pulmonary	Bacterial pneumonia (most common) Combined viral/bacterial pneumonia Pure viral pneumonitis
Cardiac	Atrial fibrillation Heart failure Myocarditis Pericarditis
Musculoskeletal	Myositis Rhabdomyolysis
Central nervous system	Encephalitis Transverse myelitis Guillain-Barré Syndrome
	Reye's Syndrome

The potential impact on health services is difficult to predict with any accuracy, but it is possible to infer the potential scale of the impact, by extrapolating from figures for previous pandemics. On top of this, there will be activity arising from the 'worried well'. These figures may be conservative estimates – for instance, in the 1918 pandemic, the acute mortality rate may have been as high as 2%.

The latest guidance from DH suggests planning for the attack and mortality rate seen in the 1957 pandemic and inter-pandemic years, giving 25% attack rate and 0.37% mortality.

It is unlikely that there will be supplies of the right vaccine at the start of a flu pandemic, as the pandemic virus will be a different strain from those which have been circulating in recent years, and against which vaccines have been developed. We can also expect to have shortages of antiviral drugs, which will be needed to help protect staff and combat infection. Healthcare and other essential staff services will also fall ill, adding to the difficulties in maintaining services in the face of increased demand.

The box on page 4 outlines the nature of the problems that may arise in the first wave of a flu pandemic.

## Potential problems in the first wave of a flu pandemic

**In all sectors:** Staff sickness and other workforce issues  
Potential disruption to supplies and utilities  
Existing patients/clients falling ill with flu  
The need to continue at least the urgent business as usual  
Communicating with staff, patients and clients

**Workforce issues\*:** Staff falling ill with flu, some perhaps dying  
Staff being at higher personal risk than if not at work  
More complex procedures to avoid cross-infection  
Patients/clients more demanding, especially if rationing  
Having to cut corners  
Working with volunteers  
Domestic pressures on staff, especially if schools close  
Family illness  
Logistics of getting to work and domestic commitments  
Agency colleagues may be being paid at a high premium

**Acute care:** increased attendances at A & E  
Excess pressure on ITU and for ventilation  
Use of time and resource consuming anti-infection

procedures

Quarantine into clean and "infected" areas/wards  
Difficulties in discharging to the community  
All the usual emergencies continuing

**Intermediate care:** Pressure to receive more patients

Difficulty in getting patients admitted to hospital  
Residential settings may see increased transmission

**Primary and community care:** Many falling ill at home and dying there

More difficult to arrange hospital admission  
Receiving patients discharged prematurely from hospital  
Front line of solving problems for patients denied their usual or expected services  
Staff sickness especially problematic in single-handed

practices

Community staff and practice premises may serve to increase transmission

**Social care:** Clients and their usual carers ill

Residential homes may see enhanced transmission  
Some clients may not be able to understand what's

happening

More children whose parents can no longer care for them  
People who become ill and are unable to return home

### 3. Aims and objectives of this contingency plan

#### 3.1 Aims

To provide a framework for coordinating the response to a flu pandemic, including the necessary background information, details of the relevant personnel and decision-making frameworks.

#### 3.2 Objectives

- To identify emergence of pandemic strains of influenza
- To reduce spread of influenza
- To reduce morbidity and mortality from influenza illness among residents
- To cope with large numbers of people ill and dying, both at home and in hospital
- To ensure that essential services are maintained for residents
- To provide timely, authoritative and up-to-date information for professionals, public and media

*In forthcoming local discussion, these will be reconsidered alongside the WHO overarching national objectives which are:*

- § *To provide leadership and coordination of resources that will: minimise morbidity and mortality; preserve health-care system effectiveness; minimise societal disruption; and minimise the economic impact of a pandemic*
- § *To ensure rational access to finite resources, including pharmaceuticals and (when available) vaccine*
- § *To evaluate the effectiveness of specific responses and interventions*
- § *To establish and maintain trust across all agencies and organisations and with the public, through a commitment to transparency and credible actions*
- § *To draw lessons from the ongoing pandemic response in order to improve response strategy and inform future planning*

#### 3.3 WHO pandemic phases (April 2005)

**Table 2:** WHO pandemic phases

	Phase	Previous WHO level (1999)	Features
<b>Interpandemic period</b>	1	0	No new virus types reported
	2	-	Circulating animal virus subtype judged a human risk
<b>Pandemic Alert period</b>	3	0 level 1	New influenza strain in human case
	4	0: level 2	Limited human to Human infection
	5	0: level 3	Human transmission still localised

<b>Pandemic period</b>	6	1	Confirmation of onset of pandemic
	6	2	Regional and multi-regional epidemics
	6	3	End of first wave of pandemic in UK
	6	4	Second or later waves of the pandemic
<b>Post pandemic period</b>	→1	5 →0	Return to interpandemic period

The above table outlines the different phases for planning and co-ordinating the response to a flu pandemic, as devised by the WHO. Appendix A here summarises the response to a flu pandemic, according to these phases.

### **3.4 Assumptions and exclusions from this plan**

This plan is based on the organizational structures and broad responsibilities as are present at the time of writing, and may not be applicable in the event of further organizational change or reallocation of responsibilities in the NHS, nor if the Civil Contingencies Act were invoked. Planning assumptions are given above for numbers affected by pandemic flu, but no account has been taken of other effects on population numbers from mass movements, nor of the secondary effects from breakdown in utilities or supplies of life essentials. It is being assumed there is no net mutual aid from other districts, nor loss of resources to assist other areas.

Whereas the DH and HPA plans concentrate on their actions to be taken in phases 1 to 5, this plan concentrates on local action for phase 6, during the most burdensome first wave of a domestic pandemic. For subsequent waves, there should be many lessons learned and revision made to the plan. In time flu vaccine should also become available.

### **3.5 Other potential uses of this plan**

This plan considers how the local health and social care economy might manage in one of the most severe disruptive challenges that is considered not only plausible but likely. The recommended processes to be used should be applicable in other scenarios too, such as a possible outbreak of SARS or an epidemic from a deliberately released agent. For some challenges, such as the release of smallpox, there are detailed existing national and regional plans but nevertheless this flu plan might help contribute another more local dimension.

#### **4. Command, Control and Responsibilities**

Overall, The Bedfordshire and Luton Local Resilience Forum (BLLRF) is the lead local organisation for the planning for and management of emergencies. The Strategic coordinating group (Gold) would sit at Police HQ Kempston. Please refer to the BLLRF Combined response document for further details.

On the health side, each NHS organisation has responsibility for its own plans for emergencies such as a flu pandemic. However, Bedford PCT is the lead organisation for emergency planning within the local health economy. The Strategic Health Authority oversees arrangements and provides external links. For emergencies such as a flu pandemic which may threaten the wider health of the community, there is a special role for the public health function. This is expected to be coordinated at regional level by the regional director of public health (RDPH) and at local level by the Director of Public Health (DPH), advised by the Health Protection Agency (HPA).

Section 6 of the national plan outlines the responsibilities at a national level, including the role of the Civil Contingencies Committee (CCC) and the Health Departments' UK National Influenza Pandemic Committee (UKNIPC).

Both the contingency planning and the operational response will need to involve close liaison between all organizations in the BLLRF area (suggested list given in appendix B).

The basic doctrine is speed and flexibility at an operational level, active mutual aid across organisational boundaries, supported by a strong central capability. It will also be important to seek and respond to guidance from regional and national authorities.

##### **4.1 Pandemic control team**

Once a flu pandemic has been declared, a local pandemic control team must be convened. The membership of the team as suggested below can be modified in the light of any further national guidance and experience. Issues such as the location of the operational headquarters should be decided according to the usual emergency planning procedures.

##### **4.2 Membership**

Membership of the control team will consist of the core decision making group, those who should always be in attendance in an advisory capacity those who can be co-opted as necessary. In addition, named deputies should be identified for each member of the pandemic control team

- Chair The Director of Public Health (DPH) – the influenza pandemic coordinator
- Chief Executive of lead PCT
- Consultant in communicable disease control
- Administrative support will be provided by the Public health directorate Bedford PCT.
- Health Emergency Planning Manager

- Pharmaceutical Advisor
- Associate Director, Corporate Services – Bedford PCT
- Director of Corporate Services – Bedfordshire Heartlands PCT
- Director of Public Health - Bedfordshire Heartlands PCT
- Director of Public Health – Luton tPCT
- Emergency Planning – Beds County Council
- Emergency planning – Luton Borough Council
- EP lead - BLPT
- EP lead- Luton and Dunstable Hospital
- EP lead – Bedford hospital
- Emergency planning – Bedfordshire Police
- Health Care Manager – Yarlswood IRC
- Others to be co-opted as necessary, or to be in attendance, e.g. emergency planning liaison officers (EPLO) of partner organisations, press officer and police.

The pandemic control team will need to receive reports from various officer subgroups, and where these are based on existing groups, this will be in addition or instead of their usual reporting lines. This process is to be coordinated by the DPH as influenza coordinator.

In addition to these subgroups, new groups, for example, a business continuity team and a communications team, will need to be formed. There may also be other executive groups dealing with and reporting on specific aspects. For example, if decisions about school closures are to be made locally, it is important that this is done in conjunction with the overall pandemic control team, in view of the expected impact on health and social care staffing levels: another group may be needed to work through this.

#### **4.3 Terms of reference of the pandemic control team**

- To provide leadership for the dealing with the local implications of a flu pandemic
- Reporting to BLLRF Health emergency planning group and Support group.
- To interpret and act upon national and regional guidance on the flu pandemic
- To make decisions about deployment of local resources, including restricting or withdrawing the usual standard of services in order to minimise the overall loss of life in the population at large during the epidemic
- To maintain essential public services wherever possible
- To encourage community cohesiveness, resilience and self-help
- Ensure full normal services are resumed as soon as possible

## **5. Local Actions Expected**

The necessary actions are outlined here, grouped according to the stated objectives of the plan. Appendix A outlines these actions according to the phases of a flu pandemic. This section will need to be revised once DH makes available more detailed guidance, promised on 'organisational issues for healthcare organisations', 'draft clinical treatment protocols', 'clear infection control guidance for all health and social care establishments' as well as other details, eg on the availability and use of antiviral drugs, 'surveillance' and a 'checklist for other organisations'.

### **5.1 Identifying potential pandemic influenza**

Education will be needed in the interpandemic alert period to assist staff, in particular those at A & E and primary care teams looking after those from the affected area, to ensure that any unusual strains of flu are detected early. Depending on national guidance, there may be additional action required in relation to those arriving in the UK from affected areas. Case-finding and isolation will be of most importance in the early phases, but in an extensive epidemic may prove increasingly unfeasible.

### **5.2 Prevention and Containment**

An annex in the WHO plan provides useful guidance on non-pharmaceutical public health interventions, which is all that might be available in the initial stages to reduce the incidence of infection.

Information will be needed for public and professionals on risks and risk avoidance. In particular, health and social care staff will be reminded of the value of simple infection control measures, such as hand washing. Face masks may be useful for cooperative symptomatic patients thought at risk of spreading infection and for staff when dealing face to face with symptomatic cases and suspect cases. Staff should use universal precautions, but gloves are not necessary for flu per se, though they could be indicated because of other infections, exposure to body fluids or in the presence of skin lesions.

It is expected that there would be a national campaign to inform the public about the symptoms of flu, on prompt self-diagnosis, on how to reduce contact with others if ill, limit social gatherings, not to share handkerchiefs or drinking cups, and what to do if symptoms of flu are suspected. Local re-inforcement of these messages would be discussed:

- With local media
- NHS Direct
- With Council and NHS staff
- With private sector local employers
- With local voluntary sector organisations

Voluntary confinement of cases, at home where possible, should help limit spread, but by the pandemic phase this would not be useful for contacts.

Measures to increase social distance may be advocated on the advice from national experts on the UKNIPC. As well as quarantine, possible measures could include restriction of public gatherings, restriction of transport and closure of schools. The implications of restricting transport need to be taken into account in planning the contingency arrangements for maintaining essential services. The implications of school closure on working parents must be taken into consideration when planning for the workforce.

### **5.3 Prevention of influenza – immunisation and anti-viral agents**

#### *5.3.1 Immunisation*

In the event of a pandemic, vaccines are likely to be in short supply. In the first wave, there may be no vaccines available which are effective against the new pandemic strain. Provisional priority groups for vaccination have been identified nationally. It is currently the responsibility of the PCT, as advised by the CCDC-HPA, to estimate local vaccine needs in the priority groups and to ensure the distribution and administration of the vaccine.

The CCDC and BLLRF sub group on Mass Vaccination must:

- Estimate vaccine needs in the population based on the nationally identified priority groups and place orders with the appropriate authorities
- Ensure that a system for distributing the vaccine has been worked out depending on the agreed groups, with occupational health and special clinics for key workers, and community and practice clinics for the high-risk groups. This will be a modification of the plan put in place each autumn for flu vaccination, and can build on work undertaken for the smallpox plan.
- Ensure that there is a system in place for the reliable identification of individuals who are key workers and who may be in the priority groups for vaccination (photopasses etc)
- Ensure security of vaccine, with guidance from the police deciding where should supplies be held, and how best to distribute them

Even if vaccine is not available in the first wave of a pandemic, planning will need to take place in anticipation of a further pandemic wave. Estimates of essential workers requiring vaccine will need to take note of those who are recovered from flu caught in the first wave and so have natural immunity. It is hoped that advice on the most appropriate test for determining immunity, and the attendant resources required, will be forthcoming from the Department of Health/Health Protection Agency.

At least by the interpandemic alert period, every effort should be made to optimize uptake of pneumococcal vaccine in those groups for whom it is indicated. When a flu pandemic first starts, pneumococcal vaccine may be available for these groups even though flu vaccine to the new strain is not.

**5.3.2 Antivirals** The currently available antivirals include amantadine/rimantadine and neuraminidase inhibitors such as oseltamivir and zanamivir, and these may have limited value in preventing infection or combating disease (NICE appraisal guidances 15, 58 and 67; guidance which does not apply to the pandemic situation).

In the event of a pandemic, supplies of antivirals will be limited. National stockpiles are being purchased and guidelines on the use of antivirals during a pandemic are being drawn up centrally. Apart from a possible role in prophylaxis at an early stage of the pandemic, use is likely to be restricted to certain priority groups who can receive treatment within a short time period of the first symptoms. Health care workers and others required for essential services will have the top priority. It is hoped the new guidance will cover issues such as more details of priority groups, dose and duration, when they should be used as prophylaxis rather than treatment, and the diagnostic tests that are recommended before use of antivirals for treatment. Hopefully, it will also cover the recommended route of distribution (over the counter or via primary care), and deal with any relevant licensing issues.

#### **5.4 Prevention of complications of influenza**

Draft clinical treatment protocols are in preparation nationally, but not yet available. Antibiotics are assumed to be the most effective means of dealing with many of the common complications of influenza, both in the hospital and in the community. The steps involved are:

- Determine most likely organisms - advice will be sought from the HPA and local medical microbiologists. In the past, staphylococcal pneumonia has been common in flu pandemics
- Determine available stocks – will need system to determine rapidly the available stocks – coordinated by PCT pharmaceutical advisers
- Distribution: since it is not practical to expect GPs to prescribe all antibiotics, nor wise to require ill patients to attend GP surgeries, alternative methods of prescribing antibiotics would be needed. Patient Group Directives could be prepared in advance and agreed with local professional bodies to allow nurses/pharmacists to prescribe antibiotics according to a protocol, once a flu pandemic had been declared. Preparation of these protocols is to take place under the direction of the PCT's prescribing committee.

#### **5.5 Health Service response: Coping with large numbers of ill and dying patients, both at home and in hospital**

During each wave of a flu pandemic, there will be large numbers of people ill and dying from flu and its complications, in addition to those that normally need urgent and routine NHS care. Hospital services are likely to be rapidly overwhelmed. It will be necessary to reconfigure the current designation of hospital beds, operate admission guidelines for hospitals and consider alternative deployment of staff.

Useful steps that can be done in advance of the pandemic are:

- Map the current capacity in acute hospital care in Beds and Luton, the number of and designation of beds, and flexibilities in the system. This information, once collated must be regularly updated on a daily basis and kept in an easily accessible place. This update happens as a matter of course in Beds and Luton. This map may have value in other contingency plans, eg for SARS and deliberate release of agents such as smallpox.
- To decide which services are essential and which non-essential. In the first instance, elective procedures can be cancelled and some outpatients postponed, as currently happens during the difficult winter period. However, this is unlikely to clear sufficient space over a pandemic wave lasting six to eight weeks, so some additional prioritization of services will be necessary.
- In order for appropriate decisions to be made about how best to deploy very limited acute resources, it is hoped that advice will become available from the Department of Health on the appropriate management of otherwise overwhelming viral pneumonitis, including the value of ventilation and oxygen. This will need to take note of the risks to staff, both when vaccine is available and were it not to be. National advice is needed on whether it would be best to use limited acute capacity on those with bacterial or viral pneumonia, and what is the best alternative management for those that cannot be offered a place in an acute setting.
- Clinical and hospital guidelines for admission, admission to ICU and treatment regimes would be useful. It would be sensible to prepare protocols with escalation procedures for varying degrees of pandemic severity. This may need to be prepared locally, depending on any national advice available (and central guidance appears to be promised).
- Prioritising health care and triage. Similarly, it would be useful to have protocols and procedures for prioritisation and triage thought out in advance. Again, the level of local involvement in this will depend on any national guidance.
- Temporary hospice facilities might be needed to cope with those who are triaged to receive supportive care only and where neither hospital nor home terminal care is feasible. Similarly, temporary flu hospitals may be needed for those unable to be cared for at home but not ill enough for acute care. Identifying potential physical locations should not be problematic, in view of the many hotels in the area, but potential volunteer staff would need to be identified too. Transport will also need to be arranged for these individuals
- Each clinical directorate within the PCT needs to have contingency arrangements for collaborative working in the event of crises. This is to

take note of the especial problems of single-handed practitioners, with temporary PMS arrangements if need be. Local pharmacies are also envisaged to have an enhanced role to help relieve pressure on general medical practices.

- NHS Direct will play an essential role in maintaining communication with patients in their own homes.

## **5.6 Social and community services**

Restriction of access to hospital, and early discharge of patients, together with the burden of influenza in the community will increase pressure on social and community services.

- Social care needs will need to be prioritized. In the first instance, priority should be given to those who are on their own, and dependents of essential workers. The care delivered should cover basic care needs only, and where dependent clients are still receiving both health and social care, these roles should be merged. As usual carers become ill, the burden on social services will continue to increase.. Currently, a register of all social care clients, together with details of needs and carers is available. However, there is no collated information on those whose needs are usually met from within the family or by the private sector, nor those with unmet needs.
- Volunteers could be used to help where carers have fallen ill. Screening of volunteers, especially those who will work with children and vulnerable adults, and contract and indemnity arrangements, needs to be considered. Some volunteers, for instance at the British Red Cross, may already have had a police check. For the voluntary sector to participate effectively in the response to a flu pandemic, consideration could be given now to the roles they may be asked to play, and training carried out as necessary.
- Residential homes. Strict infection control measures would reduce spread within the home, but many clients might have difficulty in understanding what is required and keeping to it. The decision needs to be made whether ill residents would be moved elsewhere, or whether homes would be designated "infected" if a single resident becomes ill, with ill residents cohorted. It is likely that decisions would be made not to transfer those with flu to acute care settings.

## **5.7 Mortuaries**

As part of the emergency planning arrangements and mass casualty plans, further capacity is being prepared. The flu transmission risk for mortuary workers is from families and friends of the diseased, not from the corpses.

Discussion could take place with religious leaders over modifications to the usual requirements for funerals, to be activated in times of crisis.

Guidelines on procedures for deaths at home should also be drawn up – for example, on the flexibility allowed by the coroner on the need for post mortems for unsupervised deaths at home.

## **5.8 Supplies and logistics**

A plan is needed for the anticipated stockpiling of food/fuel/medications although it is hoped that national guidance will assist in how to maintain supplies of essential items. There might need to be some sort of local rationing, or priority given to essential workers. An identity system for essential workers should be prepared in advance and in the absence of central guidance, each local employer in the public sector will be expected to identify their essential workers. Advice will be needed from the Cabinet Office/Department of Health/regional resilience team on identification of other essential workers, e.g. for the utilities.

On essential medical supplies, it appears that some purchasing such as that on vaccines and antiviral drugs will be undertaken nationally. Some equipment stored in pods ready for deliberate release might prove useful in pandemic flu, as would any protective equipment stockpiled in anticipation of a SARS epidemic. It is unclear whether common items such as facemasks will all have to be purchased locally.

It is assumed that the health and social care sector would work collaboratively during such times of crisis, with one partner willing to purchase on behalf of the other. An outline arrangement for a section 31 pooled budget emergency fund has been drawn up, for activation if and when required.

## **5.9 Personnel**

Managing the workforce is a key element in the response to a flu pandemic. Issues to be considered for the healthcare sector include:

- Compiling a register of all healthcare staff in the area, both those working in Beds and Luton and those living in Beds and Luton but working elsewhere, with information on domestic commitments and contact details. The register should also include recently-retired healthcare staff and those

not working in the NHS. Those on this register could be asked about whether they wished to keep in touch with NHS job opportunities and courses to help them keep up to date. In times of crisis, such as a flu pandemic, this group would be the first to be called upon to volunteer to help out under temporary contracts

- Protection of staff: Education on protection of staff while vaccines and antivirals are not available, eg importance of handwashing, when to use a face mask, if available  
Maintain an immunisation record for all healthcare staff (occupational health)
- Enabling staff to work: provision of childcare and care for dependent elders  
Provision of transport
- Redeployment of staff: Some staff can be identified as working in clinical areas that could be temporarily suspended, freeing them for potential deployment elsewhere. For example, the local dental committee agreed in principle to the possible use of dental practice staff not needed for emergency dentistry to assist GP practices.
- Support of staff: Ensure that indemnity arrangements are in place to cover staff who are delivering a service that necessarily falls below usual standards of acceptable care  
Ensure staff are supported in making difficult decisions  
The psychological effects on staff of family dying etc will also need to be addressed
- Use of volunteers List of ex-staff and others on reserve list  
Contract and indemnity arrangements pre-prepared  
Agreement with Trade Unions on the mentoring and other arrangements

Because of the range and complexity of these issues, separate discussions are needed to flesh out realistic staffing contingency plans. Anticipating potential easy spread within work groups, cohorting of staff may have value, especially in the very early phases when home confinement of contacts might be recommended.

#### **5.10 To ensure that essential services are maintained for residents**

Plans to ensure maintenance of essential services should link into the current emergency planning arrangements. It will be particularly important to maintain waste disposal, funeral arrangements, transport, food supplies and the

utilities. Other special considerations when planning for a flu pandemic that must be taken into account include:

- Protecting essential workers. Essential workers should be identified, so vaccines/antivirals can be distributed to them. As previously mentioned, a reliable system for identifying these workers needs to be in place now
- The contingency plans should take into account the prolonged nature of a flu pandemic. Plans should anticipate crises lasting from six to eight weeks
- The police may need help from the military and specials to maintain public order and secure essential supplies

### **5.11 Communications: to provide updated timely information for the public, professionals and the media**

A timely, reliable, accurate communication system is an essential part of the response to a flu pandemic. Firstly there is the provision of information to the public. Secondly there is the communication infrastructure that will enable all organizations and professionals involved in planning the response to communicate with each other. These arrangements can be worked through in advance.

Public information, to supplement that provided by national and international media, not all of which may be helpful. In times of crisis, local communities may increasingly fall back on their own resources, particularly if transport and public gatherings are restricted. Effective distribution of information will involve:

- Close working with the local media
- Distribution of information leaflets
- Use of NHS Direct
- Communicating via the internet/email with the Local Authority and PCT's web-sites seen as the authoritative source of local information, supplementing the HPA as the authoritative national resource
- Encouraging local networks - building on existing networks such as neighbourhood watch, and area committees..

Information for professionals at a local level can be transmitted through the usual routes for keeping staff informed, eg e-mail cascades, in-house circulations, fax cascades, with minimization of group/mass meetings. In addition, the PCT will need to continue with systems for collecting and transmitting monitoring and related information that will be required by the SHA and centrally (by the Department of Health, Cabinet Office, HPA etc), including activity information, sitrep reports etc.

Finally, there will need to be a systematic approach for recording decisions taken and reasons for them, including an estimate of costs, to feed into the debrief, reconciliation of budgets and a potential public inquiry

### **5.12 Post pandemic phase**

After the first wave, there should be a brief respite during which strategies can be reassessed, and a catch-up of delayed elective activity and other routine

business. There is expected to be a considerable role for the clinical psychology service at this time in supporting the bereaved and others affected by the pandemic.

The overall long term health of the community at the end of the pandemic will depend on how they were affected by their individual and collective experiences during the pandemic. Even if times were difficult, an open and honest approach by the public authorities is likely to reduce post pandemic psychopathology and enable a more speedy return to normality.

## 6.0 References

The following documents are the latest versions of the most important ones consulted when preparing this plan and in updating it.

- BLLRF Combined Response Document
- Handling major incidents: an operational doctrine Jan 2004  
NHS emergency planning on [www.doh.gov.uk/epcu/opdoctrine.htm](http://www.doh.gov.uk/epcu/opdoctrine.htm)
- § UK Influenza Pandemic Contingency Plan (March 2005) on [www.dh.gov.uk/assetRoot/04/10/44/37/04104437.pdf](http://www.dh.gov.uk/assetRoot/04/10/44/37/04104437.pdf)
- § HPA Influenza Pandemic Contingency plan (Feb 05) on [www.hpa.org.uk/infections/topics\\_az/influenza/pdfs/HPAPandemicplan.pdf](http://www.hpa.org.uk/infections/topics_az/influenza/pdfs/HPAPandemicplan.pdf)
- § WHO global influenza preparedness plan (Apr 05) on [www.int/csr/resources/publications/influenza/WHO\\_CDS\\_CSR\\_GIP\\_2005\\_5/en](http://www.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5/en)
- A Framework for an Australian Influenza Pandemic Plan  
Technical Report Series no.4  
From the Influenza Pandemic Planning Committee of the Communicable Diseases Network Australia New Zealand. Version 1, June 1999. Available on: <http://www.health.gov.au/pubhlth/strateg/communic/tech/influenza.htm>, also on [www.who.int/csr/disease/influenza/en/influenza.pdf](http://www.who.int/csr/disease/influenza/en/influenza.pdf)
- § Canadian Pandemic Influenza Plan (Sept 2004) on [www.phac-aspc.gc.ca/cpip-pclcpi](http://www.phac-aspc.gc.ca/cpip-pclcpi) (also accessible like other national plans through the WHO website)
- § USA Pandemic Influenza response and Preparedness Plan (Aug 2004) on [www.hhs.gov/nvpo/pandemicplan/](http://www.hhs.gov/nvpo/pandemicplan/)

**7.0 Next Revision Date** When the Department of Health makes available new guidelines on specific areas, and/or advice is provided by the Health Protection Unit which supercedes part of this plan. In the meantime, this version is to be discussed within the PCT, at the BLLRF health emergency planning group (its Mass vaccination subgroup, who are the lead for approval of this document) at its next meeting, and with other partners, and any further amendments incorporated.

## Appendix A: Summary of action points

	Phase	Actions	Lead
Interpandemic period	1	<p><b>The local team</b>            Agree membership and outline terms of reference of pandemic control team            Maintain up-to-date register of contact details            Keep this plan up to date and consistent with national guidance</p> <p><b>Information for planning</b>            Prepare and maintain up to date register of healthcare staff living &amp; working in Beds and Luton            Prepare and maintain map of hospital capacity in Beds and Luton, including ventilation facilities            Prepare and maintain list of relevant organizations            Consider list of essential staff in all essential services, not just healthcare            Ensure that system is in place to identify and vaccinate nationally identified priority groups            Have contingency arrangements for extra hospice capacity            Have contingency arrangements for extra mortuary capacity            Prepare list of all local organisations and meeting places which could act as focal points for local communities</p> <p><b>Procedures</b>            Prepare decision-making framework for making difficult decisions eg rationing of services            Prepare protocols for determining admission to hospital/ICU etc            Prepare generic contracts to allow retired healthcare staff/medical students/volunteers etc to work in clinical settings with appropriate indemnity cover, and agreed with the Unions            Prepare patient group directives to allow nurses/community pharmacists to prescribe</p>	<p>DPH/CCDC/HEPM            CCDC/DPH  <i>Ongoing from now</i></p> <p>PCT prescribing cttee and PCT</p>

		antibiotics Maintain outline agreement for section 31 budget for use in emergencies	
		Education and training of staff Ensure high risk groups receive pneumococcal vaccine Arrange for any local stockpiles, eg of antivirals, that are nationally recommended Work out communications systems to local communities Agree accelerated funeral arrangements for use in crises with religious leaders Each clinical directorate within PCT to have contingency arrangements for collaborative working in the event of crises (to note particularly the problems of single handed practitioners)	
	3	Review action expected in phase 1	all
	4	Update contact lists and ensure this plan is up to date	DPH/CCDC/EPLO
	5	Increase the awareness of potential flu, if the infection is overseas	CCDC/DPH
Pandemic period	6	Convene pandemic control committee Activate contingency arrangements, like pooled budget and PGDs Activate local communications network, and issue first communications with staff and public Take national advice about ordering essential supplies Activate outline arrangements for additional mortuary capacity	
		Frequent meetings of the control committee, communicating their decisions with rationale to staff and public Monitoring the impact of the pandemic, and each GP practice, and each residential institution Modify actions in the light of experience, national guidance and other developments Identify staff who have acquired immunity and recovered from flu, posting them to front-line positions if vaccine is still in limited supply	All, coordinated by DPH
subsided		Take stock and agree what needs to be handled differently in any subsequent waves	Pandemic control team

Second wave		Repeat of pandemic phase 1, with agreed improvements Selective vaccination should now be possible even if not available in the first wave	
Post pandemic period	Return to 1	Review the local response to the pandemic Deal with any budget issues with cross-charging between organisations if need be Ensure business gets back to the "usual" as soon as possible, including review of those waiting for elective procedures Ensure continuing support to staff	

**Appendix B:  
Organisations to be involved in planning response to flu pandemic**

- Bedfordshire Primary Care Trust
- Luton teaching Primary Care Trust
- Bedfordshire and Luton Mental health and social care Partnership NHS Trust
- Bedfordshire County Council
- Luton Borough Council
- Acute hospital trusts
  - Bedford Hospital NHS Trust
  - Luton and Dunstable Hospital NHS Trust
- Health Protection Agency,
- NHS Direct
- East of England Ambulance Service
- Bedfordshire Police
- Voluntary organisations (BLEVEC to liaise)
- In conjunction with:
  - Regional DPH and Government Office for East
  - Resilience Team
  - East of England Strategic Health Authority
  - Neighbouring health and social care economies
  - Local private nursing homes and hospice
  - Local businesses
  - HM Prison Bedford
  - Yarlswood Immigration Removal Centre