

Item 6.5a

Pandemic Flu Plan

Plan

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Policy Statement

This plan will provide a framework within which the Trust will respond to a declared flu pandemic.

The aims and objectives of this document are to ensure a procedure is in place to deal with the command and control of pandemic flu issues that might affect the operational running of the Trust, whilst minimising disruption to health and other essential services and maintaining business continuity as far as possible.

This plan is not designed to be a comprehensive contingency management system, but is a plan which will address the principles of managing a pandemic to ensure the safe delivery of patient care is delivered to the highest quality during a period with unprecedented referrals and predicted staff absence.

Given the highly uncertain nature of an influenza pandemic; it is impossible to predict accurately the impact of a pandemic on the Trust's services and staff and as such this document must be considered a live and working document. This plan will be reviewed annually as a minimum, and more frequently in the event of significant epidemiological data and direction from the Department of Health.

1 Roles and Responsibilities

Organisation, co-ordination, clear lines of accountability and clear communication are key to preparing for, and responding to, a pandemic flu outbreak. The leads for pandemic planning are as follows:

Executive Lead: Director of Research and Information (Chief Risk Officer)

Operational Lead for Emergency Planning: Risk, Safety and Emergency Planning Lead

Clinical Lead: Clinical Director of Critical Care The

leads are responsible for ensuring:-

- i) National and regional plans are scrutinised to ensure that any changes are reflected in the Trust plan and communicated to all staff.
- ii) The plan is circulated to and approved by the Emergency Planning Group who have the authority of approval of the plan from the Risk Management Committee.
- iii) The plan is circulated to all wards and departments.
- iv) The plan is regularly tested to ensure it remains contemporary and reflects the changing service needs of the organisation.
- v) The Pandemic Flu plan is circulated externally to all relevant and appropriate stakeholders as requested.

- vi) All Heads of Departments and team leaders have a responsibility to ensure the staff for whom they are responsible are familiar with the Trust plan.
 - vii) Heads of Department are responsible for attending the Pandemic Flu preparedness committee meetings and if unable to attend they send a nominated deputy. This is to ensure that updates from national and regional sources are communicated in a timely manner and acted upon.
 - viii) All Heads of Department are responsible, in conjunction with the Operational and Executive leads, for updating their departmental Business Continuity Plans in line with the Trust plan. Review and to reflect national and regional guidance. This will be communicated by the Risk, Safety and Emergency Planning Lead when the need arises.
- ix) In the event of a pandemic threat being declared as imminent the Pandemic Flu Emergency Response Team will convene and will be responsible for the following;**
- The command and control of the incident and the impact on services.
 - Formation of operational continuity team/s.
 - Direction of resources of the operational team/s as appropriate
 - Ensuring all wards and departments have invoked their continuity plans.
 - Prioritising the work of teams according to need
 - Briefing and informing the Trust Strategic Team of progress as appropriate.
 - Keeping the nominated Liverpool CCG lead informed of the operational status of the Trust as per their situation reporting timescales.
 - Remaining in operation until normal services are resumed and the Trust receives notification of an official 'stand down' command.
 - Conduct a full debrief of the issues to enable lessons learned for subsequent events.
- x) Pandemic Flu Emergency Response Team**
- Clinical Lead for Critical Care
 - Director for Research and Informatics
 - Chief Operating Officer
 - Head of Nursing and Quality - Corporate
 - Head of Nursing & Quality – Clinical Services
 - Risk, Safety and Emergency Planning Lead
 - Infection Prevention Specialist Nurse
 - Facilities Manager
 - Head of HR
 - Communications Lead

2 Information about Influenza

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|---------------------------------|--|--------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 3 of 68 |
|---------------------------------|--|--------------|

There are three types of influenza virus – A, B and C. Influenza A viruses cause most winter epidemics and can affect a wide range of animal species as well as humans. During any year, a small proportion of slightly altered viruses will emerge from the larger population of influenza viruses. The human immune system effectively protects against previously seen influenza viral strains. However, upon encountering such an altered virus pre-existing immunity will be only partial or even non-existent, leading to clinical symptoms in those infected.

Pandemic influenza occurs when an influenza A virus subtype emerges or re-emerges which is markedly different from recently circulating strains. Therefore, this is able to spread widely because few, if any, people have natural or acquired immunity to it. It is readily transmissible from person to person and capable of causing illness in a high proportion of those infected.

During the last century there were three influenza pandemics. The most significant of these, the so called Spanish Flu of 1918/1919, was responsible for more deaths in one year than the cumulative number of all those killed in all the armed conflicts of the 20th century. The other two pandemics of the last century, the Asian Flu of 1957/58 and the Hong Kong Flu of 1968/69, although associated with less morbidity and deaths than the 1918 influenza pandemic, nevertheless caused significant illness in the working population affecting the UK's capacity to care for the sick and to maintain services essential to the national infrastructure.

The 2009-2010 Swine Flu pandemic has been estimated to have had a case fatality rate of less than 0.025% with an attributable excess global mortality of less than one million.

It is important when developing pandemic plans that a number of scenarios are considered due to the uncertainties inherent in the nature of pandemics. There are uncertainties around:

- When the pandemic will occur. There is no predictable time period between previous pandemics.
- How severe the pandemic strain will be.
- The speed with which the pandemic can develop. The short incubation time of influenza and global travel means that within a short period of time a significant number of cases globally may occur.
 - The impact of a pandemic on society and services. Severity will be one indicator of impact on services, however, other factors will include the epidemiological profile of the virus, and population groups affected the need for specialist interventions and the population behavioral responses.

Onset of Influenza

The onset of influenza is very sudden. Fever, lasting several days and one or more of the following symptoms are common;

- Cough
- Headache

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| Version No.1.3 November 2015 | <p align="center"><i>Pan flu plan</i></p> <p align="center">Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue</p> | Page 4 of 68 |
|---------------------------------|--|--------------|

- Aching/pain (often severe)
- Fatigue and weakness
- Runny nose, sneezing and sore throat
- Nausea, vomiting and diarrhoea.

Complications of Influenza

Influenza poses a significant threat to the elderly, children and people with underlying health conditions which reduces their natural immunity.

Complications caused by influenza include;

- Bacterial pneumonia
- Dehydration leading to collapse
- Deterioration of existing medical conditions (e.g) renal failure
- Sinus and ear infections leading to balance and visual problems

Most complications usually occur in vulnerable groups, however pandemic strains of the virus can have serious complications in any individual.

Transmission of Influenza

Influenza is directly transmitted from person to person when people who are infected with the virus, cough or sneeze and the droplets of their respiratory secretions come into contact with the mucus membranes of the mouth, nose and eyes of another person. The droplets can survive for 24-48 hours on hard surfaces, 8-12 hours on cloth, paper and tissue materials. The virus can also survive on hands if they are not decontaminated.

The infectious period of the virus is up to five days from the onset of symptoms but may be significantly longer in children and immuno compromised people. The incubation period is 1-3 days.

Recovery usually occurs within 7 days but complications as outlined above can lengthen the duration of illness.

Pandemic Terminology

Estimated burden of illness – Between 1% and 4% of symptomatic patients will require hospital care, depending on how severe the illness caused by the virus is. There is likely to be increased demand for intensive care services.

Attack Rate For deaths, the analysis remains that up to 2.5% of those with symptoms would die as a result of influenza if no treatment proved effective. These figures might be expected to be reduced by the impact of countermeasures but the effectiveness of such mitigation is not certain

Age – The attack rate in different age groups will affect the overall impact. For example if working age adults are predominantly affected, this will have a more

serious impact on service provision and business continuity, whereas illness in the young and the elderly may present a greater demand on health services

Mortality – The combination of particularly high attack rates and a severe disease is also relatively (but unquantifiable) improbable. Taking account of this, and the practicality of different levels of response, when planning for excess deaths, NHS England ensure 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, possibly over as little as a 15 week period and perhaps half of these over three weeks at the height of the outbreak. More extreme circumstances would require the local response to be combined with facilitation or other support at a national level. In a less widespread and lower impact influenza pandemic, the number of additional deaths would be lower.

Avian Influenza – is a disease of birds caused by viruses closely related to human influenza. It has the potential to transfer into a form that causes severe disease in humans which can spread easily from person to person.

3 Impact of a Pandemic on Health and Social Services

The impact of pandemic influenza on health and social services is likely to be intense, sustained, nationwide and potentially overwhelming.

Workforce

- Increased staff absenteeism & sickness resulting in workforce depletion
- Disruption to supplies and utilities
- Inpatients acquiring influenza placing greater demand on isolation and cohort facilities
- Business continuity threat
- Need for increased communications with staff patients and visitors
- Need for complex infection prevention measures and their subsequent and sustained monitoring
- Managing great demand for antiviral therapy and vaccine (when available)
- Need to redeploy staff at short notice – may lead to indemnity, CRB complications
- Increase in domestic pressures on staff if schools close and/or support networks and childcare arrangements are threatened.

Acute Care/Specialist Care

- Pressure on critical care and high dependency beds
- Increased and complex infection prevention measures
- Logistical problems due to disruption of supplies, utilities and transport mechanisms
- Demand and Capacity issues because of reduced community capacity and increased admissions
- Pressure to maintain core services
- Pressure to maintain National standards and indicators
- Mortuary capacity and care of infected cadaver issues

Social care Issues Impacting on Acute/ Specialist Care

- Sickness in carers delaying discharge

UK Response Phases

3.3

A new UK approach to the indicators for action in a future pandemic response has been developed. This takes the form of a series of phases, named: DATER (see appendix 1 for more detail)

Detection, Assessment, Treatment, Escalation and Recovery framework incorporates indicators for moving from one phase to another.

The 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. The Strategic Control group (SCG) will analyse the local, regional and national information and act accordingly to ensure the implementation of partner plans at an appropriate level.

Detection –Triggered by the declaration of a pandemic by the WHO 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, led nationally by Dept of Health (DoH) and Public Health England(PHE) would be to gather intelligence and develop technological approaches to eg diagnosis from affected countries. At this stage organisations may consider reviewing local plans.

Assessment – The focus in this stage led by (DoH/PHE) would be the collection and analysis of detailed clinical and epidemiological information on early cases presenting to community and acute services, on which to base early estimates of impact and severity in the UK. Public Health work would focus upon reducing the

risk of transmission and infection with the virus within the local community by active case finding and the use of isolation and antiviral prophylaxis for close / vulnerable contacts, based on risk assessment.

These two phases - Detection and Assessment - together form the initial response. This stage 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; to attempt to do so would waste scarce public health resources and capacity.

Treatment – The focus in this stage would be treatment of individual cases and population treatment via the usual services and the National Pandemic Flu Service (NPFS) in conjunction with local antiviral collection points if necessary. Enhancement of the health response to deal with increasing numbers of cases. Consideration to enhancing public health measures to disrupt local transmission of the virus such as localized school closures.

Upon the development of a pandemic vaccine, to prepare for targeted vaccinations as the vaccine becomes available.

Arrangements will be activated nationally 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.

Escalation

The Escalation Phase will be invoked as the scale of the outbreak or pandemic surpasses the capabilities of the arrangements out in place during the early stages of response and could see more severe impacts requiring an escalated response e.g. school closures, minimising large scale gatherings, increase in the number of deaths associated with the outbreak / pandemic etc

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 phases - Treatment and Escalation - form the Treatment component 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.

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-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt.
- Taking steps to address staff exhaustion.
- Planning and preparation for 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 service capacities are able to meet demand will also inform this decision.

The uncertainties in any pandemic mean that the actual characteristics of the pandemic may be different from the planning assumptions, and that planned actions may need to be modified to take account of changing circumstances.

4 **Infection Prevention Measures**

Entry Procedures – a recording sheet must be placed at the entrance of the designated flu area. All staff entering should sign in so that there is a record of staff working in influenza areas. Personnel must be limited to those needed for patient care and support.

Ward Furnishings - For all single rooms and cohort rooms, an equipment station should be set up outside the entrance to the bay to hold PPE. Non-essential furniture, especially soft furnishings should be removed. Remaining furniture should be easy to clean and non-porous

Standard Precautions for patients presenting with flu like illness

- Standard infection prevention procedures apply at all times
- Hand hygiene is crucial and strict adherence to practice must be enforced by all members of staff.
- Staff must ensure the availability of tissues and hand decontaminants
- All persons within the Trust including staff should be encouraged to

minimise potential transmission by

1. Covering the mouth and nose with disposable tissue when sneezing or coughing.
2. Disposing of used tissues in the nearest clinical waste bin
3. Decontaminating their hands

Personal Protective Equipment

** Aerosol generating procedures include intubation, CPR, nasopharyngeal aspiration, tracheostomy care, chest physiotherapy, and autopsy of lung tissue. Only essential personnel should be available, they must wear PPE and procedures should only be carried out in well ventilated rooms with the door shut.

| | On Entry To Room Isolation or Cohort Area | Close Patient Contact (Less than 3 feet) | Aerosol Generating Procedures |
|------------------------|--|---|--------------------------------------|
| Hand Hygiene | Always | Always | Always |
| Gloves | Should be worn during cleaning procedures | Yes | Yes |
| Plastic aprons | Should be worn during cleaning procedures. | Yes | No |
| Full Body Gown | No | Yes if contact with blood or bodily fluids is anticipated | Yes Gown must be fluid repellent |
| Surgical Mask | Yes | Yes | No |
| FFP3 Respirator | No | No | Yes |
| Eye Protection | No | Yes if contact with blood or bodily fluids is anticipated | Yes |

- Surgical masks must not be touched once in place
- Surgical masks must be single use only
- Surgical masks must cover the mouth and nose
- Surgical masks must be changed when moist
- Surgical masks must be discarded as clinical waste after use
- FFP3 respirators must be fit tested prior to use
- FFP3 respirators must be changed following each use
- FFP3 respirators must be discarded as clinical waste after use

Removing PPE

| | | |
|---|--|---------------|
| <i>Version No.1.3 November 2015</i> | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 10 of 68 |
|---|--|---------------|

Staff should remove PPE upon leaving the room/cohort area to minimise the potential for cross contamination. If a single room has been used for aerosol generating procedures, those involved in the procedure should;

- Before leaving the room remove gloves, gown and eye goggles (in that order) and dispose as clinical waste. The order of removal is specific to minimise cross contamination.
- After leaving the room, remove respirator and dispose as clinical waste.
- Perform hand hygiene after all PPE is removed.

Removing Gloves

- Assume the outside of the gloves are contaminated
- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand
- Slide fingers of the ungloved hand under the remaining glove at the wrist
- Peel off second glove
- Discard as clinical waste

Removing Gown/Apron

- Assume that the front and sleeves of the gown or apron are contaminated
- Unfasten or break the ties
- Pull the gown or apron away from the neck and shoulders, touching the inside of the gown only
- Turn the gown inside out
- Fold or roll it into a bundle and discard appropriately

Removing Goggles/ Faceshield

- Assume that the outside of the goggles or face shield is contaminated
- To remove, handle by head band or ear piece only
- Discard as clinical waste

Removing respirator or surgical mask

- Assume that the front of the respirator or surgical mask is contaminated.
- Untie or break the bottom ties, followed by the top ties or elastic and remove the respirator or mask by handling the ties only
- Discard as clinical waste

Respiratory Care Issues

A number of practical measures can be taken to reduce exposure, such as anticipating those who are likely to require respiratory support and careful

preparation for procedures and modifying techniques such as preparing a kit in advance which contains all necessary equipment, drugs etc . Procedures such as intubation should be carried out by experienced clinicians who can minimise the length of time spent during the procedure and prevent multiple attempts.

Respiratory Equipment

- Should be disposable where possible
- Re-usable instruments must be decontaminated in accordance with local policy and manufacturer's guidelines.
- Closed systems must be used where possible
- All respiratory equipment used on patients, including transport ventilator circuits and manual resuscitation aids, should include high efficiency bacterial/viral breathing system filters.
- Breathing system filters should be changed in accordance with manufacturer's guidance.
- The ventilatory circuit should not be broken unless absolutely necessary.
- Staff should be alert to the potential for unplanned breathing circuit disruption and as such breathing circuits should be checked regularly for tightness of fit of component parts and caution should be exercised when moving or performing other care on patients who are ventilated, so as to minimise the risk of accidental disconnections.

Non invasive ventilation in Pandemic influenza pneumonia

- Staff must adhere to infection prevention and control policies
- A full body gown, gloves and eye protection must be worn for all aerosol generating procedures; an FFP3 respirator instead of a surgical mask must be worn.
- A high efficiency bacterial/viral breathing system filter must be used between the non-vented mask and the expiratory port and at the outlet of the ventilator.
- Expiratory port options include a whisper valve or controlled leak. Ideally expiratory flow should be directed in a single jet away from the patient and staff.
- The ventilator should be turned off before removal of close-fitting mask or when lifting the mask away from the face.
- Water humidification should be avoided

Environmental Infection Prevention Procedures During a Pandemic

- Standard infection prevention environmental principles apply but in addition the following must be adhered to;

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| Waste | Any items contaminated with secretions or sputum including tissues must be disposed of as clinical waste |
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| Linen and Laundry | Gloves and aprons must be worn for handling of all linen. Bed curtains must be changed following discharge. |
| Staff uniforms | Staff must not travel to and from work in uniform. Changing areas will be provided. Uniforms laundered in domestic machines must be transported to the Trust in a sealed bag. Uniforms must be washed separately in a load not more than half capacity, tumble dried and ironed. Staff that do not usually wear uniform will be supplied with disposable theatre uniforms to wear at work. The need to supply all staff with disposable theatre uniforms will be evaluated by the Pandemic emergency response team at Alert level 3. |
| Crockery and Utensils | No need for disposable crockery or cutlery. Dishes must be washed in a dishwasher at all times and must not be washed by hand. |
| Environmental Cleaning and Disinfection | The patient environment should be kept clean and clutter free. Cleaning schedules will be reviewed by the pandemic emergency response team on a daily basis. Dedicated or disposable equipment must be used for cleaning. Spillages must be managed as per Trust policy. Domestic staff will be allocated to specific areas and will not rotate |
| | Frequently touched surfaces such as tables, door handles must be cleaned at least three times daily as well as when known to be contaminated with secretions. Domestic staff must wear surgical masks, gloves and aprons when cleaning infected areas. |

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| Decontamination of Patient Care equipment | Where possible, isolation equipment should be dedicated for use by pandemic flu patients only. Reusable patient care equipment must be rigorously decontaminated before and after every use. Visibly soiled equipment must be promptly cleaned as per Trust policy. Fans must not be used under any circumstances. |
| Furnishings | All non-essential furniture and furnishings, especially soft furnishings from waiting/treatment areas must be removed on confirmation of a pandemic event – Alert level 4. All magazines and reading material must be removed from waiting areas |

Cohorting of Flu Patients

- Wherever possible, pandemic flu patients should be cohorted and kept away from non flu patients.
- This is to maximise resources and minimise transmission of the virus.
- Elm Ward has been designated as the initial flu ward due to its location within the hospital, the number of isolation rooms it affords and the number of self contained bays that can be used for cohorting.

Inter Hospital Transfers

It is recommended that patients must not be transferred from one hospital to another for routine care related to pandemic influenza including mechanical ventilation.

However, some patients may require transfer for specialist care arising out of complications or concurrent medical events (e.g neurology/neurosurgery, maternity care etc). If transfer is essential, the Infection Prevention team as part of the Pandemic emergency response team will liaise with the infection prevention team at the receiving hospital and the ambulance service, who must be informed of the patient's full condition in advance.

Intra Hospital Movement of patients

Where possible dedicated equipment such as X-ray equipment and ECG recorders should be allocated to the segregated areas so that all procedures and investigations can be carried out in the segregated area.

Patients with pandemic influenza should not leave the segregated area except for urgent/critical procedures. If a patient is required to another department within the hospital the following procedures must be followed;

1. Receiving department must be informed in advance
2. Patients must be taken straight to and returned straight from the department and must not wait in communal areas.
3. Patients must be last on the list to allow for full decontamination of the room and equipment.
4. Influenza patients must wear a surgical mask while in transit to help prevent droplets being expelled into the air.
5. No patient should be moved out of the segregated area without discussion with the Infection Prevention team and the Pandemic Emergency Response team.

Visitors

Visiting should be curtailed as far as possible.

No visitors with symptoms of influenza will be permitted to visit.

Visitors will be advised against making unnecessary visits and visits will be confined to immediate family only.

Relatives will be advised of the option to make contact via telephone.

No anti-viral therapy or personal protective equipment will be supplied to visitors.

Lockdown Procedures

NHS Merseyside in conjunction with the Pandemic Emergency Response Team will review lockdown procedures for the Trust in the event of a pandemic. Many variables will contribute to the need to lockdown the Trust and as such the decision to activate the lockdown process will be taken by the Chief Executive or their nominated deputy.

Vaccination

In the early stages of the pandemic, vaccine is likely to be unavailable for at least 4-6 months after the first wave has hit. Provisional priority groups for vaccination have been identified nationally.

Prioritisation

In accordance with the NHS Influenza Pandemic Contingency Plan the prioritisation for receiving the influenza vaccine when it is available is as follows;

- Healthcare workers with direct patient contact in areas of high risk exposure
- Critical care staff, critical care outreach staff, Hospital co-ordinator,

- theatre staff, recovery and anaesthetic staff, CCU staff and Cath lab staff
- Diagnostic service staff
- Healthcare staff responsible for patient registration
- Vulnerable patient groups within LHCH who are unsuitable for early discharge to the community.

Administration and Consent

This plan makes the assumption that when available the pandemic flu vaccine will be issued in pre-dosed syringes complete with needles. This matches the seasonal flu vaccine process and is the preferred option. If this is not the case the Trust will need to procure additional consumables.

Identified Vaccinators within LHCH

Staff who have received suitable immunization and vaccination training and are able to prescribe or have undergone training in patient group directives will be able to participate in the vaccination programme.

Antiviral therapy at LHCH

Antivirals act independently of vaccination and predominantly shorten the duration and severity of illness and length of hospital stay.

Nationally, the distribution of antiviral therapy will be managed via 'Flu Line' a system provided by the DOH. The aim of this service is to minimise the number of patients presenting to hospitals and other NHS premises. A clinical algorithm will be used to determine eligibility for antivirals. If clinically eligible, they will provide personal identification and be issued with a unique reference number.

The ordering of antivirals will be the responsibility of NHS Merseyside/ NHS England

National HR Guidance

The DH and NHS Employers have published guidance on the key human resource issues that would arise in the event of an outbreak of pandemic flu. The guidance has been revised and updated following feedback received from employers after the publication of the draft guidance. The pandemic flu HR guidance covers the range of issues which may emerge in the event of a pandemic;

- Redeployment of staff
- Pooling of staffing resources among organisations
- Creating a reserve pool of staff to minimise impact of sickness absence
- How to manage staff absence in staff who have caring responsibilities
- Ensuring staff are used most effectively
- Compliance with working time regulations

- Staff support during pandemic and recovery period.

Ethical Considerations

The Trust also has representation on a Liverpool wide ethics committee and therefore has access to medical ethicists should the need arise.

Public Information, Media and Communications

National and local media campaigns will be disseminated during a pandemic and the Trusts Pandemic Influenza Communications team will provide the communications strategy in line with National Guidance.

Pharmacy

Additional pharmaceutical supplies will be required during a pandemic for the prevention and treatment of complications. Antibiotics are the most effective means of treating secondary bacterial complications of influenza, but must be prescribed in accordance with the Antimicrobial Prescribing policy.

Procurement and Supply Chain

Contingency planning for any pandemic requires balancing risks and practicalities of stockpiling essential supplies, costs, storage, and shelf life of goods. Each LHCH department has a business continuity plan which includes a contingency plan for supplies required to maintain core functions. The Receipts and Distribution Department will hold sufficient supplies so far as is practicable.

Mortuary Facilities

During a pandemic it is likely that mortuary facilities will need to be increased at short notice to accommodate the storage of the deceased.

Whilst a mortuary is available on site, NHS Merseyside will detail the processes and locations for dedicated mortuary facilities when / if required.

Emotional and Practical support following bereavement

The Trusts Customer Care Team and Chaplaincy departments along with the Specialist Palliative Care Service will be available to provide support to the bereaved.

Estates and Facilities

Estates staff will be required to concentrate on essential supplies and clinical areas and curtail services to non clinical areas. Engineering staff on new and routine work will be transferred to essential maintenance.

Transport services

The Patient Transport service will be asked to facilitate the discharge of patients during a pandemic. There may also be the need to assist with staff transport as travel restrictions, fuel shortages and public transport disruptions threaten staffing capability. The Trust will be exploring the option of providing hospital transport to enable staff to attend work if severe disruptions prevent staff attending work.

Business Continuity Planning

Business continuity planning forms an integral part of the Trusts risk management procedures and is a requirement of the Civil Contingencies Act which will have a key role to play in reducing the risk to employee's health and safety as far as possible, as well as maintaining essential operations.

It is the responsibility of each department to prepare and maintain their plans. The Trust will regularly test each departments Business Continuity Plans in Line with BSI 25999 standards.

Major Incident plans and Business Continuity Plans are usually tested separately, however in a pandemic they will be tested at the same time due to the clinical and non clinical impact of such an event.

Monitoring and Review

This policy will be considered a live working document which may be subject to change at short notice in response to emerging national guidance.

This plan will be tested as part of the Trusts schedule to test all emergency plans and the trust will participate in desktop exercises as required to test this plan at local and regional level.

Supporting Guidance Documents

1. BS25999-1:2006 British Standard: Business Continuity Management: ICS03.100.01: HMSO: London
2. Department of Health. Clinical Guidelines for Patients with and influenza like illness during and influenza pandemic. Version 5
<http://www.dh.gov.uk/assetRoot/04/12/17/55/04121755>
3. Health Protection Agency UK: SARS Hospital Infection Control Guidance.
http://www.hpa.org.uk/infections/topics_az/SARS/hosp_infect_cont.htm
4. Planning for Emergencies Merseyside Resilience forum – Pandemic Influenza Plan 2015 v5 (appendix1)

Policy Implementation Plan.

- The Emergency Planning Group Committee is responsible for reviewing this policy.
- This plan should be reviewed in light of further guidance from the Department of Health.
- All staff can access this policy via the intranet, and a copy will be placed in the major incident boxes.

Appendix 1



Planning for Emergencies

MERSEYSIDE RESILIENCE FORUM

Pandemic Influenza Plan

2015

Version V5

This plan has been developed on behalf of the Merseyside Resilience Forum

Table of Contents

| | |
|----------------------------------|---|
| 1.Introduction | 3 |
| 2.Background | 4 |
| 2.1 Influenza Pandemic | 4 |
| 2.2 UK principles | 4 |
| 2.3 Phases of Influenza pandemic | 4 |
| 2.4 UK Response phases | 5 |
| 2.5Planning assumptions | 7 |
| 3.Command and Control | 7 |
| 3.1 Introduction | 7 |
| 3.2 Outbreak Control Team | 8 |
| 3.3 NHS Command and Control | 8 |

| | |
|--|----|
| 3.4 Multi agency Command and Control..... | 8 |
| 3.5 Multi-SCG and National Coordination..... | 10 |
| 4.Expected roles / responsibilities of agencies during the Pandemic ... | 12 |
| 4.1 Detection phase..... | 12 |
| 4.2 Assessment phase | 15 |
| 4.3 Treatment phase | 17 |
| 4.4 Escalation phase | 19 |
| 4.5 Recovery phase | 20 |
| Appendix 1: Epidemiology of pandemic influenza and planning assumptions | 23 |
| Appendix 2:Special Pandemic measures..... | 29 |
| Appendix 3:Communications | 31 |
| Appendix 4: Pandemic infection control assumptions | 33 |
| Appendix 5:Role of voluntary and Faith sector..... | 34 |

1. Introduction

The Community Risk Register (CRR) of the Merseyside Resilience Forum (MRF) lists risks that have been identified as posing a potential threat to the people and region of Merseyside. The government judges that one of the highest current risks to the UK is the possible emergence of influenza pandemic.

The purpose of this document is to provide guidance to the MRF and its multiagency partners on the actions that may be taken in order to establish a working environment that will effectively prepare for and coordinate the response to an influenza pandemic.

The MRF is the owner of this plan. All local organisations need to work with and through the MRF to develop plans to respond to the Pandemic and for maintaining services and business continuity during a pandemic. The Chair of the Local Health Resilience Partnership (LHRP) will retain responsibility for review and update of the document.

The plan describes the local pandemic influenza response in the context of the national guidance which was revised after the 2009 influenza pandemic [influenza A (H1N1)]:

- Department of Health UK Influenza Pandemic Preparedness Strategy 2011
- Health and Social Care Influenza Pandemic Preparedness and Response, April 2012
- Preparing for Pandemic Influenza, Guidance for Local Planners 2013
- Public Health England Pandemic Influenza Response Plan August 2014

The Merseyside Emergency Response Manual (MERM) (2013) is used as the basis for Command and Control.

In addition, the Health and Social Care Act 2012 made significant changes to the health system in England from 1 April 2013. In relation to pandemic influenza response:

- Strategic Health Authorities, Primary Care Trusts and the Health Protection Agency (HPA) were abolished as statutory bodies (at end March 2013).
- Public Health England (PHE) was established as an Executive Agency of the Department of Health and delivers the functions delivered by the HPA.
- NHS England was established as an Executive Non-Departmental Public Body and leads the NHS response to emergencies which require coordination across health organisations through its local structures as appropriate.
- Local Authorities have taken on new roles in relation to health protection and Directors of Public Health are now employed by Local Authorities.
- NHS Trusts and Ambulance Services are relatively unaffected and previous arrangements remain in place.

This plan incorporates these new roles and responsibilities.

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 22 of 68 |
|---------------------------------|--|---------------|

The plan includes summaries (as appendix) of the epidemiology and modelling of an influenza pandemic. It is supported by additional local plans e.g. Merseyside Antiviral distribution plan, Vaccination Plans and Excess Deaths Plan.

The operational detail underpinning the plan can be found in multiagency partner and individual organisational business continuity and/ or pandemic flu plans as well as within the MRF Merseyside Emergency Response Manual and Extra Deaths Plan 2012.

Components of this plan (Command and Control) are also applicable to epidemic/pandemic threats within the UK relating to other infectious diseases.

2. Background

2.1 Influenza Pandemic

Influenza pandemics occur when a new strain of the influenza A virus emerges that is capable of infecting people and spreading from person to person. The virus spreads rapidly and can be associated with a significant mortality and morbidity because few of the population will have any immunity to the new strain. Control is difficult as it is likely that no vaccine will be immediately available against the new strain of influenza and antiviral medication may have a limited effect in mitigating the effects of the disease.

There were three pandemics of influenza during the 20th Century, the most severe, the 1918/19 'Spanish' flu pandemic is estimated to have killed between 20-40 million people worldwide and caused enormous economic and societal disruption. The 1957/58 'Asian' flu and the 1968/69 'Hong Kong' flu, though not as large, nevertheless had devastating effects worldwide. During the first pandemic of the 21st Century in 2009 there were 457 deaths in the UK (to March 2010) related to the pandemic flu virus.

2.2 UK Principles

It is uncertain when a new pandemic virus might appear. Until it emerges and affects a significant number of people, it will not be possible to identify the key features of the disease, such as any pre-existing immunity, the groups most affected, and the effectiveness of clinical countermeasures. Given this, there are three main principles that must underpin planning and response.

- Precautionary – plan for an initial response that reflects the level of risk, based on information available at the time, accepting the uncertainty that will initially exist about the scale, severity or level of impact of the virus.
- Proportionality – plan to be able to scale up or down in response to the emerging

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 23 of 68 |
|---------------------------------|--|---------------|

epidemiological, clinical and virological characteristics of the virus and its impact at the time.

- Flexibility – plan for the capacity to adapt to local circumstances that may be different from the overall UK picture – for instance in hotspot areas.

2.3 Phases of influenza pandemic

The World Health Organisation (WHO) is responsible for identifying and declaring influenza pandemic based on the global situation. The WHO has issued interim guidance in June 2013 and a new four phase pandemic alert system has been proposed, designed to focus more on disease risk than geographic spread and to streamline communications to the public (these can be found in Appendix 1).

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

2.4 UK Response phases

The new UK approach uses a series of phases: detection, assessment, treatment, escalation and recovery (DATER). It also incorporates indicators for moving from one phase to another.

The 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. There will also be variation in the status of different parts of the country reflecting local attack rates, circumstances and resources. The Strategic Control group (SCG) will analyse the local, regional and national information and act accordingly to ensure the implementation of partner plans at an appropriate level.

Detection

Triggered by the declaration of a Pandemic by the WHO or earlier on the basis of reliable intelligence or if influenza related Public Health Emergency of International Concern (PHEIC) is declared by the WHO. The focus in this stage, led nationally by Department of Health (DH) /PHE, 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 phase would be the identification of the novel influenza virus in patients in the UK.

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| Version No.1.3 November 2015 | Pan flu plan Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 24 of 68 |
|---|--|----------------------|

Assessment

The focus in this phase, led by DH/PHE, 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
 - Voluntary self-isolation of cases and suspected cases
 - 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 phases - Detection and Assessment - together form the initial response. This stage 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; to attempt to do so would waste scarce public health resources and capacity.

Treatment

The focus in this stage would be:

- Treatment of individual cases and population treatment, if necessary using the National Pandemic Flu Service (NPFS).
- Enhancement of the health response to deal with increasing numbers of cases.
- To 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.
- Upon the development of the pandemic vaccine, to prepare for targeted vaccinations as the vaccine becomes available.

Arrangements will be activated nationally 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.

Escalation

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|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 25 of 68 |
|---------------------------------|--|---------------|

The Escalation Phase will be invoked as the scale of the outbreak or pandemic surpasses the capabilities of the arrangements out in place during the early stages of response and could see more severe impacts requiring an escalated response e.g. school closures, minimising large scale gatherings, increase in the number of deaths associated with the outbreak / pandemic etc.

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 phases - Treatment and Escalation - form the Treatment component 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.

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-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt.
- Taking steps to address staff exhaustion.
- Planning and preparation for 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 service capacities are able to meet demand will also inform this decision.

The uncertainties in any pandemic mean that the actual characteristics of the pandemic may be different from the planning assumptions, and that planned actions may need to be modified to take account of changing circumstances.

2.5 Planning assumptions

Appendix 1 gives more detail on the epidemiology of pandemics and possible clinical attack rates and case fatality rates. Health and Social Care Influenza Pandemic Preparedness and Response introduced the useful concept of low, medium and high impact pandemic scenarios. There has to be flexibility in early response as information emerges on transmissibility of the virus, disease severity and affected groups against the background of other factors influencing response by health services and others.

3. Command and Control

3.1 Introduction

This section outlines command, control and coordination principles and arrangements for pandemic influenza. It is intended as an accessible guide for both health professionals and non-health partners who will be a key part of the response with impacts on wider society.

Command, control and coordination should follow the general emergency management principle of subsidiarity, whereby decisions should be taken at the lowest appropriate level with co-ordination at the highest necessary level. This principle governs national UK guidance in Emergency Preparedness and underpins the command and control elements of the Merseyside Emergency Response Manual (MERM) which guides Merseyside Resilience Forum (MRF) preparedness and response.

In this plan, arrangements will integrate with the MERM and will dovetail with normal NHS incident response. They will be flexible, determined by the speed and means of development of a pandemic, by the progress of the pandemic, and by its impact, including geographical spread.

In some limited circumstances this may mean initial management at a local level within the standard procedures of Public Health England by an Outbreak Control Team (OCT) in line with the Cheshire and Merseyside Multi Agency Outbreak of Infectious Diseases Plan (3.2 below). It may be necessary to escalate response from OCT to NHS Command and/or to full multi-agency response, i.e. from the Cheshire and Merseyside Multi Agency Outbreak of Infectious Diseases Plan to trigger this Pandemic Influenza Plan.

This Pandemic Influenza Plan can be activated directly without the prior use of the Cheshire and Merseyside Multi Agency Outbreak of Infectious Diseases Plan in response to intelligence, guidance or direction, whether international, national or local. In an influenza pandemic, activation, and hence command, control and coordination, may by-pass the outbreak response. In this case the MRF structure for full pandemic will be activated in part or fully as required in the context of the national command, control and coordination structures.

3.2 Outbreak Control Team (OCT)

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 27 of 68 |
|---------------------------------|--|---------------|

Outbreaks of infectious diseases in human are normally handled effectively through existing control mechanisms and within the Cheshire and Merseyside Multi Agency Outbreak of Infectious Diseases Plan developed and agreed by Public Health England and local partners.

During the early phase of a Pandemic the Cheshire and Merseyside PHE Health Protection lead may call an OCT if appropriate. This should be at the point of the first detection of the novel virus in the UK, if not sooner. The OCT may be the first line of response where infection enters the UK in an identifiable, locally limited way (e.g. via passengers on a particular aircraft or ship). PHE will provide the leadership for managing incidents and outbreaks with support from the NHS and Local Authority Public Health. A PHE Consultant Epidemiologist may provide support as necessary where there is a more widespread pattern and an overview is needed.

Where necessary or appropriate the OCT may consider escalation of the response by seeking NHS support or by requesting activation of a Multi-agency Tactical Coordination Group (TCG) (e.g. for an incident affecting a single local authority area), or by escalation through a request to activate a Strategic Coordination Group (SCG) for full multiagency response .

For many pandemic scenarios it is likely that command and control will be initiated centrally in line with national and international guidance, which may mean that an OCT is not required

3.3 NHS Command and Control

NHS England (NHS E), at an appropriate level, will lead the NHS response to any emergency that has the potential or impacts on the delivery of NHS services. If required in a significant outbreak the Area Team will establish an Incident Management Team (IMT) at an early stage. This will act as NHS tactical command, establishing an incident control centre if indicated. In the event of an influenza pandemic the NHS E response may be mandated nationally.

If the outbreak or pandemic progresses to a medium or high impact scenario the Area Team may operate in a NHS strategic co-ordination role and co-ordinate the NHS commissioned and provided resources in the area. System level decisions may need to be made in relation to operational NHS capacity and prioritisation of other NHS care.

NHS tactical and strategic command structures will be activated in line with standard operating procedures. This may be as a result of information from the OCT or other sources of intelligence, on recognition of anticipated or emerging system pressures in the NHS arising from the outbreak or pandemic, or in compliance with national directive

3.4 Multiagency Command and Control

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 28 of 68 |
|---------------------------------|--|---------------|

The Merseyside Resilience Forum (MRF) MERM sets out the activation, response and recovery coordination arrangements of Category 1 and 2 Responders, as defined in the Civil Contingencies Act 2004 (CCA), to an emergency or other incident that requires multi-agency co-ordination at any one or a combination of Operational, Tactical and Strategic levels.

The MERM does not restrict response to 'major' emergencies, but outlines a series of 'Circumstances for Response' which include emergencies as defined by the CCA, other significant threats or events, incidents requiring a substantial or complex response, and requests for mutual aid. This includes response in anticipation of an emerging rising tide incident. The threat or emergence of an influenza pandemic self-evidently comprises such circumstances for response.

The police have the coordination role in multi-agency emergency response, and will chair the TCG and/or SCG for most incidents. Where the emergency is health-related, as in an influenza pandemic, the chair of these groups may be ceded to appropriate health agencies. It will be the lead agency's responsibility to provide secretariat functions.

In a pandemic or other health-related rising tide event, SCG, TCG and other management structures may be led and chaired by health from the outset. This does not exclude the option for the Chair to revert to the Police where societal impacts become very significant, as may occur with wider effects of a severe or prolonged pandemic.

In line with the UK Influenza Pandemic Preparedness Strategy 2011, the SCG will be established to provide intelligence-led decision making which is responsive to the local picture. Local operational flexibility will be weighed against national decisions and priorities throughout the pandemic in keeping with the principle of subsidiarity. The SCG will form the local link to the national response and communication strategy.

The MERM contains guidance on the function, administration, membership and conduct of multi-agency coordinating groups, including specimen agendas for first meetings. These should be adapted for the specific needs of a pandemic as required.

There will be an expectation upon all agencies to provide appropriate representation for the duration of the response. Initially it is anticipated that the SCG and/or TCG, as appropriate, will meet frequently to assess the situation and provide direction. Both escalation and de-escalation can be considered as appropriate as the pandemic unfolds. Groups may choose to utilise telephone conference calls as an alternative to face-to-face meetings as appropriate.

In the national pandemic influenza response structure, scientific advice will be issued centrally by the Scientific Advisory Group for Emergencies (SAGE). During a pandemic it is unlikely that a Scientific and Technical Advisory Cell (STAC) will be formed locally. The local representative of Public Health England (PHE) at the SCG will act as the conduit and interpreter for technical information. An Incident Control Cell (ICC) will be activated at the

local PHE Centre to support the representative and the SCG in interpretation of health advice.

If the threat from the outbreak is severe and has the potential for disruptive impacts on communities the command and control structures will be implemented at the appropriate level to ensure that, in addition to the health-focussed response, the following issues are considered:

- Conveying of accurate and standard region-wide public health advice and policies effectively to (and via all) resilience partners
- Maintenance of essential services such as emergency services, transport, food distribution, pharmaceutical supplies, utilities and communications
- Management of extra deaths
- Maintenance of public order, with support from police and armed services if necessary.

A SCG can be supported by other components such as a communications subgroup. See Appendix 3 for details of communications in the context of an influenza pandemic.

The MRF Extra Deaths Plan 2012 deals with the management of excess deaths from any rising tide event, with a particular emphasis on the key risk of pandemic influenza. This will include the establishment of the Merseyside Extra Deaths Management Group (MEDMG) as an adjunct to the SCG.

Where the full multi-agency response is initiated, the co-ordination of the health system emergency preparedness, resilience and response will be aligned to the MRF footprint. Wirral will also be aligned to the MRF footprint.

Within the above structure, responsibilities for the health response will be as follows:

- NHS E will be responsible for ensuring that there is a comprehensive Emergency Preparedness, Resilience and Response (EPRR) system that operates at all levels, working collaboratively with PHE and Local Authorities. NHS E will also be responsible for the release of NHS resources during an incident (working with local Clinical Commissioning Groups, CCGs).
- Directors of Public Health in Local Authorities will be responsible for the provision of advice, challenge and advocacy to protect the local population. The responsibility for responding appropriately to the Local Authorities advice, challenge and support will lie with other organisations.
- PHE will deliver specialist public health services to national and local government, the NHS and the public. Its remit will include national leadership and coordination of a

public health response to emergency preparedness, resilience and response system.

To underpin the SCG's activities, the group may require the formation of a TCG (if not already running) which will manage the response on behalf of the SCG. Local pandemic influenza groups (PIGs), based on a local authority footprint, may be established to address local issues of management and response and to integrate council and CCG activities at the local level. Other sub groups will be formed as directed by the SCG in response to the requirements of the situation.

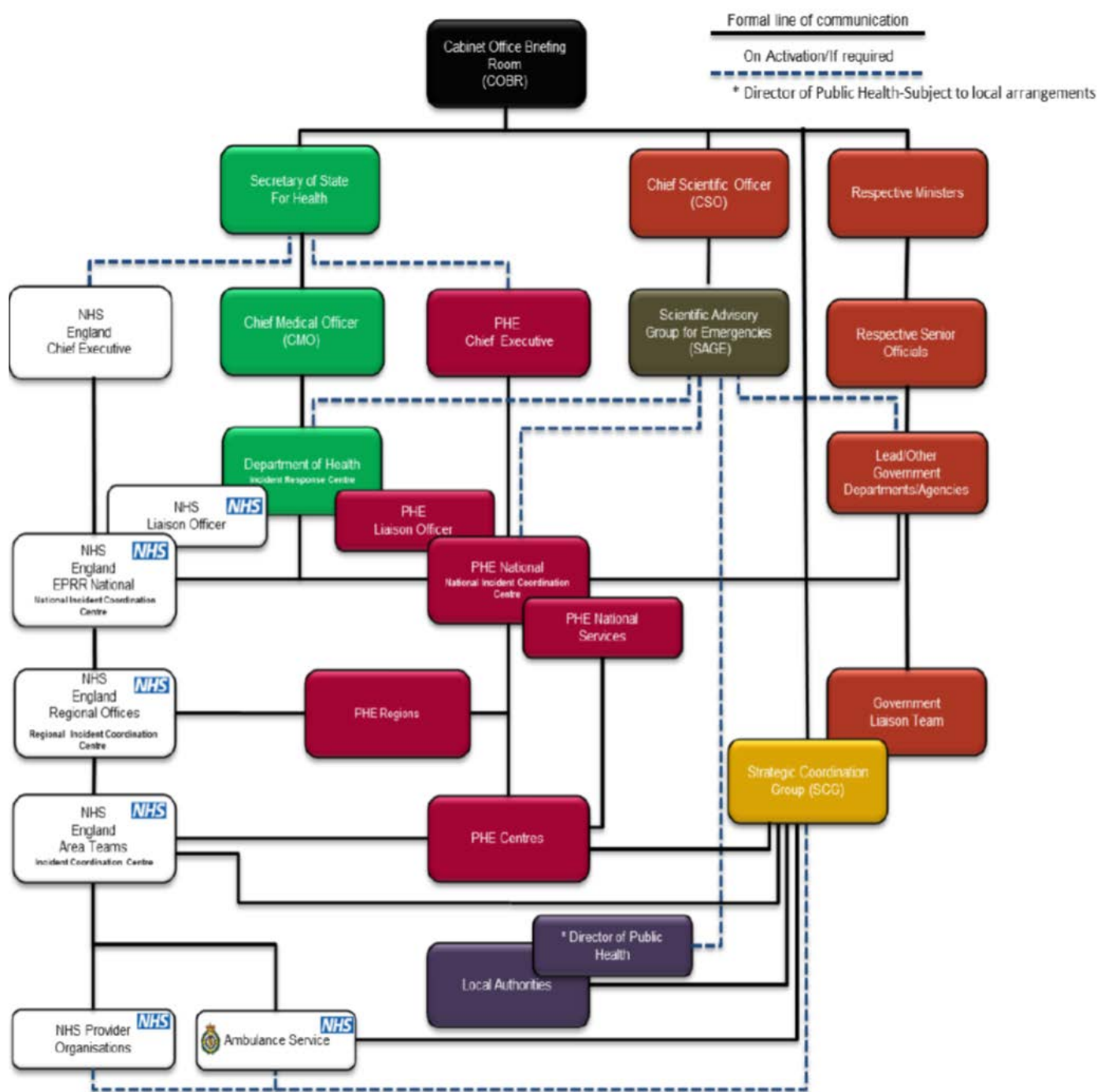
The chair of the SCG in discussion with group members will decide when it is appropriate to de-escalate the response and/or stand down the group.

3.5 Multi-SCG and National Coordination

Whilst this guidance relates to Merseyside related events, it is likely that national and/ or regional circumstances may require collaboration / coordination facilitated by regional or national bodies. A Multi-SCG Response Co-ordinating Group (ResCG) may be convened where the local response has been or may be overwhelmed and wider support is required, or where an emergency affects a number of neighbouring SCGs and would benefit from co-ordination or enhanced support. In situations where there are a number of concurrent incidents ongoing across England, COBR will be used to draw together the national picture.

The Department for Communities and Local Government (DCLG), may on its own initiative, or at the request of local responders, or the Lead Government Department (LGD, e.g. DH), in consultation with the Cabinet Office, convene a ResCG in order to bring together appropriate representatives from local SCGs where activated. In a pandemic, coordinating structures may be defined from the centre in line with national guidance, as below.

Figure 1: Pandemic Influenza: National Command, Control and Coordination:



Note: further local arrangements such as the MEDMG, single authority area PIGs, links with NHS CCG and others may be added to the above at the bottom right as required.

4. Expected roles and responsibilities of the main agencies during phases of the Pandemic

4.1 Detection Phase

During the Detection Phase the MRF will:

- Maintain a dialogue with the NHS England lead, lead Director of Public Health and PHE to agree local appropriate responses. Where appropriate the MRF will convene a meeting to discuss the developing situation and to identify the requirement for a SCG or TCG and implement command and control as appropriate.

During the Detection Phase the NHS will consider:

- Implement NHS command and control, as appropriate.
- Represent the NHS at the local SCG (NHS Strategic Commander) as appropriate;
- Provide advice on local NHS service delivery
- Ensure local surveillance activities are put in place in line with national and regional intelligence and surveillance systems. This will include community and acute-based providers and communication systems
- Review their response and business continuity plans, including staff skills audits etc
- Review plans and communicate with pharmacies to prepare for delivery of antiviral medicines from national stockpile ; prepare for local antiviral collection points as further contingency if required
- Ensure provision of any accelerated training programmes for front-line staff as needed eg infection control
- Ensure the co-ordination and dissemination of national situational reports (sitrep), as appropriate
- Contact all GPs and primary care providers and Emergency/A&E departments to ensure surveillance and management guidance is in place
- Co-ordinate and cascade appropriate professional and public messages where appropriate
- Ensure review of local stocks of medicines and other essential supplies, including personal protective equipment (PPE) for flu pandemic
- Liaise with relevant stakeholders to ensure records of potentially vulnerable people are up-to-date and consider how their needs will be met
- Advise partner agencies, and monitor activity and pressures across the system
- Consider the activation of any local support lines in consultation with stakeholders
- Work closely with occupational health services to prepare for vaccination programmes.
- In partnership with other partners review existing communication plans, including

business continuity arrangements for communication teams and internal communication channels

- Consider at an area team level whether to establish an NHS communications cell

During the Detection Phase PHE will consider:

- Ensure frontline Health Protection Team (HPT) staff have access to and are trained in the use of HPZone and other case management influenza databases
- Develop a coordinated and standardised local response to pandemic influenza across PHE
- Work with local partners to ensure influenza outbreak detection and response in schools, care homes and other community settings. Establish an OCT when appropriate
- Provide early expert guidance on the investigation of possible cases and their contacts, clusters and outbreaks
- Provide early expert guidance for use of antivirals including decisions about thresholds and usage in outbreaks
- Provide accurate and timely information for the public and health staff (reinforcing, good hand and respiratory hygiene) as per media/communications strategy.
- Liaise with PHE Regional laboratory and hospital laboratories to ensure testing arrangements in place and appropriate swabs available widely in hospitals and primary care/out of hours.
- Support NHS England Area Teams to contact all GPs and primary care providers and Emergency/A&E departments to ensure surveillance and management guidance is in place
- With NHS England Area Teams, provide updates through locally agreed systems to the NHS and LRFs
- Report all returning traveller and influenza incidents to influenza preparedness section
- In partnership with other partners review existing communication plans, including business continuity arrangements for communication teams and internal communication channels

During the Detection Phase Merseyside Police will consider:

- Forming a SCG as appropriate to discuss potential impact and mitigation factors for the pandemic including media strategy
- Handing over chair of the SCG to the most appropriate lead agency (NHS/PHE)
- Hold Gold Business Continuity Management Team (BCMT) Meeting to discuss the following:-
- Reviewing business continuity plans based on the planning assumptions and advice from STAC
- Identifying vulnerable critical function staff

- Reviewing relevant risk assessments
- Purchasing stocks of antiviral wipes, hand gel, face masks and gloves
- Developing internal communication methods for increasing staff awareness regarding personal hygiene and social distancing (face to face meetings vs. teleconferencing etc)
- Develop strategy for staff leave, compassionate leave, time due, etc
- Developing a system for monitoring and dealing with staff sickness, leave, compassionate leave, time due requests etc
- Cancellation of external / internal training and secondments
- Reviewing critical function shift patterns, working from home policy, cancellation of leave / rest days, transporting staff to and from work etc
- Contacting critical suppliers to ensure supply chain resilience

During the Detection Phase Local Authorities will consider:

- Review and refresh relevant plans related to flu pandemic.
- Review up-to-date records of potentially vulnerable people, consider how their needs will be met
- Visit business continuity plans in relation to the absence of Local Authority staff and those of direct suppliers and contractors.
- Contact critical suppliers, contractors and partners to ensure they can provide resilience to the council during the outbreak.
- Review the Merseyside Extra Deaths Plan and ensure all arrangements are still practicable.
- Directors of Public Health in Local Authorities have responsibilities around ensuring adequate responses to emergencies and incidents in conjunction with the NHS.
- Provide communications support for their Director of Public Health. The DPH will maintain oversight of the population health throughout the pandemic and ensure effective communication with local communities.
- In partnership with other partners review existing communication plans, including business continuity arrangements for communication teams and internal communication channels

During the Detection Phase NWAS will consider:

- Establish a NWAS Pandemic Influenza Management Group to manage the response to any pandemic across the Trust;
- Provide representation at the Local SCG
- Disseminate up-to-date information/advice as provided by DH/ PHE to staff at all levels, including the reinforcement of infection control/special infectious diseases policies
- Review “staff mapping” to identify potential areas of challenge and strengths outside

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 35 of 68 |
|---------------------------------|--|---------------|

staff normal roles that may be better utilised in critical areas;

- Undertake fit testing of FFP3 masks for all operational staff;
- If appropriate, liaise with the PHE with regards to the identification of those staff groups deemed to be priority for receiving antiviral drugs or, if available, vaccination;•
- Increase stock levels of those consumables associated to respiratory condition management so as to maintain the appropriate level of patient care for those suffering the effects of the virus and other respiratory compromise;
- Increase standard consumables, including fuel stocks, within NWAS to a level that would allow the sustained provision of care to all patients should stocks become compromised due to production or delivery problems.
- In partnership with other partners review existing communication plans, including business continuity arrangements for communication teams and internal communication channels

During the Detection Phase Merseyside Fire and Rescue Service (MFRS) will consider:

- Send a Senior Officer to represent MFRS at SCG if formed
- Review MFRS Business Continuity Plan & Departmental Business Continuity plan
- Review MFRS Pandemic Influenza Plan

Voluntary Agencies / Faith / Third Sector

- In an impending pandemic, consideration of the possible contribution of the voluntary and faith sector should be part of the very early dialogue between British Red Cross (BRC), MRF and the local authorities.
- Appropriate representation on MRF or LHRP groups managing a pandemic will readily be provided and should be arranged at the earliest stage.
- Appropriate roles and responsibilities can be defined quickly by consensus in this context.(See Appendix 5 for detail)

4.2 Assessment phase

During the assessment phase the SCG or TCG should:

- Receive information and assess the situation and the potential effects of pandemic influenza on the local community.
- Provide strategic or tactical leadership and guidance as appropriate

Note: when the SCG is formed, appropriate high level (i.e. strategic officer / manager) representation from all organisations at SCG will be expected in order to allow for

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 36 of 68 |
|---------------------------------|--|---------------|

intelligence-led decision making and the appropriate release of resources; in this case, the TCG will continue to lead the response at a tactical level on behalf of the SCG.

During the Assessment Phase the NHS will consider the following tasks in addition to the tasks outlined earlier:

- Support 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
- Implement organisational business continuity plans and pandemic flu plans, as appropriate
- Ensure providers are reducing the risk of transmission and infection with the virus within the local community by actively finding cases; advising 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.
- Further communications, education and training around infection control and key messages for NHS and partners
- Preparations to implement the antiviral distribution procedures
- Consider staff surge.
- Community staff provide support to PHE in controlling outbreaks
- Review vaccination plans
- Monitor mortuary capacity daily ,review business continuity arrangements
- Work with partner agencies to support recruitment of 'Flu Friends'
- Establish an NHS communications cell to co-ordinate and manage communications across NHS organisations

During the Assessment Phase PHE will consider:

- Use the national FF100 systems to rapidly investigate initial pandemic cases, clusters and contacts in order to gain insights into the clinical presentation, epidemiological features including severity and other aspects of the illness associated with the new virus
- Implement enhanced pandemic influenza surveillance systems including systems to measure community transmission and severe disease
- Activate PHE incident control centre (likely to be nationally determined)
- Provide leadership for the investigation and management of local incidents and outbreaks as necessary
- Actively engage with NHS command structures and multiagency response structures, providing specialist health protection advice as they are established
- Provide updates through locally agreed systems to the NHS and LRFs
- Provide timely and accurate information for the public and health professionals on the pandemic and the clinical effects of the infection working within agreed local

communications arrangements (depending on establishment of multiagency command structures)

During the Assessment Phase Merseyside Police will consider:

- Attend regular SCG Meetings
- Hold regular Gold / Silver / Bronze Business Continuity Management Team meetings (teleconference)
- Increase cleaning regime focusing on high risk areas
- Raise staff awareness regarding personal hygiene responsibilities
- Raise staff awareness regarding social distancing
- Issue stocks of antiviral wipes, hand gel, face masks and gloves to vulnerable staff groups with appropriate usage guidance
- Monitor staff sickness, leave, compassionate leave, time due, etc
- Borough Command Unit (BCU) / Department BCMT's to monitor any potential or actual critical function deficiencies and provide situation reports to Gold BCMT
- Moving staff from one BCU / Dept to another to mitigate resilience gaps

During the Assessment Phase Local Authorities will consider:

- Dependent upon the scale and context, provide support to identify the patterns and areas affected.
- For business continuity purposes, monitor sickness absence and service provision and report where appropriate.
- Ensure relevant services (eg. Registrars, Cemeteries and Cremations) and agencies (eg. Funeral Directors) to be put on alert with a lead-in time in line with MRF extra deaths incremental response strategy, as a preliminary to extra deaths plan.
- Ensure relevant messages to be communicated to Local Authority staff and assistance provided in communicating messages to the general public.
- PPE to be recognised and distributed appropriately with training provided where necessary. Stocks should be sourced and replenished when levels are low.
- Provide assistance to partner agencies.

During the Assessment Phase NWS will consider:

- Issue guidance to staff on the diagnosis and management of pandemic influenza
- Provide NHS North/DH with sitreps as required
- Consider the cancellation of non-essential meetings and training
- Where requested, provide representation at local NHS command groups
- Monitor and manage staff levels as appropriate, utilising mutual aid and voluntary ambulance agencies, if available, as necessary
- Ensure that all staff have access to appropriate levels of enhanced PPE – FFP3 masks etc – so as to provide effective protection against the influenza virus where

required in line with national guidance

- On the advice of the PHE and/or the Medical Director, consider the segregation of critical staff groups to minimise the spread of the virus

During the Assessment Phase MFRS will:

- Communicate with MFRS personnel
- Monitor sickness absences
- Ensure adequate supplies of PPE are available for relevant MFRS personnel

4.3 Treatment phase

During the treatment phase the SCG and TCG should:

- Continue to respond to national and local intelligence, and undertake command roles in line with the MERM (By the treatment phase, it is highly likely that full command and control will be operational)
- The SCG will ensure that local organisations are committing sufficient resources into the response
- The TCG, and other tactical level multi-agency groupings, if deemed appropriate and activated) will undertake tactical direction as required

During the Treatment Phase the NHS will consider the following actions:

- Continue surveillance
- Implement business continuity plans as appropriate
- Provide daily sitrep on NWS pathway DOS and provide input as required nationally into UNIFY2 ,with regard to confirmed cases, pressure on emergency departments, intensive care units, respiratory wards, paediatrics and other relevant departments (as appropriate)
- Ensure triage and isolation facilities are in place in secondary care;
- Review and reinforce infection control advice;
- Implement operational antiviral and vaccination plans where appropriate.
- Monitor pressures on primary care to inform recommendation about mobilising the NPFS
- Enhancement of the health response to deal with increasing numbers of cases. Prepare for surge activity, but may be no significant deferral of usual activities; individual organisations will be preparing for surge activities including agreeing core work and non-core work
- Consider mutual aid where appropriate and feasible. As appropriate there may be suspension of non-core services if impact great in some areas;
- Continue communications with professional and public
- Continue staff training as required

- Ensure the co-ordination and dissemination of national sitreps

During the Treatment Phase PHE will consider:

- Actively engage with NHS command structures and Multi-agency response structures, providing specialist health protection advice, including local interpretation of advice from SAGE
- Communicate the national infection control guidelines and case management algorithms to local partners and support local training needs
- Ensure an adequate understanding of the local epidemiology and response, supported by FES
- Provide timely and accurate information for the public and health professionals on the pandemic and the clinical effects of the infection working within agreed local communications arrangements (depending on establishment of multiagency command structures)
- Disseminate information on the pandemic, when available, to health professional and local partners working within agreed local communications arrangements (depending on establishment of multiagency command structures)
- Provide advice to support local decision making about measures to control the spread of the virus through agreed multiagency coordinating structures
- Provide updates through locally agreed systems to the NHS and LRFs
- Support NHS in the implementation of the immunisation programme

During the Treatment Phase Merseyside Police will consider:

As at previous phase plus:

- Support partner agencies in the event of significant public order issues.
- At vaccination centres and medical premises
- Responding to additional numbers of sudden deaths
- Excess deaths
- Support staff welfare needs

Note: Routine security will not be provided by the police; private contractors will need to be considered and commissioned as required.

During the Treatment Phase the Local Authorities will consider:

- Monitor staff absence statistics and consider business continuity issues.
- Consider mechanisms to provide vaccinations to staff when/ if they become available and the decision is made to provide vaccinations.
- Assist the NHS in any preparations and to provide vaccinations to specific and vulnerable staff.
- Review and provide communications to people both internally and externally.

- Monitor service provision

During the Treatment Phase NWAS will consider:

- Continue to disseminate up to date DH/PHE information/advice to staff on diagnosis and management of pandemic influenza;
- If not already undertaken, in liaison with the DH/PHE, provide guidance on the administration of antiviral medication or vaccine;
- Direct patients to the most appropriate treatment centre– as determined locally;
- Provide NHS North/DH with sitreps as required;
- Reinforce infection control policy/disseminate guidance to staff regarding the correct procedures following the transport or treatment of an actual or suspected case of pandemic influenza;
- Vaccination of staff when/if available

During the Treatment Phase MFRS will consider:

- Activate the MFRS pandemic influenza plan
- Provide vaccinations when/if available for critical personnel
- Continue to monitor sickness absences
- Continue to communicate with MFRS personnel

4.4 Escalation phase

During the Escalation phase the SCG will

- Ensure that the movement into this phase is communicated to all partners and that an adequate response is mounted
- Continue to provide strategic direction to the TCG and overall response
- The TCG (and other tactical level multi-agency groupings, if deemed appropriate and activated) will undertake tactical direction as required

During the Escalation Phase the NHS will consider:

- Ensure coordinated planning across the NHS in Merseyside and monitor progress;
- Support delivery of targeted vaccinations (if supplies are available)
- Consider suspension of targets for a limited period of time(likely to be a national decision);
- NHS England in consultation with commissioners and critical care networks may consider the suspension of elective procedures with only essential elective procedures taking place;
- Implementation of business continuity plans as necessary.
- Creating additional ITU/ critical care capacity as per critical care network plans;
Consider utilisation of clinical assessment tools and admission criteria to hospitals;

- Secondary care will maintain continuous situation reporting utilising NWAS OP UNIFY2
- Consider utilisation of all professional clinical groups including voluntary sector to provide support;
- Phased admissions and treatment policies introduced;
- Palliative care facilities supported and expanded if possible;
- Consider mechanisms for certification of deaths at home whilst maintaining clinical capacity for dealing with patients
- Ensure delivery of emergency supplies of medicines and utilise flexibility in legalities surrounding this as per national guidance(supply chain not individual prescriptions)
- Monitor pressure on antiviral collection points
- Ensure local distribution of national stocks of medicines as appropriate;
- Ensure contact details are up to date for all organisations;
- Consideration of de-escalation of response if the situation is judged to have improved sufficiently, and;
- Continue appropriate communications to public and professionals.

During the Escalation Phase PHE will:

- Support to the NHS in the implementation of the immunisation programme (if supplies are available)
- Assist NHS colleagues in developing framework for delivery of vaccination to target groups
- Maintain ICC as required
- Coordinate specialist health protection advice to NHS command structures and to multiagency command structures. Coordinate support to the NHS and other agencies through these structures.

During the Escalation Phase Merseyside Police will continue as in the Assessment phase.

During the Escalation Phase Local Authorities will:

- Consider escalation plans, surge management and hospital discharges.
- Ensure general monitoring regarding the attendance and sickness of staff.
- Consider HR issues for staff that have been undertaking a different role.
- Activate business continuity plans, where appropriate, and cross work with other agencies, eg. Health to deliver services.
- Provide support to partner agencies, where possible.
- Monitor provider services and day care provision, ensuring further demands are met.
- Prioritise critical services, including assigning staff with variable skills to those areas, and ensure the business continuity of other necessary services.

- Seek assistance from voluntary agencies where appropriate

During the Escalation Phase NWAS will consider:

- Implement arrangements contained within the NWAS Resource Escalation Action Plan (REAP) specific to the level of challenge being experienced;
- Redeploy staff as appropriate to skill level and NWAS priorities;
- Monitor and manage staff levels as appropriate, utilising mutual aid and voluntary ambulance agencies, if available, as necessary;
- Request information relating to admission/exclusion criteria from NHS North for all hospitals and relay to all staff on a daily basis;
- Liaise with NHS at a local level regarding the suspension of non-essential patient transport;
- Suspend non-essential meetings/training - internal and external at all levels;
- Consider the release of staff in support of partner health agencies where surplus to immediate the NWAS requirements.

During the Escalation Phase MFRS will consider:

- Review core services
- Reinforce HR services and Occupational Health Services
- Continue to monitor sickness absences
- Continue to communicate with MFRS personnel
- Review provision of PPE for relevant MFRS personnel

4.5 Recovery phase

Recovery will be overseen by the Recovery Coordinating Group (RCG), which will take over formal strategic coordination from the SCG. Further guidance for the recovery stage can be found in the MERM and the MRF Recovery Plan.

For most emergencies, the RCG is chaired by a local authority Chief Executive, or appropriate senior nominee, responsible for the affected area. Following a pandemic, recovery may be more complex and wide-ranging, and the overall leadership may be best undertaken by NHS or the Police. This will be the subject of discussion and consensus at the SCG.

All agencies should contribute to any multi-agency debrief and review processes as required.

During the Recovery Phase the NHS will:

- Ensure there is coordinated planning across Merseyside and monitor progress;
- Ensure business continuity plans are maintained;

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| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 43 of 68 |
|---------------------------------|--|---------------|

- Ensure contact details are up to date for all organisations;
- Ensure recovery arrangements are understood
- Continue to support targeted vaccination, when available;
- Prepare for any surges in patient activities(e.g. Second wave)
- Identify lessons to date to inform planning.
- Reinstate targets and reschedule routine, non-urgent elective procedures if appropriate.

During the Recovery Phase PHE will:

- Carry out internal debrief to contribute to the overall PHE debrief (by the end of 1st wave)
- Review response activities and identify lessons learned for possible and subsequent waves/ other wide scale emergencies
- Contribute to the update of algorithms, pandemic preparedness plans, business continuity plans as required
- Review effectiveness of pandemic preparedness plan and business continuity activities
- Issue regular communications to internal and external stakeholders
- Maintain regional surveillance mechanisms for evidence of resurgence in activity during 2nd wave
- Provide updates through locally agreed systems to the NHS and LRFs
- Contribute to the scientific evaluation of the impact of the pandemic

During the Recovery Phase Merseyside Police will:

- Conduct internal debrief(s)
- Take part in any multi-agency debrief
- Ensure lessons identified are incorporated into BC maintenance programme.

During the Recovery Phase Local Authorities will:

- Focus on normalisation of services, perhaps to a new definition of what constitutes normal service
- Conduct a full debrief, considering what went well and what could have been handled differently
- Review relevant plans related to flu pandemic and amend as necessary

During the Recovery Phase NWAS will:

- Maintain liaison with PHE and those external health agencies to identify further waves of the virus
- Identify any staff welfare issues that may be required following any period of intense workload such as stress-related illness. Consider occupational health provider

involvement as necessary

- Review business continuity arrangements and revise as appropriate
- Prioritise the resumption of normal services of NWS critical functions

During the Recovery Phase MFRS will:

- Send a senior officer to represent MFRS at a MRF RCG if established
- Carry out an internal debrief to identify lessons learnt
- Review relevant MFRS plans
- Return to business as usual

APPENDIX ONE: SUMMARY OF THE EPIDEMIOLOGY OF PANDEMIC INFLUENZA AND PANDEMIC PLANNING ASSUMPTIONS

Influenza is caused by the influenza virus and is characterised by the sudden onset of fever, headache, muscle/joint pain and prostration, often accompanied by a cough with or without other respiratory symptoms, lasting for seven or more days.

The illness has a short incubation period (1-3 days) and spreads rapidly within susceptible communities. The acute symptoms usually last for about 7 days, full recovery takes longer. During the usual seasonal flu period, most people recover however, some are affected more severely and suffer complications from secondary bacterial pneumonia or bronchitis. Those most affected are the very young, elderly and people with pre-existing heart or chest disease. The virus has the ability to change rapidly and requires annual vaccination in order to confer protection in the vulnerable population.

Influenza pandemics occur when a new strain of the influenza A virus emerges that is capable of infecting people and spreading from person to person. The virus spreads rapidly and can be associated with a significant mortality and morbidity because few of the population will have any immunity to the new strain. Control is difficult as it is likely that no vaccine will be immediately available against the new strain of influenza and antiviral medication may have a limited effect in mitigating the effects of the disease.

There were three pandemics of influenza during the 20th Century, the most severe, the 1918/19 'Spanish' flu pandemic is estimated to have killed between 20-40 million people worldwide and caused enormous economic and societal disruption. The 1957/58 'Asian' flu and the 1968/69 'Hong Kong' flu, though not as large, nevertheless had devastating effects worldwide. During the first pandemic of the 21st Century in 2009 there were 457 deaths in the UK (to March 2010) related to the pandemic flu virus.

Phases of influenza pandemic

In June 2013, WHO published revised pandemic influenza guidance. This has moved away from the six previous clearly delineated pandemic phases, and instead uses a risk-based approach to pandemic influenza represented as a continuum of global phases (interpandemic, alert, pandemic and transition). The global phases describe the spread of the new influenza subtype, taking account of the disease it causes, around the world as follows:

Interpandemic phase:

- This is the period between influenza pandemics.

Alert phase:

- This is the phase when influenza caused by a new subtype has been identified in

humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur.

Pandemic phase:

- This is the period of global spread of human influenza caused by a new subtype. Movement between the interpandemic, alert and pandemic phases may occur quickly or gradually as indicated by the global risk assessment, principally based on virological, epidemiological and clinical data.

Transition phase:

- As the assessed global risk reduces, de-escalation of global actions may occur, and reduction in response activities or movement towards recovery actions by countries may be appropriate, according to their own risk assessments.

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

A new UK approach to the indicators for action in a future pandemic response has been developed. This takes the form of a series of phases: **Detection, Assessment, Treatment, Escalation** and **Recovery** and incorporates indicators for moving from one phase to another. These phases are described within this plan.

Whilst referring to and recognising the importance of WHO arrangements, the UK response is not completely or solely predicated on a WHO alert and as such is not necessarily reliant on this information to activate NHS pandemic response plans.

Key Planning Assumptions

This section should be read alongside Section 2 of the UK Influenza pandemic Preparedness Strategy

Clinical Attack Rate

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,

| | | |
|---------------------------------|--|---------------|
| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 47 of 68 |
|---------------------------------|--|---------------|

a second or subsequent wave could be more severe than the first. Response plans should recognise the possibility of a clinical attack rate of up to 50% in a single-wave pandemic.

Up to 4% of those who are symptomatic may require hospital admission;

Case Fatality Rate

Depending upon the virulence of the influenza virus, the susceptibility of the population and the effectiveness of countermeasures, up to 2.5% of those who are symptomatic may die. However, given the relatively low likelihood of a virus with both a high attack rate and severe disease, and against which medical countermeasures are ineffective, it was agreed that local planners should focus on ensuring that robust arrangements are in place for managing excess deaths in a lower range. This range has been set at 210,000-315,000 nationally (approximately 0.4-0.5% of the population). Although we do not yet have a clear epidemiological view of the 2009 pandemic, we know there were 457 deaths in the UK.

The Impact of Age and Other Factors

Age specific impact is difficult to predict in advance. In the UK in 1918, a dramatic shift in age specific impact (morbidity and mortality) occurred towards younger adults whereas the pandemics in 1957 and 1968 impacted across the age range of the population in a fashion much more akin to seasonal influenza (greatest impact in the elderly). In the 2009 pandemic the burden of disease was disproportionately carried by younger age groups and hospitalisation rates increased with younger age. Pregnant women were also more likely to suffer from the complications of flu.

Modelling suggests that all ages are likely to be affected, but those with certain underlying medical conditions, pregnant women, children and otherwise fit younger adults could be at relatively greater risk. The exact pattern will only become apparent as the pandemic progresses

The spread of disease is also difficult to predict, as is geographical variation. For example in the 2009 pandemic some parts of the country were severely affected whilst others less so. Local hotspots may occur and detailed surveillance and monitoring is essential to enable a robust response. Global spread is likely to occur rapidly due to established travel routes.

A further complicating and unpredictable factor is the impact of behaviour on the spread and duration of the pandemic. Good hygiene compliance result in a shorter duration of the pandemic.

Table 1: Summary table of key planning assumptions:

| | |
|---------------------------|---|
| Clinical attack rate | Cumulative clinical attack rates of up to 50% of the population in total spread over <u>one or more waves</u> 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. |
| Peak clinical attack rate | Locally, 10% - 12% of population per week |
| Hospitalisation rate | Between 1% - 4% of those who are symptomatic may require hospital admission. |
| Case fatality rate | 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) |
| Peak absence rate | Up to 15% - 20% of workforce (Large Organisations) Up to 30% - 35% of workforce (Small Organisations) |

Potential impact of Pandemic Flu in Merseyside

- Merseyside has a total population of 1,381,189 (ONS estimated resident population 2011). This is divided into the five LA areas.
- Up to 50% of the population may show clinical symptoms of influenza over the course of a pandemic, and up to 25% of those may develop complications.
- Up to 2.5% of those who become symptomatic may die.
- Up to 22% of influenza cases can be expected during the 'peak week' of a pandemic wave.
- Up to 30% of symptomatic patients will require assessment and treatment by a general medical practitioner or suitably experienced nurse.
- Up to 4% of those who are symptomatic may require hospital admission if sufficient capacity is available.
- Most health and social care is expected to be delivered in the community setting with hospital capacity reserved for those with the most clinical need. Symptomatic patients who have complications and some specific groups (eg very young children/ pregnant

women) will need to be assessed by a GP or suitable healthcare professional.

Table 2: Potential impacts of reasonable-worst case scenarios of pandemic flu on Merseyside
(Clinical attack rate 50%, case fatality rate 2.5%)

| Week | % total cases | Clinical cases in LRF | Additional GP consultations | Additional hospital admissions | Additional Deaths | Total Deaths |
|--------------|---------------|-----------------------|-----------------------------|--------------------------------|-------------------|--------------|
| 1 | 0.1 | 691 | 197 | 28 | 17 | 42 |
| 2 | 0.2 | 1381 | 394 | 55 | 35 | 60 |
| 3 | 0.8 | 5525 | 1575 | 221 | 138 | 163 |
| 4 | 3.1 | 21408 | 6101 | 856 | 535 | 560 |
| 5 | 10.6 | 73203 | 20863 | 2928 | 1830 | 1855 |
| 6 | 21.6 | 149168 | 42513 | 5967 | 3729 | 3754 |
| 7 | 21.2 | 146406. | 41726 | 5856 | 3660 | 3685 |
| 8 | 14.3 | 98755 | 28145 | 3950 | 2469 | 2494 |
| 9 | 9.7 | 66988 | 19091 | 2680 | 1675 | 1700 |
| 10 | 7.5 | 51795 | 14761 | 2072 | 1295 | 1320 |
| 11 | 5.2 | 35911 | 10235 | 1436 | 898 | 923 |
| 12 | 2.6 | 17955 | 5117 | 718 | 449 | 474 |
| 13 | 1.6 | 11050 | 3149 | 442 | 276 | 301 |
| 14 | 0.9 | 6215 | 1771 | 249 | 156 | 180 |
| 15 | 0.7 | 4834 | 1378 | 193 | 121 | 146 |
| Total | 100.1 | 691285 | 197016 | 27651 | 17282 | 17307 |

Table 3: Potential impacts of reasonable-worst case scenarios of pandemic flu on Merseyside

(Clinical attack rate 25%, case fatality rate 2.5%)

| Week | % total cases | Clinical cases in LRF | Additional GP consultations | Additional hospital admissions | Additional Deaths | Total Deaths |
|------|---------------|-----------------------|-----------------------------|--------------------------------|-------------------|--------------|
| 1 | 0.1 | 345. | 98. | 14 | 8. | 29 |
| 2 | 0.2 | 690. | 197 | 28 | 17. | 37 |
| 3 | 0.8 | 2762. | 787 | 110. | 69 | 89 |

| | | | | | | |
|--------------|-------|---------|--------|-------|-------|------|
| 4 | 3.1 | 10704. | 3051 | 428 | 268 | 288 |
| 5 | 10.6 | 36602 | 10431 | 1464 | 915 | 935 |
| 6 | 21.6 | 74584. | 21256 | 2983 | 1864. | 1885 |
| 7 | 21.2 | 73203. | 20863 | 2928. | 1830 | 1850 |
| 8 | 14.3 | 49377. | 14073 | 1975. | 1234 | 1254 |
| 9 | 9.7 | 33493. | 9546 | 1340 | 837 | 857 |
| 10 | 7.5 | 25897. | 7381 | 1036. | 647 | 667 |
| 11 | 5.2 | 17955. | 5117 | 718. | 449 | 469 |
| 12 | 2.6 | 8977. | 2559 | 359. | 224 | 244 |
| 13 | 1.6 | 5524. | 1575 | 221 | 138 | 158 |
| 14 | 0.9 | 3107. | 886 | 124. | 78 | 98 |
| 15 | 0.7 | 2417. | 889 | 97 | 60. | 80 |
| Total | 100.1 | 345642. | 98508. | 13826 | 8641. | 8661 |

Table 4: Total Population for Merseyside LAs
(ONS 2011 Census)

| | Total Population (ONS 2011 Census) |
|-------------------|--|
| Merseyside | 1,381,189 |
| Knowsley | 145,893 |
| Liverpool | 466,415 |
| Sefton | 273,790 |
| St. Helens | 175,308 |
| Wirral | 319,783 |

For additional data, and to calculate impacts for Local authorities go to:

<https://www.gov.uk/government/publications/pandemic-flu-national-planning-assumptions-assessments-tool>

Absence from Work

Absence from work will depend upon the age related attack rate. Absenteeism may also result from staff needing to take time off to care for family members or for child care. Accelerated transmission may occur in work places where people work in close proximity e.g. hospitals, nursing and residential settings.

Modelling suggests absenteeism of 50% of the workforce may require time off at some stage over the entire period of the pandemic. Individuals are likely to be absent for a period of seven to ten working days. These will build up rapidly peaking at between 15-20% of staff at the peak of a pandemic in large organisations and up to 30-35% of workforce in small organisations, however, absence is likely to be higher in health care settings due to the close proximity in which people work, the carer responsibilities of many health and social care staff and the normal levels of sickness and absence being higher than UK workforce average.

There are also workforce implications for non-NHS/social care organisations in terms of business continuity.

The closure of schools would have major impact on business continuity through absence from work of adult carers.

It is anticipated that more detailed modelling would be undertaken as the epidemiology of a pandemic becomes clearer.

APPENDIX 2: SPECIAL PANDEMIC MEASURES

National Pandemic Flu Service (NPFS)

The national Pandemic Flu service is a national resource that can be activated if primary care is struggling to assess individuals presenting with influenza symptoms. It consists of an online and telephone-based self-assessment service which, through a series of questions, determines whether an individual is eligible for antiviral medicine. Individuals may be referred back to primary care or an ambulance response if further medical assessment or emergency care is appropriate.

A national network of Antiviral Collection Points (ACPs) will be set up to enable people to stay at home and send nominated “flu friends” to collect the medicines

Anti-virals:

There are currently two medicines licensed for the treatment of influenza in the UK - Oseltamivir (Tamiflu) and Zanamivir (Relenza). The UK has a central stockpile of these medications for use during a pandemic and pharmacies commissioned directly by NHS England will provide antiviral medicine to patients. NHS England is responsible for leading the delivery of antiviral collection points (ACP) in partnership the wider NHS..

The Merseyside Antiviral Plan will contain further information regarding access to antivirals.

Details have not been finalised and specific information will be shared as it is developed.

Vaccination

The possibility of vaccination at a pre-pandemic stage will be considered depending on the virus strain. It should be noted that any pre-pandemic vaccination would likely be only on an extremely limited basis and subject to national identification of priority groups. A vaccine specific to the pandemic strain of influenza would only be available 4-6 months after the identification of the new strain. Prioritisation will be required, led by national policy set by the Joint Committee on Vaccination and Immunisation (JCVI). Further local prioritisation may be required depending on vaccine quantities. Specific information will be available as Merseyside Vaccination plan is developed and finalised by NHS England.

School Closures:

School closures would only be taken in an influenza pandemic with a very high impact when the Government considers that the pandemic is severe enough to advise schools, early years and childcare settings to close.

However, under some circumstances depending on the public health risk assessment, public health may advise localised closures (individual schools or catchment areas), or the decision may be made by head teachers (and their Board of Governors where relevant) to close

establishments temporarily using a precautionary approach in the early stages of an influenza pandemic to reduce the initial spread of infection

Once the virus is more established in the country, the general policy would be that schools should not close unless there are specific local business continuity reasons (staff shortages or particularly vulnerable children).

In case of school closures the Department for Education will advise local authorities who are responsible for ensuring that all maintained schools and settings are told of the decision. The Department will inform independent schools, academies and free schools directly.

The DCLG RED team will advise SCGs of the decision or to reduce social impacts, including:

APPENDIX 3: COMMUNICATIONS:

Further information on health communication in a pandemic is available in the UK Pandemic Influenza Communications Strategy 2012 and in the UK Influenza Pandemic Preparedness Strategy 2011.

The Department of Health will be the primary source of central government's health-related public messages and will work closely with the Cabinet Office, other government departments and Public Health England to deliver a nationally coordinated communication strategy. During a pandemic the UK Government will use a wide range of media to communicate information effectively to the public, to engage in discussions and to identify areas of concern.

Information may also be made available directly to the public through telephone help lines and other interactive channels

Effective internal two-way communication will also be vital to an effective response in a pandemic.

Local communications

The Civil Contingencies Act (CCA) 2004 places two specific duties on category 1 responders regarding communicating with the public:

- The public are to be made aware of the risks of emergencies and how Category 1 responders are prepared to deal with them: the public are currently made aware of the risks and preparations to mitigate them by the annual review and subsequent publication of the Community Risk Register
- The public are to be warned and provided with information and advice as necessary at the time of an emergency: the MRF Merseyside Media Protocol during an Emergency is currently the agreed mechanism for warning the public and providing them with information at the time of an emergency

In addition the NHS at an area team level will form an NHS Communications Cell to help inform and co-ordinate NHS communications. The NHS Communications Cell will be led by the area team. The decision to form the NHS Communications Cell will be taken by the Area Team.

A representative from the NHS Communications Cell will take part in a multi-agency media cell if one is called. The NHS Communications Cell may be formed early on – potentially at the Detection level if necessary – to enable communications systems and resources to be activated, tested if necessary, and to establish in advance a clear way of working.

All the public bodies from the Department of Health downwards are keen to ensure that the public will have an understanding of pandemic flu before it happens. Early communications will attempt to:

- Explain the difference between pandemic flu and ordinary flu
- Stress the importance of hygiene, hand-washing and infection control generally
- Stress the monitoring and planning work that is underway involving central Government, World Health Organisation (WHO), Public Health England and the NHS
- Highlight the difficulties with having the right vaccine for specific types of flu and emphasise that is being done to develop appropriate vaccines

All mainstream information and campaign materials need to be accessible to the widest possible audience, including the vulnerable, hard-to-reach groups and those with special needs.

Communication plans need to remain flexible and pragmatic. They should also be scalable and straightforward to implement.

One aim within Merseyside will be to raise awareness amongst NHS staff so that they will have a role in delivering consistent messages to the public.

APPENDIX 4: SUMMARY OF PANDEMIC INFECTION CONTROL ASSUMPTIONS

Infection control assumptions for pandemic influenza are based on current knowledge about seasonal influenza viruses. These include:

- Person-to-person spread of human influenza viruses is well established
- The patterns of transmission observed during nosocomial outbreaks of influenza suggest that large droplets and contact (direct and indirect) are the most important and most likely routes of spread
- Airborne or fine droplet spread may occur in some settings (e.g. during the performance of aerosol generating procedures in healthcare settings)
- The incubation period of human influenza ranges from 1-5 days (typically 2-3)
- Infectivity is proportional to symptom severity and maximal in the first few days after the onset of symptoms
- The period of communicability is typically up to 7 days after symptom onset in adults and possibly longer in children, although longer periods of virus shedding have been documented in a small proportion of children
- Virus excretion may be considerably prolonged in immunocompromised patients.
- Virus may be recovered from infected but pre-symptomatic persons, but there is little published evidence to support person-to-person transmission of influenza from a pre-symptomatic individual to a susceptible host
- Influenza viruses are easily deactivated by washing with soap and water, alcohol based hand sanitizers, and cleaning with normal household detergents and cleaners

Pandemic infection control measures in all general settings will be based around:

- Persons with symptoms staying in their own homes
- Persons who develop symptoms at work or whilst away from home, returning to home as quickly as reasonably possible
- Good respiratory hygiene practiced by all
- Frequent hand-washing practiced by all
- Appropriate cleaning of frequently touched hard surfaces in the home and in public places
- Avoidance of unnecessary contact with others and unnecessary overcrowding (reduction of contact rates) Rapid access to antiviral treatment for symptomatic persons (reduction in transmissibility)

In health and communal care settings, additional measures will include:

- Prompt recognition (and treatment) of staff with influenza
- Exclusion of staff with respiratory symptoms
- Segregation of staff into those dealing with influenza patients and those not (with exceptions)

- Maintaining physical and/or temporal separation between ‘flu’ and ‘non-flu’ patients/clients
- Standard Infection Control Principles
- Droplet Precautions
- Personal Protective Equipment according to risk of exposure
- Environmental cleaning and disinfection

APPENDIX 5: VOLUNTARY AGENCIES / FAITH / THIRD SECTOR

In line with national guidance and best practice, the voluntary and faith sectors on Merseyside are engaged with the Merseyside Resilience Forum (MRF) in general emergency preparedness. This relationship is formalised through the MRF Voluntary Agencies and Faith Sector Forum (the Forum), which is a standing group of the MRF, chaired by a local authority.

Membership is drawn from those agencies which have a key role or expertise in crisis, emergency and disaster response, and from the faith sector, as well as being attended by both Category 1 and 2 responders. The response structure, capabilities and terms of reference of the contributing voluntary agencies and faith groups are outlined in the MRF UNITY Plan. There is a further specific Faith Plan which sits under the UNITY Plan with additional details of faith group coordination in an emergency.

Activation can be initiated through any of the local authorities and the British Red Cross (BRC) is the ‘Primacy Agency’ with coordinating responsibilities for emergency response. The chair of the Forum and/or representatives of the agencies (usually the BRC) sit variously on the full MRF, the MRF General Working Group and MRF sub-groups, as well as the Local Health Resilience Partnership (LHRP) ensuring both visibility and effective liaison with the sector in emergency preparedness.

For pandemic planning, the Forum is regularly updated and consulted as required as part of routine business. Given the potential uncertainty of requirements, and the diversity of the sector, no formal plan is maintained for the voluntary agencies, but the umbrella organisation ‘Churches Together in Merseyside’ maintains an outline pandemic response plan for the faith sector. The faith sector has also been engaged pandemic excess deaths planning and has an ongoing role in the production and maintenance of the MRF Extra Deaths Plan.

In an impending pandemic, consideration of the possible contribution of the voluntary and faith sector should be part of the very early dialogue between BRC, MRF and the local authorities. Appropriate representation on MRF or LHRP groups managing a pandemic will readily be provided and should be arranged at the earliest stage. Appropriate roles and responsibilities can be defined quickly by consensus in this context.

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| Version No.1.3 November 2015 | <i>Pan flu plan</i> Current version is held on the Intranet Check with Intranet that this printed copy is the latest issue | Page 58 of 68 |
|---------------------------------|--|---------------|

In these consultations expectations on the part of the statutory agencies should be realistic, including the awareness that 'voluntary' does not necessarily mean 'free of charge'. These agencies provide a wide range of expertise and capability, maintaining their organisations and providing for the training of their personnel to high (often professional) standards through public donations and, in some cases, paid service provision. If engaged in support of pandemic response, there will be necessary expenses and other costs to be considered.

In addition, some of the agencies are commissioned providers or fulfill regular support functions in the health economy (BRC and St John's supporting NWAS, for example) and in the social care sector (Royal Voluntary Service, BRC, for example) and will have overlapping responsibilities to be considered.

Some of the agencies also engage with hard to reach groups (refugees, homeless, for example) and other vulnerable people who may sit outside statutory agency provision, and will be a major source of expertise and support in this area in a pandemic.

Note: National pandemic planning guidance (UK Influenza Pandemic Preparedness Strategy, DH, 2011 and Preparing for Pandemic Influenza; Guidance for Local Planners, Cabinet Office July 2013) now contains no specific roles or responsibilities for the voluntary and faith, or 'Third' sectors in pandemic response. This is a change from previous national guidance (pre-2009 H1N1 outbreak) which suggested considerable expectations of response, including the proposal that voluntary agencies and faith groups would be a source of 'flu friends'.

During the 2009 outbreak in Merseyside, some work was undertaken in line with the previous national guidance to engage voluntary agencies to deliver anti-viral medications, but this was not done early in the process, met with a range of issues, and was never fully implemented. Notwithstanding this experience, it is emphasised that the voluntary and faith sectors will have a significant role and can make a substantial contribution in the event of an influenza pandemic. Their engagement in Merseyside is an expression of the principles of 'building on established systems' and 'whole of society preparedness' espoused by current national guidance (UK Influenza Pandemic Preparedness Strategy, DH, 2011, p31)

Equality Analysis

Introduction and Guidance

The change in terminology from “equality impact assessment” to “analysis of the effects” is intended to put more focus on the quality of the analysis and how it is utilised in decision making and less on the production of a document. It is not a one-off exercise but an on-going and cyclical process.

It is important that you conduct your equality analysis (EA) from the very beginning of the process of development (be it a strategy, policy, practice, provision or decision). The person who is responsible for the development, or is advising the decision maker, needs to undertake the assessment with appropriate support. If working in partnership a collaborative approach saves time, shares expertise and knowledge and avoids duplication of effort.

You must demonstrate that:

- engagement with the appropriate stakeholders has taken place in **accessible** and **proportionate** ways
- comprehensive equality monitoring of all engagement activities that you have initiated has taken place with all stakeholders (e.g. if a particular provision is targeted at a specific group, e.g. disabled people, it is still important to monitor all equality categories)
- evidence relating to dates and venues and/or methods used to engage is available
- feedback has informed and influenced developments.

In the case of reviewing and updating current practice you must ensure that any lack of engagement or incomplete monitoring in the past is rectified during the updating process.

EA applies to all activities including analysing the cumulative effect of a number of decisions when made together, and the implementation of something that has been developed by an external body e.g. a government department.

The “**protected characteristics**” (PCs) listed in the Equality Act 2010 and covered by the Equality Duty are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Civil partnership and marriage are also covered

but not for all aims of the duty. **Protected Groups** (PGs) are based on the protected characteristics. These groups must be considered during the EA process.

Please note that it is not possible to include all the required information in the boxes below. The following is a framework for noting key points within which you must refer to underlying documents and other supporting detail. When completing this you will find it helpful to refer to the “Equality Analysis Checklist” at the end of this document for additional information.

A copy must be kept within your department for audit purposes.

To keep up to date on the latest guidance go to the website of the Equality and Human Rights Commission: www.equalityhumanrights.com

8. Equality Analysis Framework

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|--|--|-------------------------------------|--------------|--|
| Tick Category (after completion of assessment) | Not Relevant (NR) | <input checked="" type="checkbox"/> | Relevant (R) | |
| Signature of Manager/Group Responsible | Helen Martin, Risk Safety and Emergency Planning Lead | | | |
| Date | August 2015 | | | |

| | |
|--|--|
| Department/Function | |
| Lead Person | |
| Contact Details | |
| Name of Strategy/ Policy/ Procedure/Service to be Analysed (including procurement) | |
| Is this a new or existing Strategy/Policy/Procedure/Service? | |
| <p>1. What are the main aims and/or objectives of the strategy/ policy/procedure/service and to what extent is equality a relevant consideration? (e.g. a policy that lists the frequency of checking the temperatures of hospital fridges would have no relevance to equality (NR) but a change or cut back to a current service would have relevance (R)).</p> <p>Take account of the protected characteristics (PC's)/ groups and outline your reasons for your chosen category in as much detail as possible. Tick "R" or "NR" at the top of this page. If "NR" has been chosen finish here once your reasons have been given in the box on the right.</p> | |

| | |
|---|---|
| <p>1. How will you scope your equality analysis?</p> <p>2. Fill in details under the headings in the box on the right.</p> <p>You may want to involve other key people and organisations at this stage and you may find that you need to change your plans as you work through the questions.</p> | <p>How do the aims of the development relate to equality? (Consider purpose, operational context, beneficiaries, intended results and needs including those of PGs.)</p> <p>Which groups could be usefully engaged? (Consider ways by which you can engage with stakeholder groups and seek out new sources of information to help fill gaps.)</p> <p>What aspects are relevant to equality? (Consider each part of the development and any related issues.)</p> <p>Which PCs are relevant? (If potential impact on PCs could vary you may need to prioritise.)</p> <p>What equality information is available? (Consider local, regional and national data, other related information e.g. Joint Strategic Needs Assessment (JSNA), Community Strategy and anecdotal information.)</p> <p>What are your information gaps? (There is a shortage of information regarding some PCs)</p> |
| <p>3. How will you analyse your equality information?</p> <p>Fill in details under each heading in boxes to right</p> | <p>Using information to understand the effect on equality. (Take an overview of the information but be wary of drawing general conclusions e.g. “this benefits everyone”. It may be that outcomes will differ between PCs or targeted interventions are required.)</p> <p>Findings of your analysis. (This can result in 4 decisions: no major change / adjust what was proposed / continue as planned / stop and re-think or remove. If there is a need for an action plan at this stage develop one.)</p> <p>Documenting your analysis. (It is important to record details of your assessment and analysis. Public authorities subject to the specific duties must publish their analysis.)</p> <p>Next steps. (When you have decided on your course of action you may consider it helpful to invite views on your findings. It is important that you can validate the conclusions that you have arrived at.)</p> |
| <p>4. How will monitoring and review be carried out? EA is an on-going process that does not end once implementation has begun.</p> | |

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| <p>Plan a review timetable taking into account any specific requirements that have been identified and enter in box to right.</p> <p>(NB Ensure that procurement activity of any size identifies the equality, diversity and human rights requirements, including evaluation, monitoring and review arrangements, within tender and contract documents)</p> | |
| <p>5. Are you ready to have the development signed off and publicised? Although EA is an on-going process there is a stage when adoption and signing off can occur.</p> <p>Fill in details under each heading in boxes to right</p> | <p>Decision makers must be clear about how the EA has informed and influenced content and have due regard to the findings when giving final approval.</p> <p>The specific duties require that equality information is published and recommend that the EA is published alongside the development, policy or decision that it relates to.</p> |
| <p>6. List the additional supporting evidence and sources of information that have informed this EA in box to the right.</p> | |

Equality Act 2010 – Background Information

Protected characteristics (PCs) are: age, disability, gender reassignment, pregnancy & maternity, race, religion or belief, sex and sexual orientation. **Marriage and civil partnership** are only covered by the first aim of the general duty outlined within the Equality Act 2010.

Those covered by the general duty must in the exercise of their functions have regard to the 3 “aims” or “arms” of the duty:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the act (*i.e. removing or minimising disadvantage suffered by people due to their PCs*)
- Advance equality of opportunity between people who share a protected characteristic and those who do not (*i.e. taking different steps to meet the needs of people from protected groups (PGs) where these are different from the needs of other people*)
- Foster good relations between people who share a protected characteristic and those who do not (*i.e. encouraging people from PGs to participate in public life or in other activities where their participation is disproportionately low.*)

Disabilities must be catered for and meeting the above requirements may involve treating some people more favourably than others.

The **general duty** applies to all Schedule 19 listed bodies e.g. health bodies, police and transport authorities, government departments. Other organisations that carry out public functions are also covered by the general duty e.g. voluntary sector or private bodies that carry out public functions. There are a few exceptions – if in doubt seek legal advice.

The **specific duties** apply to virtually all bodies listed in Schedule 19 and require the listed body to:

- Publish sufficient information to demonstrate compliance with the general duty across all functions including: information on the effect that its policies and practices have had on people who share relevant PCs, to demonstrate the extent to which it furthered the aims of the general duty for employees and for others with an interest in its functions. (*Public authorities with fewer than 150 employees are exempt from the employee provision*)
- All public authorities must **publish**: evidence of analysis that they have undertaken; details of the information considered; details of engagement they undertook; **prepare** and **publish** equality objectives that must meet one or more aims of the general duty.

- The published information must also be considered before preparing objectives that are specific and measurable; how progress will be measured must be stated. **Information on objectives must be published at least every 4 years** in an accessible format either separately or as part of another document. **Progress must be reported on annually** and it is recommended that this is done incrementally throughout the year.

To keep up to date on the latest guidance go to the website of the Equality and Human Rights Commission: www.equalityhumanrights.com

9. Endorsed By:-

| Name of Lead Clinician/ Manager or Committee Chair | Position of Endorser or Name of Endorsing Committee | Date |
|---|--|---------------------------------|
| Helen Martin | Emergency Planning Group | 15 th September 2015 |
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10. Record of Changes

| Section Number | Version Number | Date of Change | Description of Amendment | Description of Deletion | Description of Addition | Reason |
|----------------|----------------|----------------|--------------------------|-------------------------|-------------------------|--------|
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