Dumfries & Galloway MAJOR Emergency Scheme

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GLOSSARY OF ABBREVIATIONS & ACRONYMS

BCP	Business Continuity Plan
D&G	Dumfries and Galloway
DGRI	Dumfries and Galloway Royal Infirmary
DPH	Director of Public Health
ED	Emergency Department
HDU	High Dependency Unit
HPS	Health Protection Scotland
ICT	Infection Control Team
ILI	Influenza Like Illness
JCVI	Joint Committee on Vaccination and Immunisation
LHP	Local Heath Partnership
LRP	Local Resilience Partnership
MES	Major Emergency Scheme
OHS	Occupational Health Service
OOHS	Out of Hours Service
PGD	Patient Group Directive
PIC	Pandemic Influenza Co-ordinator
PICC	Pandemic Influenza Co-ordinating Committee
PICT	Pandemic Influenza Control Team

PPE	Personal Protective Equipment
RRP	Regional Resilience Partnership
SGHD	Scottish Government Health Department
TSG	Tactical Support Group
WHO	World Health Organisation

1. INTRODUCTION

1.1 AIM

To provide a framework for Dumfries and Galloway's local response to an influenza pandemic that will minimise the health, social and economic impact and that reflects the lessons learnt from the H1N1 pandemic in 2009.

1.2 OBJECTIVES

This plan:

- Sets out organisational arrangements for the management of a pandemic in Dumfries and Galloway in line with Major Emergency Scheme (MES) arrangements.
- Sets out the roles and responsibilities of various services and multi-agency groups through the different phases of a pandemic and the required level of response in scenarios of varying impact that may develop.

1.3 SCOPE

This plan is for local purposes but is based on, and should be read in conjunction with, the UK Departments of Health Influenza Pandemic Preparedness Strategy 2011.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131040.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf

To avoid duplication the Plan reflects and refers to more detailed national guidance on specific issues where appropriate. Further information can be found at:
http://www.scotland.gov.uk/Publications/2008/10/28141252/0
http://www.hps.scot.nhs.uk/Search/default.aspx?search=pandemic%20flu

The plan is not a Business Continuity Plan (BCP). Each local organisation and department is expected to develop their own BCP.

Where other relevant existing local plans and strategies are already in place, such as for mass vaccination, infection control and communication, these are referred to but not covered in detail in this plan.

2. RESPONSIBILITIES AND ORGANISATIONAL ARRANGEMENTS FOR MANAGING A PANDEMIC

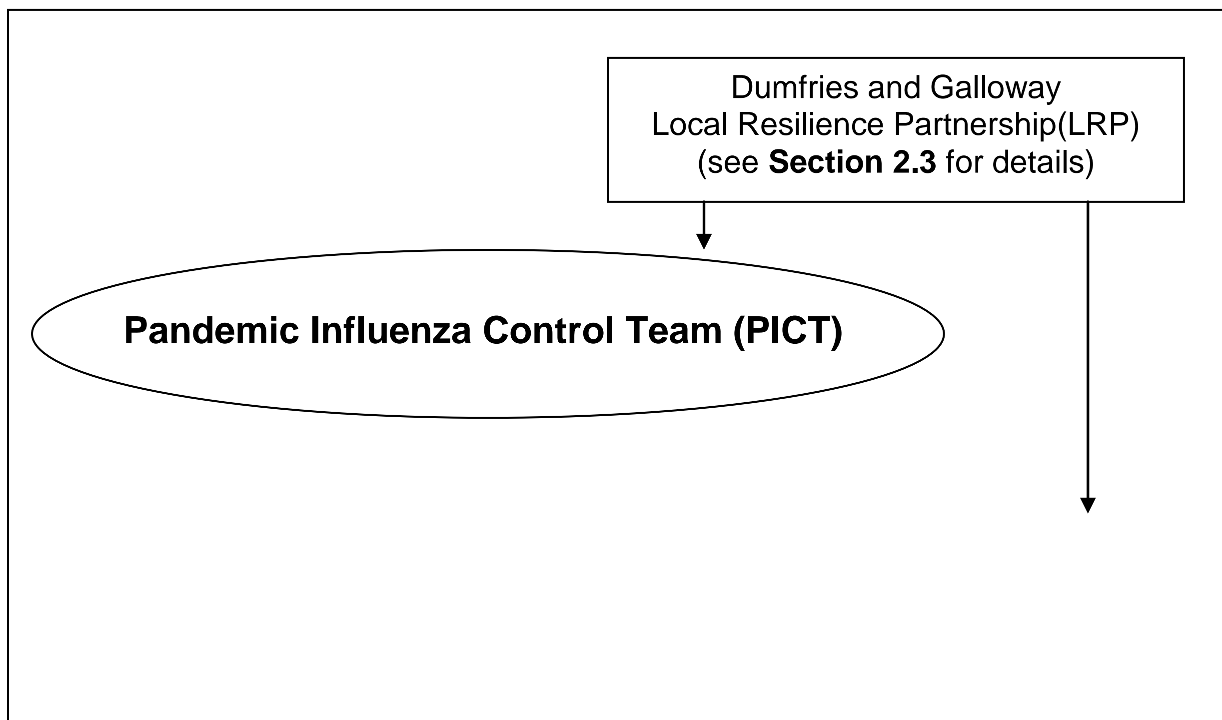
2.1 GOVERNANCE AND OWNERSHIP

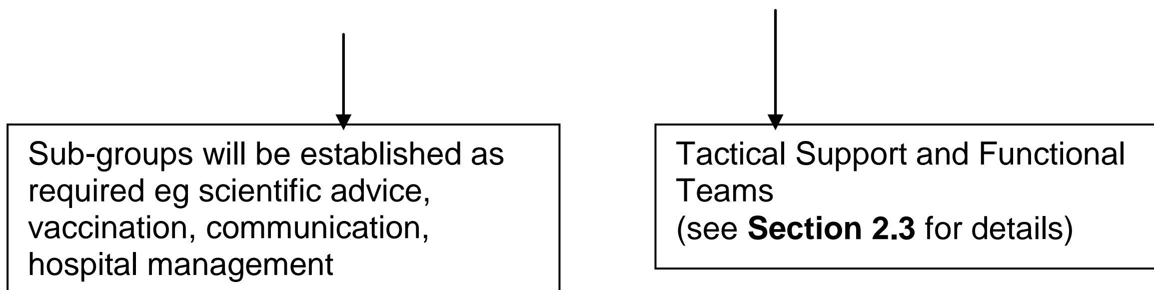
This plan is 'owned' by the Chief Executive of NHS Dumfries and Galloway on behalf of the Local Resilience Partnership (LRP). The plan will operate within the overall framework of the Dumfries and Galloway Major Emergency Scheme (MES).

2.2 MANAGEMENT STRUCTURE

The management of a Flu Pandemic is a combination of the generic arrangements of D&G MES and contingency-specific arrangements for a flu pandemic. Specifically, in addition to the generic MES arrangements, dealing with a flu pandemic will entail constitution of a 'Pandemic Influenza Control Team' (PICT). The LRP strategic group may consider establishment of a separate Scientific and Technical Advisory Cell (STAC) but in most circumstances this function will be fulfilled through the PICT. The management structure for an Influenza Pandemic Outbreak in Dumfries and Galloway is shown diagrammatically below in Figure 1:

Figure 1: Local Pandemic Management Structure





2.3 MAJOR EMERGENCY SCHEME GROUPS

- **Local Resilience Partnership (LRP)**

Remit
For the general role of the LRP and required documentation refer to the D&G MES.
The LRP will have overall authority for, and will provide overall direction to, the management of the local emergency response to a pandemic and its consequences.
The LRP strategic group will set the policy framework for a coherent clinical and non-clinical local response.
The LRP will ensure integrated implementation of arrangements and effective joint working across MES partner organisations.
LRP will manage the overall command and control structure including crucial links with the Scottish Government Health Department (SGHD), Health Protection Scotland (HPS) and other relevant national level groups and committees established at the time (eg Scottish Pandemic Influenza Co-ordinating Group, the Civil Contingencies Committee, Scottish Emergency Co-ordinating Committee).
Specific functions of the LRP will include:

- Agree with HPS and DPH risk assessment and escalation triggers;
- Ensure escalation policies are clearly defined and communicated to relevant parties;
- Ensure business capacity plans are available;
- Clarify which performance targets for NHS and partner organisations can be dropped or modified;
- Agree to support policies for the optimum care of those affected;
- Ensure appropriate facilities for infection control;
- Communicate relevant national policy to local Pandemic Influenza Control Team (PICT);
- Agree a communications and media handling strategy compatible with MES arrangements.

Membership

- Chief Executive, NHS Dumfries and Galloway
- Chief Executive, Dumfries and Galloway Council
- Divisional Commander (Dumfries and Galloway) Police Scotland
- Area Manager (Dumfries and Galloway) Scottish Fire and Rescue Service
- Procurator Fiscal
- Scottish Ambulance Service Representative
- Director of Public Health
- Other organisations and expertise invited as appropriate

During a flu pandemic the Local Resilience Partnership (LRP) will most likely be chaired by the Chief Executive of NHS Dumfries and Galloway. The chairing of the LRP may pass to other members particularly in the later recovery phases or if prevailing circumstances make it appropriate.

- **Tactical Support Group (TSG)**

Remit
For the full general functions, responsibilities and documentation required of the TSG please refer to MES documentation.
The TSG provides multi-agency tactical support management within the framework of the MES and is managed by Dumfries and Galloway Council.
Functional Team Managers are called out to mobilise and co-ordinate the activities of the non-emergency services to complement the response of LRP partners.
The Functional teams implement the operational support for consequence management requirements of the MES. Liaison Officers within the teams have a full part to play in decision making

Membership
The TSG is composed of Functional Team Managers and Liaison Officers.
The Functional Team Managers are first line managers covering four broad areas: Communications; Logistics; Care for People and Operations. Any or all of these teams may be formed according to response requirements.
Membership of these teams comprises Liaison Officers drawn from the Police, Fire & Rescue Services, Ambulance Service, Maritime and Coastguard Agency, NHS Dumfries and Galloway and Armed Forces as appropriate to the demands of the particular emergency.
The Group is chaired by the Chief Executive of Dumfries and Galloway Council or a nominated Deputy.

2.4 PANDEMIC SPECIFIC ARRANGEMENTS

- **Pandemic Influenza Coordinator**

The Pandemic Influenza Coordinator (PIC) will consult with the major stakeholders of the Flu Pandemic Plan and liaise with NHS and other

organisations to ensure that the Plan represents a shared multi-agency response in the event of implementation. The PIC will respond to SGHD queries regarding the Plan, will participate in the Pandemic Influenza Control Committee (PICC), and will be the named individual for ensuring that the Plan is kept up to date. The current PIC is:

Dr Nigel Calvert, Consultant in Public Health Medicine.
Ryan South, Crichton Hall, The Crichton, Dumfries, DG1 4TG
Tel 01387 272724
E-mail nigel.calvert@nhs.net

- **Pandemic influenza Control Committee**

The PICC will be responsible for ensuring the plan is reviewed at the appropriate point annually and in year as appropriate (particularly following exercises and training). The Group will also take into account and contribute to the Community Risk Register (maintained by the Fire and Rescue Service on behalf of the LRP). Membership of the PICC will include:

- Nigel Calvert – Consultant in Public Health Medicine, NHS Dumfries & Galloway
- David Gurney - Safety & Resilience Manager, Dumfries and Galloway Council
- David Irving – Emergency Planning Officer

- **Pandemic influenza Control Team**

Remit

The PICT will be responsible for the day-to-day operational management of the Board level health response to the pandemic in liaison with the LRP and within the framework of the MES. This will include on-going risk assessment and implementing appropriate and proportionate response at all phases of a pandemic. The PICT will receive strategic instruction from the LRP strategic group and will advise and feed back to them on specific scientific and operational issues as they arise. The PICT will be able to co-opt and utilise the full capacity of the MES partners and Tactical Support Teams as required. The PICT may decide to establish specific sub-groups to focus for example on primary care, hospital care, vaccination etc as required. More specific functions of the PICT will include:

- Advise LRP regarding epidemiology and actual and predicted trends of disease spread
- Advise LRP regarding local health service management and outbreak control measures that are required in line with national guidance;
- Arrange local management (diagnosis, investigation, treatment) of patients with flu-like illness and confirmed influenza and its complications in line with national guidance;
- Ensure optimum care for those affected;

- Ensure appropriate facilities for infection control;
- Arrange to have laboratories investigate influenza-like illness (ILI), isolate strains of influenza and test anti-microbial susceptibility of secondary bacterial infections;
- Arrange a co-ordinated health protection response in line with national guidance;
- Implement arrangements to cope with staff absence and increased patient loads;
- Manage the disruption caused by influenza on other NHS services and other medical conditions;
- Implement contingency staffing arrangements as required;
- Arrange to provide anti-viral treatment and to immunise essential staff according to national guidelines (with Occupational Health Service);
- Implement plans for emergency mass vaccination programmes according to national guidelines (see NHS Dumfries and Galloway Mass Prophylaxis Plan);
- Estimate requirements for vaccine and anti-viral drugs;
- Arrange distribution of vaccine and anti-viral drugs;
- Ensure vaccine and anti-viral drug administration to all specified priority groups according to national guidelines.
- Arrange to routinely report all data required by HPS and SGHD on pandemic influenza and it’s local impact;

A model agenda for meetings of the PICT is attached in **Appendix 1**.

Membership

The PICT will be led by NHS D&G Chief Operating Officer. Function and membership of the PICT will be adapted as required during the changing circumstances of a pandemic but the following provides a guide to core membership.

- General Manager, Health and Social Care Partnership
- Hospital management
- Medical and nursing staff managers
- Primary care
- Scottish Ambulance Service
- NHS 24 and D&G Out-of-Hours services
- D&G Council Social Work
- Health Protection (Directorate of Public Health)
- Infection Control Team
- Occupational Health Service
- Pharmacy
- Microbiology laboratory
- HPS
- Communications

3. PRINCIPLES OF THE PLAN

The overall principles for this plan are that it will be:

Precautionary
The plan will reflect the potential risk based on best information available.
Proportionate
The plan will provide only the necessary response that appropriately reflects the risks and circumstances.
Adaptable
The plan will have capacity built in to be flexible to changing risks and circumstances and scale the response up or down as required. In particular it will be able to cope with the full potential clinical spectrum of influenza severity (see 3.1 below).

3.1 PLANNING ASSUMPTIONS

This plan is based on the following basic planning assumptions:

- The scope of any pandemic will be uncertain ie in its speed, duration, geographical spread and severity.
- The nature of a pandemic means it will have a very high public and media profile.
- Influenza pandemic planning in the UK has been based on a 'reasonable worst case scenario' derived from experience and analysis of previous 20th century pandemics. This has indicated that 50% of the population may be affected over a 15 week period. 30% of those affected may present to primary care, 3% of those affected may be hospitalised and 2.5% of those affected may die. This remains an acceptable basic indicator for planning. However, as previously identified, the scope of any pandemic is highly uncertain and the data on which planning model scenarios are constructed are also highly unreliable. This plan is designed to be flexible to cope with a range of circumstances based on low, moderate and high impact scenarios.
- It may be that in a future pandemic similar to the 2009 H1N1 picture (ie widespread but in most cases very mild illness) a decision will need to be

made whether or not to invoke this plan. Central guidance will be followed in this situation.

A breakdown of estimated projection figures for low, moderate and high impact scenarios of a pandemic in Dumfries and Galloway can be found in **Appendix 2.** The projections for high, medium and low impact scenarios suggest that the peak (week 7) there would be 16,500, 8,500, and 3,500 new cases.

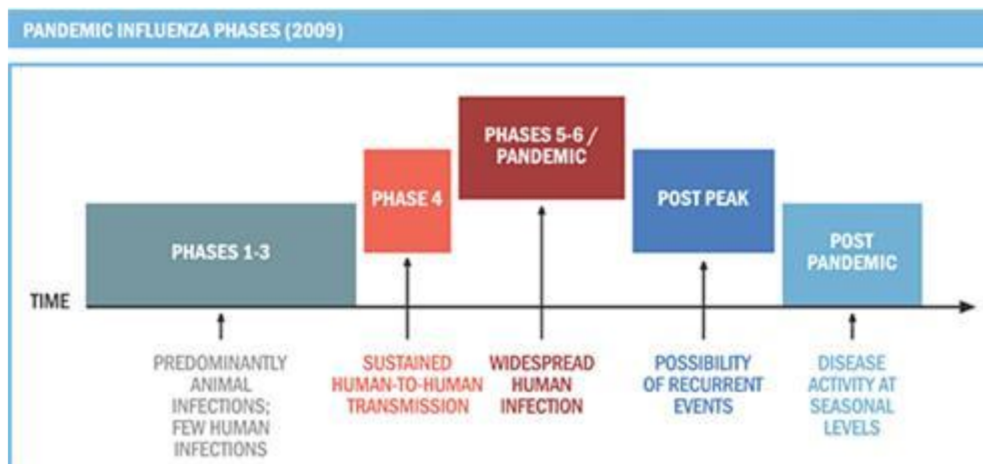
3.2 APPROACH

The approach to this plan involves four key objectives:

- Early detection and assessment
- Reducing transmission and protecting the population
- Minimising serious illness and mortality
- Promoting resilience

The WHO have a six phase trigger and alert system for pandemic planning at global level as depicted below in Figure 2 (for further detail see **Appendix 3**).

Figure 2: WHO Pandemic Alert System



This tool reflects the global system and is not directly applicable at national or local level. However, it provides a useful starting point for a phased approach at local level.

On declaration of WHO pandemic Phase 4 (or earlier depending on specific national or local circumstances) the local pandemic response will be initiated and would consist of 3 key phases:

1. **Detection and Assessment**

2. **Treatment and Escalation** – this phase commences once there is evidence of sustained transmission of the virus in the community. The response is graded to allow flexibility for a pandemic with ***Low, Moderate or High*** impact

3. **Recovery** – this phase commences once influenza activity is significantly reduced from its peak or is considered to be within acceptable parameters.

Information and guidance at national level will assist in assessing and continuously reviewing the phase and the impact level of the pandemic locally.

3.3 RISK ASSESSMENT

During treatment and escalation phases it will be vital for the PICT to continuously review the level of impact of the pandemic locally in order to respond in a precautionary but proportionate and adaptable manner. It is not possible to clearly define what would constitute a low, moderate or high impact pandemic. However, Figure 3 provides a tool to assist risk assessment based on the numbers of people affected and the severity of the illness / deaths caused. This has been adapted from the Watt Group Outbreak Risk Matrix (see http://www.scotland.gov.uk/Resource/Doc/46997/0013951.pdf) and the Hospital Infection Incident Assessment Tool (see http://www.documents.hps.scot.nhs.uk/hai/infection-control/toolkits/hiiat-2011-10.pdf) and is based in principle on a range of evidence from previous pandemics and epidemic seasons (see http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125333.pdf).

This tool will be used by the PICT on an on-going basis in conjunction with available local intelligence, national guidance and professional judgement. This will provide a valuable indication and assessment of the risk and impact of a pandemic and so ensure a reasonable, flexible and practicable response.

Figure 3: Risk Assessment and Monitoring Tool

	Public Health Impact (numbers affected)	**Individual Impact** (severity of illness)	**Impact on Services**	**Public Anxiety and Concern**	**SCORE**
Minor Impact (Score 1 for each)	Attack rate <20%	Case Fatality <0.3%	Minimal – small increase in staff sickness and increased workload in some areas but manageable	Some public reassurance required but no significant increase in media interest	
Medium Impact (Score 2 for each)	Attack rate 20-40%	Case Fatality 0.3 - 2.0%	Moderate increase in workload and staff sickness absence in some areas requiring some specific management interventions	Increased public and media anxiety and concern requiring some periodic attention and response	
Major Impact (Score 3 for each)	Attack rate >40%	Case Fatality >2.0%	Major impact across all services requiring widespread implementation of BCPs	High level of public and media alarm requiring continuous attention and response	
				TOTAL SCORE	

TOTAL SCORE = 4 – 6 **GREEN** **FOLLOW PLAN FOR ‘LOW IMPACT SCENARIO’**	**TOTAL SCORE = 7 – 9** **AMBER** **FOLLOW PLAN FOR ‘MODERATE IMPACT SCENARIO’**	**TOTAL SCORE = 10 – 12** **RED** **FOLLOW PLAN FOR ‘HIGH IMPACT SCENARIO’**

4. DETECTION AND ASSESSMENT PHASE

On declaration of WHO pandemic Phase 4 (or earlier depending on specific national or local circumstances) the PIC will alert LRP. LRP will review the specific circumstances and decide on the need to establish PICT. In this initial phase the main priorities are:

- clinical surveillance and intelligence gathering to inform both the local and national response;
- clear communication to all relevant personnel and the public in order to maximise preparedness.

4.1 KEY ACTIONS

1. Surveillance, Testing, Diagnosis and Treatment	Implement enhanced virological testing and data collection
2. Prevention and Protection	Implement enhanced infection control procedures in healthcare settings Prepare for anti-viral distribution Prepare for vaccination programme
3. Service Planning and Continuity	Review BCPs urgently Review plans for enhanced staff sickness absence surveillance
4. Communication	LRP consider need for Information Cell and / or Public Information Co-ordinator and Public Information Cell Communicate key issues on progress, prevention and preparation internally and externally

Further guidance on the key actions at Detection and Assessment Phase under these four headings is set out below.

4.2 SURVEILLANCE, TESTING, DIAGNOSIS AND REPORTING

PIC will alert local clinicians (primary and secondary care) to establish guidelines and practice for testing of Influenza-Like-Illness (ILI) cases. Patients presenting in primary care (at GP surgery or out-of-hours) will be managed as per usual clinical care. However, in addition to usual management nasal and pharyngeal swabs should be taken for virology and minimum dataset information (**Appendix 4**) collected and returned.

PIC will alert Head of Microbiology at DGRI to establish arrangements for handling influenza specimens. Viral throat swabs, sputums or naso-pharngeal aspirates should be collected as normal and sent to DGRI Microbiology Lab for local RT-PCR testing. The Microbiology Laboratory (DGRI) will forward influenza specimens as necessary for confirmatory testing to the Regional Virus Laboratory (RVL), Glasgow, packaged as per UN 602 Regulations. The Consultant Microbiologist will arrange urgent transport if required and liaise with the Director, RVL, regarding number of specimens and turn-around times of results. The RVL will perform an RT-PCR for the detection of influenza virus RNA. An acute and convalescent clotted blood sample can be can also be sent, and will be tested by complement fixation test (CFT).

PIC will alert Health Intelligence Unit to establish arrangements for collecting information. There will be two main purposes to data gathering:

- Identifying epidemiological and clinical features of the pandemic including numbers affected, speed and geography of spread, severity of illness, risk groups affected.
- Monitoring the likely impact on services and informing plans and responses.

The responsibility for collecting, cleaning, collating and reporting information relating to the flu pandemic will be the responsibility of the NHS Dumfries & Galloway Health Intelligence Unit (HI Unit). The staff of the HI Unit will support the information function of the pandemic management to the exclusion of all other work, as required, but within office hours. Data will be collected using a minimum core dataset (**Appendix 4**). The dataset is likely to be modified at the time according to the specific nature of the pandemic threat and local practicalities. This will provide the basis for a definitive record for clinical and epidemiological information, monitoring and planning throughout the pandemic. Other sources of information will also be utilised including the bed management system and death records. The HI Unit will endeavour during the detection and assessment phase to implement an electronic system for gathering this information so that the datasheet can be completed from a computer at any location across NHS Dumfries & Galloway. This would potentially enable a wide range of personnel to generate data through the course of the pandemic as required eg:

- General Practitioners
- Pharmacists
- Health Visitors
- School Nurses
- Community Nurses
- Accident & Emergency staff
- Ambulance staff
- NHS 24/Out of Hours service

The information will then be returned via the intranet (HR Net) or to a dedicated e-mail box using MS Infopath and collated and cleaned at the Health Intelligence Unit. In the circumstances that the electronic solution is inoperable a paper copy of the minimum core dataset should be completed with the patient CHI number on each page and faxed to the public health secure fax (01387 272759). Submissions from such non-internet routes will be entered by hand into the database by HI Unit staff. The HI Unit will endeavour to establish a web-based reporting tool allowing any member of the flu pandemic team to access the most current information. Where this is not possible, regular reports will be made available as required and provided to the LRP, and to the PICT once it is established. Regular reporting could include:

- Number of new cases, showing trend
- Age profile
- Geographic breakdown
- Breakdown by GP / LHP
- CURB 65 outcomes
- Number of admissions
- Flu-related deaths

4.3 PREVENTION AND PROTECTION

- **Infection Control**

The PIC will alert ICT and heads of service to review and be prepared to implement specific infection control measures and guidelines. This will include ensuring that all relevant training and supplies of PPE are in place. In this initial phase in all healthcare settings, patients with symptoms of pandemic flu should be segregated from non-influenza patients as rapidly as possible The Occupational Health Service (OHS) will assess any staff with respiratory symptoms and supervise and monitor staff deployment. OHS will also monitor sickness absence and provide psychological and social support to staff.

- **Anti-Viral Drugs**

Anti-viral drugs will not routinely be used or available in primary care until a pandemic is established (treatment and escalation phase). Specific guidance will be issued as to their use at national level as the characteristics of the virus

are understood. The PIC will be responsible for keeping clinicians in primary care updated as guidance becomes available on their appropriate use. The PIC will also review plans for anti-viral distribution in preparation for more widespread use.

- **Vaccination**

In this early stage no pandemic specific vaccine will be available. It is likely to be 4 – 6 months from the emergence of a new virus before supplies of vaccine would enable a population wide campaign. Some limited supplies may become available for priority groups sooner than this. Estimates of time required to manufacture supplies of the new pandemic flu vaccine for priority groups and for widespread use will be provided as soon as such information is available via the JCVI and Health Protection Scotland. Guidance will also be issued concerning who the priority groups will be as the characteristics of the virus are identified. This information will be widely circulated to the general public and the media locally.

The PIC will be responsible for reviewing vaccination plans including storage, distribution, delivery, priority groups and mass vaccination, in preparation for vaccine becoming available.

4.4 SERVICE PLANNING AND CONTINUITY

During the Detection and Assessment Phase all Heads of Service will review and update their business continuity plans as a matter of urgency. The Occupational Health service will review and establish plans for enhanced surveillance in regard to staff absence.

4.5 COMMUNICATION

The LRP will decide on the formal establishment of an Information Cell and / or Public information Cell under MES arrangements.

The Public Health Directorate together with Communications Department will be responsible for ensuring and facilitating the appropriate dissemination of information to external and internal audiences on key issues such as:

- The progress of the pandemic at international, national and local level
- The importance of good respiratory and hand hygiene
- The establishment of resilience measures such as ‘flu-friends’

5. TREATMENT AND ESCALATION PHASE

The Treatment and Escalation Phase commences once there is evidence of sustained transmission of the virus in the community. LRP will have established the PICT and overall Pandemic Management Structure (see **Section 2.2**) The PICT in conjunction with the LRP will determine when the pandemic moves into a treatment and escalation phase locally (as determined by national guidance and local risk assessment). The PICT will be responsible for the on-going risk assessment of the pandemic and whether a Low, Moderate or High Level response is appropriate (**Section 3.3**).

5.1 LOW IMPACT SCENARIO

5.1.1 Key Actions

1. Surveillance, Testing, Diagnosis and Treatment	Follow patient management algorithms according to national guidance Virological testing not now routinely required Continue data collection and reporting
2. Prevention and Protection	Maintain enhanced infection control procedures in healthcare settings and implement isolation and cohorting measures (ie infected patients are cared for together in a single unit by the same staff) Implement anti-viral distribution for treatment and prophylaxis according to national guidance Prepare for vaccination programme and implement prioritised roll-out in accordance with national guidance and availability
3. Service Planning and Continuity	Enhanced monitoring of capacity in priority services Enhanced monitoring of staff sickness absence Be prepared to implement BCPs Consider ceasing non-urgent elective activity as a first step
4. Communication	LRP and PICT review need for Information Cell and / or Public Information Cell Communicate key issues on progress, prevention, self care, appropriate use of services, tailored information for high risk groups, update on use of anti-virals and vaccine

Further guidance on the key actions for a Low Impact scenario response under these four headings is set out below.

5.1.2 Surveillance, Testing, Diagnosis and Reporting

Even in a low impact scenario it is important that a clear process is established for testing, diagnosis and appropriate treatment. It is anticipated that the vast majority (up to 95%) of flu cases can be managed at home. Depending on the availability of vaccine and anti-viral drugs, the management will be largely symptomatic.

For appropriate triage of patients presenting to GP Practices, Emergency Department triage stations, and out-of-hours services, the algorithm in **Appendix 5** should be followed. At this stage taking swabs for virology is no longer routinely required. Specific guidance on the use of anti-viral drugs will be given at the time depending on their availability and the nature of the virus. For uncomplicated illness in those people not in high-risk groups no antibiotics are necessary and home management is appropriate. For patients with non-severe pneumonia initial primary care assessment and treatment with antibiotics is appropriate.

For severe pneumonia, referral to DGRI is indicated. The management and investigations for adults referred to hospital are as recommended in **Appendices 6 and 7**.

The assessment, management and investigation of children is outlined in **Appendices 8 and 9**.

Note that all the treatment and diagnosis algorithms referred to above are likely to be modified according to the specific nature of the pandemic through national guidance at the time. The algorithms are taken from the British Thoracic Society / British Infection Society / Health Protection Agency: “Clinical guidelines for patients with an influenza-like illness during an influenza pandemic” and provide the most current advice available. For more detail on management of influenza during a pandemic practitioners should consult these guidelines available at:
https://www.brit-thoracic.org.uk/document-library/clinical-information/flu/pandemic-flu-guideline/pandemic-flu-guideline/

The CURB65 score is used in these algorithms as a means to assess severity of individual symptoms. This is based on the British Thoracic Society Community Acquired Pneumonia Guidelines 2009 (http://www.brit-thoracic.org.uk/guidelines-and-quality-standards/community-acquired-pneumonia-in-adults-guideline/) and is offered as the best example available of a triage tool. However, it should not replace individual clinical judgement.

Minimum dataset forms should continue to be completed and returned in order to inform national and local risk assessment and decision making.

5.1.3 Prevention and Protection

- **Infection Control**

Once the treatment and escalation phase of a pandemic commences influenza and non-influenza patients will be isolated or cohorted ie cared for in separate units as far as possible. This will include, where possible, different staff caring for influenza and non-influenza patients. Local guidance on the use of personal protective equipment (PPE) and infection control will be provided by the ICT and widely issued amongst healthcare practitioners across Dumfries and Galloway.

Comprehensive guidance on infection control aspects is provided in the Department of Health/Health Protection Agency, "Pandemic Influenza: guidance for infection control in hospitals and primary care settings" http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080771

and 'Pandemic H1N1 2009 Influenza: a summary of guidance for infection control in health care settings'

(now archived at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_110899.pdf.

The principles therein will be followed closely by the Infection Control Team, the Health Protection Team and all healthcare staff in Dumfries and Galloway. The Infection Control Team and Health Protection Team will have joint responsibility for ensuring compliance with the guidance for DGRI and for community locations respectively. They will work closely with the support of PICT to ensure guidance is complied with across NHS D&G. The guidance applies to community care setting such as care homes and the HPT will support implementation in these settings.

- **Anti-viral Drugs**

Once the pandemic is established anti-virals are likely to be the first line of defence until a vaccine is available. Anti-viral drugs will be stored at DGRI Pharmacy and in Community Pharmacies. They will be used for treatment as per **Appendices 5,6,7,8,9**. They may also be used for prophylaxis in limited and targeted specific circumstances eg for those close contacts in clinical high risk groups. A widespread household prophylaxis approach will not be taken. It should be noted these algorithms are likely to be modified through national guidance according to the nature of the specific pandemic.

- **Vaccination**

At some point during the course of a pandemic limited supplies of vaccine may become available to pre-determined priority groups. Advice will be given by WHO through to JCVI on priority groups at each phase of the pandemic depending on the epidemiology, clinical features, natural history and overall risk profile of the new pandemic and on the availability of vaccine. It is likely that front line health and social care staff and clinical at risk groups would be high on the priority list. The LRP and PICT will follow this advice as appropriate to local circumstances. Monitoring of vaccine uptake, effectiveness, and side-effects will be recorded using a minimum dataset form. The public will need to be kept informed promptly and sensitively regarding issues of vaccine availability.
Appendix 10 provides an example of priority groups for vaccination, according to gradually increasing availability of vaccine, along with a rationale for vaccine administration to this group and identification of who will be responsible for administration of the vaccine to that group. The Occupational Health Service (OHS) will have responsibility for all healthcare staff vaccination in a pandemic flu situation. This table would be amended according to the national guidance at the time.

5.1.4 Service Planning and Continuity

During a pandemic of influenza it may be necessary to retract from normal activity to a position in which hospital services manage more respiratory cases at the expense of managing fewer non-respiratory cases. The first step would be to stop all non-urgent elective activity. In these circumstances "non-urgent" would mean cases such as hernias or hip replacements in which, although the condition itself may be annoying, frustrating, limiting on daily activity and painful, it is not in any way life-threatening. At low impact it may not be necessary to implement such measures. A list of services which would remain critical to continuing NHS activity and which would be prioritised can be found in **Appendix 11.** There will be enhanced monitoring of capacity in these services in particular and all Heads of Service will be prepared to implement BCPs. OHS will implement enhanced surveillance of staff absence.

5.1.5 Communication

The LRP, with advice from PICT, will review the need for an Information Cell and / or Public Information Cell under MES arrangements. The principles set out in the Pandemic Flu Communications Plan will be adopted and adhered to (**Appendix 12**). Issues that will be considered for communication with both internal and external audiences at this time will include:

- The progress of the pandemic
- The importance of good respiratory and hand hygiene
- How to access local help appropriately in order to minimise the impact on services

- Self help and care information
- Tailored information for at risk groups
- Information about anti-virals and vaccination as it becomes available

5.2 MODERATE IMPACT SCENARIO

5.2.1 Key Actions

1. Surveillance, Testing, Diagnosis and Treatment	Follow patient management algorithms which may be modified according to national guidance. Continue data collection and reporting as far as possible. Consider modifications to minimum dataset and additional admin resource for HI Unit.
2. Prevention and Protection	Maintain enhanced infection control procedures. Consider and prepare for contingency measures if required (**Section 5.3.4**). Continue anti-viral distribution for treatment and prophylaxis. Communicate any revised national guidance such as priority groups. Prepare for vaccination programme and implement prioritised roll-out in accordance with national guidance and availability
3. Service Planning and Continuity	Consider and implement specific contingency plans and BCPs where required. Consider ceasing further activity in addition to non-urgent elective cases.
4. Communication	Establish Information Cell and / or Public Information Cell Continue to communicate key issues on progress, prevention, self care, appropriate use of services, tailored information for high risk groups, update on use of anti-virals and vaccine. Also provide regular communication on

	how services are coping and being managed.

Further guidance on the key actions for a Moderate Impact scenario response under these four headings is set out below.

5.2.2 Surveillance, Testing, Diagnosis and Reporting

As far as possible patient clinical management should continue as per national and local guidance set out in the algorithms in **Appendices 5 – 9**. It is likely these may be modified at the time depending on the specific nature of the pandemic.

Surveillance and reporting should also continue through the minimum dataset as far as possible. The nature of information gathering may be modified depending on the nature of the pandemic and at this level the PICT and LRP may need to consider additional administrative resources being allocated to the Health Intelligence Unit to aid data entry and collection.

5.2.3 Prevention and Protection

- **Infection Control**

Infection control procedures should be followed as set out previously in a low impact scenario. As capacity to maintain isolation or cohorting under normal service arrangements is exhausted the PICT will make decisions to implement specific measures such as designated ED areas, Wards and Flu Hospitals as set out in **Section 5.3.4**.

- **Anti-viral Drugs**

Specific guidance will be issued at national level regarding the prioritisation and use of anti-virals dependent on the nature of the virus and the availability of stock at the time eg front line health and social care staff and clinical high risk groups may be prioritised for treatment. The PICT will be responsible for updating and communicating policy on an on-going basis throughout the pandemic.

- **Vaccination**

In a moderate level pandemic a prioritised roll out of vaccination would be the most likely circumstance as previously outlined in the low impact scenario.

5.2.4 Service Planning and Continuity

If the level of the pandemic locally is designated by the PICT as Moderate this will alert all heads of service including ED, NHS24 / OOHS, Maternity, Paediatrics, Community Hospitals, Critical Care, that they should review and be prepared to implement their specific business continuity and contingency plans. Further guidance on surge capacity and prioritisation can be found at http://www.scotland.gov.uk/Resource/Doc/242911/0067570.pdf .

Beyond ceasing all non-urgent elective activity the second group of patients for whom hospital admission may need to be curtailed would be those remaining cases, including cases of malignancy, where in the judgement of the clinician concerned delay of some weeks would not materially affect the outcome.

5.2.5 Communication

In addition to the issues set out under a low impact scenario it would be important to keep both internal and external audiences informed about how services are coping at this level. This is essential in order to manage both public expectation and staff awareness of how colleagues are being affected.

5.3 HIGH IMPACT SCENARIO

5.3.1 Key Actions

1. Surveillance, Testing, Diagnosis and Treatment	Follow patient management algorithms modified according to national guidance. Continue data collection and reporting as far as possible with active participation of HI Unit staff and additional admin resource.
2. Prevention and Protection	Implement specific contingency measures (**Section 5.3.4**) in order to maintain enhanced infection control procedures. Continue anti-viral distribution for treatment and prophylaxis using PGDs and in line with any revised national guidance in regard to priority use. Prepare for mass vaccination programme in line with Mass Vaccination Plan.
3. Service Planning and Continuity	LRP implement crisis response Emergency admissions only Specific contingency plans and BCPs implemented Mass Fatality Plan implemented
4. Communication	MES Information Cell and / or Public Information Cell established and continue to provide regular communication on all key issues including daily situation update.

Further guidance on the key actions for a High Impact scenario response under these four headings is set out below.

5.3.2 Surveillance, Testing, Diagnosis and Reporting

Patient clinical management should continue according to algorithms (**Appendices 5 – 9**) taking into account modifications in line with any revised national guidance.

HI Unit staff will work closely with bed managers to keep an update on hospital admissions as required. HI staff will assist in collecting information from the wards in person if required and will be clearly identified as part of the flu pandemic team.

5.3.3 Prevention and Protection

- **Infection Control**

In order to maintain appropriate care, isolation and cohorting of influenza patients the contingency plans set out in **Section 5.3.4** will be adopted.

- **Anti-viral Drugs**

In the event of a high impact pandemic Patient Group Directions which have already been agreed will be implemented. This will facilitate the distribution of Oseltamavir in the peak phase (4-6 weeks) of a flu pandemic from the following locations:

  - GP surgeries
  - OOH services
  - Community Pharmacies
  - NHS Occupational Health Service

Algorithms will be modified to reflect any revised national guidance eg limited priority groups for treatment.

- **Vaccination**

In the event of a high impact pandemic a mass population vaccination campaign may be required. The NHS Dumfries & Galloway "Mass Vaccination Plan" will be implemented using available Primary Care infrastructure, NHS Occupational Health Service, and Health Protection Team. The PICT will oversee and monitor the implementation of the mass vaccination programme and the PIC will be the named responsible person accountable for the successful completion of the programme.

All vaccine will be stored prior to distribution at Pharmacy, DGRI and cold chain will be maintained from delivery to distribution.

The overwhelming majority of mass vaccinations for pandemic flu will be completed by primary care staff (mostly Practice Nurses, Health Visitors,

Community Nurses and School Nurses), who currently implement the seasonal flu campaign. Additional nursing staff will be redeployed and recruited to assist a mass flu vaccination programme. Volunteer nurses will also be recruited and trained. It would be intended to complete a pandemic flu vaccination programme in two weeks.

5.3.4 Service Planning and Continuity

In a High Impact Scenario the PICT will advise LRP that a High Impact 'crisis response' is necessary. This will trigger the following interventions:

- **Admissions**

It might be necessary to restrict surgery to only the most acute emergencies. PICT would consider the need to protect surgical capacity by moving remaining surgical emergency beds to the Day Surgery Unit. Deciding on admission of the remaining emergencies would demand a higher level of triage than is presently practised and would, therefore, require the presence of the on-call surgical consultants, both general and orthopaedic, in the ED or elsewhere when decision to admit was being considered.

- **Community**

The community nursing and social services will be on full alert and are likely to be stretched for a number of weeks until the pandemic subsides. At this point through the LRP arrangements additional volunteer workers will be sought to provide social support and essential food items for elderly or frail cases at home. Plans to enable Community Pharmacists and other community healthcare professionals to respond to influenza-like illness from sufferers will be brought into action in accordance with the Patient Group Directions (PGDs) already in place.

- **NHS24 / OOH**

Liaison with NHS 24 will ensure that the treatment algorithms and protocols for:
  - Triage and management of flu-like illness at home;
  - Referral to flu hospitals;
  - DGRI referral;
  - Prescription of anti-viral agents;
  - Vaccination with new pandemic flu vaccine when available;

will be followed, and appropriate documentation completed electronically. Copies of all data will be made available to the Health Protection Unit for epidemiological analysis. NHS 24 will take appropriate planning steps to ensure staffing resilience at all phases of a flu pandemic. There is a separate more detailed Out-of-Hours Pandemic Influenza Continuity Plan.

- **Scottish Ambulance Service (SAS)**

Ambulance services are a critical part of the pandemic flu response. The Scottish Ambulance Service have their own Pandemic Outbreak Contingency Plan which includes:

- Patient Transport Service (PTS) will be scaled down;
- Prioritisation of all SAS services;
- Exception reporting will be in place where there are severe delays in call handling or delays in operational response;
- Increase in staffing levels will be in place to meet peak demand;
- Phased implementation of support from Voluntary Aid Societies, other volunteer groups, mutual or military aid and commercial assistance will be in place;
- Managers are empowered to vary resource levels to take account of high demand;
- Redeployment of staff to priority tasks will be in place.

The SAS will be represented on the Local Resilience Partnership (LRP) and will be fully engaged with partner agencies on the Pandemic Influenza Control Team (PICT).

- **Flu Wards and Hospitals**

It is planned to designate Moffat, Annan, Castle Douglas, Thornhill and part of the Galloway Community Hospitals as 'flu hospitals'. Existing patients in the designated "flu hospitals" will be relocated to other convenient and appropriate facilities. All flu cases with CURB 65 scores (less than) <3 needing admission will be diverted to these locations. To ensure that DGRI and the Galloway Community Hospital continue to function optimally, General Practitioners will be asked to refer any potential or probable flu cases to the nearest selected flu hospital location. Furthermore a 'triage' admission will operate at DGRI (Out-of-Hours Room A) and the Galloway Community Hospital, whereby all new admissions will be clinically screened for flu. Where at all possible, influenza cases will be managed in flu hospitals.

Wards 3 and 6 in DGRI will be the initial 'flu isolation wards' for extremely ill cases who need DGRI admission. Infection Control Nurses in the acute service will ensure that these arrangements are in place and are complied with.

- **Critical care**

Artificial ventilation will be in DGRI and will require clinical prioritisation of those in greatest need and who are most likely to benefit. All elective work is scaled down except urgent cancer work. A 24 hour emergency theatre and a weekday 8am-5pm theatre will need to be staffed. Isolation facilities may be rapidly overwhelmed but beds are likely to be limited more by staff than equipment (ventilators etc). Day Stay would need to function as the hospital recovery and possibly the elective HDU with help from staff from SHDU. Staffing ratios will need to be higher than usual to manage a skills shortage so that trained ICU staff can have a more supervisory and training role. Medical HDU and Surgical HDU staff would need to triage and provide non invasive

ventilation (NIV) when necessary. Further guidance on critical care provision during a pandemic can be found:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117129

Contingency plans for paediatrics, maternity services and ED arrangements will be activated.

- **Fatalities and Mortuary Facilities**

In normal circumstances the mortuary at Dumfries and Galloway Royal Infirmary has the capacity to accommodate up to 31 bodies, with suitable facilities to support post-mortem examinations. In addition, some undertakers have facilities for the storage of a limited number of bodies. A High Impact Pandemic may result in the above arrangements being unable to accommodate the required demands for mortuary and body holding facilities. In the event of any emergency occurring within the Dumfries and Galloway area requiring mortuary and body holding facilities greater than normal capacity, arrangements are in place through the Major Emergency Scheme (MES) for the establishment and management of local emergency mortuaries. The National Emergency Mortuary Arrangements facilities will not be able to be invoked during a flu pandemic. In the event of a High Impact Pandemic occurring within Dumfries and Galloway, the following issues, that may require MES Emergency Mortuary arrangements to vary from the norm, will be given appropriate consideration:

  - Potential requirement for additional localised refrigerated facilities for body holding purposes;
  - Impact of extended timeline between death, certification and burial/cremation on mortuary and body holding arrangements;
  - Unavailability of mutual aid;
  - Limitation of human resources across all responder organisations;
  - Potential requirement for significant additional family assistance facilities.

- **Staff Management**

At this level it is likely that staff will also be significantly affected either by sickness themselves or affected by additional caring requirements for family members and dependents. A guide to some key issues in managing staff during such a period can be found in **Appendix 13**.

5.3.5 Communication

The MES Information Cell and Public Information Cell will provide regular communication on all key issues previously identified. At this level a daily situation update report for all key internal and external audiences will be required.

6. RECOVERY PHASE

Recovery can be defined as the process of restoring, rebuilding and rehabilitating individuals, the organisation and the wider community. Based on risk assessment the PICT will advise the LRP when levels of activity are reducing to a level that will allow a gradual return to a normalisation of services. The LRP will formally agree the transition to recovery phase and the PICT will review its remit and membership to become the Recovery Working Group (RWG). The RWG will need to consider a wide range of issues as determined by the circumstances at the time but these will include those set out below.

6.1 KEY ACTIONS

1. Surveillance, Testing, Diagnosis and Treatment	Public Health (HPT and HPU) will be responsible for maintaining surveillance.
2. Prevention and Protection	ICT will maintain appropriate enhanced infection control procedures. HPT will ensure completion of vaccination programme.
3. Service Planning and Continuity	OHS will be responsible for ensuring the care and well-being of staff affected by the pandemic. Workforce Directorate will be responsible for identifying and responding to longer term workforce planning issues. Heads of Service will be responsible for addressing service backlog issues including estates and facilities management. Finance Directorate will be responsible for identifying and resolving issues of exceptional spend.
4. Communication	Communications Department will be responsible

	for co-ordinating the communication of recovery and debriefing activities both internal and external. Communications will also assist in co-ordinating the production of a formal 'lessons learnt' report informed by the debriefing.

Further guidance on the key actions at Recovery Phase under these four headings is set out below.

6.2 SURVEILLANCE, TESTING, DIAGNOSIS AND REPORTING

A heightened level of vigilance will need to be maintained to allow for early warning of a second wave of a pandemic in the coming months. Guidance will be issued at national level and this will be appropriately disseminated and implemented locally.

6.3 PREVENTION AND PROTECTION

Maintaining increased vigilance will entail maintenance and early implementation of enhanced infection control precautions in healthcare settings in the event of admissions with influenza like illness. The ICT will be responsible for advising on this aspect of the recovery phase.

The HPT will be responsible for ensuring any vaccination programme is completed and ensuring that uptake of seasonal flu vaccination in the following season is maximised.

6.4 SERVICE PLANNING AND CONTINUITY

In the recovery phase it will be important to ensure that staff are able to return to normal patterns of working and are encouraged, as service demands allow, to take time off for rest and relaxation. In relation to workforce planning it will be important to assess the impact of the pandemic across the organisation. Staff may be suffering from stress and fatigue. Some will have suffered bereavement. Particularly in a high impact scenario there will also be cases of severe illness, long term sickness absence and even deaths amongst the workforce. The OHS and Workforce Directorate will have an important role to play in caring for staff affected and planning for recovery.

The RWG will need to address a wide range of service issues. These will include establishing a sustainable plan to recover levels of service across the organisation and address any backlog or waiting lists in key services. There will also be a need to plan to address any backlog in maintenance of equipment and facilities, recover levels of stocks and supplies and address any budget and financial issues arising from exceptional spend required in particular areas.

6.5 COMMUNICATION

The RWG will need to address a range of communication issues in the recovery phase. It will be important that recovery actions are widely communicated to staff, partner agencies and the public in order to instil confidence and a sense of return to normality across the community. There will need to be plans put in place for debriefing activities. These will need to include all staff involved but also any volunteers and other service providers. The wider public community should also be provided with an opportunity to share experiences and feedback. Depending on the circumstances of a pandemic it may be appropriate to consider memorial activities to acknowledge losses within the community or organisation.

Debriefing activities will need to be sensitive to the circumstances of the pandemic. It may be an opportunity to celebrate successes in any response as well as to acknowledge difficulties. An important aspect of the recovery phase will be to capture all the lessons learnt in a more formal report that can be shared both locally and at national level. This will allow for plans and strategies to be revised and updated.

7. PLAN MONITORING AND IMPLEMENTATION

7.1 DOCUMENT AMENDMENT HISTORY

Reviews

Date Plan Reviewed	Aug 2015	**Next Review Date**	May 2016	**Author**	Lucy Denvir Dr Dave Breen
Summary of review: The Plan has been extensively revised following wide stakeholder involvement and consultation and taking into account the new UK Influenza Pandemic Preparedness Strategy 2011 and lessons learnt from H1N1 pandemic 2009.					
Review Group and Approval : This Plan was reviewed by the PICC in consultation with the key stakeholders and approved by the LRP.					

Amendments

Plan / Section	Date	By Whom	Summary of Amendment
Whole Plan	27 August 2015	Nigel Calvert, David Irving	Updating national and local planning and response structures; updating hyperlinks.

7.2 DISTRIBUTION

This Plan is disseminated through NHS Dumfries and Galloway Intranet as part of the Infection Control Manual and the Major Emergency Scheme. This will be the only place for access to the most current and updated version.

7.3 ASSOCIATED DOCUMENTS

UK Departments of Health Influenza Pandemic Preparedness Strategy 2011.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131040.pdf

Department of Health/Health Protection Agency: Pandemic Influenza - guidance for infection control in hospitals and primary care settings
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080771

Watt Group Outbreak Risk Matrix
http://www.scotland.gov.uk/Resource/Doc/46997/0013951.pdf

Hospital Infection Incident Assessment Tool
http://www.documents.hps.scot.nhs.uk/hai/infection-control/toolkits/hiiat-2011-10.pdf

British Thoracic Society / British Infection Society / Health Protection Agency: Clinical guidelines for patients with an influenza-like illness during an influenza pandemic
https://www.brit-thoracic.org.uk/document-library/clinical-information/flu/pandemic-flu-guideline/pandemic-flu-guideline/

Department of Health Scientific Summary of Pandemic Influenza and its Mitigation
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125333.pdf).

Further information can be found at:
http://www.scotland.gov.uk/Publications/2008/10/28141252/0

http://www.hps.scot.nhs.uk/Search/default.aspx?search=pandemic%20flu

Further information on the D&G Major Emergency Scheme can be found at:
http://www.dumgal.gov.uk/index.aspx?articleid=8977

7.4 EDUCATION AND TRAINING

Record of Previous Training

Date	Event Description	No. Involved
December 2005	Exercise Fever Pitch	100+
December 2007	Exercise Arctic Monkey	60+
April 2008	Smallpox Mass Vaccination Exercise	40+
March 2009	Exercise Quintana Roo	100+
September 2009	H1N1 Preparedness Tabletop Exercise	10+
June 2011	Exercise LEMA Mass Fatality Tabletop Exercise	30+

Future Training

Following approval this revised plan will be published on the intranet and there will be stakeholder briefings to relevant agencies, departments and staff groups as appropriate and required.

Future Exercises

The LRP exercise and training sub-group will ensure that exercises involving pandemic flu, and other scenarios related to communicable disease outbreaks and mass vaccination, continue to be part of the rolling emergency exercise programme.

APPENDIX 1: PICT MODEL AGENDA

1	Notes of Previous Meeting
2	Epidemiology of Pandemic (Update) and review of Risk Assessment
3	Issues Raised from LRP
4	Management of Influenza Cases (a) investigation (b) diagnosis (c) treatment (d) referral (e) ITU/HDU requirements (f) artificial ventilation facilities
5	Other Clinical Management Issues
6	Bed Management issues
7	Infection Control
8	Laboratory issues
9	Anti-viral distribution and administration
10	Vaccination distribution and administration
11	Staffing Issues: • review and impact • contingency staffing arrangements • staff redeployment
12	Support Services Issues
13	Prioritisation of Services
14	Communications
15	Report to LRP
16	AOCB
17	Date and Time of Next Meeting

APPENDIX 2: PROJECTED FIGURES FOR LOW, MODERATE AND HIGH IMPACT SCENARIOS IN DUMFRIES AND GALLOWAY

Impact of Pandemic Flu on NHS Dumfries & Galloway general population.

Applying double the incidence of 1918 pandemic, and higher hospitalisation and mortality rates.

Region:	Dumfries & Galloway
CHP Population CHI Dec 2011:	155,370
Total GPs (@ Oct 2011):	123

Level	Clinical Attack Rate:	Flu cases seeking consultation w. GP:	GP Staff Absence:	Hospitalisation Rate:	Mortality Rate:
Low	10%	5%	10%	0.5%	0.50%
Medium	25%	15%	25%	1.5%	1.25%
High	50%	30%	50%	3.0%	2.50%

HIGH	Weekly % of cases in pandemic wave	New Clinical Cases	Consultations	Consultations per GP	Excess hospitalisations	Excess deaths
Week 1	0.1%	78	23	0	2	2
Week 2	0.2%	155	47	1	5	4
Week 3	0.8%	620	186	3	19	15
Week 4	3.1%	2,402	721	12	72	60
Week 5	10.6%	8,214	2,464	40	246	205
Week 6	21.5%	16,740	5,022	82	502	418
Week 7	21.1%	16,430	4,929	80	493	411
Week 8	14.3%	11,082	3,325	54	332	277
Week 9	9.7%	7,518	2,255	37	226	188
Week 10	7.5%	5,812	1,744	28	174	145
Week 11	5.2%	4,030	1,209	20	121	101
Week 12	2.6%	2,015	605	10	60	50
Week 13	1.6%	1,241	372	6	37	31
Week 14	0.9%	697	209	3	21	17
Week 15	0.7%	542	163	3	16	14
Total	100%	77,575	23,273	378	2,327	1,939

MED	Weekly % of cases in pandemic wave	New Clinical Cases	Consultations	Consultations per GP	Excess hospitalisations	Excess deaths
Week 1	0.1%	39	6	0	1	0
Week 2	0.2%	78	12	0	1	1
Week 3	0.8%	310	46	1	5	4
Week 4	3.1%	1,201	180	2	18	15
Week 5	10.6%	4,107	616	7	62	51
Week 6	21.5%	8,370	1,255	14	126	105
Week 7	21.1%	8,215	1,232	13	123	103
Week 8	14.3%	5,541	831	9	83	69
Week 9	9.7%	3,759	564	6	56	47
Week 10	7.5%	2,906	436	5	44	36
Week 11	5.2%	2,015	302	3	30	25
Week 12	2.6%	1,008	151	2	15	13
Week 13	1.6%	620	93	1	9	8
Week 14	0.9%	348	52	1	5	4
Week 15	0.7%	271	41	0	4	3
Total	100%	38,788	5,818	63	582	485

LOW	**Weekly % of cases in pandemic wave**	**New Clinical Cases**	**Consultations**	**Consultations per GP**	**Excess hospitalisations**	**Excess deaths**
Week 1	0.1%	16	1	0	0	0
Week 2	0.2%	31	2	0	0	0
Week 3	0.8%	124	6	0	1	1
Week 4	3.1%	480	24	0	2	2
Week 5	10.6%	1,643	82	1	8	8
Week 6	21.5%	3,348	167	2	17	17
Week 7	21.1%	3,286	164	1	16	16
Week 8	14.3%	2,216	111	1	11	11
Week 9	9.7%	1,504	75	1	8	8
Week 10	7.5%	1,162	58	1	6	6
Week 11	5.2%	806	40	0	4	4
Week 12	2.6%	403	20	0	2	2
Week 13	1.6%	248	12	0	1	1
Week 14	0.9%	139	7	0	1	1
Week 15	0.7%	108	5	0	1	1
Total	100%	15,515	776	7	78	78

APPENDIX 3: WHO PANDEMIC ALERT SYSTEM

Phase 1: "No viruses circulating among animals have been reported to cause infections in humans."

Phase 2: "An animal influenza virus circulating among domesticated or wild animals is known to have caused infection in humans, and is therefore considered a potential pandemic threat."

Phase 3: An animal or human-animal influenza reassortant virus (a combination of at least two other viruses) has caused sporadic cases or small clusters of disease in people, but there haven't been "community-level" outbreaks. This "limited transmission" means that the virus is not currently spreading easily enough among humans to cause a pandemic.

Phase 4: A reassortant virus is causing community-level outbreaks, meaning there are sustained disease outbreaks in a community. This marks a "significant upwards shift in the risk for a pandemic." However, a pandemic isn't necessarily a forgone conclusion.

Phase 5: There is human-to-human spread of the virus into at least two countries in one WHO region. Most countries aren't affected at this stage, but declaration of Phase 5 is a "strong signal that a pandemic is imminent." There is little time remaining to finish the organization, communication and implementation of the planned mitigation measures.

Phase 6: In addition to the countries affected in Phase 5, there are community-level outbreaks in at least one other country in a different WHO region. A global pandemic is occurring.

APPENDIX 4: MINIMUM CORE DATASET

Please note this dataset is likely to be modified according to the specific nature of the pandemic.

Notification of Suspected Pandemic Influenza Case – FORM 1

Patient CHI: ☐ **Patient D.O.B:** ☐

Details of staff member completing form:

Staff Group:
- GP ☐
- Pharmacy ☐
- Comm. Nursing/H.V. ☐
- A&E/OOH ☐
- Hospital ☐
- Social Services ☐
- Other: ______

Centre of work:
(Which practice/pharmacy/hospital etc?)

Patient Details:

Date: ______ Time: ______

Name: ______

Address: ______

______

Full Postcode: ______ Phone: ______

GP: ______

------------------------- **Please follow algorithm** -------------------------

Symptoms: **Fever** ☐ If >38°C <2 days → Antiviral given? YES☐ NO☐

+ 2 of:

Cough	☐	Anorexia (off food)	☐
Malaise (unwell/exhausted)	☐	Coryza (head cold symptoms)	☐
Chills (cold, shivery)	☐	Myalgia (muscle aches/pains)	☐
Headache	☐	Sore throat	☐

= Influenza-Like Illness (ILI) **YES** ☐ **NO** ☐ → stop algorithm
(go to Outcome field, over)

↓

CURB-65 ASSESSMENT (1 point for each of following:)	Yes	No	N/Available
Confusion (new disorientation in person, place, time)	☐	☐	☐
Urea (not immediately available)	☐	☐	☐
Increased Respiratory Rate > 30/min	☐	☐	☐
Low Blood Pressure (SBP < 90 or DBP ≤ 60mm Hg)	☐	☐	☐
Age ≥ 65 years	☐	☐	☐
CURB-65 Score =			(see over)

'At Risk' Group Assessment for Patient and their close contacts:

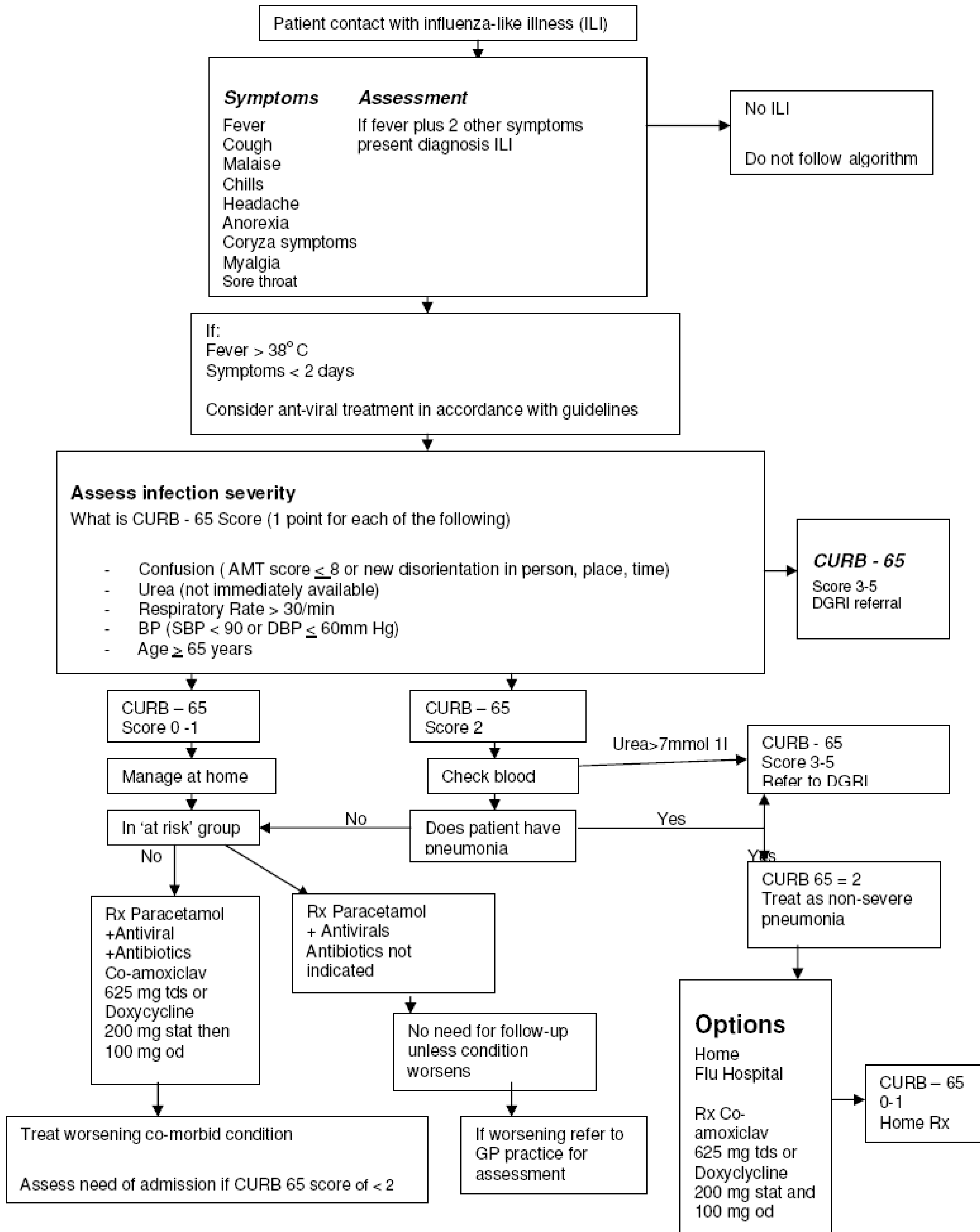
	Patient	Close Contact		Patient	Close Contact
Immuno-suppressed	☐	☐	Diabetes	☐	☐
Chronic respiratory condition	☐	☐	Pregnant	☐	☐
Chr. cardiovascular condition	☐	☐	Carer	☐	☐
Chr. renal condition	☐	☐	Aged ≥ 65	☐	☐
Chr. liver condition	☐	☐	Long stay patient	☐	☐
Chr. neurological condition	☐	☐	Health/Social Care worker	☐	☐

CURB-65 SCORE = 0-1	Not indicated	Yes	No
Home treatment		☐	☐
'At Risk' Group? (See above)		☐	☐
Paracetamol given	☐	☐	☐
Antiviral given	☐	☐	☐
Antibiotic given	☐	☐	☐
CURB-65 SCORE = 2	Not indicated	Yes	No
Check blood: Urea > 7mmol/l? **[If Yes, refer to hospital]**		☐	☐
Pneumonia		☐	☐
'At Risk' Group? (See above)		☐	☐
Paracetamol given	☐	☐	☐
Antiviral given	☐	☐	☐
Antibiotic given	☐	☐	☐
CURB-65 SCORE ≥ 3	Not indicated	Yes	No
Referred for DGRI/Galloway admission		☐	☐
Referred to other hospital: (which?)		☐	☐
Paracetamol given	☐	☐	☐
Antiviral given	☐	☐	☐
Antibiotic given	☐	☐	☐
Artificial ventilation indicated?		☐	☐

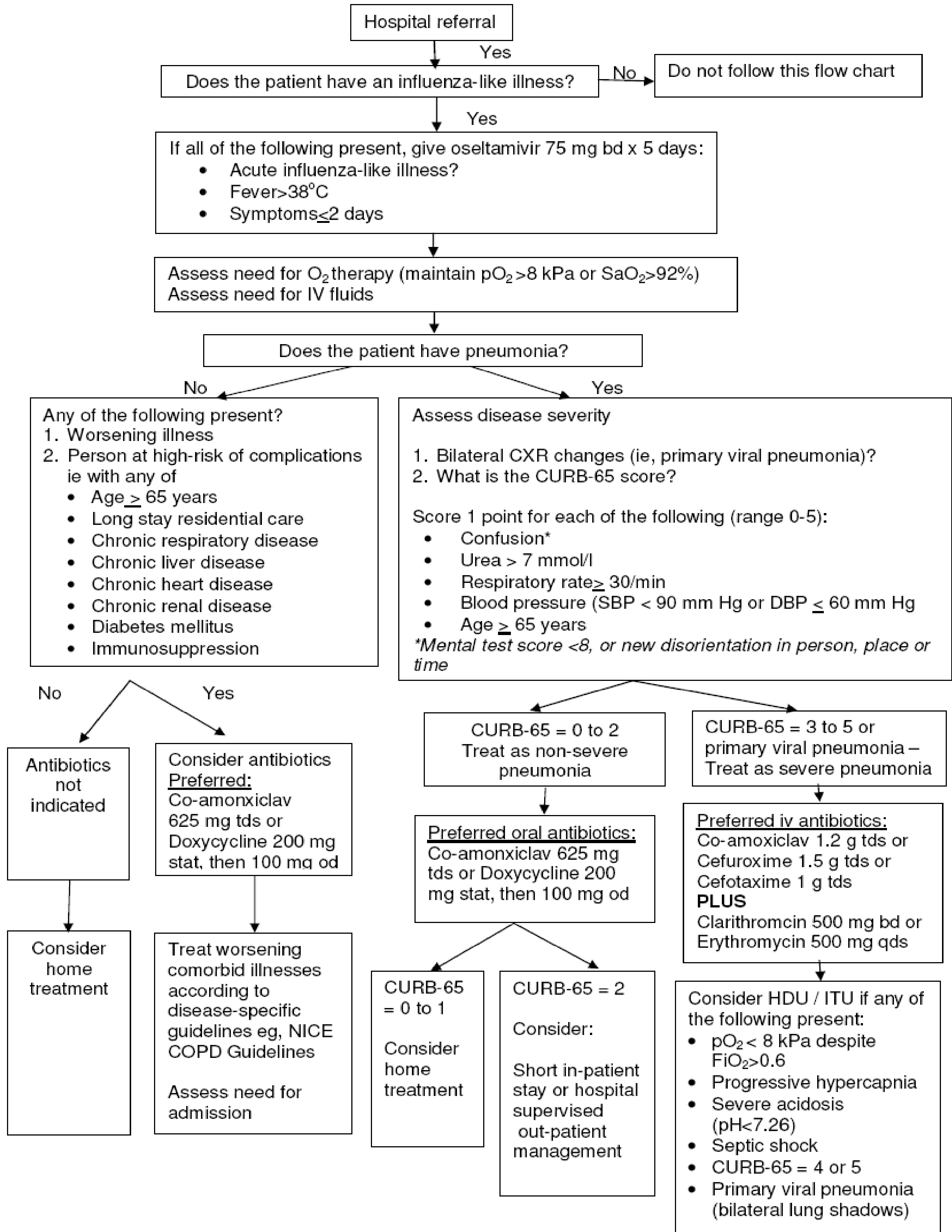
OUTCOME (Refer to algorithm)	Yes	No
Gave self-care advice, manage at home	☐	☐
Advised to contact Primary Care if they worsen	☐	☐
Any close contacts 'At Risk' offered antivirals	☐	☐
Referred elsewhere (where): ______________________	☐	☐
Admitted to hospital (which): ______________________	☐	☐
Patient died	☐	☐

Staff Completing Form:		**Date:**	

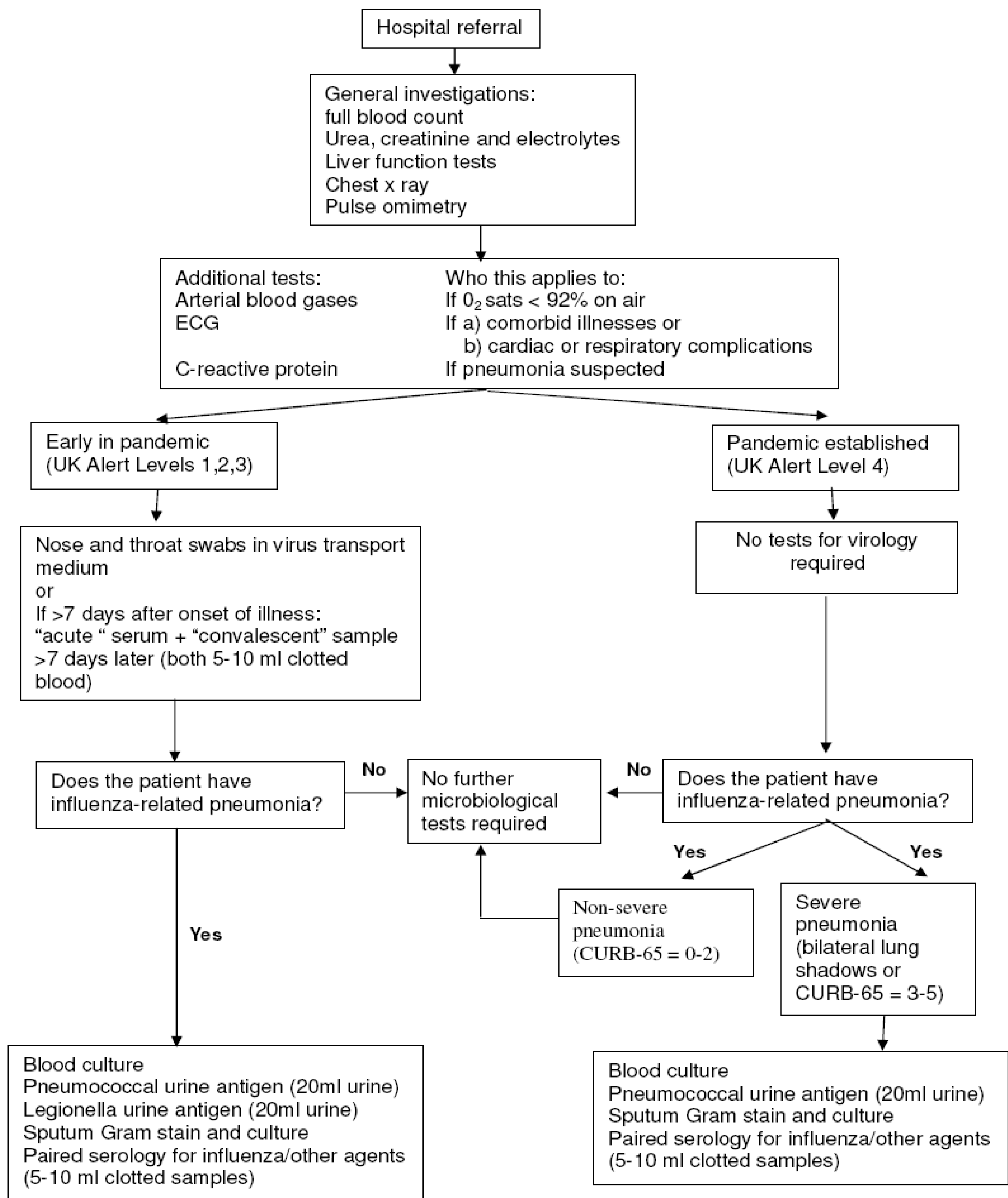
APPENDIX 5: ALGORITHM FOR MANAGEMENT OF ADULTS WITH ILI IN PRIMARY CARE



APPENDIX 6: INITIAL MANAGEMENT OF PATIENTS REFERRED TO HOSPITAL



APPENDIX 7: INITIAL INVESTIGATIONS FOR ADULTS REFERRED TO HOSPITAL



Appendix 8 – Initial Assessment and Management of Children

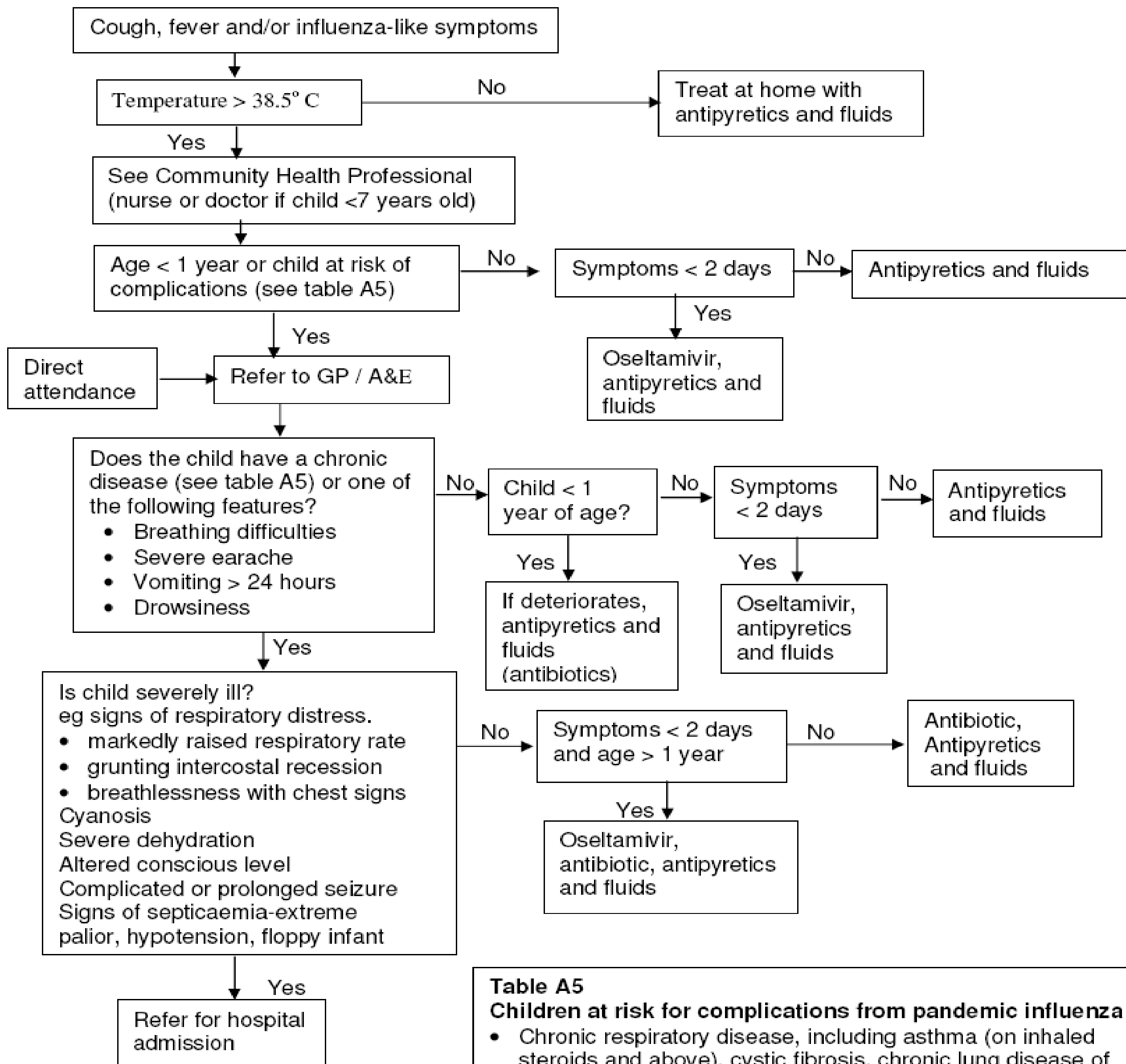
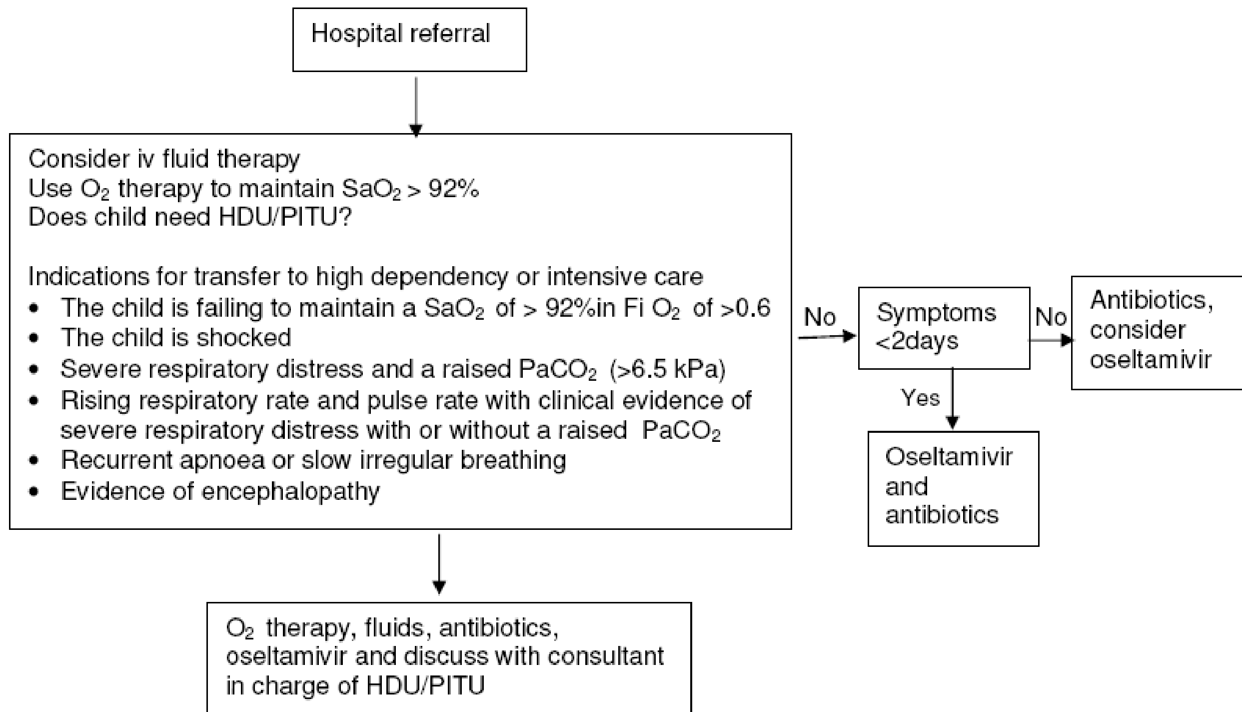


Table A5
Children at risk for complications from pandemic influenza

- Chronic respiratory disease, including asthma (on inhaled steroids and above), cystic fibrosis, chronic lung disease of prematurity, bronchiectasis
- Congenital heart disease
- Chronic renal disease eg nephrotic syndrome, renal failure
- Chronic liver or gastrointestinal disease including inflammatory bowel disease
- Immunodeficiency
- Malignancy
- Diabetes and other metabolic conditions
- Haemoglobinopathy
- Neurological disease eg diseases with muscle weakness and cerebral palsy

Appendix 9 – Management of Children Referred to Hospital



Antibiotic doses in children:

Co-amoxiclav

<1 year 0.266 ml/kg of 125/31 suspension tds
1-6 years 5ml of 125/31 suspension tds
>6 years 5ml of 250/62 suspension tds

If allergic:

Clarithromycin

<8.5kg	7.5mg/kg bd
1-2 years	62.5 mg bd
3-6 years	125 mg bd
7-9 years	187.5 mg bd
> 10 years	250 mg bd

Oseltamivir doses in children over 1 year:

30 mg every 12 hours
(body weight < 15kg, <3years);

45 mg every 12 hours
(body weight > 16-23kg, <7 years);

75 mg every 12 hours
(body weight >24 kg, over 7 years)

APPENDIX 10: PRIORITY GROUPS FOR VACCINATION

PRIORITY 1	**Healthcare staff with patient contact (including ambulance staff) and staff in residential care homes for the elderly.**
Advantage	Disruption of vital health care delivery is minimised.
Administered By	***NHS Occupational Health Service.***
PRIORITY 2	**Those with high medical risk e.g. chronic respiratory or heart disease, renal failure, diabetes mellitus or immunosuppression due to disease or treatment, women in the last trimester of pregnancy.**
Advantage	Consistent with normal influenza immunisation policy. Demand for health care will be minimised.
Administered By	***Primary Care Team, NHS Dumfries & Galloway***
PRIORITY 3	**Providers of essential services e.g. fire & rescue, police, emergency management, communications, utilities, undertakers, armed forces.**
Advantage	The potential effect of absenteeism on vital community functions would be minimised.
Administered By	***D&G Council and agencies OHS Contractor***
PRIORITY 4	**All aged 65 years and over.**
Advantage	Consistent with normal influenza immunisation policy. Demand for health care will be minimised.
Administered By	***Primary Care Team, NHS Dumfries & Galloway***
PRIORITY 5	**Selected industries.**
Advantage	Maintenance of essential supplies of e.g. pharmaceuticals.
Administered By	***Company Occupational Health Service and/or with Primary Care Contract.***
PRIORITY 6	**Selected age groups, depending on advice from WHO e.g. children.**
Advantage	Minimise spread by those most likely to transmit virus and the impact in population groups showing highest impact.
Administered By	***Primary Care Team, NHS Dumfries & Galloway***
PRIORITY 7	**Offer to all**
Advantage	Prevent illness and minimise the impact of pandemic in the UK.
Administered By	***Primary Care Team, NHS Dumfries & Galloway***

APPENDIX 11: PRIORITY NHS SERVICES

Accident and Emergency
Acute/emergency medical admissions (including paediatrics)
Acute/emergency surgical admissions (including paediatrics) (including trauma)
Emergency Mental Health admissions

Anaesthesia
Cover for Emergencies, Intensive care, Ventilation.
Bacteriology
As much supporting service as possible, particularly for Health Protection and Infection Control Team.
Biochemistry
Sufficient for emergency admissions and related services.
Haematology
Sufficient for emergency admissions, cross-matching and similar services.
Prioritised for emergency service support.
Catering Services
Service for institutional care.
Computer support
Support for emergency services IT needs**.**
CSSD
Sufficient for emergency/admissions.
Discharge (and bed management) Team
Domestic and Linen/Disposables Service
Essential cover for clinical areas used for emergency and related care.
ECG
Support for emergency admissions.
Emergency Ambulance Services
General Practice
Front line consultation and immediate support services (including Community Nurses).
ITU/HDU
Maintenance Services
Prioritised for services supporting emergency activity
Management services
Priority for services supporting, Essential healthcare delivery, Hospital control, LHPs and community care, LRP, PICT, Internal and external communications
Medical Physics
Medical Records
Support for emergency services.
NHS24/OOH
Front line consultation and immediate support services (including Community Nurses).
Obstetrics/Maternity
Continued service for ante-natal care as far as possible within resources and essential care for deliveries, post-partum care and SCBU.
Occupational Health
Prioritised for vaccine/anti-viral programme and related work.

Operating Theatre
Capability for emergency surgery.
Pathology, Mortuary and PM Services
Includes pathology services for emergency support.
Pharmacy – for emergency patients.
Phlebotomy
Support for emergency admissions.
Portering and Waste Management
Support for emergency services.
Renal Unit
Supplies/procurement
Support to keep emergency services going.
Telephone Switchboard
Cover for essential services and systems
Transport
Logistics support for emergency care (supplies, linen, waste etc)
X-Ray
Support for emergency service (bearing in mind high CXR rate)

APPENDIX 12: COMMUNICATIONS PLAN

INTRODUCTION

This section of the plan is prepared to help guide the media response to a major outbreak of pandemic influenza in Dumfries & Galloway. The foremost principle to be observed is the need for openness, but this needs to be tempered with the possible legal and other consequences that might ensue as a result of the implementation of this aspect of the Pandemic Influenza Plan.

This section of the plan is complementary to the media and public information arrangements of the Dumfries and Galloway Major Emergency Scheme.

AIM

To convey accurate, timely and consistent advice to the public and staff of responder agencies, thereby aiding the understanding of the pandemic amongst the general population.

OBJECTIVES

- To explain the ability of NHS Dumfries and Galloway to reduce the impact of a pandemic as far as possible and to explain some of the constraints.
- Ensure consistency, accuracy and timeliness of messages to be disseminated across the responding agencies and public domain (the right information to the right people in the right format at the right time).
- Evaluate available methods of information delivery and select the options most appropriate for prevailing needs.

PROCESS AND PROCEDURES

1. NHS Dumfries and Galloway will play a key role in providing information to responder agencies and the general public during the early stages of a pandemic.

2. NHS Dumfries and Galloway will monitor the development of the pandemic through consultation with the Scottish Government Health Department (SGHD), appraising other responder agencies as appropriate.

3. NHS Dumfries and Galloway will ensure that communication channels and mechanisms are in place, tested to function and agreed with the Strategic Co-coordinating Group membership.

4. Co-ordination of local messages will be through the Strategic Co-coordinating Group local arrangements (Major Emergency Scheme), working closely with NHS Dumfries and Galloway.

5. The Strategic Co-coordinating Group, at a time suitable to the needs of the response, will implement the full media and public information arrangements of the Major Emergency Scheme. These arrangements will necessitate the constitution of a multi-agency media cell.

6. Issue of press statements and responses to media/public enquiries should only be carried out by the media cell. The media cell will consult with the PICT and IIMG on the content of the statements/responses and where appropriate, submit them for approval by the LRP prior to release.

7. Where a spokesperson is required, the LRP will be consulted and nominate an appropriate person.

8. All relevant partner agencies will provide continuity of resources within the media cell.

9. The media cell will ensure that local public information is accurate and consistent with the public information provided by SGHD.

10. The media cell will develop and get approval for responses to frequently asked questions relating to the "conduct of the outbreak management" or "clinical aspects of the outbreak". Where no pre-prepared response exists, the media cell will refer the matter to the LRP for nomination of the appropriate person to address the enquiry.

11. Press conferences will be arranged as and when they are deemed necessary. Arrangement will be through the media cell in consultation with the LRP and taking due cognisance of relevant publication deadlines.

APPENDIX 13: STAFF MANAGEMENT

Full reference should be made to the document 'Pandemic Flu, Scottish Guidance on Human Resources' http://www.scotland.gov.uk/Publications/2009/08/11132555/0. The guidance covers in more detail the workforce and human resource issues that may arise in a pandemic. It is designed to give an overall framework for NHS services to build on/work within and should be read alongside the overall planning documents. It covers NHS services and their links to community care. This guidance is relevant to staff and managers within NHS services. Many of the principles will also apply within other public sector organisations eg Police, D+G Council. However, staff and managers should consult specific policy within their own organisation.

- **Infected staff**

Staff who display symptoms should be sent home and advised not to work until fully recovered. Infected staff would be paid under normal sick pay arrangements.
It is an employee's responsibility to make personal contact with their line manager to provide notification of absence. Only in exceptional circumstances may a relative or friend phone on an employee's behalf. Where the manager is not available it is essential that contact is made with an alternative senior staff member. When notifying of absence the following details should be communicated:

- The reason for absence.
- 'Sick' or 'unwell' is not an adequate description.
- An indication of expected date of return.
- Details of any GP appointments.

If an employee becomes unwell during the working day they must speak to the appropriate manager before leaving work. In the case of emergency the employee must make contact with their manager at the earliest opportunity.

Returning staff
Although it is essential to record the reason for absence and ensure these returns are submitted, it may not be practical for a manager during periods of staffing shortages to hold a 'Back to Work' interview for each absence, however this should be done wherever practical

Recording of absences
It is essential that all managers maintain an accurate record of their staff absences and the reason for absence. All managers will have access to HR.net and should ensure that they record the individual employees' first date of absence and the reason for absence. Once they have returned they should immediately enter the return date. This will provide NHS Dumfries & Galloway with accurate real time absence information.

Staff should notify their employer using agreed local procedures. It will be vital to track absence trends. Statutory sickness certification arrangements are being kept under review.

- **Rest breaks and maximum working hours**

The Working Time Directive
The Health Board does not have a specific Rest and Relaxation policy but does expect all employees to adhere to the legislation as directed by the Working Times Regulations as amended in 2003. These are summarised as follows:

- All shift workers will be expected to take 11 hours rest a day in each 24-hour period.
- A right to an in-work rest break of 20 minutes for each period of work that exceeds 6 hours. (i.e. 1-20 minute break in an 8 hour shift).
- They have a right to a day off in each week.
- A limit to an average of 8 hours work in 24 which nightworkers can be required to work.
- An employee should work on average not more than 48 hours per week unless they have voluntarily 'opted out'. (This is calculated by multiplying the total number of hours worked over a 17-week period and dividing the total by 17.)

The right of the employee to minimum rest periods contained in the Working Time Regulations can be modified for shift workers and in certain special cases including where round-the-clock staffing is essential as in hospitals.

Exemptions from the Working Time Directive
The WTD will remain in force but their application during a pandemic will need to be reviewed. Legal advice to the Department of Health indicates that the night work limits (including the limit for special hazards), rights to rest periods and rest breaks under the WTD do not apply where the worker's activities are affected by –
(i) an occurrence due to unusual and unforeseeable circumstances, beyond the control of the worker's employer;
(ii) exceptional events, the consequences of which could not have been avoided despite the exercise of all due care by the employer.
It is the view of the Scottish Government Health Directorates and the Management Steering Group that a pandemic is covered by these exemptions.

- **Working excess hours and time-off in lieu**

Payments
All staff in AfC bands 1-7 will be eligible for overtime payments at the single rate of time and a half with the exception of double time which will be paid on Public Holidays only.
The overtime payments will be based on the hourly rate provided by basic pay plus any long term rest and recreation payment. Part time employees will receive payments for the additional hours at plain time rates until their hours exceed standard hours of 37.5 hours a week.

Right to refuse time off in lieu

Staff may request to take time off in lieu as an alternative to overtime but this must be agreed with the manager if it causes staffing problems. Staff who are unable, for operational reasons, to take time off in lieu within 3 months must be paid at the overtime rate. The appropriate line manager must sign all time sheets and claims before they are submitted for payment.

- **Staff movement and temporary posts**

Individuals may be required to take on a temporary alternative post. Individuals may be moved into higher pay band where it is necessary to fill a post on a temporary basis when a post is unfilled or vacated by other staff movements and has not been advertised.

Payments for these posts should be set at either the minimum of the new pay band, or if this would result in no pay increase, the first pay point in the band which would deliver an increase in pay. In the case of those staff whose regular pay might otherwise be lower in the new temporary post, protection on their original base salary will be applied and this rate will be used for overtime payments.

Changes to place of work or shifts

All staff within NHS Dumfries and Galloway are employed to work within the geographic region of NHS Dumfries and Galloway and may be moved, within reason, anywhere within the area to undertake work. This is also applied to hours of work and shift patterns.

Whilst employees are contractually obligated to work throughout the region, the manager must take into account the ‘reasonableness’ of the request which will take into account factors including, the employee’s personal circumstances such as domestic arrangements, including childcare responsibilities, housing, schooling, medical grounds. Where a genuine reason for refusal involves the above, the manager should make every effort to retain the employee in their original circumstances.

Subsistence allowances

If an employee is required to work in another place of work, they will not receive any travel costs if the place of work requires less travel distance than their regular work base. Should the distance be further, then travel costs between the home and temporary place of work will be reimbursed on an actual cost basis.

- **Use and accreditation of volunteers**

There may be circumstances where the organisation is required to temporarily engage the services of volunteers. Where this happens, they will be required to wear security badges at all times. If they are to be expected to come into regular contact with patients they must receive Disclosure Scotland clearance. If there is an interim period between an urgent need for the volunteer to start work and receiving

clearance they must undergo a risk assessment and they must not be left unattended with a patient and must always be accompanied by an employee who has undergone Disclosure Scotland Clearance.

- **School closures**

There may be circumstances where schools are closed for long periods of time. Managers should be sympathetic to this and consider using a combination of special leave and annual leave. When paid leave is exhausted, employees should be placed on unpaid leave if they are unable to attend their place of work. Other requests for leave should be considered on their merits e.g. for disabled or older relatives and bereavement.

There may be some scope for support via local networks of childcare coordinators or cooperation between parents. Schools are, however, likely to be closed for several weeks and managers will therefore need to consider how best to respond. It should be made clear that any abuse of these provisions would be regarded as a serious disciplinary offence.

It is recommended that managers should treat requests for paid leave for staff with children aged under 14 favourably under PIN policy guidance, in the event of pandemic related school closures. This should be provided where other arrangements are not practicable. Further extension should be a matter for local discussion.