



Pandemic Flu (H1N1) and Winter Resilience Plan 2009/10

Barking, Havering and Redbridge University Hospitals NHS Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

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Glossary

Activity	Process or set of processes undertaken by an organisation (or on its behalf) that produces or supports one or more products or services NOTE Examples of such processes include accounts, call centre, IT, manufacture, distribution.
Business Continuity	Strategic and tactical capability of the organisation to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable pre-defined level
Business Continuity Plan (BCP)	Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level
Disruption	Event, whether anticipated (e.g. a labour strike or hurricane) or unanticipated (e.g. a blackout or earthquake), which causes an unplanned, negative deviation from the expected delivery of products or services according to the organisation's objectives
Emergency Planning	Development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a civil emergency
HDU	High Dependency Unit
Impact	Evaluated consequence of a particular outcome
ITU	Intensive Therapy Unit
Likelihood	Chance of something happening, whether defined, measured or estimated objectively or subjectively, or in terms of general descriptors (such as rare, unlikely, likely, almost certain), frequencies or mathematical probabilities NOTE 1 Likelihood can be expressed qualitatively or quantitatively. NOTE 2 The word "probability" can be used instead of "likelihood" in some non-English languages that have no direct equivalent. Because "probability" is often interpreted more formally in English as a mathematical term, "likelihood" is used throughout this Standard with the intention that it is given the same broad interpretation as "probability".
NICU	Neonatal Intensive Care Unit
Organisation	Group of people and facilities with an arrangement of responsibilities, authorities and relationships EXAMPLE Company, corporation, firm, enterprise, institution, charity, sole trader or association, or parts or combinations thereof. NOTE 1 The arrangement is generally orderly. NOTE 2 An organisation can be public or private. [BS EN ISO 9000:2005]
Pandemic Flu (H1N1)	H1N1 is an illness caused by a new influenza A virus which has seen sufficient cases world-wide that the World Health Organization declared the situation a pandemic on 11th June 2009.
PICU	Paediatric Intensive Care Unit

Recovery	Process of returning to “business as usual”
Risk	Something that might happen and its effect(s) on the achievement of objectives
Risk Assessment	Overall process of risk identification, analysis and evaluation
Risk Management	Structured development and application of management culture, policy, procedures and practices to the tasks of identifying, analysing, evaluating, and controlling responding to risk
Stakeholders	Those with a vested interest in an organisation’s achievements NOTE This is a wide-ranging term that includes, but is not limited to, internal and “outsourced” employees, customers, suppliers, partners, employees, distributors, investors, insurers, shareholders, owners, government and regulators.
Trigger	An event/status which will instigate some sort of action.
Winter Resilience	The measures undertaken to ensure that “business as usual” is able to continue through the peak demands for non-elective activity which occur predictably during the winter months.

Section A: Pandemic Flu (H1N1) and Winter Resilience Plan 2009/10

1. Introduction

This plan is an operational document and contains guidance to be followed in the event of a potential influenza emergency and associated winter resilience. It is a supplement to the generic Major Incident Plan and Business Continuity Plans, providing additional information and guidance specific to preparing for and managing an influenza pandemic as well as covering the winter resilience preparedness.

The aim of the plan is to respond to the impact of an influenza pandemic whilst maintaining essential services during the winter period within Barking, Havering and Redbridge University Hospitals NHS Trust. This Plan outlines how management, clinical services, non-clinical support services work in collaboration to ensure that the Trust operates at its optimum level at all times.

National guidance for pandemic influenza is still evolving. This plan will be updated as new guidance is made available from the Department of Health (DH) and the Health Protection Agency (HPA). The plan deals primarily with issues that have to be decided and acted upon at a local level.

It is expected that the Pandemic Flu (H1N1) will last 3 to 5 months with subsequent waves weeks or months apart. The planning assumption is that 30% of the population will be affected by the first major pandemic wave and that the severity of the illness will be greater than seasonal influenza with around 0.1 – 0.35% of clinical cases resulting in a fatality. Depending on the nature of the virus, these figures could be considerably worse.

It should also be borne in mind that the Pandemic Flu (H1N1) virus is expected to affect the younger population (with the majority of cases occurring to date in those aged 5 – 15 years old) and as such demand for paediatric capacity is likely to be most affected.

2. Scope of the Plan

This plan provides the framework for planning, preparation and integrated response to both the winter pressures and predicted Pandemic Flu (H1N1) in Barking, Havering and Redbridge University Hospitals NHS Trust. **It does NOT replace existing emergency plans (e.g. Major Incident Plan, Business Continuity Plan etc) or cover seasonal influenza outbreaks.** It is to be used as a supplement to generic emergency plans, providing additional information and guidance specific to preparing for and managing winter pressures and Pandemic Flu (H1N1). The aims are to:

- Respond to surge capacity and provide care for large numbers of people ill from Pandemic Flu (H1N1) and its complications;

- Manage the increased demands for specialist beds;
- Maintain essential services;
- To reduce the spread of an influenza pandemic by implementing control measures;
- Provide a clear escalation process for increased demand and/or staff shortages during this period;
- Reduce morbidity and mortality from influenza illness amongst patients and staff;
- Work with other agencies to reduce the spread of influenza;
- Provide timely, authoritative and up to date information to professionals, the public and the media.

2.1 Time Period

This plan aims to ensure that services are continued and performance standards met during the period 1st October 2009 to 31st March 2010.

Experience of previous years shows that there can be a significant drop in performance against the emergency care standards during October and although the main winter months of concern are December, January and February, mid-December and the weeks post the New Year are the times that present the most challenges to delivering services.

When these pressures are added to the anticipated impact of the predicted Pandemic Flu (H1N1) the Trust is expecting to experience severe pressure on its services. This plan therefore anticipates these difficulties and specific actions are set out to ensure the continuous achievement of performance standards whilst being able to respond to the demands of the predicted Pandemic Flu (H1N1).

Although this plan is in place to ensure the continuation of services and performance standards during the winter period, these dates are not definitive and should winter/Pandemic Flu (H1N1) pressures be felt outside of this period this plan will still apply.

2.2 Aims of the Plan

The basic aim is to ensure that the service continues and that performance standards are met, which specifically mean that:

- Contingency bed capacity is identified at KGH and QH that can be opened in response to winter pressures;
- That there is sufficient bed capacity available, including ITU/HDU/paediatric beds, single rooms;
- That sufficient bed, nursing home and other capacity is available in the community to ensure that patients who do not need acute care are not occupying acute beds, thereby facilitating the acute Trust in meeting performance standards;
- That there are effective, practical plans to ensure that there are sufficient staff with the necessary skills available. This is to anticipate that staff may be

absent from work due to illness, caring for sick family members or unable to travel to work due to adverse weather;

- That the challenges anticipated to be caused by Pandemic Flu (H1N1) are met.

3. About Us

Barking, Havering and Redbridge University Hospitals NHS Trust is one of the largest Acute Trusts in the country and the biggest provider of acute healthcare services in outer North East London, serving a local population of circa 750,000. General healthcare and Cancer services are also provided to South West Essex, with specialist Neurosciences services being provided to the whole of Essex, a population base of some 2.1 million.

Details of the Trust's inpatient capacity are provided at Appendix 1.

4. Background and What We Should Expect

For 2009/10, in addition to the normal predicted winter pressures, the Trust must prepare for Pandemic Flu (H1N1), which, if predictions are correct, will peak during the latter part of October 2009. If historical patterns continue, this will coincide with the Trust's peak of winter activity and as such the Trust has put in place plans to cope with both increased demand on its services and a shortage of staff.

From the experience of winter 2008/09 when the Trust experienced exceptionally high demand in terms of non-elective care and A&E attendances post the New Year period which led to a shortfall in bed capacity and 12 hour trolley waits, it will be imperative that sufficient capacity is available to avoid a recurrence of this problem and to maintain performance against the 4 hour standard.

As part of the Length of Stay (LoS) Programme which the Trust has been undertaking, three wards have been closed (Sky B at Queen's Hospital and Gentian and Erica wards at King George Hospital (KGH)) and further 7 beds have been lost following the completion of building works to enable improved sex segregation of bathroom/toilet facilities in order to achieve mixed sex compliance at KGH. It is also planned to close Harvest A ward at Queen's Hospital at the end of October 2009. This has been possible due to initial work to reduce length of stay but also reflect some change in capacity requirements due to the summer months, including progression of an acute medical assessment model at Queen's Hospital.

Sky B ward is no longer available to the Trust having been handed over to a private contractor, however the contractor is collaborating with the Trust in establishing surge capacity for the organisation and the Trust will be able to use these beds in the event of a major incident/disaster, however building works are due to take place imminently and so it is unlikely that the ward would be available until early 2010. The closure of Gentian, Erica and Harvest A wards (the latter at the end of October 2009) gives a total of 85 acute beds with the potential to use 14 treatment rooms at Queen's Hospital, which can be converted to side rooms if necessary. This gives the organisation 99 beds to use for surge capacity without impacting on surgical activity. These beds will remain "ready for use" at short notice.

Additional actions relating to the length of stay programme are critical to releasing an additional 30 beds. These include implementation of full cross buffer meetings (these have replaced the Whole Systems Group meetings) of Jonah information and an action team on admission prevention in collaboration with community teams. It is critical agreed lengths of stay targets are achieved to ensure maximum throughput of the available beds.

It is also anticipated that there will be additional community capacity provision in line with community bed modelling led by Outer North East London Acute Commissioning Unit.

Discussions regarding both winter resilience and swine flu have been ongoing at both the Health Systems Improvement Board (HSIB) and Whole Systems Group meetings for some months now. These meetings are attended by representatives of the Trust's partner organisations and a selection of the meeting minutes is attached at Appendix 1a along with a copy of the current version of the Community Plan (though it should be noted that the Trust has provided comments on this plan back to the PCTs and as such this is likely to change).

The use of the Independent Sector Treatment Centre (ISTC) is also in discussion and agreed patient pathways will provide up to 4 additional beds to meet winter bed pressures, with further beds being made available should elective activity be suspended at the peak of a pandemic.

As part of the 2009/10 planning round the Trust undertook a detailed piece of work which involved the development of a capacity and demand model which took into account demand on a specialty basis, growth, PCT demand management schemes and the length of stay plans. The plan was based on an increase in non-elective activity from 2008/09 reflecting the out-turn activity adjusted down based on demand management schemes. This enabled the 2009/10 SLA activity levels to be planned to a far more accurate level and profiling was applied based on historical trends. Year to date however has demonstrated an overperformance against this year's plan and additional remedial actions including an admission avoidance program are required.

5. Duties and Responsibilities for this Plan

5.1 Responsible Director(s)

The Trust has appointed a Flu Director (*who holds the substantive role of Head of Infection Control*) and the Director of Planning and Delivery is the Executive Director with responsibility for Flu Planning and Winter Resilience and as such is ultimately responsible for the Pandemic Flu (H1N1) and Winter Resilience plan.

5.2 Review and Maintenance of the Policy

Once formally approved by the Trust Board, the Safety & Emergency Planning Manager, Flu Director (*whilst in post*) and Divisional Manager Medicine, are responsible for reviewing, updating and amending this Plan as appropriate.

5.3 Staff Training

Training will be provided to identified individuals as required and a process of “train the trainer” and action cards will be used to ensure all relevant staff fully understand and adhere to this Plan.

6. Business Continuity Planning

The Trust’s Business Continuity Plan (BCP) was approved by the Trust Board in September 2008 and was subsequently tested during the bad weather and snowfall experienced in February 2009 (attached at Appendix 2). This plan is due to be reviewed as part of overall emergency planning albeit the Trust is working towards the national standard BS25999.

The BCP document provides a general overview of Business Continuity Planning together with actions to be undertaken by individual services. As part of the planning process for the Pandemic Flu (H1N1) and Winter Resilience, individual departments have re-visited their departmental BCPs and these are attached at Appendix 2.

7. What Is Likely to Happen

The Trust has undertaken capacity modelling work to assist in the planning for the coming winter based on the lessons learnt from previous years and the information we have about the current Flu Pandemic. Detailed below are the anticipated bed requirements to enable the Trust to meet the demands of both the winter period and the Pandemic Flu.

Scenario	Site	Oct	Nov	Dec	Jan	Feb	Mar
Best	QH	(115)	(43)	39	46	29	97
	KGH	(21)	22	68	74	67	108
Medium	QH	(229)	(101)	12	26	8	80
	KGH	(125)	(44)	23	33	26	61
Worst	QH	(428)	(230)	(74)	(57)	(86)	(6)
	KGH	(247)	(120)	(30)	(20)	(35)	3

Table 1: Anticipated Bed Requirement to meet Winter and Pandemic Flu Demand

The graph below shows, where based on the predicted impacts of winter and Pandemic Flu and current bed capacity, the Trust’s position on a monthly basis in terms of a surplus/deficit position in terms of bed capacity.

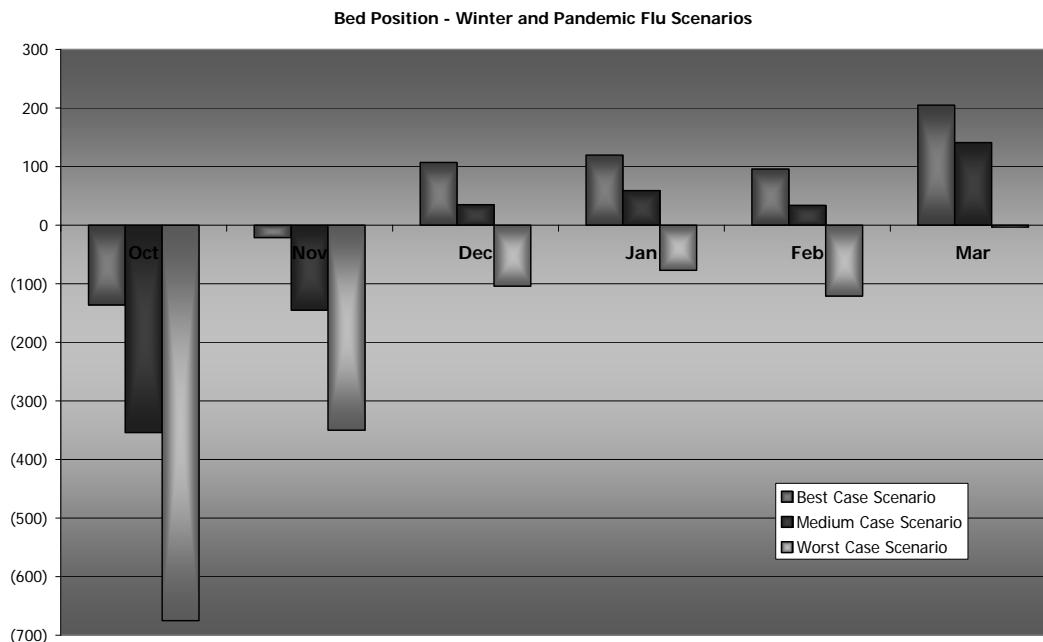


Fig 1: Anticipated bed surplus/deficit on a month basis

The key points to be borne in mind are:

- If current trends continue, at best case scenario we will need to run at in excess of 105% occupancy this winter even without flu. This will only be possible with robust discharge planning and the increased availability of supported discharge
- Information regarding the Pandemic is still emerging, but from the information currently available we can expect:
 - Greatly increased A&E attendances;
 - Previously unseen demands on Critical Care – particularly for children and young adults with the potential need to double the currently available bed capacity;
 - In the worst case scenario the Trust could be looking at 100 admissions per day purely in relation to Pandemic Flu (H1N1) – an additional 44.6% admissions per day on average levels (224 admissions per day);
 - Staffing could be significantly reduced due to staff illness or caring responsibilities;
 - The situation is likely to last for anything between 4 – 8 weeks.

8. Levels of Incident

As part of the Trust's escalation process a "Traffic Light" system has been utilised to define the Trust's status with regards to its available capacity. A summary of the definition for each status level is detailed below.

Level/Status	Definition
Level 1 – Status Green	<ul style="list-style-type: none"> The Trust has sufficient capacity to deal with its emergency and elective workload in all specialties in the forthcoming 24hr period There are no pressures on isolation facilities Under status Green the Trust would be prepared to accept referrals from GP's outside Barking and Dagenham, Redbridge, Havering PCTs or from neighbouring hospitals
Level 2 – Status Amber	<ul style="list-style-type: none"> The Trust has available (or is anticipating) less than 15 beds across site. There are 2, or less, side-rooms available for isolation purposes During status amber the Trust will not accept referrals for non Barking and Dagenham, Redbridge, and Havering GPs or transfers from other Hospitals The Trust may need to restrict non-priority elective admissions to maintain capacity for emergency admissions During status amber admissions will be to any appropriate acute ward
Level 3 – Status Red	<ul style="list-style-type: none"> Status red applies when there are less than 7 beds available (or anticipated) across site – including no isolation facilities Status red is declared by the Bed Manager, in conjunction with the Capacity and Flow manager The Trust has a responsibility to accept emergency cases through the Emergency Department
Level 4 – Status SIE	<ul style="list-style-type: none"> No beds in MAU and no bed availability on both sites DTA in A&E is disrupting A&E flow Status SIE is declared by the Bed Manager in conjunction with the General Manager Capacity and Flow who will liaise with the Director of Planning and Delivery during hours (or the decision will be made by the on-call General Manager and Director out of hours) Extreme pressure forecast expected to continue All external capacity utilised with no potential to open further beds

In addition, for Pandemic Flu (H1N1) purposes the Trust will also operate the "FluCon" alerting system which is as follows:

Level/Status	NHS London and Department of Health Definition
PANDEMIC NOT YET IN LOCALITY / PREPARATION OR RECOVERED	
FluCon 0	<ul style="list-style-type: none"> Current status as 'normal' for season Preparatory work underway Discharging non-Critical Care patients Increased number of 'worried well' Reviewing plans for business continuity Returning to normal operation

Level/Status		NHS London and Department of Health Definition
LOW SURGE: SLIGHT EFFECT ON SERVICES		
FluCon 1	<ul style="list-style-type: none"> • Implementation of business continuity plans • Reduction in non-critical services • Enhanced coordination between health and social care services • Antiviral assessment and collection points working as planned 	
MEDIUM SURGE: MODERATE EFFECT ON SERVICES		
FluCon2	<ul style="list-style-type: none"> • Triage of patients attending service • Implementation of admission and discharge criteria • Escalation of service reductions and closures (including reduced treatment regimes) • Planned closures 	
HIGH SURGE: MAJOR DISRUPTION TO SERVICES		
FluCon 3	<ul style="list-style-type: none"> • Critical – some services not being delivered • Demand outstripping supply for critical services 	

The FluCon will be communicated to the Trust in different ways depending on the level of response:

Level/Status	
FluCon 0	<ul style="list-style-type: none"> • Through the daily 10.15am Bed Meeting • Through the Weekly Swine Flu and Winter Resilience Committee Group (Weekly on Wednesdays) • Through the weekly Vital Signs Newsletter (Thursday)
FluCon 1	<ul style="list-style-type: none"> • Through the daily 10.15am Bed Meeting • Through the Weekly Swine Flu and Winter Resilience Committee Group (Weekly on Wednesdays) • Through the weekly Vital Signs Newsletter (Thursday)
FluCon 2	<ul style="list-style-type: none"> • Through the daily 10.15am Bed Meeting • Through the Weekly Swine Flu and Winter Resilience Committee Group (Weekly on Wednesdays) • Through the weekly Vital Signs Newsletter (Thursday) • Through the Strategy and Service Improvement Board¹(weekly on Wednesday) • Via SMS text
FluCon 3	<ul style="list-style-type: none"> • Through the daily 10.15am Bed Meeting • Through the Daily Swine Flu Briefings • Through the weekly Vital Signs Newsletter (Thursday) • Via SMS text

9. Pandemic Flu (H1N1) and Winter Response

It is very unlikely, if not impossible, that the Trust will be required to meet the full demands of a Pandemic in a “big bang” way and as such a staged response will be necessary. To meet these challenges the Trust will respond by prioritising services to ensure that core services can continue to run. It is not possible to say at which levels certain services will be stopped, as in order for the Trust to operate at optimum

¹ The Strategy and Service Improvement Board meets weekly and consists of the Trust’s Executive Team and Divisional Directors and Managers.

levels flexibility will be required as indeed certain services are affected/not affected by flu and/or winter pressures.

It is highly likely that some services will be required to stop or be delayed during the course of the Pandemic. The specialty and departmental BCPs attached at Appendix 2 show those tasks which are considered to be "core" and will need to continue unless as a very last resort and those tasks which can be deferred without significant impact.

At FluCon 3 all patients will be part of one of 5 patient flows. These are:

- Clinical Support Services;
- Surgery;
- Medicine;
- Women's and Children's;
- Pandemic Flu.

9.1 Delaying or Stopping Services

During the winter period (October 2009 – March 2010), there may be times when services may need to be flexed or stopped to support other emergency activity. Where necessary this will occur via three routes:

- **Patient choice:** Due to illness or fear or a re-evaluated priority patients self select to defer procedures etc. until after winter/ flu;
- **Decision of the Command and Control team:** After carefully assessing the benefits and consequences building on individual business impact assessments the decision maybe made to curtail and defer services to release capacity for other services;
- **Directive:** Although unlikely, NHS London may instruct the Trust to suspend all non-emergency activity in order to respond to the demands of the Flu Pandemic.

10. Notification of a Pandemic Flu (H1N1) Emergency

Notification that there may be a Pandemic Flu (H1N1) emergency may come from any source:

- A high number of patients attending the A&E Department presenting with 'flu' like symptoms;
- General Practitioners informing the Directors of Public Health of an abnormal rise in patient numbers presenting with symptoms of influenza;
- Directors of Public Health being notified by the London Resilience Forum that there are indications that there may be abnormal levels of influenza in other parts of London;

- The World Health Organisation (WHO) increasing the current threat levels for pandemic influenza using their published criteria for international phases of pandemic influenza;
- Media reports of abnormal levels of influenza occurring anywhere in the world;
- Higher reported rates of sickness rates above the national average.

The Trust will deem itself to be in a Pandemic Flu (H1N1) emergency at such a time as when FluCon 3 is declared.

Early Pandemic Flu Surge meetings will be organised by the Flu Director and will take place in the Flu Room, Room No G20228, Ground Floor, Administration Block, Queen's Hospital. Once FluCon 2 is reached Flu will become part of the daily 10.15am Bed Meeting with additional members co-opted as appropriate.

11. Notification of a Winter Resilience Emergency

The Trust will be assumed to be experiencing a Winter Resilience Emergency at such a time as the SIE status is declared (see section 5) between the period of 1st October 2009 – 31st March 2010.

12. Activation of the Plan

The plan will be activated at WHO Phase 6 and UK Alert Level 4 for Pandemic Flu (H1N1) and/or the triggers contained within the Corporate Adult Bed Management Policy.

In terms of bed capacity, the triggers are as follows:

Trigger 1	Less than 15 beds available in the M.A.U; and Less than 40 beds available (or anticipated) across sites. Status Amber
Trigger 2	Less than 7 beds available in the M.A.U; and Less than 15 beds available (or anticipated) across sites. Status Red
Trigger 3	0 beds available in M.A.U is full; and Less than 5 beds available (or anticipated) across sites Status S.I.E.
Trigger 4	Emergency Department cubicles are full and resuscitation area is being used as a holding bay Status Red
Trigger 5	Emergency Department cubicles and resuscitation areas are full, patients being nursed on corridors of the Emergency Department. Status Red
Trigger 6	12 hour breaches imminent all escalation areas/wards open and King George Hospital and Queen's Hospital A&E full i.e. no cubicles available and resuscitation area up to capacity with no availability to offload. Status SIE

In the case of any of these triggers being activated the Corporate Adult Bed Management Policy should be followed.

Wards at King George Hospital and Queen’s Hospital will be designated as the “Pan Flu Wards” which will facilitate the requirement to isolate infected patients to minimise the impact of the pandemic flu.

13. Plan Activation Phase

In terms of Pandemic Flu (H1N1) the following plan activation sequence will be used in respect of this Plan:

- UK alert level 1 – Review Plan
- UK alert level 2 – Review activity
- UK alert level 3 – Implementation of control measures
- UK alert level 4 - Implement Plan

14. Reporting Arrangements

14.1 SitReps

14.1.1 Daily Swine Flu SitRep

The Trust is required to submit a Daily Swine Flu Hospital SitRep which includes information on both patients and operational problems. The process for completion of this SitRep is as detailed below and a copy of the daily Swine Flu SitRep return is attached at Appendix 2a.

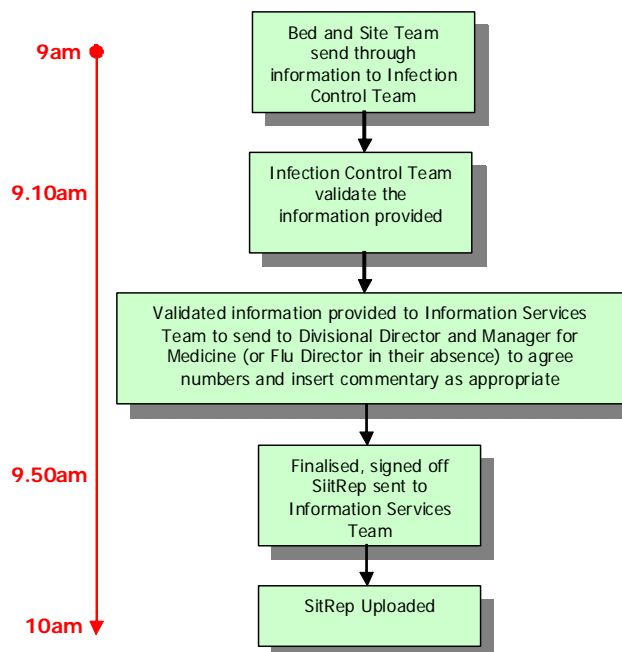


Fig 2: Swine Flu Daily SitRep Process

14.1.2 Daily Winter SitRep

As in previous years the Trust will also have to complete a Winter Resilience SitRep on a daily basis with effect from 1st November 2009. The process for completion of this SitRep is as detailed below and a copy of the daily Winter SitRep return is attached at Appendix 2b.

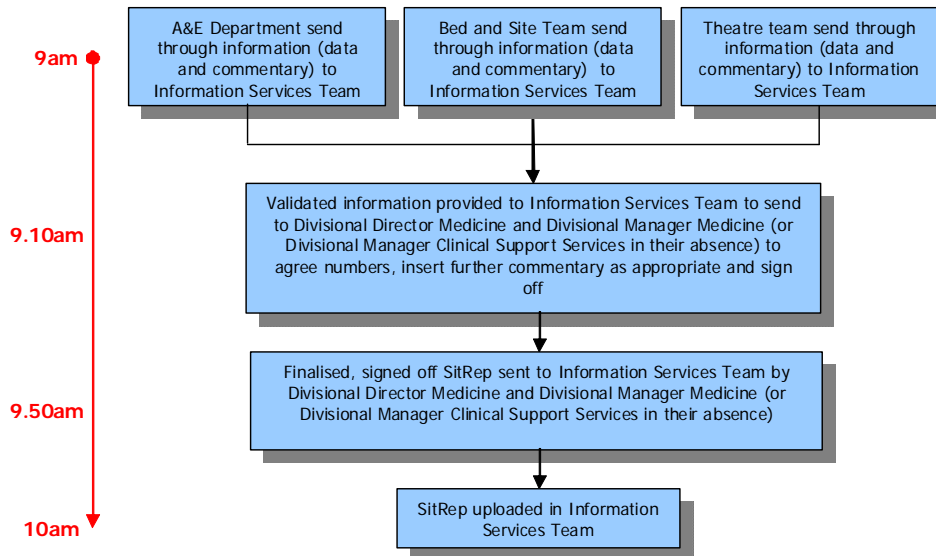


Fig 3: Winter Resilience Daily SitRep Process

14.1.3 Weekly SitRep

In addition, to the above SitReps, the Trust also has to more detailed SitRep each week on a Tuesday. The process for the completion of this return is detailed below in figure 3 and a copy of the weekly SitRep return is attached at Appendix 2c.

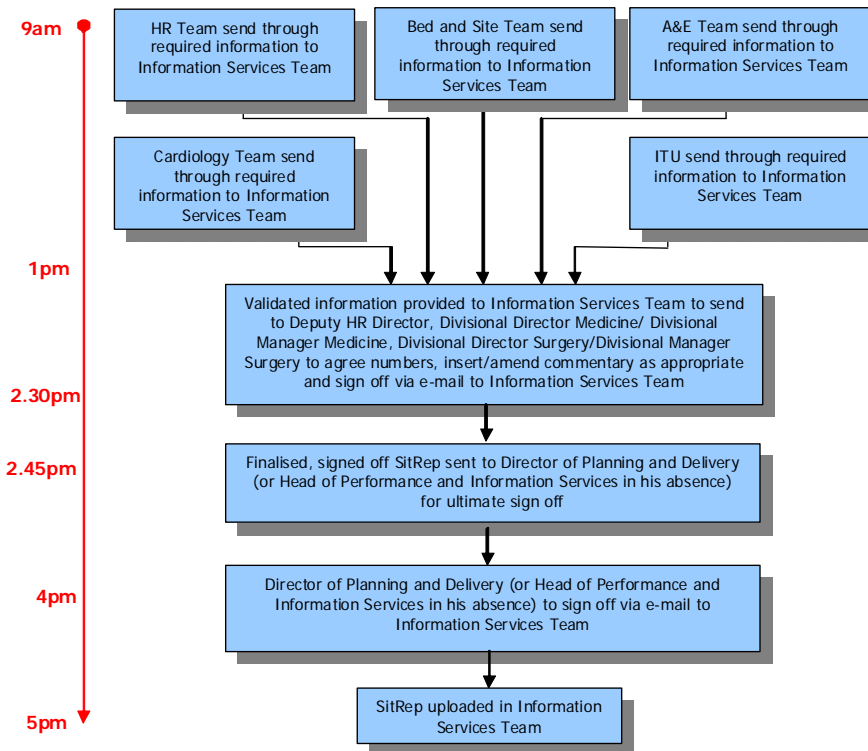


Fig 4: Weekly SitRep Process

15. Organisational Management Structure

The Trust's existing management structure is attached at Appendix 3.

On a day to day basis it is essential that the Trust is able to respond to any potential, or real, service disruptions and as such an on-call system is in operation which consists of three levels of escalation to provide support for the organisation, its staff and patients either out of normal office hours and when during office hours there is an untoward situation to be managed, such as extreme bed pressures. The three levels of support are defined as Bronze Control, Silver Control and Gold Control. A list of the roles which fall into the latter two levels is attached at Appendix 4.

- Bronze Control - Matrons, Bed Management and Discharge Planning;
- Silver Control – General Managers who are on-site between 9am – 5pm during hours on weekdays when on call and attend at least one Bed Meeting. Silver Level managers must be available immediately by telephone and able to attend the sites in the event of an incident or at the request of Gold Level. Silver on-call is for a 24 hour period;
- Gold Control - This rota consists of very senior managers and Executive directors. Gold on-call is for a 7-day period.

The Trust must be able to respond appropriately to any challenges posed as a result of Pandemic Flu. The Director of Planning and Delivery has taken on the role of Executive lead for Flu (in his absence this role is undertaken by the Executive Director On Call) and the Head of Infection Control is the Trust's Flu Director (or the

Director of Planning and Delivery in her absence). They are responsible for leading the response and advising the Executive Team and Trust Board.

15.1 Command and Control Structure

The Trust uses a three tier command and control system for all incidents and this reflects the strategic, tactical and operational areas and personnel. They reflect the Gold, Silver and Bronze terminology used by external agencies.

Gold command is based in the Board Room, Trust Offices, Queen’s Hospital.

Gold Command
Leader: Chief Executive (or On Call Executive Director)
Membership: <ul style="list-style-type: none"> ➤ The Chief Executive ➤ The Executive Director of Nursing ➤ The Executive Medical Director ➤ The Executive Director of Human Resources ➤ Communications Personnel ➤ Director of Management services and procurement ➤ Loggists
Responsibility <ul style="list-style-type: none"> ➤ Make decisions at the onset ➤ Focal point for the management of the incident ➤ Manage all communications ➤ Ensuring resources are evenly distributed across the Trust ➤ Responsible for business continuity ➤ Recovery Planning ➤ Declare organisation stand down to Pact’s and the rest of the organisation
<p>This is the focal command point for the management of the incident. All communications and issues will be handled by the team. The team consists of senior management, nursing and medical staff. It is the hospital equivalent of Ambulance Gold control.</p>

Please note, the Chief Executive retains ultimate ‘Gold’ level authority, responsibility and accountability at all times. Anyone else performing the role of Gold Command is doing so on behalf of the Chief Executive.

Silver command is based in the Academic Centre, Queen’s Hospital.

Silver Command

<p>Leader : General Manager on call</p>
<p>Membership:</p> <ul style="list-style-type: none"> ➤ Clinical Site Manager ➤ Matrons ➤ Bed Management Team ➤ Communications ➤ Loggist
<p>Reporting Lines</p> <ul style="list-style-type: none"> ➤ Gold Command
<p>Responsibilities</p> <ul style="list-style-type: none"> ➤ Collation of activity ➤ Providing the Gold Command with SIT reports ➤ Redeployment of staff ➤ Liaison between wards and departments ➤ Documenting which services have been cancelled ➤ Advice Gold Command of Incident Stand down in A&E ➤ Advice Gold Command of incident stand down in the rest of the hospital
<p>Senior support is provided by a senior manager and a senior nurse they are the 'eyes and ears' of the MICC team and will be able to troubleshoot any immediate problems. This is the hospital equivalent of Ambulance Silver Control</p>

Bronze Command – Operational Team

<p>Bronze Command</p>
<p>Leader : A&E Consultant, Senior Nurse Overall in Charge (OIC) A&E, Critical Care Lead, Critical Care Matron, Paediatric Lead, Paediatric Matron, Maternity Matron and Physician of the Day</p>
<p>Membership:</p> <ul style="list-style-type: none"> ➤ Key action card holders within A&E
<p>Reporting Lines:</p> <ul style="list-style-type: none"> ➤ Silver Command

Responsibility

- Triage incoming casualties
- Ensure appropriate documentation is maintained
- Organise staffing requirements to meet the demands of the incident
- Advise Silver command of Incident Stand down

15.2 Summary of Roles

Gold Command

The Gold Executive is in ultimate command. They work closely with the Silver Command.

Silver Command

The Silver Command, chaired by the Silver Leader, manages the organisational response. They are the decision making group and as such sanction changes in operational practice with referral to Gold as required.

Expert Teams

The Expert Teams advise Gold and Silver on issues pertaining to their area of specialism. It is important to note that they are outside the side the decision making process. They may or may not be situated in the Silver or Gold base depending on the frequency that their advice is needed. They are also responsible for briefing Gold and Silver Command regarding guidance and information from external partners e.g. Infection Control will distil information and trends in infection rates and provide advice on how to react. Communications Personnel will always be present with both the Gold and Silver while they are on site.

Hospital Control Room (within the 'Gold Command' Offices)

The purpose of the Hospital Control Room is to support Gold and Silver Communication. Staffed ideally by experienced administrative staff, they will provide the full range of administrative support to the team including fielding calls, sending e-mail notifications etc.

Patient Flow Management Teams

The organisation will be divided up into 5 Patient Flows. At the top of each 'Flow' will be a management team supported by a loggist. The team has three members a Consultant, a senior nurse and manager commanders as detailed below.

Patient Flow	Management Team	Loggist
Clinical Support Services	Divisional Director Divisional Manager Divisional Nurse Director	PA to the Divisional Manager
Surgery	Divisional Director Divisional Manager Divisional Nurse Director	PA to the Divisional Manager
Women's and Children's	Divisional Director Medical Director Divisional Manager Divisional Nurse Director	PA to the Divisional Manager
Medicine	Divisional Director Divisional Manager Divisional Nurse Director	PA to the Divisional Manager
Pandemic Flu	Infection Control Doctor Flu Director Safety and Emergency Planning Manager	Infection Control Secretary

They are responsible for assessing safety, supporting staff and providing the link with Gold Command Centre. They are the key cascade point of information from Gold Command to the wider organisation. They are responsible for organising and delegating all tasks to the available staff. Every clinical department will be allocated to one of the Patient Flows.

Departmental Commanders

'Non patient' departments will also be divided into groups to support the Patient Flows. As with the Commanders in the Clinical Management teams the Commanders at the top of each of these services are responsible for assessing safety, supporting staff and providing the link with Gold Command. They are the key cascade point of information from Gold Command to the wider organisation. They are responsible for organising and delegating all tasks to the available staff.

Loggists

After every incident we are required to perform a review. For this reason and for good governance, it is imperative that contemptuous notes are kept of decisions made not only but Gold and Silver controls but also within clinical care. Therefore, loggists should be appointed to leads in each department. When each book is complete it should be handed in to the Hospital control centre.

16. Recovery and Performance Management

Planning to return to "business as usual" and as such mitigate the impact of a response is an essential part of any plan.

16.1 The Role of the Recovery Director/Lead

Gold Command will appoint a Recovery Director (*most likely to be the Director of Planning and Delivery*) at the point when the Trust moves from FluCon 1 and 2. The responsibility of this individual will be to:

- To lead a team to examine the impact of the decisions made by the command and control team;
- To create scenarios for returning to 'business as usual';
- Lead the review into the performance and resources implications of the response and how the Trust reach a 'recovered' position;
- Provide Gold control with up to date position

The Recovery Director will report directly to Gold Command. When the incident begins to recede, Gold, in conjunction with the Recovery Director and Silver Control will make the strategic decisions regarding the re-instatement of services. When the "stand down" is declared the Recovery Director role will continue until full normal service and performance is maintained.

The Recovery Team

The constitution of the team will depend on the available resources available but will generally be made up of:

- Finance Officers
- Purchasing team
- Strategy
- Performance Officers
- Information Officers
- Clinical advice and triage (on a need basis and greater as the operational response to the surge passes)
- Operations representation (on a need basis and greater as the operational response to the surge passes)

16.2 Performance Management

This plan assumes that current performance management standards and targets will remain in place throughout the Pandemic and Winter period and the Trust will strive to maintain performance in all areas throughout this period.

The Recovery Team will be responsible for monitoring performance and, as outlined above, create scenarios and plans to recover taking in to account residual leave burden etc created.

16.3 Resuming normal service

The decision to begin resumption of normal service and any catch up work is a Gold decision. Working with the Silver Control and Recovery Director, using the information generated by the Recovery Team, decisions will be made to resume

services. Attention should also be given to departmental BCPs and the prioritisation of services.

17. Management of Cases

17.1 Capacity

17.1.1 Critical Care

The Trust has established a Paediatric and Adult Critical care Group which consists of Consultant Paediatricians, Consultant Anaesthetists, Consultant Microbiologists, Matrons (ITU and Paediatrics) as well as the Clinical Lead and Clinical Director for ITU and Paediatrics respectively to look at the Critical Care needs for both adults and paediatrics alike.

For the purposes of this plan, paediatrics are described as those younger than 16 years and 16 to 18 year olds if they are vulnerable or have special and the definition of admission to a level 3 or ITU bed is a patient with double organ failure and for level 2 or HDU bed is a patient with single organ failure. The admissions and discharge criteria for critically ill patients is provided in Appendix 5.

The existing capacity across the Trust sites is as shown in the table below:

	QH	KGH	TOTAL
ITU	7	6	13
HDU	6	2	8
Neuro ITU	6	0	6
Neuro HDU	6	0	6
NICU	11	0	11
SCBU **	14	14	28
<i>**Bed base is flexible across sites</i>			

Table 2: Existing critical care capacity

An additional 2 HDU beds could be opened from within existing facilities should this be required, assuming that the appropriate staff were available.

A total of 19 ITU and 14 HDU beds would give a potential 26 ITU beds if HDU beds were flexed to ITU levels. This level would be available if all Neurosurgical critical care beds are included in the "pool" of general critical care bed capacity. This plan proposes to ring fence 6 neurosurgical critical care beds for neuro emergency patients, leaving 6 beds to be incorporated into the general 'pool'.

Further to the Critical Care Strategy issued by the Department of Health (DH) on 10th September 2009 (attached at Appendix 6) which confirmed that all SHAs had provided assurance to the DH that a doubling of critical care capacity (for adult level 3 care defined as "the most complex care, including multi-organ support and ventilation") is possible, through work undertaken with the Trust's Critical Care team, it has been agreed that should extreme pressures be experienced by the service, as is expected as a result of the Pandemic Flu (H1N1), it would be possible to operate

44 critical care beds by utilising the theatre recovery areas in addition to the existing critical care areas, however this would necessitate the cancellation of all elective work, with the exception of emergency and trauma surgery which would be accommodated within 3 theatres and be entirely dependent on the ability to source suitably trained specialist staff to manage level 2 or 3 patients, either from the theatre workforce (available due to the cessation of elective theatre sessions) or agency/own NHSP staff, given the provision of suitable equipment i.e. ventilators.

From the original Checklist completed for the DH and the assumptions contained therein with regard to the maximum expected activity, this would indicate that the Trust would have a shortfall of 12 HDU beds, a surplus of 25 ITU beds (thus the additional 12 HDU bed capacity required could be met by flexing some of the ITU beds) and a shortage of 39 Paediatric Intensive Care (PICU) beds. However, it must be noted that the Trust does not currently have neither any PICU facilities, nor appropriately trained staff and as such the intention would be to repatriate all such cases to specialist centres as and when they are able to accept these patients.

NHS London recorded the need for a total capacity of 66 ITU beds to meet the expected surge capacity. Therefore the Trust would have a shortfall of 40 critical care beds (excluding PICU) based on current critical care bed numbers available.

By utilising the Recovery areas within Theatres at both Queen's and King George Hospitals, the following additional critical care beds could be opened:

Department	No of Beds	Comments
Critical Care	22	Open unfunded HDU bed
Neuro Critical Care beds to be included in "pool"	6	Leaves 6 beds for emergency neurosurgical and Essex patients (tertiary service)
Theatre Recovery	16	Closures of elective theatres required
Theatre rooms	15	Closure of elective theatres required
Total	59	

Table 2: Additional critical care capacity

As demonstrated above, the total number of level 3 ITU/HDU beds that could be available Trust wide is 59 beds, thus there would be a shortfall of 7 beds based on the expected surge capacity required.

Learning from the experience of 2008/09 when the Trust utilised Theatre Recovery capacity to care for ITU patients (these areas are appropriately equipped for this level of patient care) and during 2009/10 these areas will have rostered staff to care for patients in a planned manner through utilising the Trust's own staff on NHSP/ITU agency availability.

In addition to this, a business case has recently been approved for an additional 4 ITU beds and 2 HDU beds which will help to alleviate the pressures within the service although enabling works are required to establish these beds, as well as recruitment

of additional staffing and as such it is unlikely that these beds will be available before February 2010.

Phased Theatre Closures to Increase Critical Care Capacity

It should be noted that at all times emergency access must be maintained in Theatres, the following theatres will be available for emergency services every day:

Queen’s Hospital:

Weekday 8am to 8pm

- Theatre 1 – CEPOD am and pm;
- Theatre 5 – Trauma am, pm and twilight;
- Theatre 10/11 – Neurosurgery emergencies including coiling;
- A N other for Cancer surgery.

Out of Hours Weekdays 8pm to 8am:

- Theatre 1 all emergencies – life and limb post midnight;

Weekends and Bank Holidays:

- 08.00 to 08.00 – all emergencies – life and limb post midnight;
- 09.00 – 21.00 – Trauma;

If Recovery Areas and Theatres are required to admit critical care patients, non-urgent theatre services will need to be reduced accordingly. The following information shows the phased theatre closure that would take place to accommodate critical care beds in Recovery and Theatres.

Number of critical care patients in recovery	Number of Theatres closed	Number of ITU patients in recovery
0-2	0	2
3-4	2	4
5-6	4	6
7-8	6	8
9-10	8	10
11-12	10	12

Table 4: Phased theatre closures at Queen’s Hospital

King George Hospital:

Emergency theatre access will be maintained in Theatre 1 at King George Hospital.

Weekdays:

- Theatre 1 – am CEPOD - pm cancer surgery
- Out of hours – current capacity

Weekend and Bank Holidays:

- Current capacity

If recovery areas and theatres are required for critical care patient admissions, theatre services will need to be reduced. The following information shows the phased theatre closure that would take place at King George:

Number of critical care patients in Recovery	Number of Theatres closed	Number of ITU patients in recovery
0-1	0	1
2-3	2	3
4	4	4

Table 6: Phased theatre closures at King George Hospital

Any expansion in critical care beds over and above the norm will necessarily have an impact on the intensivist support that can be provided to each patient, as well as an impact on services elsewhere in the Hospital. It will be underpinned by education and training of staff to support upskilling of competencies to maximise flexibility. This will ensure good governance, appropriate supervision and patient safety.

As shown above, the extra capacity created will come from upgrading of (HDU) beds theatre/recovery areas and post-operative surgical beds. In some cases, this means that Level 2 care will need to be provided by staff with appropriate skills and competencies on general acute wards to patients who are recovering and are able to be "stepped-down" from Level 3 beds. This is necessary to maintain the flow of patients through the Hospital and free-up Level 3 facilities for other, sicker, patients.

Critical Care patients in Recovery areas will be cohorted into three groups:

- Paediatric patients with swine flu;
- Adult patients with swine flu;
- Post operative patients.

Patients requiring haemofiltration will be nursed in critical care and not recovery areas.

Part of the critical care service provision in Recovery will be for paediatric patients. In response to the predicted surge in demand there will be an allocation made for circa 8 paediatric critical care beds which will be segregated within the recovery areas at Queen's and King George Hospitals Recovery areas. It has been agreed by the Clinical Lead for Intensive Care and Paediatrics that children under 5 kgs will be cared for in the Neonatal Unit.

In order to create this capacity, it may be necessary to redeploy ventilators and other essential equipment normally used elsewhere although the Trust is currently in the process of procuring additional equipment. Similar decisions will need to be taken in relation to medicines and consumables.

To staff the additional beds, existing critical care staff may be asked to work longer hours and “reserve” staff deployed to critical care facilities. In addition, some staff, e.g. Anaesthetists, who normally work in recovery areas or on specialist respiratory wards and as such have the skills which can be used to manage patients in critical care may be re-located. Furthermore, depending on how many extra beds are required, it may be necessary to change the normal staffing ratios with fewer highly specialist staff, supported by non-specialist nurses, looking after more patients.

It may be necessary for a child of an appropriate age or weight (>25 kg) to be treated in adult critical care facilities, with direct input from appropriately trained paediatric medical, anaesthetic and nursing staff and with support from the specialist centres.

Educational initiatives are focussed upon the upskilling of staff competencies, and/or expanding the scope of existing skills, for example in supporting staff who normally care for adults to safely look after children. The CATS has provided initial advice to BHRUT and made available appropriate training programmes and online training resources.

17.1.2 Elective and Emergency Inpatient Capacity

The requirement to meet the 18 week Referral to Treatment (RTT) standard (on a speciality basis) means that elective activity must continue throughout the winter period, as far as possible. Much elective surgery does not require an inpatient bed. However, if the emergency care 4 hour standard is at risk at certain times during the winter period, then elective surgery that requires inpatient beds will be kept under review and operations will be cancelled if considered appropriate and, at all times in accordance with the Trust’s escalation plan. This will only apply if additional surgical capacity is full i.e. overnight recovery at Queen’s Hospital, possibility of using the day unit overnight at Queen’s Hospital, use of ADCU at KGH.

As a further development of the capacity and demand modelling work referred to earlier, the Trust has modelled the contingency capacity that it is anticipated will be required over the winter period of 2009/10 (1st October 2009 – 31st March 2010). These calculations are for a “normal” winter period and do not take into account any additional demand as a result of Pandemic Flu (H1N1).

Three scenarios have been modelled assuming that in the best case scenario all planned length of stay reductions are achieved and that activity does not exceed planned levels and in the worst case scenario that length of stay plans are not achieved and that non-elective activity increases to 2.2% above plan.

The summary results of the modelling of inpatient bed requirements on a month by month summary are as follows:

		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Scenario 1 - Best Case	QH	20	14	(8)	(71)	(26)	43	46	29	97
	KGH	71	71	60	8	33	71	74	67	108
Scenario 2 - Medium Case	QH	(3)	(9)	(33)	(98)	(50)	23	26	8	80
	KGH	27	28	16	(37)	(10)	31	33	26	61
Scenario 3 - Worst Case	QH	(39)	(53)	(88)	(165)	(128)	(51)	(57)	(86)	(6)
	KGH	37	8	(12)	(72)	(52)	(15)	(20)	(35)	3

Table 2: Inpatient bed requirement

This modelling assumes that for each scenario all treatment rooms and unfunded capacity is excluded and that 8 beds are lost at KGH due to building works (mixed sex compliance requirement). In addition the following assumptions have been made:

Scenario 1:

- Length of stay plans are achieved;
- Both elective and non elective activity is to plan;
- 10 beds at KGH and 10 beds at Queen's Hospital are lost at any one time due to Norovirus;
- An occupancy rate of 95%;
- Community capacity (and ability to assist) is as previous experience.

Scenario 2:

- Length of stay plans are achieved;
- Elective activity is to plan;
- Non-elective activity is 2.2% higher than plan;
- 10 beds at KGH and 10 beds at Queen's Hospital are lost at any one time due to Norovirus;
- An occupancy rate of 95%;
- Community capacity (and ability to assist) is as previous experience.

Scenario 3:

- Length of stay is the same as Q1 throughout the year due to increased acuity or partial delivery of the length of stay plans;
- Elective activity is to plan;
- Non-elective activity is 2.2% higher than plan;
- 10 beds at KGH and 10 beds at Queen's Hospital are lost at any one time due to Norovirus;
- An occupancy rate of 95%;
- Community capacity (and ability to assist) is as previous experience.

The worst case scenario indicates a need for an additional contingency capacity of 72 beds at KGH and 165 beds at Queen's Hospital to manage the usual winter demand at the peak which it is anticipated (using the model) will be reached in October 2009. The current community bed model suggests that an additional 60 beds will be made available in the community to manage patients in various settings, including nursing home re-ablement beds. A current pilot is in the process of evaluation (this needs to be completed by the whole economy).

The elective workload will be reviewed on a regular basis during times of increased demand with TCIs only being cancelled as a last resort due to the impact on both patient experience and maintenance of the 18 Week RTT standards. However, it is acknowledged that it will be necessary to cancel elective surgery to enable theatre and recovery staff to be redeployed to care for critical care patients should the number of critical care beds need to be expanded.

All surgical General Managers, on collaboration with their Clinical Directors/Leads and Admissions Officers, will be responsible for agreeing the cancellation process based on patient need and taking into consideration 18 week breach dates of cancelled patients. Surgical General Managers will be responsible for producing a recovery plan upon the re-commissioning of Theatre services to address lost capacity and recover the 18-week pathway for any elective patients cancelled.

An emergency Theatre service will be in operation at all times to ensure that, as a minimum, Cancer patients (who will be on a 31/62 day pathway) and those requiring life and limb surgery.

Should the hospital be experiencing extreme bed pressures, elective inpatient admissions will be progressively cancelled according to clinical urgency, following consultation with the Head of Service and Director for the area and relevant Consultant Team(s). Day case (Planned Same Day) activity, by its very nature, will continue unaffected unless it proves necessary to use the staff in these areas to support more urgent elective activity elsewhere within the Trust. However, the Trust will aim to maintain day case activity as much as is possible over this period.

Every effort will be made, by the appropriate clinical and management team, to give patients sufficient notice prior to cancellation of an elective surgical procedure. In hours this will be done by the Bed Management team. In order to achieve the access targets, we need to achieve a position whereby a maximum of 0.8% of elective patients can be cancelled on the day due to non-clinical reasons and as such, the intention will be to plan for any necessary cancellations on the day prior to surgery. These patients will then need to be re-dated within 28 days and would form part of the priority treatment groups.

Whilst, under normal circumstances, cancellations to elective lists within surgery do not occur, at times of severe capacity issues discussion will take place with the appropriate General Manager and Clinical Director to prioritise possible cancellations. The Bed Management Team will ensure any cancellations are recorded and the information passed to the Admission Team to follow up the next working day.

In order to ensure that discharges are maximised, the Acute Assessment service at both Queen's Hospital and KGH has been redesigned with 60% of patients being discharged within 48hrs. For any apparent slow-down in discharges, actions will be taken in line with the Corporate Adult Bed Management policy.

17.1.3 Contingency Inpatient Capacity

As detailed above, planning suggests that some contingency capacity will be necessary at KGH and Queen's Hospital. Our work up accumulation is that Gentian ward (31 beds) at KGH and Harvest A ward (31 beds) at Queen's Hospital will be kept as "contingency" wards which can be opened in response to winter capacity

requirements. Should this not be sufficient, the operational general management teams will work with private providers to establish additional capacity.

The contingency bed capacity from 30th September 2009 is as follows:

Current surge capacity:

Erica KGH 25 beds
Gentian KGH 30 beds
Harvest A Queen's Hospital 30 beds
TOTAL 85 beds

Additional surge capacity (for non-critical care beds) will be available in the following areas. This would involve stopping elective admissions at the peak of a pandemic (in the worst case scenario, only patients in a "life or limb" surgery scenario would be admitted electively):

Dahlia KGH 25 beds
Heather KGH 30 beds
Adult day care KGH 20 beds
Surgical Day Care Unit Queen's 30 beds
Ocean B Queen's 30 beds
Mandarin A 10 beds (Acute Assessment beds)
Sky B Queen's 30 beds (only in the event of a major incident/disaster)
ISTC KGH 22 beds
TOTAL 197 beds

Plus Community beds 92

Final surge capacity is outpatient areas for LOW dependency patients who require no supportive care (portable assistance i.e. Oxygen, suction etc will be required).

As a very last resort, the Trust would risk assess the use of treatment rooms and the Clinical Diagnostic Unit.

17.1.4 Delayed Transfers of Care (DTOCs)

One of the key elements for ensuring efficient patient flows throughout the Hospital and therefore in turn, maximising capacity, will be the minimisation of DTOC patients occupying acute beds. Work is already ongoing with regard to improving discharges through appropriate community facilities and recently Cross Buffer meetings have been established to ensure focus. These meetings are attended by representatives from the PCTs, Social services, Ward Staff, Discharge Team, Matrons, Divisional Directors etc.

The Cross Buffer meeting takes place weekly to:

- Discuss the top 20 DTOC patients;
- Review the JONAH (bed management system) data regarding delays;
- Pick up on commissioning issues which need to be raised at the Whole Economy Meeting.

This meeting allows the Trust to raise the issues regarding capacity and delayed transfers with the aim of resolving the global issues as well as discussing the individual patient issues.

The Terms of Reference for this group are attached at Appendix 7 along with information on the number of DTOCs for June and July for information.

In addition, a balanced scorecard has been developed by the Trust's Performance Team containing key indicators which is also attached at Appendix 8.

Clinical Engineering Services

It is widely accepted that one of the major issues with increasing critical provision will be the availability of the necessary equipment.

Queen's Hospital is a PFI hospital where critical care medical devices are provided and managed through Siemens Healthcare under a Managed Equipment Service (MES). In contrast, King George Hospital is not a PFI hospital and the management arrangements for critical care medical equipment falls under the remit of the Clinical Engineering Department.

Great care has been taken to ensure that the different arrangements are rationalised and that equipment is handled in a safe and consistent manner across the Trust.

Lists of all available critical care equipment have been supplied by both Siemens and the Clinical Engineering Department to the Director of Pandemic Flu Planning. It is envisaged that critical care equipment can be utilised and rationalised across both sites providing coverage for expected critical bed requirements.

17.1.5 Maternity and Paediatric Capacity

Maternity

The Associate Director of Midwifery has developed a Policy for the Management of Pandemic Influenza specifically in relation to the Maternity service (the full document is contained within Appendix 2) with the aim to:

- Adequately care for the volume of women ill from the pandemic influenza and any accompanying complications;
- Ensure that early recognition and diagnosis of first cases of the pandemic strain are made in a prompt manner and reported immediately, to minimise/prevent its spread;
- Ensure the continuity of every day activities/essential services as far as is practicable;
- Implement adequate and workable control measures to reduce the spread.

The Maternity Manager on-call will inform the Pandemic control team of the alert stage to keep them fully abreast of the current situation within the Maternity areas. The Director of Midwifery and General Manager will determine the frequency at each level when bed reviews are to be undertaken and jointly determine the alert level, escalating to the Director of Planning and Delivery (or Director on-call) and Flu

Director. Out of hours the Midwifery Manager on-call and Consultant Obstetrician will undertake these reviews.

Should a significant amount of women require admission due to Pandemic Flu, a designated ward area will be used to cohort this patient group and in exceptional circumstances may be mixed with other appropriate female patients as part of the wider Pandemic Flu plan.

The full "Guideline for the Management of Swine Flu in Pregnancy" which will be followed is attached at Appendix 8a.

Paediatrics

During a pandemic the intention is that for any seriously ill children requiring intensive/critical care to transfer in partnership with the CATS team who will provide the main contact between general paediatric services at BHRUT and Paediatric Intensive Care Units in London. The retrieval services (CATS and STRS) assume the "Command and Control" role, co-coordinating fair access to paediatric intensive care within the Pan Thames region (at UK Alert level 2 in the Pandemic period) and where possible, critically ill children will be transported from the general paediatric services at the Trust to available PICU beds by the specialist retrieval teams.

The CATS and STRS teams will provide both clinical advice (this will be undertaken by the Retrieval Team's Consultant and Senior Nursing staff) and support to the Trust clinicians and act as a bed location and transfer service. CATS support will fall into two categories:

- Clinical support of seriously ill children in paediatric, non-ITU areas v. children's wards;
- Clinical support of seriously ill children in non-paediatric, ITU areas.

All cases discussed with the Retrieval Team will be logged internally and discussions documented to enable tracking of information within BHRUT.

In addition, CATS have developed resources that will assist adult-trained critical care staff and paediatric ward staff in the management of seriously ill or ventilated children which will be accessible on the CATS website. These will include: aide-memoires, age/weight- related physiology and drug dose checklists, web-based training packages.

It is the Trust's intention that BHRUT adult trained critical care staff and paediatric staff will work in collaboration to manage seriously ill or ventilated children locally until retrieval can be affected.

As previously stated, the Trust would look to care for any children requiring PICU care in the adult intensive care unit or the theatre recovery area. This would be the same approach as would be used for adults requiring critical care as this model of care will ensure that the skills of the medical and nursing staff are consolidated in one area.

At the Pandemic Flu (H1N1) training day held at Whipps Cross Hospital on 18th September 2009, the following arrangements were confirmed in terms of paediatric critical care:

- Great Ormond Street Hospital (GOS) will retain an advisory service;
- The CATS website will be updated daily to show bed availability across the sector;
- The CATS team will look to offer a call consultation service if they are within the area to give advice on patients;
- All children will be triaged using the "three wise men approach"²;

It was also confirmed that that nearly all London sector hospitals plan to nurse children within their adult Intensive Care Units, with adult critical care nurses caring for the ventilator and paediatrics nurses either sharing the care or undertaking ward rounds to provide advice. The Trust would look to undertake a similar arrangements should this be necessary.

The services involved are fully aware of the CATS clinical guidelines which are available to download from the CATS portal as well as the training packages provided by CATS (which will take place within the GOS PICU for nursing staff) or the Department of Health and this is being taken forward by the Flu Director.

In order to ensure that the Trust is able to offer a Continuous Positive Airway Pressure (CPAP) service for paediatric patients (*Whipps Cross, Newham and North Middlesex Trusts are already able to provide this service*) a Business Case has been developed and this will be considered at the Business Case Review Panel on Thursday 24th September 2009. Work will then be required to establish clear protocols and processes for undertaking such treatment if the equipment is available.

To manage capacity within paediatrics should a Pandemic Flu (H1N1) surge occur between the ages of 5 – 15 years, plans include the establishment of an adolescent ward for the age group 13/14 – 16 years old. It is recognised that risk would need to be minimised in terms of safeguarding and paediatric-trained staffing availability, recognising that these are exceptional circumstances and the risks would be minimised as far as humanly possible.

Triage, Access to Paediatric Intensive Care and Limitation of Support

All decisions regarding the limitation of service and limitation of access for individual patients will be undertaken by more than one clinician in line with the three wise men approach referred to at the Whipps Cross event. In the case of the Trust this is likely to be a Consultant Paediatrician, Paediatric Anaesthetist and a Senior Nurse. It will be imperative that this process is fair and transparent and that all decisions are clearly documented.

The Pandemic Subgroup of PICS (Paediatric Intensive Care Society) is developing a triage tool to inform the decision-making process of Clinicians faced with limited resources during the Pandemic.

² Triage undertaken by more than one senior clinician

The guiding principles of the triage tool will be:

- Apply to all children requiring intensive care;
- Applied as an admission criterion and daily thereafter as part of the assessment of clinical response to treatment;
- Judge the likely benefit of intensive care for individual children (the evidence base collated by the PICS pandemic subgroup will inform this judgment) - Co-morbidities (whether static or progressive) and severity of organ failure during this episode are key determinants in the likely benefit of intensive therapy for individuals;
- Acknowledge that if resources are limited, these will be allocated to those most likely to benefit;
- Acknowledge that, if limited critical care resources are available both in adult and paediatric services, younger children will have priority to the paediatric service and older children will be accommodated in the adult service, with prior agreement of those clinicians;
- The combination of information on the available resource and the likely benefit of intensive therapy will build flexibility into the tool. (For example, in times of maximum resource availability, all children requiring intensive care, even if the proposed benefit was marginal, would be treated. If invasive ventilation was not possible due to resource limitation, only children likely to survive with non-invasive ventilation could be treated, while those with severe respiratory failure or multiple organ failure would be made comfortable with palliative care).
- Individuals will have a finite, equal share of allocated resource. As resources become more limited, the allocated share will decrease equally for individuals. (For example, ECMO and haemofiltration may not be possible during the Pandemic and similarly, if PICUs are overwhelmed, invasive ventilation may not be possible during the peak weeks);
- Individuals will be assessed for clinical response, which would reflect their relative resource expenditure. Those failing to respond despite treatment or continuing to deteriorate, within an appropriate timeframe, will discontinue intensive therapy and palliative care will be instituted. The appropriate timeframe will be informed by early surveillance data on the virus characteristics, but is likely to be in the order of 48 hours;
- The tool will be applied on a regional scale by the duty PICU and Retrieval Consultants in a daily conference. This will provide flexibility in the response to changing resource availability and adds transparency and uniformity in determining admission criteria through the region;
- The daily conference outcomes will be communicated with the District General Hospital referring staff;
- PICU Duty Consultants will apply the tool daily in assessment of individual patient progress.

The full document, *Pandemic Influenza Contingency Plan for the Provision of Paediatric & Neonatal Care at BHRUT* which has been developed by the Paediatric and Critical Care teams at the Trust is attached at Appendix 8b.

17.1.6 Use of ISTC

The Trust has been in contact with Care UK, who manage the ISTC, located on the Trust's KGH site, with regard to any support that they may be able to offer the Trust in the event of a Pandemic Flu (H1N1) and discussions are ongoing to further this work, however it is anticipated that this facility could be used as an isolation area or alternatively theatre sessions and staff could be moved to the ISTC to maintain elective activity in hours and out of hours weekdays and weekends. Urgent Care Centres (UCC).

Urgent Care Centres are operational on both Trust sites. These are run by the Partnership of East London Co-operatives (PELC). In the event of significantly increased A&E activity, particularly in minor illness/injury the Trust will work with PCTs to commission increases in the UCC capacity in order to ensure that patients are not inappropriately diverted into the A&E departments.

The PCTs, as part of the community escalation plan, will offer to place salaried GPs in Trust assessment units to provide additional resource and capacity.

PCTs are actively marketing alternatives to A&E departmental care.

17.1.7 Trauma and Orthopaedics

Increased demand for trauma services can be fairly accurately predicted from weather forecasts. During the lead up to such predicted increases in demand, the Trust will work with PCTs to maximise orthopaedic and surgical discharges to ensure sufficient bed capacity is available. Additional trauma surgical lists will be established if required. This will be put in place according to demand in the anticipation that procedures will be carried out within 24 hours of admission. Dropped elective sessions will be used to accommodate this activity under the leadership of the Divisional Manager for Surgery.

17.1.8 Identification of 'core' clinical activity in response to severely reduced staff capacity

Under certain conditions staff may need to be redeployed in order to ensure the continuation of core emergency and urgent services.

The HR department will hold a list of all registered staff who are not working in front-line roles that can potentially be redeployed to cover periods of increased demand or staff shortage in clinical areas. As a result of the departmental BCPs, a matrix of essential staffing levels has also been completed so that non-clinical staff can also be identified to provide support. Additionally in periods of extreme pressure caused by increased staff absence the Trust will consider cancellation of annual/study leave with discretion, in order that patient services can continue unabated.

17.2 Admission Assessment/Triage

At present patients are streamed at the front door of the A&E department to the Urgent Care Centre and the Trust would expect this to continue. Triage of patients will continue unchanged. For patients brought in by ambulance, Consultants will be applying the rapid assessment and triage assessment service at the front door to facilitate improved processes for direct specialty referrals. DH guidelines will be followed for criteria based admission.

The Consultant-led Admissions Unit will also provide input on early patient management for 12 hours a day, 7 days per week.

17.3 Preventing Admissions

17.3.1 Nursing and Residential Homes

PCTs as part of their winter resilience planning will ensure that patients are seen and assessed in nursing/residential homes by appropriate practitioners in order to manage any unnecessary admissions to secondary care. PCTs are also providing training for nursing home staff and as pressures mount will ensure a review of all residential home residents.

BHRUT will be following national guidance on accepting patients from nursing homes at the height of a pandemic.

It is critical that PCTs have appropriate rapid response services to manage either acute care or palliative care of any residents for whom secondary care intervention is unlikely to benefit.

Other possible actions currently being investigated by the Trust to both increase discharges and prevent admissions include:

- Increasing the frequency of the Cross Buffer meetings;
- Holding Sunday Bed meetings;
- Increasing the seniority of the individual undertaking A&E triage;
- Direct GP admissions to the Medical and Surgical Assessment Units;
- A GP Advice Line staffed by Consultants;
- Moving from Daily Panels to Virtual Panels when the number of DTOCs reaches an agreed trigger point;
- Daily Consultant ward rounds over the Christmas and New Year period for the medical specialties;
- Setting a target number of discharges per ward per day (to be owned by the Clinical Lead and Senior Sister).

17.4 Ethics Committee

The Trust will establish an Ethics Committee, predominantly consisting of members of the Evidenced Based Practice Committee, as the body to make Trust-wide decisions on ethical issues. The approved Terms of Reference for this committee are attached at Appendix 9.

17.5 Fit Testing

The DH recommend that surgical masks are worn when caring for patients with Pandemic Influenza. The exception is when aerosol generating procedures are

carried out, in this case FFP3 masks/respirators should be worn. BHRUT are guided by the document HSE 282/28 re compliance.

Key senior staff including a Physiotherapist, ITU Outreach Nurse and a Matron have been trained in Fit testing. Fit testing kits have been purchased and a programme of "training the trainers" is in place to ensure all priority groups are Fit tested accordingly.

It is likely BHRUT will use a combination of single use FFP3 and respirator masks although this is dependent upon the outcome of the Fit testing exercise which is being overseen by the Flu Director.

18. Impact on Services

Whilst the intention is to maintain normal services as far as is reasonably possible, the unique nature of the challenges presented by a pandemic and their likely duration will inevitably require a reduction in some services and redeployment of staff and resources to other areas.

Escalation plans, both at the Trust and PCTs, have been reviewed and revised post the experience of Winter 2008/09 in order to ensure that responses are effective and actions taken in a timely manner. For the Trust, this has resulted in the development of a single escalation process which is to be used in all situations (with the exception of a major incident). This plan contains trigger points in terms of beds, isolation facilities, ambulance turnaround, A&E and staffing for the Trust to move from green status through amber and red to Serious Internal Event (SIE) and documents the actions to be taken in response to the triggers at each stage. This is attached at Appendix 10 along with the London Ambulance Turnaround action plan.

It is expected that up to 12% of staff (in addition to "normal" levels) could be absent during a pandemic wave. The Business Continuity Plans and impact analysis in place reflect how individual departments and services will operate on this basis. However, if the rate of absenteeism should rise to a level of above 15% above normal sickness it is likely that all non-essential activity will be minimised or stopped to enable the Trust to concentrate on emergency services only. Appendix 11 gives a brief overview at which level of sickness services/departments will consider reducing services and activity with further details available in the full business continuity plans at Appendix 2.

During a pandemic, daily meetings with key individuals will establish how and where excess patients will be placed and how departments, such as A&E, will cope with large numbers of self-referred patients or patients who present via their GP and walk-in centres. Staffing and other operational issues will also be reviewed at these meetings. This will be co-ordinated through the Command and Control structure.

18.1 Staffing

The purpose of this section is to provide guidance regarding BHRUT procedures for managing staff in the event of an influenza pandemic and/or during winter pressures. This guidance has also been developed to help the HR department to provide an effective and viable response to influenza pandemic and support the Service Delivery operations as and when appropriate. Surgical and orthopaedic

assessment units are due to be established by the end of September 2009 which will mean that patients will not need to remain in the A&E department for assessment. This will maximise A&E capacity.

The Trust will seek to operate within its existing employment principles whilst dealing with a pandemic situation. This guidance has been drafted in partnership with staff side representatives and considering the requirements of the Department of Health (DH) HR Pandemic Flu Guidance.

The HR department will take a lead on the implementation of systems to provide employee based information, to those responsible for the management of services during a pandemic. They should also provide guidance and advice on the legal and policy frameworks in place regarding the employment of staff and the interpretation of these during such a scenario.

In the event of a pandemic occurring there will undoubtedly be a higher degree of absenteeism amongst health service employees at a time when the service would be facing unprecedented demand. This guidance aims to ensure that mechanisms are in place in order to ensure the maximised availability, utilisation and deployment of our workforce during a period of potential major staff shortages coupled with potential major surge in demand.

18.1.1 Roles and Responsibilities

Divisions and Departments:

- Identify clinical areas that could be temporarily suspended, therefore possibly freeing employees for potential deployment elsewhere;
- Communicate individuals available for redeployment;
- Work collaborative with other Divisions;
- Ensure smooth handovers for employees who are filling in for colleagues in unfamiliar roles;
- Facilitate flexible working or home working as necessary;
- Provide required information on HR issues during the daily Pandemic Flu "Battle Rhythm" briefings;
- Complete a daily staffing absence situation report for collation and escalation.

Human Resources:

- Ensure that, as required, the HR Department becomes fully integrated in the Trust Command and Control Structure;
- Maintain a flexible approach to succession planning for staff who are absent during an outbreak;
- Access Electronic Staff Records used to record and track staff sickness absence;
- Access information regarding service needs, staff's skills, and availability;
- Liaise with nominated lead managers, either present or available, to discuss redeployment options and other sources of staffing;

- Ensure:
 - Prompt recruitment practices so that new staff can commence as soon as possible; and
 - Specialist HR advice including the Working Time Regulations; and
 - Liaison with Occupational Health regarding fitness for work and Staff Support and Chaplaincy teams to direct staff to appropriate sources of support; and
 - Management guidance is followed concerning “death in service” of Trust staff;
- Liaise with countywide HR Managers regarding secondment of staff between organisations;
- Facilitate the arrangement of accommodation, food and beverages, and toiletries to staff working long hours, with priority being given to those providing direct patient care;
- Assist in making decisions to suspend annual leave and non-statutory training;
- Assist in making decisions regarding assisted transport to work, using public transport or taxis;
- Monitor HR issues reported during the daily ‘Battle Rhythm’ briefings and take necessary action(s);
- Manage the weekly staffing absence situation reports for collation and onward transmission to the DH via the SITREP.

18.1.2 Mapping the Workforce

Following recommendation from the Department of Health (DH), all staff, in all services and departments must complete a skills audit and personal details questionnaire.

This process is vital in understanding what skills staff have over and above their usual role/functions and/or outside of their usual discipline and what skills are transferable will help with the assessment of re-allocation/deployment options/requirements. In addition this information will be required as part of the planning process to ensure the development of training programmes and competence assessment to maximise staff preparedness

Plans need to be prepared (according to the level of the emergency/staff shortage) and these need to be flexible enough to take account of changing circumstances. This information will link with and assist Divisional Business Continuity & Contingency Plans.

In accordance with the Data Protection Act and the Trust Information Governance Policy, staff can be reassured that this information is being used only for emergency planning purposes and not for any other reason

It is essential that all staff ensure that they follow the correct notification procedure for any changes to their personal details in order to ensure that the Trust holds the correct contact details for all staff.

The skills audit and personal details is available for completion in electronic format via the Trust intranet site; in addition hard copies can be obtained via the HR department.

Analysis of the Results of the Workforce Mapping Exercise

In order to support service delivery operations during a flu pandemic and/or winter pressures and, in anticipation of the likely increase in demand on services and associated reduction in workforce supply, the HR department has analysed the responses to the mandatory questionnaire and skills audit. Undertaking this process will stimulate and inform discussions relating to:

- Available skills sets and competencies of existing staff – especially in areas such as critical care and paediatrics;
- Development of training programmes to bridge skills gaps, refresh/update staff;
- Potential options for the redeployment of staff;
- Maximising available staffing levels through establishing staff's ability/willingness to work flexibly during the period of increased activity.

For reference purposes a copy of the original questionnaire can be found at Appendix 11a.

In order to bridge any skills gaps the results of the training needs identified by staff within the questionnaire will be escalated to the Education Directorate in order to facilitate the development of appropriate education & training programmes.

Analysis of the results of the emergency planning mandatory staff questionnaire and skills audit is contained below.

Section1 – personal circumstances

Personal circumstances						
miles travel to work % of workforce	< 5 41%	5-10 30%	11-15 13%	16-20 6%	>20 10%	
How travel to work % of workforce	Walk 9%	Cycle 2%	Car 64%	Public transport 24%	Other 1%	
Facilities to work from Home	Yes 23%	No 77%				
Caring responsibilities % of workforce	Children under 16 36%	Elderly Dependants 13%	Disabled/long term ill dependants 5%	Would rather not say 2%	None 46%	Other 4%
4% of respondents entered TRUE in more than one category as they have caring responsibilities for elderly or disabled dependants in addition to having children under age 16						
Of the 36% of the workforce with children under the age 16						
School/nursery closures cause difficulty in attending work % of workforce	Yes 52%		No 48%			
Have put childcare Contingency arrangements in place % of workforce	Yes 89%	No 11%	Yes 46%	No 54%		

Section 2 – Skills audit

Skills competent or willing to undertake outside of normal role/skills			
	Number of Respondents willing/competent to undertake clinical skills outside of their normal working role		
Clinical			
A. Basic and advanced nursing care	181		
B. Critical care skills	91		
C. Basic and advanced respiratory care/monitoring	158		
D. Emergency care	145		
E. Venous access	167		
F. Infection control	187		
G. Care of the elderly	295		
H. Paediatric care	114	of which 58 have undergone an enhanced CRB check	of which 45 have undergone a standard CRB check 11 have NOT undergone a CRB check
I. Anaesthesia	38		
J. Medical specialities	112		
K. Pharmacy	117		
L. Counselling	151		
M. Other. Please specify		Examples of responses provided	
		Biochemistry Laboratory Work, Basic care, community, Audiology, outpatients, Pathology laboratory based duties, ONLY ADMIN, Out-patient/Walk-in service, midwifery duties, Duties of a CT2 in Anaesthetics and ITU, Orthopaedics & Trauma, HCA duties, CANCER CARE, nursing care, HELPING WHERE NEEDED, medical, sec, Paediatrics and Neonatal APLS and NLS, Operating Theatres, support worker duties, Phlebotomy, Language speaking, administration and clerical work, PHLEBOTOMY (ADULTS), MENTAL HEALTH, Rehabilitation, Liaison / Communications, Portering, Neonatal Nurse, RADIOLOGY, wound dressing, Out Patient clinics, NVQ Level 2 in Social Care, patient washing, bed making, handing out food, maternity, Radiography, Independent Non-medical prescribing, Recovery, NICU - but not cpap/nippv/hdu/itu, interventional radiology, Neuropathology, Anatomical Pathology, learning disabilities, TRANSPORTATION OF PATIENTS/STAFF, main theatres, Physiotherapy	

Skills competent or willing to undertake outside of normal role/skills			
	Number of Respondents willing/competent to undertake clinical skills outside of their normal working role		
Non – clinical			
A. Catering/food handling	288		
B. Transport	217		
C. Records handling	600		
D. IT	263		
E. Finance	131		
F. Procurement & Logistics	117		
G. Security	123		
H. Linen Handling	201		
I. Call handling	606		
J. Chaplaincy/religious support	88		
K. Appointment Booking	567		
L. Reception Duties	753		
M. Childminding	248	of which 75 have undergone an enhanced CRB check	of which 124 have undergone a standard CRB check 49 have NOT undergone a CRB check
N. Qualified First Aider	113		

Section 3 – Professional, CRB and flexibility

	Number of respondents
Nurse with live registration not currently practising clinically	20
AHP's with live registration not currently practising clinically	19
Previous HCA currently not in clinical role	59

CRB	Enhanced CRB	Standard CRB	Have had a CRB for an external role
Percentage of Staff having undergone	23%	48%	12%

	Percentage of Staff	
	Yes	No
Able to work at another site	64%	36%
Prepared to work outside normal working hours	52%	48%
Prepared to work unsocial hours	41%	59%
Has opted out of 48 hour WTD for period of Flu pandemic only	32%	68%

18.1.3 Identifying the Likely Impact on Staffing

A Pandemic may involve one or more waves of around 15 weeks each, spread some weeks or months apart. In principle, members of staff displaying symptoms of Pandemic Flu should be excluded from work. Individuals may be absent for seven to ten working days. Some staff may have fears of being infected and then passing on the infection to their friends and families. The closure of schools and the Trust's nurseries may affect staff's ability to come to work. Staff with carer responsibilities may also need time off to care for dependants and as such part of the assessment of potential levels of absence, includes asking for information regarding staff that have carer/dependant responsibilities, for example, in the case of the possibility of closure of schools, child-minding facilities and other carer facilities.

Home working – in times of emergency, staff will be expected to work in other locations, including home working, where practicable.

18.1.4 Monitoring Absence

Sickness absence data for the period August 2008 – June 2009 has been reviewed by Division and individual staff groups. Based upon the data obtained peak sickness absence occurred in the months of December and January at rates of 6.80% and 6.40% respectively., with peak absence due to cold and flu occurring in the same months- at 0.42% and 0.40% respectively of all reported absence.

Should the predicted 25% absence rate for the workforce be realised BHRUT could see in excess of 1300 staff reporting absent from work.

Staff will be expected to continue following the existing reporting procedures in accordance with the sickness absence, special leave policies and annual and sick leave policy for medical staff.

In order to track staff absence – including bank and agency staff 'virtually live' i.e. on a daily basis and effectively manage operational services and the workforce - Nursing

staff will report their absence to the bed & site team. The Bed & site team will collate all daily absence data pertaining to the nursing workforce, make decisions relating to redeployment of staff and escalate absence information to the daily bed meetings.

Medical staff will report their absence to the medical staffing coordinators by 9am on the day of absence, who will enter the information onto the HealthRoster system. The daily absence data for medical staff will then be escalated to the Flu Director who will work with the medical staffing coordinators to effectively redeploy staff – taken from a pool of medical staff who have opted out of the 48 hour EWTD.

The management of Non-clinical staff absence will follow an exception reporting process. All non-clinical staff will report their absence to their line manager, Supported Hr and the by the workforce information gained from the emergency planning questionnaire, Divisional managers will prioritise services and manage the redeployment of their staff to cover absence until the pre-defined trigger points are reached. All non-clinical absence will be escalated via the Divisional managers to the daily bed meetings.

In addition in order to be able to provide robust, timely information to the NHSL and the Senior Management Teams, Managers/supervisors will be expected to carry on following the existing absence recording procedure by continuing to complete weekly absence return templates.

The existing Trust process will remain the same and managers/supervisors must submit their completed absence return to McKesson within the timeframe specified. McKesson will continue to input all absence data into ESR in order to allow the workforce Information team to run and analyse weekly absence reports as required.

The HR department will contribute to the 'Battle Rhythm' briefings³ as detailed within this overall plan.

The Trust is also expected to provide this information to the PCT/Strategic Health Authority.

The Trust is aware that staff will have difficulties obtaining Medical Certificates for their absence, in these circumstances; staff will be expected to advise their manager of the reason that they have not been able to obtain a Medical Certificate and ensure that a self certification form is completed for these absences.

There may be staff whose health status would potentially be high risk if exacerbated by flu, for example staff with pre-existing respiratory disease or another chronic disease. In these circumstances, Staff must make their manager aware if they fall within this category and managers need to bear this in mind when delegating roles and responsibilities. Advice can be sought from the Occupational Health Department.

18.1.5 Redeployment/Re-allocation of Staff

In order to address a pandemic it will be necessary to take pragmatic decisions to sustain services. As such the Trust reserves the right to redeploy staff as the need

³ *Scheduled daily briefings will be held and reported through the chain of command, these will be known as the 'Battle Rhythm' briefings*

arises. This could be to a different role, function, or locality. Staff may also be requested to work different hours from those in their contract of employment. Supported by the HR and the workforce information gained from the skills audit, Operational services will make daily decisions regarding prioritisation of services and redeployment of staff.

However it is recognised that it is more effective for staff to work in areas, both in terms of locality and duties, that they are familiar with and this will be, where possible, the first course of action taken.

As part of the normal course of employment staff would be consulted with regard to re-locating to other areas of the Trust to meet service demands.

During the Pandemic, the Trust's priority will be to maintain consistent patient care and because of the anticipated decrease in staffing levels it may be necessary to consider re-locating non-critical business staff to support clinical areas.

Where it is considered that patient care is being compromised and it is deemed necessary to ask non-critical staff to support clinical services this will be done in full consultation with staff.

It is understood that staff that are currently outside of the clinical setting may want to assist within a clinical service, but feel they do not have the capability to undertake this role. In these circumstances either on-the-job training/mentoring and support will be provided by clinical staff or a role that utilises an individual's existing skills will be identified, this will be done in conjunction with the education department.

18.1.6 Indemnity and litigation

The Trust cannot prevent patients from pursuing legal options but should reassure staff that they will provide support in such circumstances. Discussions have taken place with the NHS Litigation Authority at a national level concerning indemnity insurance issues. The Authority has indicated that it does not believe there would be a substantially greater risk of successful legal challenges to the NHS in scenarios that may arise during an influenza pandemic. The authority has confirmed the following:

The Individual:

- NHS staff will be covered by existing indemnity insurance arrangements during a pandemic and staff will be covered by the Trust's employer's insurance. This will apply even if staff are working on a different site or seconded to a different employer;
- Temporary staff will also be covered, provided that there is a clear contractual relationship with an employer. Volunteers should have an honorary contract;
- The NHS Litigation Authority does not believe that there is a substantially greater risk of employers or employees being sued as a result of actions taken during a pandemic as long as a healthcare professional was able to show an appropriate degree of reasonableness in their actions;

- Reasonable steps should be taken to maintain records, as would happen normally, but the courts will take into account the emergency nature of the context when making judgments;
- Where staff or students are working outside their normal role they need to continue to work within their scope of competence and receive adequate training and supervision.

The Trust:

- The Trust must also be aware of its responsibility to make adequate provision for health and safety during the pandemic;
- The Trust will take every care to deploy staff to the most suitable area of need to match their skills.

18.1.7 Increasing Workforce Capacity

A Flexible Workforce

Planning preparation includes consideration of additional flexibility/capacity which could be generated through variation to shift patterns e.g. longer hours, extra hours, staggered shift arrangements.

The implications of the Working Time Regulations must be borne in mind and appropriate risk assessment carried out by the responsible manager. As part of the skills audit and personal details questionnaire staff have been approached at an early stage to identify willingness to “opt out” of the 48 hour/week working limit for the duration of the pandemic only.

Retired staff

The Trust has put in place plans to maximise the contribution of former staff. These include those staff nearing retirement who may be willing to return should the need arise and a register of staff who have recently retired or not left for other employment and who are willing to be available for periodic training to update their skills and to be recalled.

110 recently retired staff were contacted in order to ascertain their interest and suitability to return should the need arise. 60 of the staff who were contacted responded with 34 being assessed as suitable candidates to return.

Staff Group	Number of suitable candidates
Nursing	17
Clinical support – AHP’s	5
Non- clinical support	1
Admin & Clerical	11

Such plans must include appropriate competency assessment and the need for continued professional registration or rapid re-certification (if appropriate). Managers will be required to ascertain interest in being recalled to BHR as part of the normal exit arrangements and to inform HR so that this can be recorded.

Temporary staff

Temporary staff via NHS Professionals will continue to be booked in the usual way, but increased usage identified through coding at time of booking.

However, at present 56% of all NHSP staff supplied to BHRUT are currently substantive Trust staff. Therefore the likelihood of additional resources becoming available is reduced.

In order to monitor usage agency staff will continue to be booked via NHSP and MUST not be booked directly.

The Trust is actively recruiting to an internal bank for staff groups outside of nursing, this includes AHP's to increase the workforce capacity available. In addition, although the Trust already has a supply of volunteers, members of the public may be asked to volunteer to help during a pandemic. If a request for volunteers is made through local media, a dedicated telephone number will be identified to enable central collection of information. The HR department will then ensure that the recruitment and induction of volunteers is undertaken in the normal way, as well as issuing them with honorary contracts if appropriate.

Medical staff

A staged approach to contingency management will be implemented for this group. The first stage of the process if medical staffing becomes an issue will be to take advantage of the EWTD opt out in order to keep optimum services functioning. A list of all medical staff who have chosen to opt out for the period relating to the flu pandemic has been compiled and formulated into a 'pool' of medical staff which can be drawn upon should the need arise.

Should the situation worsen non-essential services will be reduced according to the contingency plans defined within this overall plan and available staff will be redeployed. Fair allocation and H&S requirements of the workforce will be maintained as far as possible using HealthRoster which is currently being used to manage all junior doctors' rotas.

Should a national temporary derogation of the WTD be instated the trust in the first instance would attempt to remain within the local opt out parameters, whilst maintaining a sensible cap on the number of hours.

Doctor's In Training

EWTD rotas within the Trust remain compliant but it is vital to point out that due to a national shortage of middle grade training doctors rotas in areas such as A&E, Trauma, Paediatrics and medicine are in precarious position. In response an overseas task force has been initiated which has an aggressive recruitment campaign which envisages filling vacant posts by December, this in turn will generate spare capacity of available doctors.

The shortfall of doctors due to absence has been considered within the Trusts current medical staffing recruitment strategy. The Trust started the new intake with a significant shortfall in the placement of training doctors, largely due to national shortages, and partly down to the rotations we are offering to the deanery. This has resulted in an aggressive overseas recruitment campaign targeting Europe and Australia/New Zealand/Asia, this campaign commenced on 14th September 2009 and

has been optimistically filling vacant posts in A&E and T&O with plans to fill in Paediatrics and Medicine by the end of the year. The campaign will continue to progress through out the winter months to increase the availability of floater doctors and increase of bank pool of doctors.

We are also revisiting our Clinical Attachments policy to bring in attachments for a period of 3 months on completion of a sponsored attachment they will undertake locum work for the Trust for the next 3 months..

18.1.8 Special Leave

It is expected that there will be an increase in requests from staff for Special Leave, for the care for dependant(s) who have flu; if schools close (in the event of teaching staff shortages or to reduce cross infection), which may require parents/carers to request special leave to look after children who are not able to attend school; for compassionate leave due to a bereavement of a family member/dependant.

If a member of staff requests special leave then this should be requested in writing to their line manager as indicated within BHR Special Leave Policy. If the individual is unable to put the request in writing prior to commencing their leave then it can be completed on their return.

All staff have a responsibility to attend work particularly when there are staff shortages due to a flu pandemic. Whilst there are instances where this will not be possible managers will assess each special leave request on a case by case basis and acceptance of the request is at manager's discretion. Therefore all staff will be asked to explore all possible avenues before requesting special leave.

Where staff request special leave then Managers will be required to inform HR. This is to ensure that BHR is able to report daily on absence levels to assist in the redeployment of staff and to provide the SHA with statistical information.

The professional codes that apply to registered NHS staff make clear that staff have a responsibility to provide care to those in need. Whilst staff do not have the right to refuse to attend work unless there is a clear health and safety risk, the Trust needs to acknowledge the level of anxiety that a pandemic is likely to generate and seek to work with staff to reassure them

Staff who are not ill themselves, but have carer responsibilities, will be given a combination of paid and/or unpaid leave or annual leave, at managers discretion, as per the Special Leave Policy.

18.1.9 Annual Leave

The procedure for requesting annual leave will remain unchanged. Based on the level of the flu pandemic, arrangements for the restriction and/or postponement of both planned and ad hoc annual leave will need to be determined. Requests for leave should be considered on their merits at the time as it is important, in balancing needs, to allow staff to recuperate from the pressures of working during the pandemic.

All annual leave is subject to operational needs and demands therefore a specific policy is not deemed necessary; however, appropriate communications briefings will be issued to remind staff of such contingency arrangements. Therefore, as at any

other time, a manager may accept or decline this leave in accordance with service or staffing demands.

In extreme circumstances the decision may be made at Director level to cancel all non-essential annual/study leave. Financial commitments and disruption to personal circumstances will be taken into consideration.

Following a flu pandemic outbreak there may be a large amount of staff that have had their annual leave cancelled or have been unable to take annual leave. Due to being unable to predict the impact and the effect a flu pandemic will have on BHR, a decision will be made following an outbreak to determine if there is a need to carry more than the 5 days annual leave over to the next annual leave year. This will be agreed by the Director of HR following an assessment of the situation.

18.1.10 Recruitment Process & CRB Checks

HR will provide a truncated process to enable fast turnaround of applications into new starters. This will involve utilising verbal offers and reference checks and they will undertake this on behalf of managers. However this can not be the case with CRB checks. Managers therefore, must not allow unaccompanied new starters to be unsupervised with any patient until given the clearance from HR. This is not negotiable. All contractual documentation will be provided from HR following the start date of the new employee and will be in accordance with legal requirements.

18.1.11 Sharing Staff between Organisations

HR Directors will draw up local agreements to allow the secondment of staff between organisations on existing terms and conditions. These agreements will include the provision of organisational induction training.

All NHS staff will be covered by their employer's insurance even if they are working on a different site or seconded to a different employer.

Following discussions with community representatives HR envisages that the majority of community based staff will remain in the community during a pandemic in order to prevent admission and to expedite discharge.

18.1.12 Graduate Healthcare Professionals

Newly qualified staff, who have not yet secured employment, may be offered temporary contracts, during a pandemic. However, if nurses, for example, have not yet gained registration, they may only be employed as Healthcare Assistants, until registration is received.

The Trust is also in discussions with the London South Bank University and Medical Schools to pursue all possible avenues.

18.1.13 Workforce Assurance

The Department of Health has established a national NHS Pandemic Flu Workforce Task and Finish Group to oversee NHS workforce contingency planning for pandemic flu, risks, and actions being taken to mitigate risks. The Group has sought assurance that there is maximum resilience in every NHS organisation by 30 September 2009.

The DH requires each SHA to provide assurance to the NHS Pandemic Flu Workforce Task and Finish Group that there is maximum resilience in every NHS organisation in London by 30 September 2009.

As a result the Trust was required to complete a Risk Analysis template (provided by NHSL) for 3 months for the period July – September 2009, the template provides a level of awareness for specified risks, informing NHSL of any other service difficulties that arise during each month period due to workforce/HR issues.

A copy of the final template submitted is provided at Appendix 11b.

18.1.14 Escalation of Non-adherence to Plan

Failure to comply with centralised sickness and absence reporting will be escalated through line managers to Divisional Directors, and disciplinary action may result (Trust policies Managing Poor Performance & The Disciplinary policy)

Excessive levels of sickness absence/maternity leave/vacancies, which cannot be covered by the use Bank/agency staff, may result in staffing levels which do not allow the normal number of beds to be open. This is particularly relevant when we are being told to prepare for an anticipated staff absence of up to 25% due Pandemic Flu (H1N1) alone.

The Trust will be innovative in maintaining bed capacity by redistributing nurses and other resources throughout the organisation and Appendix 3 identifies the process that should be followed when identifying areas that may be at risk due to reduced staffing levels.

18.1.15 Joint Staff Committee

In order to ensure staff engagement and support, the Trust's Joint Staff Committee (JSC) has been kept fully briefed on the status of the Pandemic Flu and the arrangements being made within the Trust to tackle the challenges posed, not in the least with regard to the vaccination of the Trust's staff.

A copy of the meeting minutes where these topics have been discussed are attached at Appendix 11c.

18.1.16 Influenza Vaccination

The current plan is to push out the vaccination of all staff via the Matrons, this being completed by nominated nurses to implement and roll out both the H1N1 and seasonal influenza vaccinations. Please see attached at Appendix 12 the Vaccination Plan for further information.

The Trust has a target of 90 – 100% uptake of both vaccinations – the normal seasonal influenza vaccination uptake is historically low with only a 14% uptake being achieved in 2008/09. As such, a high profile communications drive is being undertaken to raise the profile and to encourage staff with the aim of increasing the uptake.

Inpatient vaccination

BHRUT are considering the vaccination of high risk and immunosuppressed patients whose length of stay may be longer than 2 weeks. This work is currently in progress with select physicians and the Flu committee.

18.2 Communications

The Trust's Communications Team will:

- Adopt processes detailed in "Communications Out of Hours" and "Dealing with Press Enquiries" attached at Appendix 13;
- All members of Communications Team to work remotely when required, utilising the out of hours dial-up technology already implemented;
- Facilities in place for a media centre at Queen's and KGH, with a Communications Representative liaising with Gold Command, as per the Trust's Major Incident Plan;
- Provide the media with updates on a regular basis, keeping them well informed;
- Spokespeople to be clinical staff whenever possible (in the case of Pandemic Flu, the Flu Director). In other cases the Medical Director, or if not available, the Director of Nursing;
- Put arrangements in place for pre-determined messages that can be given automatically to those telephoning the hospital at times of winter pressure;
- Keep the Communications Team at NHS London informed and prepare joint statements in liaison with partner organisations and local stakeholders if required;
- Utilise established links with local papers and radio to issue messages to the public, as and when required.

18.2.1 Communication with staff and media

The Trust's Communications Plan is as detailed overleaf.

In addition to the main Pandemic Flu (H1N1) and Winter Resilience Plan, the Trust intends to produce a summary plan to circulate to staff. This will be available both in hard copy and via the Trust's Intr@net to ensure that all staff have access to the information.

Type	Description	Activities
Internal Communications	<p>Updating Divisions/Directorates regarding the latest developments on winter resilience and flu and the impact on their work.</p> <p>Ways of receiving flu specific services, such as vaccinations and antivirals.</p>	<p>Internal communications will be discussed at each bed management meeting. All attendees would be required to communicate issues/actions to their respective Divisions/Directorates.</p> <p>A cascade process will be implemented for those services that are expected to have a substantial impact and representatives at a daily whole health economy meeting/teleconference call will disseminate appropriate information to their teams.</p> <p>Internal communications will be sent out following a daily whole health economy meeting/teleconference call via an agreed communication cascade pathway. Membership of meeting/teleconference calls will consist of agreed 'core' members.</p> <p>Weekly e-communications to all staff from Communications Department and staff briefings organised daily/weekly when required.</p> <p>Utilise existing communication links with NHS London Communications Department and keep them fully informed, preparing joint statements when required in liaison with partner organisations and local stakeholders.</p> <p>Additional communications to be prepared via the Infection Control Team.</p> <p>Update the Trust website and Intr@net with key messages on a regular basis. Remote access in place for members of the communications team.</p> <p>Any internal communications regarding flu services, vaccinations and antivirals, will be communicated either in the weekly e-communication or staff briefings.</p>

Type	Description	Activities
External Communications	<p>Communication with all Commissioners and Local Stakeholders.</p> <p>Communication with local media.</p> <p>Ways of receiving flu specific services, such as vaccinations and access to antiviral.</p> <p>Status of services in the local area which may be under pressure during winter.</p> <p>Direct contact with patients and answering questions through a local telephone line.</p> <p>Keep local MPs informed and involved.</p>	<p>If a system wide event takes place, which requires all Commissioners and Local Stakeholders to receive a communication, this will be distributed by the local Lead Commissioner, working with the PCT Communication Teams on the production of content. For confidentiality NHS net email addresses would be considered.</p> <p>Proactive communications prepared where we seek to engage with partners in the media and elsewhere, in order to communicate with the public.</p> <p>Remote access in place for members of the communications team.</p> <p>Provide the media with updates on a regular basis, keeping them well informed. Utilise established links with local papers and radio to issue messages to the public as and when required.</p> <p>Processes for vaccination and antiviral on websites and through using local press and radio stations.</p> <p>Planned messages released through the Trust website and local press/radio stations. Facilities in place for a media centre at Queen's and King George Hospitals, with a communications representative liaising with Gold Command, as per the Trust's Major Incident Plan.</p> <p>Spokespeople available (to be clinical staff whenever possible - in the case of Pandemic Flu, the Flu Director). In other cases, the Medical Director, or if not available, the Director of Nursing.</p> <p>Work with the existing Patient Advice and Liaison Service (PALS) to disseminate information to callers as required from briefing provided by Communications Department. Additional capacity for existing PALS service to be considered, if required.</p> <p>MP briefings to be prepared, regularly updated and distributed.</p>

18.3 Clinical Support

18.3.1 Diagnostics

Radiology: Radiology has contingency and business continuity plans for Pandemic flu (H1N1) which detail the action to be taken with increased demand for radiological tests and decreasing staff levels as staff are affected and sickness rises on a sliding scale to from 0% to 50% loss of staff of all grades across all specialities (Radiographers, Radiologists, Nurses, Radiographic Helpers and Clerical staff).

These plans outline the action that will be taken by the Radiology Department depending on the percentage of staff absent on a particular shift.

The actions include:

- Restricting annual leave and study leave;
- Stop imaging non-urgent radiological requests by suspending non-urgent work for GP and Out-patient referrals;
- Offering overtime to necessary staff;
- Maximising use of flexible contracted staff;
- Consider cross-site working by re-deploying site specific staff, to ensure all areas are covered by qualified staff;
- Prioritising work for in-patients and theatres and A&E referrals;
- Utilise weekend and/or evening staff (on-call) to provide the necessary level of cover;
- Eventually considering consolidating core work on one site and have only essential Imaging on the other site;
- Cancelling annual leave and study leave;
- Ultimately reducing Radiological service to a core essential service akin to the on-call (out of hours emergency service).

We assume all other local hospitals and Radiology Departments would be in a similar situation and would be unable to accept referrals from us, as we would not be able to accept from them.

The Managerial structure is known to all Radiological staff and would indicate the chain of command and the senior manager for decision making if key staff are unavailable for work due to influenza.

Pathology: Pathology has contingency and business continuity plans for Pandemic flu which detail the action to be taken with increased demand for tests and decreasing staff levels as staff are affected and sickness rises on a sliding scale to 70% loss. These plans include:

- Restricting annual/study leave;
- Stop processing non-urgent screening work;
- Prioritising work by suspending non-urgent work;
- Additional weekend and/or evening work;

- Suspending phlebotomy service;
- Consolidating core work on one site;
- Cancelling annual leave;
- Ultimately reducing to a core service akin to the out of hours emergency level.

The details of each laboratory's plans are available separately.

Chain of Command

Pathology is headed by a General Manager supported by 6 service managers (Head Biomedical Scientists) managing specialised workforces in:

- Biochemistry;
- Haematology and Blood Transfusion and Phlebotomy (QH and KGH separately);
- Histology;
- Cytology;
- Microbiology.

Together with an IM&T Manager, Quality Manager and Lead Blood Transfusion Practitioner.

In prolonged absence of the General Manager, the Head Biomedical Scientist for Haematology, Blood Transfusion and Phlebotomy at Queen's Hospital would formally deputise. In her absence this would pass to other HBSs depending on the situation in their services at the time.

18.3.2 Pharmacy

Actions to be taken by the Pharmacy service are detailed in the Pharmacy Business Continuity Plan which covers all services provided.

On-call services and weekend/late evening services will be provided and a list has been developed of previous BHRUT staff (retired etc) who could be called upon and of part-time staff who could increase their hours.

Those services which could be reduced or stopped in order to maximise services to core/acute areas have been identified.

In addition, arrangements have been made with locum agencies to provide qualified staff should this be necessary.

18.3.3 Infection Control

The provision for single/en suite rooms across King George and Queen's Hospitals is adequate to accommodate patients requiring this facility. The facilities include 6 negative pressure rooms:

KGH:

- Foxglove ward x 1
- Gentian ward x 1

Queen's Hospital:

- Ocean B ward x 2
- Medical assessment unit x 2

Consideration must be given to other respiratory cases in particular Tuberculosis (TB) specifically Multi Drug Resistant Tuberculosis (MRDTB) patients as well as patients with other highly transmissible infections.

The plan is to place up to 20 patients on either site in single rooms. When this number is reached the cohort wards must be established and patients moved from single rooms. These wards may have to be reviewed if admissions exceed the single room numbers as elective surgery may not necessarily have been reduced and Ocean ward may still be functional. Alternatively the IDSYTC may be used as an isolation ward.

These wards will accommodate the clinically confirmed or clinically risk assessed to be H1N1 positive. The patients will be placed in either bays or single rooms according to their clinical requirement and other co-morbidities. Patients with other normal seasonal chest infections/pneumonia will have to be carefully assessed so as not to confuse their condition with H1N1 Influenza. A priority list of excluded patients is being developed locally. There is a separate local plan for isolating and cohorting children in the full paediatric plan. The Maternity unit will manage their patients in single rooms or bays with the support of the infection prevention and control team. Daily SitReps will be cross referenced with bed and site team and the infection prevention and control team.

The Trust's Hand Hygiene Policy, Isolation Policy, Pandemic Influenza Infection Control Guidance, Outbreak Management Policy and Management of Influenza Flowchart are attached at Appendix 13a.

18.3.4 Mortuary Capacity

The mortuaries have ample capacity, however in the event of overwhelming body numbers the Trust has contracts in place with Undertakers to increase capacity. If this capacity is exceeded the Trust would rent or purchase approved temporary body storage units however it is unlikely that this would be necessary as community facilities have been arranged to ensure that there is sufficient storage available.

There are 6 staff across two mortuaries - one mortuary can function with a minimum of 2 staff, so services would be centralised at Queen's Hospital should staffing reduce by 50% or more.

The Trust would not anticipate other local Trusts accepting bodies from us, as in cases of extreme pressure we would not be able to accept from them.

18.4 Non-Clinical Support

18.4.1 Accommodation

Staff accommodation is available at both KGH and Queen's Hospital:

KGH – London & Quadrant

- Bed Capacity 294;

- Bed availability at present 35;
- On Call Rooms 8;
- Quiet Room Accommodation on Management Corridor 5.

Queen's Hospital – Swan Housing

- Capacity 369 properties
- Bed availability at present 229
- On Call Rooms – Trust to look at parity with KGH
- Quiet Room Accommodation on hospital site 12 each with 2 full recliners

The Accommodation Manager will arrange for keys to be made available to staff should they not be able to commute to and from work as normal due to winter pressures/pandemic flu (H1N1). Keys will be held by Security on each site and authority for release of keys to members of staff should be given by the General Manager of the service. All keys will need to be signed for and noted on the key log.

In addition to this, the Trust is investigating the cost of holding a number of rooms for emergency use on both sites.

In the coming days/weeks a list of local hotels (to both sites) is to be compiled as well as a listing of local letting agents.

18.4.2 Linen

Increased demand for Linen Services will be managed through current practices of review and monitoring of stock levels (inclusive of Buffer Stock) daily. Additional supplies of stock would be ordered and received from our Contracted provider. Access to additional buffer stock "Out of Hours" is already in place on both the main hospital sites. Cross-site sharing of stock items is also facilitated where needs are identified.

Contract Monitoring Officers would revert to a "hands on" approach for the duration of short-term increased absence and staggered shifts could also be considered/implemented if necessary.

In extreme circumstances with national shortages of linen, stock needs would have to be prioritised for packing and delivery on a clinical/ward based priority.

Close partnership working with Porterage staff (FM contract provider) would ensure delivery in priority order (needs basis) to clinical areas and enable porterage staff to deliver linen to wards/clinical areas on the Queen's Hospital site allowing experienced Linen staff to remain processing and packing of stock for onward delivery to the clinical areas/wards.

18.4.3 Food

The Trust's catering services are provided by Sodexo who have confirmed that they have received assurance from all Suppliers that contingency plans are in place, so that deliveries will not be affected. Sodexo will not be 'stockpiling' food items and have confirmed that they would revert to a simplified menu, should the need arise.

18.4.4 Procurement

NHS Supply Chain (NHSSC) has already put contingency plans in operation with their Suppliers and the Trust has its own stock pile of essential PPE supplies. There is a rolling stock of 7-10 days on all consumables from NHSSC. We also have other consolidated Suppliers on whom we can call. With regard to Non Stock, orders would be prioritised and all staff would multi skill including senior managers becoming operational.

The Stockpiling Operational Plan is attached at Appendix 13b.

18.4.5 Transport

Any staff shortages are covered with overtime and/or agency staffing. In the event of staff shortages, services would be prioritised and we have a contingency arrangement with our external contracted services. Transport services will continue to run until such times as road conditions become unsafe for driving.

18.4.6 Chaplaincy

The Chaplaincy Team work across site and include currently 2.0 WTE with an additional full time member due to join the team in October 2009. They work with an extensive bank of chaplains and volunteers and undertake on call duties on a rotational basis. Their role would be pastoral as well as spiritual in the support of patients, relatives as well as staff within their capacity to counsel in all circumstances including bereavement. Their rotation to on call would be extended to include the bank chaplains over this extended period of time with remuneration accordingly. They would also see patients and staff from other faiths and advise/counsel or seek advice e.g. Muslim chaplains for instance from nearby Trusts such as Newham for specific information.

18.4.7 Counselling

The Pastoral care team provide a counselling service that is generic and not specifically related to solely spiritual care (as specified above). As such they become involved proactively within maternity settings for baby deaths as well as Intensive Care and general ward patients.

The Bereavement service currently constitutes 3 administrative staff who cover cross site services and have support from other staff trained the administration of death certification and provision of information for relatives concerning registration.

There is a Registrar based at Queen's Hospital affiliated with the service.

In addition, the Maternity service has two part-time Counsellors who work with women and their families following events such as a still birth. These staff could be used within the Maternity service for a wider role during the Pandemic if this is necessary.

19. Pandemic Flu (H1N1) and Winter Resilience Control Team Membership

The Trust has an Executive Director responsible for Pandemic Flu (H1N1) Planning (Director of Planning and Delivery), a Flu Director (substantively the Head of Infection Control) and a Safety and Emergency Planner.

The Trust has a Pandemic Flu (H1N1) and Winter Resilience Committee which consists of a multidisciplinary team covering all areas within the Trust. The Terms of Reference for this Committee are attached at Appendix 14 along with copies of the minutes and an example of the action log which is completed at each meeting.

The core members of this Committee who will form the Control Team are:

- Director of Planning and Delivery (Deputy: TBA);
- Medical Director (Deputy: TBA);
- Flu Director (Deputy: Safety & Emergency Planning Manager);
- A representative from each clinical Division Management Team;
- Director of Estates and Facilities (Deputy: TBA).

These members will form the minimum requirements with further members of the Pandemic Flu (H1N1) and Winter Resilience Committee attending as far as practicable.

20. Reporting Lines

Regular updates are provided to the Strategy and Service Improvement Board (S&SIB) which constitutes the Trust's Executive Board by both the Director of Planning and Delivery and the Flu Director. The Trust Board are also fully on board with Pandemic Flu (H1N1) planning and will formally sign off this plan at its September meeting.

The Trust, as a first line responder, has a responsibility under the Civil Contingencies Act 2004 and is required to ensure that its Emergency Plans are maintained and up to date. To this end the Trust has produced Service Continuity Plans which will ensure that its core services are delivered during any emergency.

21. Triggers to Activate the Plan at Standby Level

Please refer to the Corporate Adult Bed Management Policy and Staffing Impact Assessments (see Appendices 15 and 11 respectively).

22. Triggers to Activate the Plan at Implement Level

Please refer to the Corporate Adult Bed Management Policy and Staffing Impact Assessments (see Appendices 15 and 11 respectively).

23. Management of Response to Pandemic Flu (H1N1)

Please refer to Appendix 16, Management of Response.

24. Response Team Roles and Responsibilities

As detailed within the Corporate Adult Bed Management Policy and the Escalation Policy.

25. Stand Down Phase and Recovery

As demand for services subsides the level of alert will be stood down through the stages of SIE status through to Green status in accordance with the Corporate Adult Bed Management Policy.

As part of the response it may have been necessary to cancel elective activity. As a result TCIs and outpatient clinics should be re-instated as soon as possible following the event. However, liaison with the Theatre Manager should be undertaken to establish if any theatres are to be out of general use as a result of the need to increase critical care capacity resulting from Pandemic Flu (H1N1).

TCIs should be discussed with the General Managers and Clinicians, to ensure that re-instated patients can be accommodated on proposed theatre lists and where necessary, the availability of ITU and HDU beds.

The departmental BCPs identify critical and non critical services. During an event and the immediate aftermath, it is reasonable for non critical services to be temporarily stopped so that resources can be re-allocated to the more critical areas. However these functions cannot be suspended indefinitely and any suspension will have consequences during the recovery phase.

Services should be discontinued in a priority order with the most important business service being discontinued last. The recovery order will, in the main, be a reversal of the Service Priority order.

The departmental BCPs highlight the most and least critical functions for each area.

26. Audit and Review Process

26.1 Audit

With any incident or event that requires the Pandemic Flu (H1N1) Plan or Winter Resilience Plan to be enacted there will be a requirement for post event enquiry, (whether public or private). It is imperative that comprehensive notes are made to ensure that a record is kept of:

- Actions taken;
- Decisions made;
- Events that occurred;

A complete audit trail of all decisions made/actions taken (meeting minutes, correspondence copies etc) should be kept which should focus on the three areas above.

All paperwork generated from the activities should be held centrally and once complete passed to the Safety and Emergency Planning Manager.

27. Debrief

When the organisation/department has recovered and all areas returned to normality, a debrief should be held by the lead person responsible for the Pandemic Flu (H1N1)/Winter Resilience effort.

The Debrief should focus on:

- Which areas went well;
- Which areas could be improved and how they could be improved;
- Lessons learnt.

A full list of all expanded resources should also be gathered and whilst this may not be possible for completion prior to the debrief this information should be passed to the Head of Emergency Planning or other nominated individual as financial compensation may be possible.

27.1 Review

This plan will be reviewed on an annual basis or every time a significant change has occurred within the Divisions necessitating a substantial change to the plan. The plan will be reviewed and signed off by the Emergency Preparedness Group, the Strategy and Service Improvement Board and the Governance Committee.

Annex 1

WHO Phases and UK alert levels

Phase	WHO international phases	Overarching public health goals
Inter-pandemic period		
1	No new influenza virus subtypes detected in humans	Strengthen influenza pandemic preparedness at global, regional, national and sub-national levels Minimise the risk of transmission to humans; detect and report such transmission rapidly if it occurs
2	Animal influenza virus subtype poses substantial risk	
Pandemic alert period		
3	Human infection(s) with a new subtype, but no (or rare) person-to-person spread to a close contact	Ensure rapid characterisation of the new virus subtype and early detection, notification and response to additional cases Contain new virus or delay its spread transmission to gain time to implement preparedness measures, including vaccine development Maximise efforts to contain or delay spread, to possibly avert a pandemic and to gain time to implement response measures
4	Small cluster(s) with limited person-to-person transmission but spread is highly localised, suggesting that the virus is not well adapted to humans	
5	Large cluster(s) but person-to-person spread still localised, suggesting that the virus is becoming increasingly better adapted to humans	
Pandemic period		
	<p><i>Increased and sustained transmission in general population</i></p> <p>UK alert levels: (for planning purposes only)</p> <p>1 Virus/cases only outside the UK</p> <p>2 Virus isolated in the UK</p> <p>3 Outbreak(s) in the UK</p> <p>4 Widespread activity across the UK</p>	Minimise the impact of the pandemic

Key:

Indicates current WHO phase (as at June 2009)



APPENDICES

- 1 BHRUT Inpatient Capacity
- 2 Health Systems Improvement Board Minutes, Whole Systems Group Minutes and Community Plan
- 2a BHRUT Business Continuity Plan and Specialty/Departmental Business Continuity Plans
- 2a Daily Swine Flu SitRep Template
- 2b Daily Winter SitRep Template
- 2c Weekly SitRep Template
- 3 Trust Management Structure
- 4 Gold and Silver Control Officers Listing
- 5 Admissions and Discharge Criteria for Critically Ill Patients
- 6 DH Critical Care Strategy
- 7 Cross Buffer Terms of Reference
- 8 Economy Wide Balanced Scorecard
- 8a Guideline for the Management of Swine Flu in Pregnancy
- 8b Pandemic Influenza Contingency Plan for the Provision of Paediatric and Neonatal Care at BHRUT
- 9 Ethics Committee Terms of Reference
- 10 Escalation Process and Ambulance Turnaround Plan
- 11 Staff Sickness Rates
- 11a Staff Mandatory Questionnaire
- 11b HR Risk Analysis
- 11c Joint Staff Committee Documentation
- 12 Vaccination Plan
- 13 Out of Hours Communications and Press Enquiries
- 13a Infection Control Documentation
- 13b Stockpiling Operational Policy
- 14 Pandemic Flu and Winter Resilience Committee Documentation
- 15 Corporate Bed Management Policy – DRAFT
- 16 Management of Response