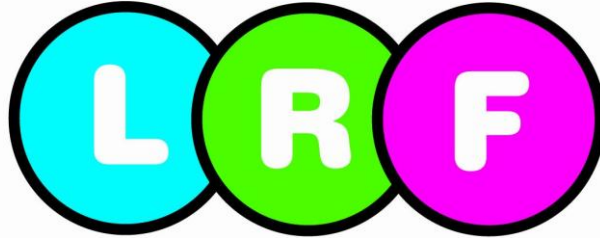


Devon • Cornwall • Isles of Scilly



Local Resilience Forum

INFLUENZA PANDEMIC CONTAINMENT PLAN



PREPARING FOR EMERGENCIES

All items in this document are classed as open under the Freedom of Information Act unless otherwise stated. All closed items include the relevant Freedom of Information Act exemption.

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Revision History

Revision Date	Version No	Summary of Change	Changes made by	Authorised by	Date
21 May 09	1	Initial draft version.			
28 May 09	2	2 nd Draft			
28 Oct 09	2.1	Final Draft			

Distribution

Name	Department	Organisation

This Plan is owned by the Devon, Cornwall and Isles of Scilly LRF, maintained, and updated by the LRF Heath Emergency Management Subgroup. All users are asked to advise the Secretariat of any changes in circumstances that may materially affect the plan in any way.

Details of changes should be sent to:

Devon, Cornwall and Isles of Scilly Local Resilience Forum Secretariat

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Influenza Pandemic Containment Plan

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TITLE & OWNERSHIP

This document is entitled the 'Devon, Cornwall and Isles of Scilly LRF Influenza Pandemic Containment Plan.

It has been produced by the Devon, Cornwall and Isles of Scilly Local Resilience Forum (LRF). The LRF has the rights of ownership of this document, with distribution being agreed by the LRF members. No amendment of this plan is permitted without the express agreement of the LRF.

BACKGROUND

The National Risk Register requires all LRFs to plan for an Influenza Pandemic. The requirement is to have the capability to have a plan in place to deal with all aspects of an outbreak of Influenza Pandemic across the LRF region and this plan specifically addresses the issue of containment within the early stages, i.e. for the first 3000 cases in the UK, hereafter known as F3000. This plan should be read in conjunction with the Devon, Cornwall and Isles of Scilly Local Resilience Forum Pandemic Influenza Plan and the school mass prophylaxis pack.

Each agency is responsible for identifying key personnel who may be involved in the containment plan response to confirmed cases. Appropriate training will be administered by the HPA and or Director of Public Health in each area. The main agencies this plan relates to are those with either mass prophylaxis or contact tracing skills and experience namely:-

1. The Health Protection Agency
2. PCTS and Care Trusts within the LRF Area
3. LA Environmental Health Services

Although other health agencies may be called on to assist, if the scale of containment becomes such that several containment operations are required within the LRF area at the same time.

PURPOSE OF THE DOCUMENT

The purpose of the document is to act as the tactical plan by which all containment incidents are managed within the Devon, Cornwall and Isles of Scilly LRF area.

It is intended for use by the NHS and the HPA within the LRF area when each respective organisation is invoking special procedures to deal with Influenza Pandemic containment.

This tactical plan contains the detailed information by which personnel deployed to deal with Influenza Pandemic containment will carry out their required functions. This plan emphasises the necessity to establish liaison between all the responders involved in the response from the onset of a confirmed case and continually throughout at all levels of command. By its achievement each agency will be able to carry out their roles and responsibilities to maximum efficiency as part of a unified joint strategy.

REVIEW & AMENDMENT

The Influenza Pandemic Containment Plan is a 'living document' therefore it is subject to review by the LRF to ensure it is current, reflects best practice, and is fit for purpose.

The plan will be amended when required, and will be subject to annual review, guided by the date of the document and version number. The review will be undertaken by the Infectious Diseases (Human) sub group.

1 INTRODUCTION

1.1 The aim of this document is to outline arrangements for the containment of A/H1N1 influenza in Devon, Cornwall and the Isles of Scilly during the planned F3000 containment phase.

1.1.1 This plan has been developed with the co-operation of appropriate members of the Devon, Cornwall and Isles of Scilly Local Resilience Forum, Infectious Diseases – Human sub-group.

1.1.2 It is intended that this plan should be as flexible as possible so as to produce an appropriate response in a wide range of different circumstances, as containment may be necessary in certain settings like school or workplace or in local communities.

1.2 This plan will be reviewed and updated as necessary no later than 3 years from the date of publication.

2 BACKGROUND

2.1 The Civil Contingencies Act 2004 (CCA) requires all 'Category 1' Responders, which include the Health Agencies, Emergency Services and Local Authorities, to co-operate with each other and maintain plans to respond to civil 'emergencies'. An influenza pandemic would undoubtedly come under the definition of 'emergency'.

3 TRIGGER POINTS/ACTIVATION

3.1 Phase 1 deals with the current situation as of May 2009 where the containment plan F3000 has been activated.

Internal Health Protection Agency (HPA) and Primary Care Trust (PCT) activation

3.2 Phase 2 deals with plans to move to mitigation once spread of the virus is such that containment is no longer effective. This will be decided at national level but may be triggered on advice from the HPA or SHAs with large numbers of cases.

Department of Health/HPA activation estimate of trigger point.

4 NOTIFICATION PROCEDURE

4.1 In the event of a pandemic or other public health emergency the notification of a decision to activate this plan will be given by the Devon, Cornwall and Isles of Scilly Local Resilience Forum on advice from either the Health Protection Agency or the local Director of Public Health.

4.2 The responsibility for notifying the identified cohort at risk to present for assessment and prophylaxis lies with the HPA.

5 MODELLING

- 5.1 If the cases within the LRF area develop as isolated cases like Paignton, then the amount of resources needed to deliver the containment plan can be calculated roughly. The year group and staff numbers from Paignton have been used as an average.
- 5.2 One containment procedure for approx 300 pupils plus 75 staff with setting up, briefing, assessing and administering, debriefing and clearing away, took 7 hours in total for 11 members of staff.

Number of confirmed cases	Pupils plus school staff needing assessment and treatment	Health personnel needed	Total hours to complete procedure	Total days to complete procedure
1	375	11	7	1
10	3,750	110	70	10
100	37,500	1,110	700	100
300	112,250	3,330	2,100	300
3000	1,125,000	33,000	21,000	3,000

6 RESPONDING TO A CONFIRMED CASE IN A SCHOOL PUPIL

- 6.1 Once a decision to offer prophylaxis to a group of people has been made, a team of people will be needed to run the session. The preference is for nurses signed up to the accepted patient group direction or patient specific direction (PGD/PSD) which enables prescription only medicines to be given without individual prescriptions. One Doctor will be needed for interpretation of complex cases and a health protection nurse/competent clinician to do the swabbing of people with symptoms, and appropriate personal protective equipment (PPE).

Separate team to deal with wider media and neighbouring authorities

7 FORMULA FOR RESOURCING THE ADMINISTRATION OF DOSES.

- 7.1 From early experience of containment (Paignton) approx 300 doses can be given in 4 hours (so about 75 doses per hour) running 9 tables, one extra table in a separate room would be needed for swabbing symptomatic contacts. **This is for containment around one confirmed case** or for situations where a number of children in the same school are confirmed cases within the same time frame.

One table (administrator) = 8 students each hour

$$\text{Time to deliver} = \frac{\text{Number of doses to administer}}{8 \times \text{No. of tables}} \quad (\text{time in Hours})$$

OR

$$\text{Number of tables needed} = \frac{\text{Number of doses to administer}}{\text{Time available (hrs)} \times 8}$$

8 STAFFING AND RESPONSIBILITIES

8.1 Each member of the attending team will be required to undertake specific duties to ensure the efficient running of the containment vaccination session.

8.2 Suggested duties for each member are as follows:

Senior Staff Member (Coordinator)	<ul style="list-style-type: none"> Liaise with head teacher for facilities and traffic control List of children and staff required Ensure children have guardian consent Fielding calls from off site teams including SHA Participation in teleconferences with Strategic Co-ordinating Group or Silver Liaise with requests via GOLD/ SILVER re progress Deal with exceptional parental concern Assist with traffic flow to the tables (capacity allowing)
Clinician	<ul style="list-style-type: none"> Brief team on advice and information to be disseminated during each 1:1 contact Provide appropriate clinical support to parents of children with existing medical conditions, liaising with GPs where necessary Agree letter to children if required Available to address all clinical uncertainties Ensure acceptable levels of administration Assist with traffic flow to the tables
Room supervisor	<ul style="list-style-type: none"> Ensure tables topped up with required tools Drugs, information, water, cups etc Refreshments for administrators Assist with traffic flow
Administrators (need to be trained for task)	<ul style="list-style-type: none"> Number required in accordance with formulae 8 people seen per hour (average)
Health Protection Nurse	<ul style="list-style-type: none"> Oropharyngeal swab from symptomatic people

9 EQUIPMENT

9.1 Although the exact amount and type of equipment will vary with each location a suggested list is as follows:

At each station

- Table and three chairs
- Proforma for recording details and acceptability for anti-viral drugs, further action to be identified e.g. swabbing
- Supply of anti-viral drugs
- Jug of water
- Supply of disposable cups
- Patient information (Q&As from HPU – check for most recent available)
- Bin for disposal of cups
- Calibrated scales for weighing children to determine appropriate dose

In the room

- Paper, pens
- copies of BNF
- national and local policies/algorithms
- telephone numbers for advice e.g. HPA, local GP surgeries, Hospital, regional HPA etc and contact list for resupply

A separate room (swabbing of symptomatic individuals)

- Supply of gloves, aprons, moisture resistant masks
- Specified swabs in transport medium
- Disposal items

Ensure there is sufficient anti-viral drugs, swabs and PPE (for swabbing only) for expected cohort group.

10 CONTAINMENT PROCESS

10.1 Each member of the attending team will be required to undertake specific duties to ensure the efficient running of the containment process.

10.2 A copy of the suggested institutional containment record is shown at Appendix 1.

Senior Staff Member/coordinator agrees with school

- Number of doses required
- Size and location of facility available (separate entry and exit preferred)
- Staff available to escort groups

Running the session

- Deal with one form group at a time who should be moved to an area outside of the room and returned to their original start point
- Ensure all team members take breaks
- Ensure all information required is imparted and understood with time for questions
- Administer anti-viral drugs pack and observe first dose being taken (best taken after meal so essential to have alternative supplies of food e.g. biscuits in case pupils have missed a meal)
- Identify symptomatic contacts for swabbing by trained personnel e.g. HPA nurse

Administering the anti-viral drugs

- Dispel myths and provide factual context
- Ascertain contraindications
- Explain side effects
- Discuss dosage and schedule
- Ensure consent to treatment
- Record on the pack
 - Person's name
 - Person's date of birth
 - Date of administration
 - Dosage e.g. for prophylaxis 1 tablet to be taken each day until completion (10 days).
 - Check dosage for those with symptoms, 1 tablet twice a day for 5 days for treatment.

Process at the table

- Introduction
- Establish that the person knows why they are here
- Explain what Swine flu is and its symptoms
- Check for symptoms
 - Temperature of 38C (if no thermometer history of hot/flushed)
 - Sore throat
 - Cough
 - Aching/cold limbs

A full set of the Health Protection Agency case definition for swine flu is shown at Appendix 2.

- Explain the current situation nationally
- Explain what the tablet is, what it will do and the schedule
- Establish contraindications and explain side effects
- Discuss what to do if they become ill

- Stay at home
- Ring the GP
- 'Bag it, bin it, kill it', wash hands, clean surfaces

- Witness the taking of the first dose
- Inform to take daily – preferably after food
- Ensure box has person's name and administration instructions on
- Record person's details, contraindications, symptoms and action taken.
- Confidentiality of records

11 POST EVENT

11.1 The closure of the event will require the careful correlation of all the necessary information.

11.2 Suggested actions include:

- Collect all forms
- Administrator to sign forms
- Totalise people seen
- Follow-up action to be identified and communicated/handed over where necessary
- HPA liaison

12 CONTAINMENT IN NON-INSTITUTIONAL SETTING AND CONTACT TRACING IN ADULTS.

12.1 Contact tracing, followed by treatment or isolation, is a key control measure in the battle against infectious diseases. It is an extreme form of locally targeted control, where the potential next-generation cases are the primary focus and as such has the potential to be highly efficient when dealing with low numbers of cases. For this reason it is frequently used to combat new invading viruses such as A/H1N1 or swine influenza. It is difficult to model the likely numbers as this will be situational and may range from relatively small numbers to a significantly large group.

12.2 The definition of a close contact is consider as;_Close contacts are considered to be family, friends or health care workers who lived with, or who had direct contact with the index case, for over an hour, of confirmed cases of A/H1N1 while that case was ill or in the 24 hours before illness onset.

12.3 Close contacts remain at risk until ten days after their last contact with a symptomatic case.

12.4 A list of close contacts of the A/H1N1 case should be generated within 12 hours of the case being reported.

12.5 PCTs will be responsible for identifying and following up staff and other inpatient contacts. Although PCTs will have responsibility for contact tracing in the community, initial details should be sought from the case by the HPA clinical team where possible.

- 12.6 Close contacts of the case should be assessed within 24 hours of the case being reported.
- 12.7 Assessment should be by telephone in the first instance. A subsequent home visit may be necessary because of individual circumstances such as patient concern or unsuitable home circumstances.
- 12.8 Verbal and written information on A/H1N1 swine influenza should be provided to close contacts, detailing the need for active/passive surveillance and on the need to contact their GP urgently should they themselves become unwell.
- 12.9 Contact information should be fed back to the local contact tracing team for entry onto the contact database, within 24 hours of the assessment.

Appendix one: institutional containment record

Complete form using black ink) **School/Organisation Name:** _____

Name and Address	DOB	Form Yr/Group	Symptoms	Contraindications (Pregnancy/Breast Feeding/Kidney disease)	Swab Required	Action Taken (i.e. Tamiflu dose given, refer for Swab)	Contact tel numbers Comments
			Yes/No		Yes/No		
			Yes/No		Yes/No		
			Yes/No		Yes/No		
			Yes/No		Yes/No		
			Yes/No		Yes/No		
			Yes/No		Yes/No		
			Yes/No		Yes/No		
			Yes/No		Yes/No		

Appendix 2: Swine Flu case definition

30th April 2009 Version 1.0

The Health Protection Agency is using the following case definition for swine flu.

Clinical criteria

Any person with one of the following:

- Fever $\geq 38^{\circ}\text{C}$ OR history of fever AND flu-like illness (two or more of the following symptoms: cough, headache, rhinorrhea or vomiting/diarrhoea)
- Other severe/life-threatening illness suggestive of an infectious process

Laboratory criteria

At least one of the following tests:

- Specific real-time RT-PCR swine influenza
- Four-fold rise in swine influenza A (H1N1) virus specific antibodies (acute phase sera and convalescent >10-14 days later)

Epidemiological criteria

At least one of the following in a person during the seven days before onset of illness:

- Close contact with a confirmed or probable case of swine flu A (H1N1) virus infection while the case-contact was ill or in the 24 hours before illness onset
- Travelled to a geographical area known to have confirmed or probable cases of swine influenza A/H1N1

Case classification:

A. Possible case

Any person meeting the clinical and epidemiological criteria

B. Probable case

Any person meeting the clinical and epidemiological criteria AND with a positive influenza A infection of an untypable type

C. Confirmed case

Any person with laboratory confirmation

D. Discarded case

Any suspect case not fulfilling the possible case definition or a possible case if the laboratory result is negative.