HSC Health and Social Care Board

HSC Public Health Agency

HSC Business Services Organisation

Joint Response (PHA: HSCB: BSO)

Pandemic Operational Plan

December 2015

Content

Document Control

Version Control	Title	Date
Version 3 Approved with amendments by JEP Board	Joint Response (PHA: HSCB: BSO) Pandemic Operational Plan	September 2015

1. INTRODUCTION

As per the NI HSC Influenza Pandemic Preparedness & Response Guidance (Jan 2013) all HSC organisations should have pandemic plans in place that provide:

- a clear definition of responsibilities;
- reporting and collation of surveillance requirements;
- contact tracing; swabbing and testing of samples, and issue of antivirals before
- antiviral collection points (ACP) are set up;
- surge plans for primary, secondary and critical care;
- implementation of the National Pandemic Flu Service;
- implementation of a pandemic specific vaccination programme; and
- recovery and return to business as usual.

The following pages set out the PHA, HSCB, and BSO joint operational processes that would be activated during an influenza pandemic and are based on the learning from the 2009 pandemic response.

NB: It is important to note that the basis of any joint response across PHA, HSCB and BSO to an emergency is the Joint Response Emergency Plan (JREP). As such the JREP would be activated in a pandemic and the following sections / processes would sit in parallel to the JREP. This operational paper should therefore be read in conjunction with the following plans:

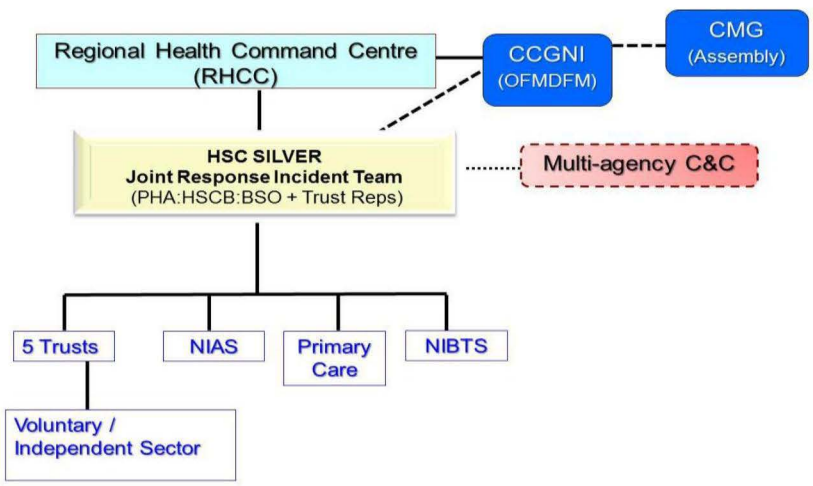
- PHA: HSCB: BSO Joint Response Emergency Plan
- Pandemic Influenza Plan Health Protection Division
  W:\DPHM\SHARED\Pandemic plan HP division 2014-15
- The DHSSPS Northern Ireland HSC Influenza Pandemic Preparedness and Response Guidance.
  http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

2. PHA: HSCB: BSO COMMAND & CONTROL

As described in the JR plan the level of command and control activated (Figure 1) as part of the joint response is incident specific and based on an initial joint risk assessment of the potential / real public health and service continuity impact of the incident.

In a pandemic the JREP would be activated at its highest level ie Level 4 and as shown in figure 1 the DHSSPS Regional Health Command (chaired by the CMO) would also be activated. The Joint Response Pandemic Incident Team would utilise the JREP revised documentation (Appendices)

Fig 1 HSC Command & Control in an Incident



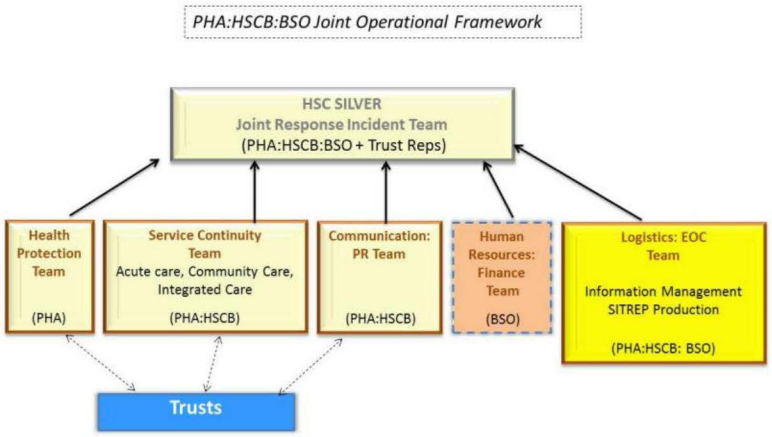
In a large incident such as a pandemic several groups of staff from across the three organisations (PHA: HSCB: and BSO) would also come together in teams (Figure 2) and feed into the Joint Response Incident Team (HSC Silver Figure 1).

The teams will include:

- health protection team,
- service continuity team
- communications team
- HR & finance team (s)
- Logistics / EOC team

The nature of a pandemic is such that the balance and focus of the issues being managed by the joint response would move in the early stages from health protection with case management and contact tracing, to service continuity and co-ordination issues in the later stages. As such the size and membership of each team may change over time. A Joint Response ICT draft agenda, Decision Log and Action Log is available in Appendices 1& 2.

Fig 2



3. Pandemic Specific PHA: HSCB: BSO Joint Response working

As noted in section 2 above in a pandemic the JR Emergency Response plan would be activated however the learning from Phase 1 of a national pandemic exercise in May 2014 highlighted the need for several pandemic areas of 'joint' working to be further clarified. The following sections highlight the agreed joint position in each area that should be followed during a pandemic response.

3.1 Service Continuity

3.1.1 Integrated Care

- **Model for Swabbing in Primary Care**

  Where clinically indicated, swabbing is a routine aspect of a GPs work and will be managed at practice level as necessary. If swabbing is required for surveillance reasons during a pandemic then HSCB would put an enhanced service in place. This would require additional resources. Each Trust is to identify appropriately trained professionals

(District Nurses) to provide swabbing services to care homes and schools to fill any service gap. Corporate Services will be required to communicate with the Trusts to advise them of their role and responsibilities with regard to swabbing in schools and care homes.

Integrated Care will develop the enhanced services for increased swabbing whenever the pandemic requires it and Health Protection staff will advise them if necessary. Health Protection will provide advice on the appropriate training to the Trust professional representatives who will carry out swabbing in nursing homes and schools.

Who will do what?

1. Integrated care will inform the GPS if enhanced services for swabbing are needed. This may involve spotter practices in the first instance prior to all practices being involved.
2. Corporate Services will engage with trusts in the early stages of a pandemic to inform them that they will be required to undertake swabbing in care homes, boarding schools, etc.
3. PHA will provide advice to GPs in relation to PPE needed when swabbing
4. Trusts will undertake/identify and appropriately train relevant OH or nursing staff.
5. PHA will provide advice on training for Trust staff

The PHA will need finance for training, and Integrated Care will need finance for enhanced services. Corporate services will need to link with finance on these issues when a pandemic is declared. See section 3.5.

- **Model for activating and implementing accelerated flu vaccination in Primary Care including Supply**

  The proposed model will be to further extend the current enhanced service for the provision of the flu vaccination. This affords practices the opportunity to extend opening hours to facilitate additional clinics and

vaccinate increased numbers of "at risk" patients in the event of a pandemic.

The current enhanced service can be extended at short notice by integrated care but is dependent on an adequate supply of the vaccine and adequate financial resources to develop and secure up-take of the enhanced service.

It is expected that the PHA will organise the vaccine supply and that Corporate Services will secure the financial resources necessary at the time the pandemic is announced.

- **Rapid reporting of practice flu data to HSCB**

  The model relies on Spotter Practices and the Apollo system which are already in place. If a pandemic is declared and further data is required from all practices a template will be produced by Public Health and issued to practices by Integrated Care with an instruction to complete this and return it to a central point as required. (see Section 3.5 for finance implications of this).

- **Reporting of service continuity issues within practices to HSCB**

  Practices, GP OOHs providers and community pharmacies across Northern Ireland will report service continuity issues in accordance with the normal process ie they will communicate the issue directly to their local integrated care office. If required, the information submitted to local offices can be collated centrally and shared with other relevant staff.

3.1.2 Critical Care

One of the main learning points from the 2009 pandemic related to ICU capacity. The NI Critical Care Network at the time and since then has carried out a significant piece of work to develop and agree a regional escalation plan for adults and paediatrics. This plan set out below is based on the expectation that critical care capacity should be doubled.

As noted above this plan has been revised to incorporate the experiences of previous years and Swine Flu Critical Care Clinical Group recommendations[1] (2010). The trigger to activate the Network escalation Plan can be one of two events: a 'slow burn' (such as the yearly influenza) which takes place over a period of days / weeks and can last for up to eight weeks; the 'big bang' (major incident or mass trauma or pandemic) which occurs over a shorter time period hours / day and generally last for a much shorter period. The timing of the phases described within the plan will be actioned according to the situation which may result in some phases occurring simultaneously.

Fundamental to the management of critical care beds as a regional resource is the principle of mutual aid. Any expansion plan relies upon open transparent discussion (re capacity/ activity/clinical issues) among units, HSC Trusts, HSCB, PHA and DHSSPSNI. This is a dynamic process which will be facilitated during times of exceptional activity by means of daily/ weekly conference calls. Inherent in this plan, which manages beds as a regional stock, is the availability of a safe, timely transfer system for critically ill (adult and paediatric) patients.

Critical Care Bed expansion

Critical care beds will increase using a 4 phased approach dependant on the situation. Phase 4 suggests that In the event of collapse of all hospital infrastructures, absence of staff, equipment, supplies and suitable environment priority will be given to preserving lives and reducing suffering of the wider public - critical care will take lower priority

Adult expansion from a combination of 86 level 3/2 beds (pre surge) to a maximum of 150 level 3 beds in phase 3

Paediatric escalation from a base of 12 level3 beds to a maximum of 28 beds which includes 5 Level 3 and 5 Level 2 beds being provided by DGHs in phase 3 (table 1)

[1] Report of the Swine Flu Critical Care Clinical Group and Key Learning Point DoH March 2010

Table 1 Proposed bed escalation by unit

Trust	Phase 1	Phase 2	Phase 3
BHSCT	33	59	76
NHSCT	10	12	20
SEHSCT	8	10	16
SHSCT	7	8	16
WHSCT	13	17	22
Total	71	106	150
PICU	12	18	28*

*Paediatrics include 5 ICU and 5 HDU beds in DGHs

Staffing

The nature and cause of the expansion may have an impact on the number of skilled staff available such as during a pandemic where staff may also be affected. Patients will receive as much of their care as possible from experienced critical care staff. As the surge escalates, non-critical care staff may be redeployed to assist. The latter will have been provided with additional training and will be supervised by experienced staff. The availability of appropriately trained staff is much more likely to be a constraint to expansion. It is uncertain during an escalation how many staff will be directly or indirectly affected, therefore this plan comes with the *caveat that each Phase of expansion is dependent on availability of trained staff.*

Equipment

Due to the major investment in equipment (ventilators and infusion pumps) in 2009 essential equipment should not be a limiting factor to expansion.

Decommissioning of older ventilators since 2009 required some of the '2009 surge' ventilators to be brought into routine use as replacements. However there is not a need to purchase more machines at this stage, because of recent advances in general anaesthetic machines. Newer machines now have similar functions to that of a critical care ventilator and can be used if expansion is necessary. This assumes that elective surgery would be reduced at this point in a surge so these machines would be available for use. (Table 2)

Table 2 Availability of ventilators

UNIT	Adult escalation beds	Paediatric escalation beds	Adult Ventilators	Paediatric Ventilators	Anaesthetic Machines available
Belfast City Hospital	16		11		13
Cardiac Intensive Care	17		26		4
Mater	8		8		4
Royal Victoria Hospital	35		29		27
PICU		18		19	
Antrim	16	1	15	2	1
Causeway	4		7		1
Ulster	16	3	19	4	4
Altnagelvin	15	2	9	4	2
SWAH	7		7		7
CAH	16	4	14	2	
	150	28	145	31	63

CRRT is labour intensive so lack of CRRT equipment would not be the main limiting factor in a surge. In the event of a pandemic it is thought possible to use existing equipment more flexibly (so that each patient receives CRRT for a shorter time in each 24 hour period) and/or access some intermittent dialysis support from nephrology.

Critical Care Communications

- Communication between units will be essential to maintain a regional approach. Phased response based upon the principle of mutual aid will be supported in consultation with CCaNNI, HSC Trusts, HSC Board, PHA and DHSSPSNI

- Direction from HSCB commissioners / DHSSPSNI regarding the cancellation / suspension of elective surgery, day procedure and out patients' services to ensure equity across the region.

- Daily / weekly teleconference calls involving all units / HSCB / PHA will take place when required.

- Information flows on critical care admissions and discharges will be provided daily/ weekly to critical care community, HSCB, PHA and DHSSPSNI. This information will be used to inform the escalation and de-escalation process.

- The decision to de-escalate and return to normal service will be taken in consultation and agreement of Units, Trust and HSC Board.

Neonatal Critical Care Escalation Plan

A separate escalation plan for neonatal services has also been developed using the same principles and assumptions as those used for paediatric and adult services (Appendix 3). Depending on the nature of the pandemic, opportunities will be sought to share resources and coordinate joint approaches to escalation where possible.

3.1.3 Social Care / Community Care

This should be read in conjunction with the HSCB Business Continuity Plan (Version 5) November 2014.

Across Northern Ireland Care Domiciliary Care, Residential Care and Private Nursing Home Care ranges from 50%-80% provision by the Independent Sector and therefore the IS sector has a crucial role to play alongside the Statutory sector. Therefore, it is important that the IS is included in preparation planning by relevant HSC organisations.

When contracting, commissioners should require providers to have robust and tested business continuity plans in place to help ensure continuation of services, specifically addressing the potential effect of staff absenteeism. HSC

organisation plans should include mutual aid and/or shared agreements to support service delivery and to sustain an integrated response.

It is important that HSC organisations have continuity plans in place to maintain services for those who are already known to be in vulnerable groups. HSC organisations should have systems in place so that during the pandemic they are able to establish quickly and accurately which additional individuals and groups are vulnerable and the reasons for this.

Organisations should ensure that their suppliers have business continuity plans in place that are resilient to the potential supply chain challenges they may face in a pandemic. One of the lessons identified in the 2009 pandemic was to use, and build on, existing systems where possible.
For those in supported living or otherwise supported in the community, it is important that care plans identify a minimum level of essential support and contingency arrangements to maintain this.

Social care providers are aware of, and are in regular contact with, many vulnerable individuals in the community. Such individuals might be either more vulnerable to, or more affected by, pandemic influenza. Other individuals, not normally perceived as vulnerable, may become so in the setting of a pandemic, e.g. single parents with young children, and adults living alone who may be remote from family.

As demand for hospital care increases, patients discharged home may require a greater level of care than they would do normally. Social and community care services may face particular challenges that include:

- maintaining services and pandemic response with reduced staffing capacity due to increased levels of illness;
- identifying those most at risk;

- sustaining indirect care services for example meals on wheels, community equipment and community alarm services;

- meeting additional burdens on overstretched services due to additional pressures on acute hospital beds;

- sustaining people with complex needs who are currently supported with concentrated care packages in the community;

- providing emergency care for vulnerable people looked after at home by informal carers, or personal assistants employed via direct payments, if their carer is ill;

- providing support to those discharged from hospital in light of possible reduced availability of residential places to those whose community support package is unsustainable for reasons other than influenza, ie normal admissions, and

Care of individuals in the community therefore presents a diverse and complex challenge at a time when staffing capacities are likely to be reduced. Close working relationships across health and social care organisations, the independent sector and voluntary groups will be essential to sustaining services during a pandemic.

As part of business continuity plans, arrangements should be in place for responding to increased demand for assessments and support alongside reduced capacity to deal with such circumstances. Processes to sustain fair and fast access to services for those most in need may need to be revised during a moderate to high impact pandemic, for example by:

- prioritisation of referrals for assessment (according to urgency)
- the use of telephone assessment;
- greater use of self-assessment (e.g. Internet);
- a one-stage referral and assessment model;
- deferral of non-urgent referrals until after the pandemic;

- redeploying staff from other tasks to delivery of actual support/care, and
- temporarily reallocating support from those with lower levels of need to those with higher levels.

A range of information may be needed to assist in making decisions about urgency and a person's likely eligibility for services during a pandemic. Those responsible for managing assessments will need to agree criteria for prioritising.

Care homes and domiciliary care may find that difficulties such as staff shortages, resident illness, death, and transport problems all coincide over a prolonged period during a pandemic. Infection rates can be particularly high in group living environments such as care homes so residents may need more help with personal care tasks and more may be in need of end of life care. Trusts must be assured that providers have appropriate pandemic flu plans in place. The nursing and residential care standards require care homes to have a contingency plan in place for dealing with an influenza pandemic.
Care homes plans will need to include:

- protocols concerning whether people with influenza should be admitted to hospital during the pandemic;
- communication to staff, residents and visitors about infection control requirements;
- arrangements for minimising the risk of transmission and infection during the pandemic by isolation or cohort-grouping of infected clients;
- information on provision of face masks to care staff according to national guidance on their use, and
- procedures for managing additional deaths, including storage of bodies if necessary.

Care homes within the same area should consider collaboration and mutual support, e.g. by forming 'clusters', to enable each to be aware of:

- capacity;
- the kind of care available, and
- which care homes are taking new admissions, including those with flu.

The United Kingdom Homecare Association (UKHCA) has developed specific guidance on domiciliary care during the influenza pandemic that is available on their website. http://www.ukhca.co.uk/flu/

3.2 Excess deaths

Many issues in relation to extra mortuary capacity in hospital OR in council areas as well as issues around funeral directors movement of bodies onwards were unresolved in the 2009 pandemic. Since then the Department of Justice and PSNI have developed a Mass Fatalities plan under the CBRN work programme where extra temporary capacity has been identified using Nutwells. This provides an extra 300 spaces on the Royal site and it is possible that these could be used in a pandemic.

As excess deaths in a pandemic are not solely a health issue local multiagency planners have been advised under their business continuity arrangements to look to how they would extend capacity on a precautionary, but reasonably practicable, basis. Within health should the storage of bodies from excess pandemic deaths become a major issue in hospitals this matter would be escalated via the DHSSPS to OFMDFM for consideration and a whole systems resolution at the time. The Emergency Planning Civil Contingencies Group NI is to pick up mass fatality responsibility in an emergency in their new work programme in 2015.

3.3 Health Protection

As noted above the role of health protection throughout the various phases of the pandemic are set out in the Health Protection Pandemic Plan September 2014. The main functions of health protection during an influenza pandemic are surveillance, case management, input into other groups and vaccination implementation

- **Surveillance**

  During a pandemic surveillance will play a key role in informing the response whilst contributing information to the overall national picture. Comprehensive surveillance arrangements are essential to provide information on the characteristics of the virus as it emerges, estimating severity and risk groups affected, tracking the spread and impact of the virus and measuring uptake of various pharmaceutical countermeasures. Surveillance activities are therefore critical to informing the response during the detection and assessment phases and thereafter. It will also be essential in the early detection of subsequent waves of infection.
  To facilitate surveillance in an influenza pandemic, routine influenza surveillance measures will need to be enhanced by building on existing structures and processes. The surveillance team will oversee the responsibilities listed in the HP Pandemic plan. There will need to be training for staff that are redeployed from other surveillance sections.

- **Case Management**

  The aim of case management is early detection and diagnosis of cases to reduce the spread and impact of a pandemic influenza virus among the population of Northern Ireland. It is important to identify potential models of delivery for active case finding and contact tracing and also to consider the training that should be to be offered to staff working outside their usual roles. See HP Pandemic plan for further details.

- **Antivirals**

  The issue of antiviral collection points although NOT health protection led will have significant health protection input. As such it is felt that the 2009 memorandum of understanding with local councils should apply. Given the reorganisation of councils it is proposed that the new regional Civil Contingencies sub group of CCGNI will consider this. As such a draft paper has been prepared in readiness for this (Appendix 4).

- **Personal Protective Equipment**

In relation to Personal Protective Equipment (PPE) Health protection will have a role in disseminating agreed national guidance on 'Fit testing' and training of staff in the use of FFP3 masks. It is the responsibility of each trust to carry this out. As such HSC organisations have been instructed by DHSSPS to maintain sufficient stock for seven to ten days use in the initial stages. The central emergency pandemic stock pile (of FFP3 masks) will then be released in a timely fashion to ensure delivery (via PaLS) within 7-10 days to all organisations, before the local Trusts initial stocks were exhausted. This is essential to provide necessary assurance that the local Trusts will not need to source further supplies of FFP3 mask (via PaLS or otherwise) after the 7-10 days of initial stocks are exhausted.

3.4 Communications: PR

PHA Corporate and Public Affairs and HSCB Communications will work together to ensure that a robust process is in place based on the important principle of ensuring that the patient and their family is communicated with **prior to** any wider public information being released to the media. The same principle applies to keeping staff and board members in their respective organisations apprised of key issues in relation to cases and the pandemic response."

The Public Health Agency (PHA) and the Health and Social Care Board (HSCB) will work with the Department of Health, Social Services and Public Safety press office (DHSSP), local Health and Social Care trusts and other partner organisations to ensure a coordinated communications approach during a pandemic. The communications approach will dovetail with and support the Department of Health and UK-wide communications and media management protocols in place.

NB: Media communications can be either proactive or reactive. Proactive messaging will be signed off by ICT at each meeting and as such will be a standing item on the agenda. In relation to individual reactive messages these will be worked up by the relevant professional in conjunction with the relevant

comms team e.g. should the issue relate to the service side then HSCB comms will lead and likewise if it is a health protection issue PHA comms will lead and co-ordinate.

External PHA and HSCB communication arrangements

The PHA and HSCB in conjunction with the DHSSPS will:

- establish a communications teleconference with trusts and other relevant organisations with the aim of coordinating the communication response and to share information. This will be done at least once daily, with ongoing e-mail and direct telephone contact in between. This will be kept under review.

- set up an HSC Pandemic Communications group email to share information and to ensure coordinated communications messaging across the HSC. As noted above this will include both proactive and reactive media activity.

- ensure arrangements are in place for the daily monitoring of press and social media coverage during a pandemic. Communication Leads will take steps to respond to any concerns or address incorrect or misleading media coverage through the proactive issue of media statements, as and when required.

- As a general principle whichever of the two, PHA or HSCB, initially fields the media query will lead on the media query and liaise with colleagues in the other organisation.

Internal PHA and HSCB communication arrangements

PHA Communications will advise and lead on communications in relation to health protection issues arising from the pandemic in consultation with PHA Health Protection. HSCB Communications will advise and lead on communications around the management of the impact of a pandemic on health and social care services in consultation with the appropriate HSCB

Directorate(s) – Performance Management, Integrated Care, Social Care and Children, Commissioning and Finance and PHA colleagues where appropriate.

The PHA and HSCB will:

- Designate a lead communications department – the Communications Department of the lead organisation for an incident, will be the lead Communications Department and will therefore be responsible for the overall coordination of communications whether public health or service related

- appoint a Lead Communications Officer from each organisation to join JR Silver to provide appropriate communications support, lead on communications activity for their respective organisations and act as the link with communications colleagues in partner organisations

- liaise with members of their respective communications teams both in and out-of hours to ensure they are adequately briefed to handle media enquiries and other activity as required

- Come together as a team (Figure 2) and consider issues involved in dealing with a prolonged incident. This will include the need for further communications staff such as such as Deputy Lead Communications Officers, shift changes and achieving a graduated response in the event that an incident escalates

- advise on the communications approach and share proposed media statements and responses with the DHSSPS Press Office and Communications Leads in trusts and other relevant organisations

- advise on content and approach of media activity including; media statements, briefing materials, interviews etc of their relevant organisation.

Communications activity may include preparing and issuing news releases, updating corporate websites, messaging through social media, handling interview requests and organising media briefings relating to the pandemic. A media room may be set up.

In relation to Health Protection communications which in the early stages may be significant a health protection Designated Liaison will be appointed to act as the main point of contact between communications staff and health protection staff working on the pandemic. It will be the role of this person to keep abreast of developments and apprise themselves of the latest information and data so as to inform media activity. This person will also be the agency's media spokesperson. A key principle of this arrangement is that it will create a single point of contact between Corporate Communications and Health Protection to ensure that both teams can play their role in the management of the pandemic as efficiently and effectively as possible.

Working with the Health Protection Designated Liaison, the Lead Communications Officers will manage the communications requirements around the pandemic, such as the frequency and timing of updates, the management of media interview requests and the general scale and form of engagement.

In relation to service continuity communications each HSCB Directorate will appoint a Directorate Lead to act as the main point of contact with HSCB communications staff. It will be the role of this person to keep abreast of developments and apprise themselves of the latest information to inform media activity. The Directorate Lead will also be the HSCB media spokesperson. A key principle of this arrangement is that it will create a single point of contact between HSCB Communications and each Directorate involved in managing the impact of a pandemic in an effective, efficient and timely manner as possible.

As part of contingency planning arrangements, each Directorate will also appoint a Deputy Directorate Lead.

Pandemic communications protocols (media enquiry, news release, media bids) are set out in more detail in Appendix 5.

3.5 Human Resources:

During a prolonged pandemic response many significant human resources issues may arise and for many employees involved in emergency operations there will be a change to their normal working pattern. As such efforts will be made to try to minimise any disruption. In the joint pandemic response a senior Human resources staff officer (BSO) will be a member of the JR Silver Pandemic Team.

Existing HR policies relating to emergency working will be implemented and individual 'pandemic specific issues' such as those relating to redeployment of employees for prolonged periods and additional travel will be referred to a pre-identified HR nominated officer(s) for consideration on a case by case basis.

3.6 Finance

In an emergency pandemic situation **proportionate** business cases for additional resources may be prepared by HSC organisations and presented to the Director of Finance of the HSCB for consideration and approval.

Subsequent to this, a **full** business case will be submitted to the HSCB as per normal processes.

In relation to rapid reporting of flu data from primary care this will be a requirement over and above the normal Apollo system reporting arrangements. As such practices will need to be resourced accordingly. As such discussions of this nature are likely to be highlighted by the Service Continuity Team to 'Health Silver' in an emergency pandemic situation.

3.7 Logistics

In line with the Joint Response Emergency Plan an Emergency Operations Centre (EOC) would be set up. The EOC has two main functions: (a) incident

information management and (b) production of an incident specific Situation Report (SITREP). It is important to note that in addition to an EOC other rooms may be required for each of the teams in figure 2. The EOC will be set up in accordance with the Joint Emergency Response Plan (JERP) EOC.

(a) Information Management

Learning from recent incidents has highlighted the importance of having a robust information management system **and** having trained staff available throughout the incident to maintain it.

NOTE: A newly designed 'share point' Emergency Response dashboard has been designed by PHA staff and will be tested and further refined for use in a pandemic.

(b) SITREP Production

Based on the learning gained from the 2009 pandemic and recent Major Events in 2013 including the G8 Summit, a template for a pandemic specific SITREP is attached in appendix 6. As in the JREP the HSCB will lead the process for generating the SITREP.

3.8 Cross Border Working in a Pandemic

At present on a day to day basis some patients who attend HSC healthcare facilities in the north reside across the border in the Republic of Ireland. These patients are managed in line with health care policy in the North. This approach would continue in a pandemic situation. Should a situation arise where operational issues arise due to markedly different pandemic policy (eg re: antivirals) in both jurisdictions DHSSPS level discussions would be required. As part of this PHA will identify a ROI liaison (health protection consultant) to liaise in relation to health protection cross border issues and similarly HSCB will identify a ROI liaison (HSE colleague) in relation to service continuity issues.

4.0 Conclusion

The learning from the 2009 pandemic response and recent exercises recognises that there are pandemic specific elements to a joint PHA: HSCB: BSO response that sit alongside the tried and tested Joint Emergency

Response. This document is a dynamic document that sits alongside the Joint Response Emergency (Silver) plan and as such will be tested and exercised accordingly. As per good practice following an exercise the document will be revised and updated.

Appendix 1 PANDEMIC INCIDENT CONTROL TEAM (ICT)

HSC SILVER AGENDA

Date: **Time:**

Venue: **ICT (Silver) Chair:**

1. Agree chair & Review membership

2. Incident summary

3. Strategic objectives

4. Update on current situation (SITREP & Report from cell leads)

a) Public Health impact

b) Service Continuity impact (Acute: Social Care: Integrated Care)

c) Joint Response Operational Response

d) cross-cutting issues which ICT needs to be informed of (such as cancellation of electives with the knock-on impact in primary care)

5. Actions to date

6. Dynamic Risk Assessment

- Severity (morbidity; mortality)
- Spread (population affected)
- Interventions (availability; effectiveness in altering course of pandemic)
- Context (UK: ROI; Global)
- Public Concern

7. Further Key Decisions

a) Agree appropriate **liaison officers** for multi-agency partners **and** the command & control structures established (RHCC: Multiagency Silver / Gold; CCGNI)
b) Co-ordination issues across HSC Trusts
c) Civil Contingencies interactions
d) Forward Look
e) Business Continuity level

8. Communication strategy

a) Comms liaison representatives (internal)
b) Press release
c) Communication with HSC & DHSSPS
d) Communication with PHA, HSCB, BSO staff

8. A.O.B.

9. Date & Time next meeting

Appendix 2

PANDEMIC INCIDENT CONTROL TEAM (ICT)

Decision Log

HSC Silver

Date: ..... Incident: .....

Log Ref. Number

Decision Making Log Sheet

Incident Date		Decision Time	

Problem Faced:

Option 1	Agreed to Use?		Time Agreed	
	Agreed by Who			
	Rationale			

Option 2	Agreed to Use?		Time Agreed	
	Agreed by Who			
	Rationale			

Option 3	Agreed to Use?		Time Agreed	
	Agreed by Who			
	Rationale			

Name in full _____ Signed _____

Decision Maker _____ Date ___/___/_____ Time: ___:___hrs

When Completed this form **MUST** be returned to the Incident Information Manager...under **no** circumstances should it be removed from the control room nor thrown away without the appropriate authorisation.

PANDEMIC INCIDENT CONTROL TEAM (ICT) - ACTION LOG

Attendees: (Chair): _ _ _ _ _ _ _ (Cell Leads) _

_ _

Teleconference: xxxx _

Apologies: _

Date: 04/09/2014

Date	**Action No**	**Action Agreed**	**Person Responsible**	**Status** (completed-with date; not completed)
	1			
	2			
	3			
	4			
	5			

Appendix 3 Regional Neonatal Care Escalation Plan

Regional Neonatal Care Escalation Plan v

Appendix 4 Antiviral Collection Point

ACP Options Paper July 2015.pdf

Appendix 5 PHA: HCB Communications Protocols

Pandemic Flu Communications Prot

Appendix 6 Pandemic SITREP template

Pandemic Sitrep Template-15 July 201