The Whittington Hospital NHS
NHS Trust

Review of the Whittington Hospital NHS Trust response to the H1N1 Flu Pandemic 2009/2010

Draft-awaiting Trust Board approval

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1 Introduction

In April 2009 the world became aware of cases of illness caused by a novel influenza virus, then termed swine influenza A/H1N1. Over the following five days, the World Health Organisation (WHO) announced that the global pandemic alert level had increased from WHO Phase 3 to WHO Phase 5. On 11 June, WHO declared WHO Pandemic Phase 6 and the official start of the first pandemic of the 21st century.

The first UK cases were reported in Scotland on 27 April, and the first in London on 30 April 2009. Cases continued to increase and London saw the peak of the first wave in July.

The pandemic was originally managed through containment measures (treating cases and providing antiviral prophylaxis to their contacts) which included some school closures. There was a brief period of outbreak management in London (a less stringent version of containment – limited prophylaxis and contact tracing), before the whole country moved to the treatment phase (no prophylaxis or contact tracing) in response to the rapidly increasing number of cases.

Following the first wave London saw a reduction in the number of cases over the school summer holidays which started to increase around the beginning of September when children returned to schools, a second wave commenced and the number of cases increased.

Prior to a planned local event for pandemic preparedness, 3 key members of staff attended the London wide Peak Practice event at Westminster on September 2009.
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Using a similar model and lessons learnt from this event, a dry run scenario (Operation Coldplay) was attended by a wide range of staff including clinicians, operations, risk management, infection control, senior nurses and midwives, facilities, procurement and other relevant staff.

In November, the vaccine became available and was offered to the first at-risk groups, those being pregnant women, household contacts of the immune-compromised, people aged 6 months to under 65 years in the seasonal flu risk groups and those aged over 65 years in the clinical seasonal flu risk groups; and frontline health and social care workers. When more vaccine became available the vaccine was offered to healthy children aged between 6 months and 5 years old.

In January and February 2010, the numbers of cases reduced to an extent that the National Pandemic Flu Service was decommissioned (11 February) and new flu cases were managed through GP consultations.

2 Command and Control

2.1 Lessons identified – Command and Control

Good practice

- The organisation had a robust plan and strategy for dealing with major incidents which included pandemic flu.

Areas for development

- The plan needs to be reviewed at least annually to ensure it is current.

3 Internal Communication

3.1 Lessons identified – Internal Communications

Good practice

- Incorporated existing communications methods and developed them with ideas generated at swine flu committee meetings. Addressed issues as update reports came in to the committee.
- Regular contact across Trust using suitable methods, such as chief executive briefings to cascade messages, intranet as a key message and DH message hosting site combined with all staff emails. Leaflets made to access those without email access.
- In build up to arrival of swine flu vaccine, considered and detailed campaign planned.
- Main thrust of vaccine campaign was the breakdown of numerous messages around the vaccine into easy to understand statements about the risks of not receiving the vaccine. Tied into a countdown email campaign to the arrival of the vaccine with a colourful poster campaign and a timetable of vaccine clinics hosted on computer desktops. Led to second highest staff uptake in London.

Areas for development

- Breakdown of complex message came as a response to ‘Operation Coldplay’.

4 External Communications

4.1 Lessons identified – External Communications

Good practice

- Statements proactively devised for all serious cases, irrespective of press interest.
- DH messages about swine flu (and seasonal flu) and its containment 'Whittington'ised' and ready to pass to local press if needed.
- DH messages and internal communication messages hosted on intranet, emailed to staff and put up as posters across the Trust. These messages were for patients, staff and public alike.

Areas for development

- Small numbers of swine flu cases and media enquiries gave little scope to test external communication plans.

5 Working with Partners – Influenza Pandemic Committees (IPCs)

Influenza pandemic committee was chaired by the Director of Flu Planning and convened at regular intervals ranging from weekly to monthly as need arose. The Committee was attended by a range of staff including medical, nursing, operational, facilities, procurement, and communications.
The daily flu e mails were circulated to all members of relevant staff with specific actions stated by the Flu Director.
All NHS London and local PCT flu committees were attended by the relevant trust representative.

5.1 Lessons identified – Working with Partners

Good practice

- Clear leadership and good attendance at the committees. Rapid communication and instruction by e mail.

Areas for development

- Local PCTs to work more closely to reduce both the frequency of meetings and to provide better communication. Introduction of teleconference facilities across all PCTs.

6 Vulnerable Groups

We took our guidance from local PCTs. Clear messages were provided in ED about the flu pandemic helpline and other local services.

6.1 Lessons identified – Vulnerable Group

Good practice • Agreement from PCT and trust about how the vulnerable groups would be treated and reached and clarity about responsibilities and roles.
Areas for development • Continue close liaison and build on existing partnership working.

7 Personal Protective Equipment (PPE)

The organisation used the DOH algorithm to estimate the possible usage of PPE. Procurement staff stock piled this equipment in a central location easily accessible by the relevant staff. A few days stock was available in each relevant high risk area.

7.1 Lessons identified – PPE

Good practice • Procurement led the initiative and were responsive.
Areas for development • Regular education sessions on the use and disposal of PPE is required on a rolling programme.

8 Antivirals

The antivirals were managed and stored separately from main hospital drug stock to ensure clear line of drug accountability. Antivirals were supplied from pharmacy on an individual patient basis. Pre-pack antivirals (with standard outpatient labels) were made available for out-of-office-hours use on the Emergency Department, paediatric ward and respiratory ward, which were kept securely in the control drug cupboard. All prescriptions were filed in pharmacy once antivirals were issued.

8.1 Lessons identified – Antivirals

Good practice • Clear line of communication between policy makers and grass root staff. • Rapid uptake and implementation of DH recommendations on administration and issuance of AVs • Clear line of communication between PCT pharmaceutical advisors and hospital pharmacy via PCT Antiviral Stock Co-ordinator who is based at the Whittington. • Comprehensive drug accountability database was set up and maintained, which help to provide DH with require surveillance data.
Areas for development • Lack of communication from NHS London stock management team regarding delivery times of AV stock and inflexibility of delivery times. • Up-to-date information on dosage and recommendations should be uploaded on

the intranet and maintained on a regular basis by a lead coordinator for easy access by grass root staff.

9 Vaccine and vaccine consumables

Vaccines and the consumables were managed and stored separately from main hospital drug stock to ensure clear line of drug accountability. These were stored in pharmacy and supplied to the Flu Vaccination Clinic on a daily basis to ensure appropriate storage conditions. PGD were implemented to encourage uptake of vaccination by staff and to ensure appropriate information were provided to staff.

9.1 Lessons identified – Vaccine and vaccine consumables

Good practice

- Clear line of responsibility among staff involved in providing the vaccination programme.
- Regular communication between Communication Office, Visible Leadership Team, Occupational Health Nurses and pharmacy staff contributed to a seamlessly vaccination programme.
- Excellent commitment and organisation from the senior nurse team in delivering the vaccination programme.

Areas for development

- Up-to-date information of vaccine details, allocation and delivery dates from DH would have been useful to help plan/organise the vaccination programme in advance.
- Availability / provision of a drug fridge should not be assumed. This should have been planned or organised in advance.
- The ImmForm registration process was poorly organised and the software often failed.

10 Increasing capacity

Small working groups from Critical Care, Maternity, ED, Human Resources and other key areas developed actions plans to cope with the increase in capacity.

10.1 Lessons identified – Increasing Capacity

Good practice

- Good coordinated response internally.
- Trust plans for escalating capacity worked well- tested through both winter planning and pandemic flu increased pressures

Areas for development

- Response from Social Services and Mental Health
- Still an operational challenge associated with staffing increased critical care

beds
- Would be useful to consider developing a sector stock/store for specialist medical equipment if possible rather than each organisation having to resource additional equipment.
- The issue of sharing organisational occupational health clearance and CRB clearance has not been fully resolved
- Trust has since moved to an off-site TSSU service and plans for responding to a pandemic need integration into Trust plans

11 Reporting

11.1 Lessons identified – Reporting

Good practice
- The organisation established daily reporting and integrated this as far as possible into the historical daily reporting and winter Sitrep arrangements.
- The daily reporting was used to escalate capacity issues through to the external social services agencies via a daily conference call. This is being retained as a function as it helped improve patient management and support earlier discharge
- Central stock store for monitoring and holding pandemic response stock worked well internally within the organisation

Areas for development
- Would be useful to have more coordinated reporting structure through to both NHS London and local PCTs using the same documentation to prevent multiple requests for information/ ensure more intelligent information sharing
- Would be useful to review how capacity issues escalated though the reporting arrangements fit in with current escalation policies associated with managing capacity (particularly ED/inpatient beds) across the sector.

12 Flu/winter assurance process

12.1 Lessons identified – Flu/Winter Assurance

Good practice
- The process for ensuring that organisations have effectively planned for elective (day case and inpatient) surgical capacity, as well as non-elective is significantly more robust as a result of the winter planning template developed.

Areas for development
- There is currently a gap in how capacity is effectively managed across the sector- this is particularly relevant to managing organisational bed capacity. The process for managing LAS handover time is better but this has meant that sharing resources for managing inpatient capacity has become more difficult to obtain.
- Role of the NCL Agency in terms of supporting winter planning needs refining and bedding in further

13 The next steps

The report will be presented at the Hospital Management Board (HMB) and then Trust Board by the Director of Flu Planning. Any actions and progress will be reported to HMB.

14 Conclusion

The trust responded well to the increasing demands on the service and the staff involved. It was an opportunity to test resilience and major incident plans and reflect on any changes that may be required.

<<Signed and dated by the Chief Executive>>
Will be signed following agreement at Trust Board (March 24th)

15 Appendix A – Table of lessons identified and action plan

No.	Lesson identified	Action	Owner	Target date for completion	Date completed
2 Command and control	Major incident plan requires regular review to ensure it is current.	Ensure the plan is reviewed annually and updated accordingly.	Matthew Boazman-Assistant Director of Operations	June 2010	
7 Personal Protective Equipment (PPE)	Knowledge about use and disposal of PPE varied across the trust.	Rolling education programme to be developed	Patricia Folan-Infection Control Matron/Lisa Smith-Assistant Director of Education	June 2010	
10 Increasing capacity	Flexing staffing levels to cope with increased capacity challenging. Governance arrangements about sharing staff across the sector need to be agreed.	A plan needs to be developed and agreed that sets out a clear pathway that enables the trust to respond quickly and appropriately to surges. Sector to ensure that staff can cross cover if required and that all checks are consistent and transferable	Matthew Boazman/ Kate Slemeck – Director of Operations Margaret Boltwood-Director of Human Resources.	July 2010 August 2010	