


PANDEMIC FLU



Planning for pandemic influenza in
community care: an operational and
strategic framework

October 2007

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FOREWORD

This guidance aims to encourage and support local authorities and others who provide community care services in planning for a human influenza pandemic. It provides background information on pandemic influenza, the impact and potential implications for community care services. It also highlights issues that local authorities will need to consider for example managing staff absences, training and education which is consistent with the Scottish Framework for Responding to an Influenza Pandemic.

All those responsible for planning or managing services should plan for a pandemic as part of their normal planning for responding to any emergency or 'business continuity' planning and the Scottish Government recognises that some organisations are already active in terms of preparing for a pandemic.

The guidance sets out the processes that we would use to get information to local authorities. It also stresses the importance of reviewing plans periodically as our understanding of the disease develops as there may be too little time immediately before the arrival of a pandemic to review plans and take necessary action.

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Introduction

Context

'Most experts believe that it is not a question of whether there will be another severe influenza pandemic, but when.' (Scottish Executive 2005, Explaining pandemic flu: A guide from the Chief Medical Officer, <http://www.scotland.gov.uk/Resource/Doc/924/0040580.pdf>)

1. A pandemic (worldwide epidemic) of influenza remains a very real threat. Health experts, including the World Health Organization (WHO), have warned that a pandemic is inevitable and have advised public services to begin emergency planning accordingly.
2. The uncertainty surrounding timing and impact is one of the main challenges for planners and providers. An effective response needs to take account of this uncertainty and will require the cooperation of a wide range of organisations as well as the active support of the public. Experience suggests that a consistent and coordinated response will not only help to reduce the impact of such an outbreak but will also speed recovery.
3. Community care is a major public service. At any one time, more than 110,000 adults will be relying on services provided by, or through, local authorities. Although it is impossible to predict which groups of people will be most affected by influenza – the peak mortality rate in the 1918–19 'Spanish' influenza was among persons aged between 20 and 45 – it is likely that some groups may be more affected than others. Children and otherwise fit adults could be at relatively greater risk, as older people may have some residual immunity from previous exposure to a similar virus earlier in their lifetime. Alternatively, certain older people may be at greater risk of serious complications and, as such, are likely to place a greater burden on health and community care services.
4. Therefore, it is essential that local authorities with community care service responsibilities and other community care service providers put in place robust plans to ensure the continuity of business during the event of an outbreak of pandemic influenza. Plans will need to be flexible and responsive, as the impact of the pandemic will vary depending on the group most affected.
5. People assessed as being in need of care services should not be left without sufficient levels of care and support. During a pandemic it is likely there will be additional demand from those not usually in need of care services. This could include people who would, under normal circumstances, be cared for in hospital but who may need supporting in the community due to the volume of additional people needing acute hospital care during the pandemic. It is also likely to include additional short-term emergency care for people ordinarily supported at home by their friends or

relatives ('informal carers') to cover the period their carer is ill with pandemic influenza.

6. Strong leadership, efficient internal organisation and coordination, effective communication and clear lines of accountability will be key to meeting the unique challenges faced by community care services in preparing for and responding to a pandemic.

7. Leadership will be needed at all levels in all organisations. People will be making decisions and, in many cases, will have very little time for deliberation or consultation. This will not only affect senior staff; frontline staff will be faced with dilemmas and problems on a daily basis. You should ensure that staff are aware of [The ethical framework for the response to pandemic influenza](#) and how this should affect their behaviour and actions in the event of a pandemic. Local planning needs to recognise this and introduce measures that will support staff and people using their services. An example is the need for staff to record their thinking and decisions as they happen, or as soon afterwards as possible.

8. Throughout this framework, we encourage multi-agency planning. We discuss the ability to share and redeploy staff within and between organisations, and across sectors. During a pandemic the main emphasis will be for staff to work with others to keep agreed essential services running.

Current position

9. This framework is designed to assist local authorities, community care managers and staff in the statutory, private and voluntary sectors in planning a response to an influenza pandemic. It is also being copied to NHS Boards and other NHS organisations for information.

10. Planners should be aware that the information available on pandemic influenza changes over time as understanding of the disease develops. Guidance is therefore continually being updated. It is important that planners ensure they work to the latest information, including any guidance referred to within this document. It is important to emphasise that during a pandemic some elements of the planned response are likely to be initially implemented in the face of incomplete information or in the context of an evolving picture of the disease and its impacts. Therefore, assumptions and response measures need to be reviewed and where necessary changed as the pandemic evolves and further information available or the impacts are better understood.

11. It is the intention that this guidance is used as a web-based resource aimed at supporting community care services in pandemic planning. It will be available on the Scottish Government pandemic flu website (<http://www.scotland.gov.uk/Topics/Health/health/AvianInfluenza>) alongside the revised Scottish Framework for Responding to an Influenza Pandemic. Also available on the website will be *The Ethical Framework for the Response to Pandemic Influenza*. We will also issue a leaflet aimed at staff in various community care settings, entitled *Planning for pandemic influenza in community care: guidelines for community care staff*.

12. This framework is primarily aimed at:

- local authorities, including Directors of Social Work/Chief Social Work Officers
- managers and community care workers in local authorities with responsibility for the commissioning and provision of adult community care services
- staff and providers of adult community care services in the statutory, voluntary and private sectors; and
- is copied for information to Chief Executives of NHS Boards, NHS Board Pandemic Co-ordinators and General Managers of Community Health Partnerships.

13. This framework is for Scotland only. Parallel documents are being issued by the Department of Health, the Welsh Assembly Government and the Department of Health, Social Services and Public Safety, Northern Ireland

Note: for brevity's sake we usually refer to the Director of Social Work, and in every case this is intended to cover Director of Social Work/Chief Social Work Officer.

14. The aim is to:

- put in place robust local plans to respond to an influenza pandemic and minimise its impact on local community care services and the people who use them, taking into account the ethical framework
- limit mortality as far as possible
- support and complement other local contingency plans, eg those for health and education services
- develop measures to help maintain essential community care services and cope with the additional burden pandemic influenza will place on these services
- minimise social and economic disruption.

More information on pandemic flu is available at www.scotland.gov.uk/topics/Health/health/avianinfluenza/pandemicflu

Other useful information to refer to

15. This guidance accompanies the revised Scottish National Framework for *Responding to an Influenza Pandemic*. The framework is based on the published *UK National Framework for responding to an Influenza Pandemic* and provides detailed information about pandemic influenza, its likely impact and current planning assumptions applied to Scotland's population, geography and structure of services. A leaflet *Planning for a Pandemic Influenza in Community Care: Guidelines for Community Care Staff* informs staff how they can protect themselves, their families and people they work with in the course of their daily work and should be read alongside this operational and strategic framework.

16. A number of publications are also available online – these are listed at paragraph 144.

17. In addition, an online network is available to support local planners and care providers to collaborate with others and share ideas, problems, resources and best practice. Some best practice examples which help illustrate how some of this guidance can be applied in practice have already been placed on the online network. You can access this best practice and other resources to support you in planning and responding to an influenza pandemic by registering to join the Social Care Pandemic Influenza Network at www.socialcarepandemic.org.uk. This is a UK resource.

Pandemic influenza – key facts

What is pandemic influenza?

18. Influenza is a familiar infection in the UK, especially during the winter months. The illness, caused by an influenza virus, can be mild or severe and can lead to death.

19. Pandemic influenza is different from ordinary influenza because it occurs when a new influenza virus emerges into the human population and spreads easily from person to person. It may be that some groups of people are likely to be more susceptible than other groups, especially older people and those with certain health conditions, such as heart or chest disease. Observing good practice on personal hygiene is important to help reduce the spread of the virus (see paragraph 108 entitled 'Infection control and personal hygiene').

20. As it will be a new virus, it is likely that the entire population will be susceptible, because no one will have any immunity to it. Therefore, it may attack healthy adults as well as older people and other potentially vulnerable groups. The lack of immunity in the population will mean that the virus has the potential to spread very quickly between people. This will result in many more people becoming severely ill, with additional pressure on care services.

21. The circumstances exist now for a new virus to emerge and spread worldwide. Although a pandemic has not yet started, experts warn that it could begin soon.

Signs and symptoms of influenza

Most significant

- Fever
- Headache
- Cough or shortness of breath
- Malaise (general bodily discomfort/feeling of unease)
- Sudden onset of illness
- Chills

Other symptoms

- Aching muscles

- Sore throat
- Runny nose, sneezing
- Loss of appetite

Incubation period (the time from exposure to first symptoms)

22. For most people, the range is from one to four days (but typically two to three). Without intervention – or significant immunity in the population – historical evidence suggests that one person infects about two others on average and that influenza spreads particularly rapidly in communities such as schools or care homes.

Infectious period (how long you are infectious to others)

23. People are most infectious to others soon after they develop symptoms, though they can continue to shed (excreting or casting off the virus through their secretions) virus for usually up to 5 days after the onset of symptoms. (This extends to 7 days in children)

24. It is sometimes stated that patients are infectious shortly before they develop symptoms; however, the evidence for this is limited. Spread from a person before they develop symptoms has rarely been recorded, though experimental studies have shown that some people start shedding low doses of virus in the 24 hours before symptoms occur. Some people can be infected without showing symptoms and, as they may shed the virus, be able to pass on the infection.

How is pandemic influenza caught and spread to others?

25. Pandemic influenza is spread from person to person by close contact. Please refer to the section called 'Infectivity and mode of spread' for more details, at paragraph 83. Here are a few examples of how this infection can be spread:

- infected individuals can pass the virus to others through large droplets when coughing, sneezing and even talking within a close distance (usually three feet or less).
- you can pass on the virus by direct contact with an infected individual. Shaking or holding hands with an infected individual followed by touching your own mouth, eyes or nose without first washing your hands with soap and warm water will also allow the virus to spread to you.
- you can spread the influenza virus when environmental and inanimate objects, such as door handles and light switches, become contaminated with the virus. Once again, if a person touches these objects and then touches their mouth, eyes or nose without first washing their hands with soap and warm water, their chances of catching the virus are increased.

Key messages to the public (including community care and health workers)

26. The key messages to those who have flu-like symptoms are:

- stay at home
- don't spread it around
- telephone the national flu line

Training and education

27. Ensuring good hygiene and infection control practices are an essential part of what we must all do in response to an influenza pandemic. However, improving hygiene benefits individuals and services more widely. We need to get the lessons about hygiene ingrained in the population as a whole and, in particular, the health and community care workforce. To leave training of the workforce until a pandemic occurs is irresponsible. In any event, good hygiene will limit the spread of a number of infectious diseases, including seasonal influenza and antibiotic-resistant infections. Local authorities and their health colleagues should consider establishing regular training programmes in good hygiene to remind both existing and new staff of its importance.

The impact of pandemic influenza on community care

The community care response to pandemic influenza

28. In the event of an influenza pandemic, community care services will be under particular strain. Community care supports people who are likely to suffer disproportionately from the impact of the pandemic in its early phase. It is also likely that it will adversely affect other services, such as transport, health services and schools.

29. The disparate nature of community care services means that planning for an outbreak of pandemic influenza may arguably be more difficult in this sector than in many other sectors. Community care covers a wide range of services for a wide range of user groups, including care provided at home, in care homes and in day/drop-in centres, as well as services such as meals on wheels, home help/home care, personal assistant schemes and adult placement schemes.

30. Many of these services are not provided directly by local authorities but by registered social landlords and voluntary and private sector organisations. Some are provided under commission from local authorities, but many operate on an entirely private/independent or voluntary basis. However, all forms of community care services will need to be factored into local contingency plans, and not just those services that are provided directly or indirectly through local authorities.

What impact will pandemic influenza have on community care?

31. It is impossible to predict the precise impact that pandemic influenza will have on the UK population, much less its impact on community care. Much will depend on the characteristics of the virus, its clinical attack rate, the severity of the illness it causes and the resulting case fatality rate.

32. Given the highly uncertain nature of a pandemic, we cannot know in advance the scale of the disruption it will cause and whom it will most affect. All health and community care services are likely to experience severe pressure. The impact of a pandemic will not be uniform over the wave or across regions; it may take the form of a rising tide, depending on the attack profile. Any age-specific differential attack rate will affect the overall impact. If working-age adults are predominantly affected, this will have a more direct impact on provision of services and business continuity, whilst illness in very young children and older people is likely to have an indirect impact and will present a greater burden on health and community care services.

Key challenges in managing community care services

33. To meet the key challenges, careful coordination, robust leadership and effective multi-agency working will be essential. Local planners should follow the eight key principles outlined in *The ethical framework* for the response to pandemic influenza when developing their responses to those challenges. These are:

- respect
- minimising the harm that a pandemic could cause
- fairness
- working together
- reciprocity
- keeping things in proportion
- flexibility
- good decision-making.

34. Key challenges in managing community care services include:

- maintaining essential community care services in the community with reduced staff, including all the services that are not about direct care but that form an essential lifeline for some people, eg meals on wheels, shopping schemes, transport services, provision of community equipment, community alarm services, telecare, etc
- recognising and planning for individuals and groups who may be particularly at risk and hard to reach, examples of whom might be:
 - people with mental health problems
 - people who are homeless or living in temporary or insecure accommodation
 - people with communication difficulties
 - people with sensory loss
 - some black and minority ethnic communities

- isolated and older disabled people living alone
 - gypsies and travellers
 - migrant workers
 - older carers of adults
 - people with learning disabilities and/or physical disabilities
 - adult survivors of abuse
- managing the inevitable additional demand placed on local community care services and intermediate care services. Additional pressure on acute hospital beds created by the pandemic will likely result in all but the most critical clinical cases being cared for outside the hospital setting
 - ensuring that the necessary lines of communication exist to disseminate national, regional and local messages on pandemic planning. Ensuring that messages are clear, so that organisations from a diverse range of community care services across all sectors (statutory, voluntary and private) can respond to them
 - additional pressures on time needed to support care home and hostel residents and people cared for in their own homes when they have influenza
 - sustaining people with complex disabilities who are currently supported with intensive care packages in the community, including those using their own personal assistants
 - providing emergency short-term care for people who are looked after at home by informal carers if their carers become ill
 - maintaining a balance between taking appropriate safety and infection control measures and ensuring that people's quality of life is maintained as far as possible
 - ensuring risk management and business continuity.

35. Directors of Social Work have a particularly crucial role in coordinating the planning and response of community care. They should begin by holding a scoping exercise, involving other council departments and stakeholders, to ensure that their plans will include all actual and potential service users. It will be essential for the Directors of Social Work to liaise with the Directors responsible for children services (if different) to ensure an appropriately joined-up approach to planning for the needs of adults and children. They may need to consider the costs involved in managing an influenza pandemic. We are particularly concerned that individuals or groups who are already disadvantaged or at particular risk should be fully considered and planned for.

(Please refer to the list of these groups under the second bullet point at paragraph 34.)

36. In addition to planning for these groups, Directors of Social Work will need to give thought to how some of these groups will need to be protected from negative public opinion or stigmatisation if they are perceived as posing a particular threat to public health. For example, the perception may be that influenza is more prevalent amongst homeless people, and as such other groups may be reluctant to come into contact with them at communal facilities. We have offered some checklists for Directors of Social Work and others to consider when planning. These are not definitive, but we hope that they go some way to assist planners in thinking about the scope of their responsibilities. In carrying out your planning please refer to the checklists at the back of this document on pages 40-47.

Key planning considerations

37. Local authorities will be responsible for preparing the community care response to pandemic influenza locally, in the context of their wider responsibilities for performing functions under the Civil Contingencies Act 2004. (The duties under the CCA apply to all Category 1's equally (including NHS). If pandemic flu is a recognised risk they must prepare. If the risk is such that joint planning would be appropriate they must consider if that is the case and, if so, plan together under the regulations (Regulation 16)). In preparing for pandemic influenza they must co-operate with other local responders and take into account the activities of the voluntary sector. Preparation should be undertaken within the management framework established by the Strategic Co-ordinating Group (SCG) and national structures as outlined in Section 4 of Preparing Scotland
<http://www.scotland.gov.uk/Resource/Doc/94471/0022783.pdf>

38. Advance planning is essential to establish and rehearse contingency arrangements to enable normal business to continue as far as possible. Contingency arrangements will need to be proportionate, resilient and flexible enough to deal with a wide range of possibilities.

39. Response arrangements should be based on strengthening and supplementing normal delivery mechanisms, in so far as this is possible. To be effective they will need to be developed on an integrated multi-agency basis with risk sharing and cross-cover between organisations where possible, supported by strong local leadership and coordination when implemented.

40. Local advice and information should complement wider national messages. The Civil Contingencies Act duty to warn and inform the public applies to the impacts of pandemic flu.

41. Local authorities should work with local providers to ensure they have robust business continuity plans in place. Having strong relationships with local providers is key to managing an influenza pandemic.

Carers

42. Disruption is likely to be less severe if individuals with responsibility for caring for others know what to expect and what to do in the event of an outbreak. Up-to-date and authoritative information should be available to these individuals. This should include advice on where carers can go to for help if they feel unable to cope anymore due to increased demands arising from an influenza pandemic.

People using community care services

43. It is essential to inform people who use services that contingency care arrangements may need to be in place. This may include relying more heavily on families and informal carers if normal care arrangements are disrupted by the onset of pandemic influenza. Eligibility criteria for care during a pandemic should be transparent and applied in a consistent and equitable way that reserves capacity for those in the greatest need. *The ethical framework* for the response to pandemic influenza will be important here.

Key organisational and individual roles and responsibilities in community care

44. Planning for and responding to the challenges faced by community care services during an influenza pandemic will require a combined, coordinated effort using experience and expertise at all levels across a wide range of organisations in the statutory, voluntary, independent and private sectors. It will require the active support of communities, and individuals will need to take personal responsibility for protecting their health, supporting each other and contributing to the containment of disease.

45. To ensure an effective response, local authorities and their partner organisations need to understand their roles and responsibilities and be able to plan accordingly and jointly where necessary. Each organisation will need to agree its priorities and take proactive steps to ensure the continuity of its services.

46. This section describes the roles and responsibilities of the main participants in planning for community care during an influenza pandemic.

Wider local authority

47. Local authorities have specific civil protection duties and responsibilities under the Civil Contingencies Act 2004 and the Contingency Planning (Scotland) Regulations 2005 - see <http://www.scotland.gov.uk/Publications/2006/02/27140215/0>. They are directly responsible for the provision of a wide range of the functions that will be essential when responding to the health and wider impacts of an influenza pandemic. They also exercise a crucial community leadership role. Local authorities have a responsibility for planning and preparing to maintain community care and housing services in a pandemic scenario.

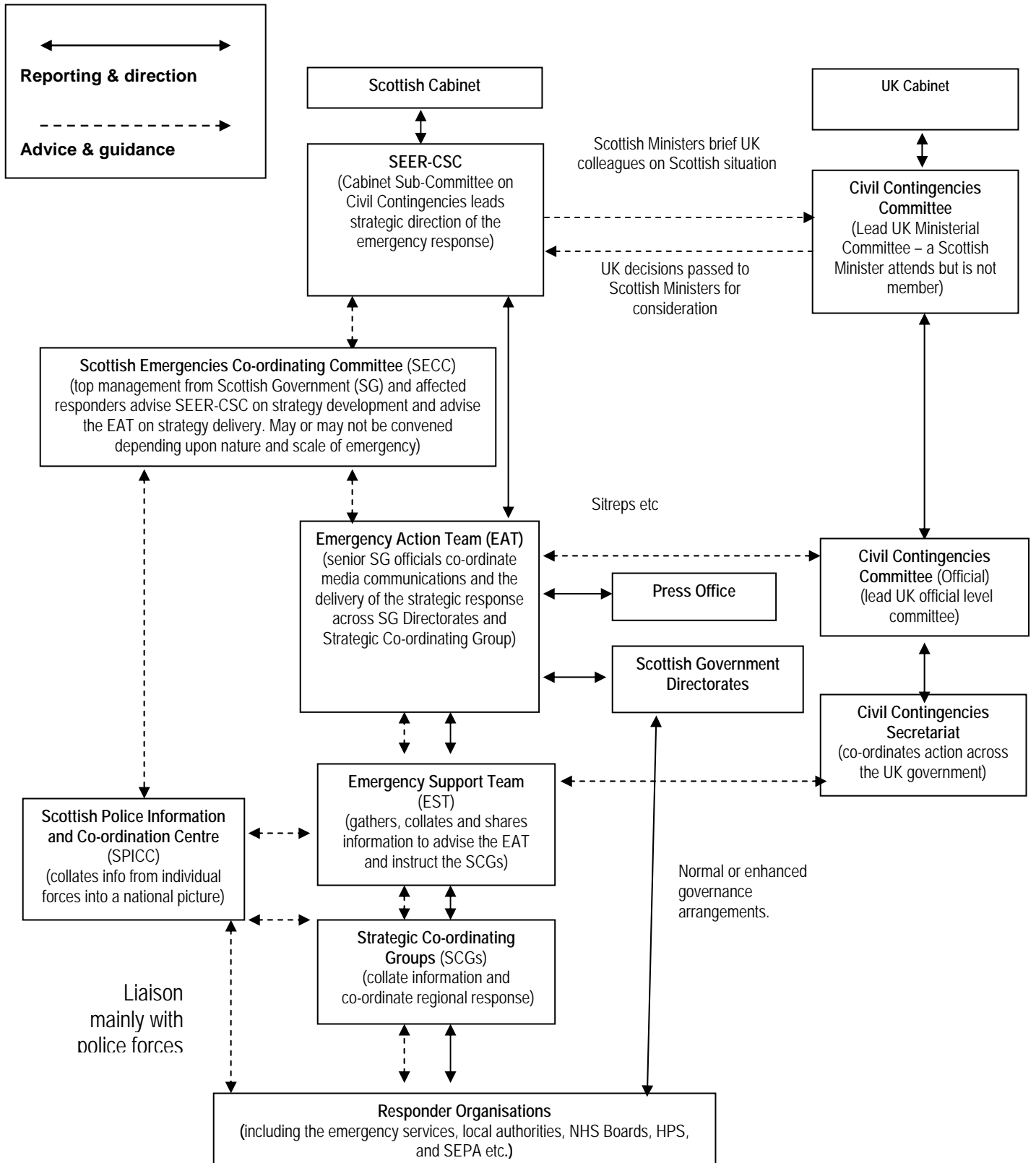
48. Individuals who have responsibility for community care functions within local authorities will need to work closely with their emergency planners to ensure the integration of their planning and that of the SCG and its partners. In the event of an outbreak of pandemic influenza, it is essential that community care is adequately represented in local authority planning and that adequate business continuity management arrangements are in place to enable community care functions to continue in the event of an emergency.

49. Local authorities will also have a leading role in coping with the increased numbers of deaths. Local authorities will want to ensure arrangements for services, such as registrars, burial and cremation authorities, work together with Procurators Fiscal, the health services (e.g. GPs and NHS Mortuaries) and can be supported by local businesses, such as funeral directors and privately owned cemeteries and crematoria. The Home Office will be developing guidance on managing excess deaths following a consultation exercise and it is expected that the Scottish Government will issue similar guidance in due course.

The Civil Contingencies Act 2004 and Strategic Co-ordinating Groups

50. The Civil Contingencies Act 2004 and its accompanying non-legislative measures provide a single framework for civil protection. Regulations under the Act require organisations, including health boards and local authorities, that will be involved in responding to an emergency to come together to form SCGs. These have been established in each of the 8 police force areas in Scotland to co-ordinate and develop/maintain links between partner agencies and to co-ordinate planning at local level. The SCGs provide an effective mechanism for developing integrated plans and responding within the management framework outlined in Preparing Scotland.

Response structure for national emergencies



Directors of Social Work/Chief Social Work Officer

51. Directors of Social Work will have ultimate responsibility for planning and coordinating the community care response for adults at a local level. They will keep the Directors responsible for children's services (if different) informed and involved, and will ensure that decisions and plans operate for optimum benefit across both services. Planning the community care response should take full account of the impact of such events as school and early years group childcare facility closures. Directors of Social Work will play a key role in cascading messages from the centre and ensuring that all community care providers within their authorities are aware of and involved in local contingency plans.

52. As part of their overall strategic coordination of plans, Directors of Social Work will need to ensure that local contingency plans don't make unfounded and unrealistic assumptions that other areas will have spare capacity to assist them in providing services during the pandemic period.

53. Directors of Social Work should be in regular dialogue with their emergency planners and other colleagues (e.g. housing), their health partners (NHS Boards/Community Health Partnerships), and voluntary sector agencies to establish what is required of them and their teams in the pandemic alert period.

54. As most influenza sufferers will need to be cared for in a community setting (rather than in a hospital setting), developing integrated health and community care planning to allow for this is particularly important in order to reduce the burden on community care services. The Scottish Government has directed all NHS Boards to designate an Influenza Pandemic Coordinator, and it would be advisable for local authorities to approach contingency planning for community care in the same way by appointing a designated officer for contingency planning in community care. The designated community care officer should work alongside their own local authority emergency planners, NHS organisations and independent community care providers to fully integrate community care planning with health and other local-level contingency planning.

55. Directors of Social Work will be responsible for communicating the alert stages of a pandemic and the key messages to community care providers in their localities (see Figure 2). Figure 3 sets out the role of the Directors of Social Work in disseminating key messages and information flows. (Note: NHS Boards are on the SCGs and will therefore be aware of key messages and information.)

Figure 2: Information flows – communicating the alert stages of a pandemic

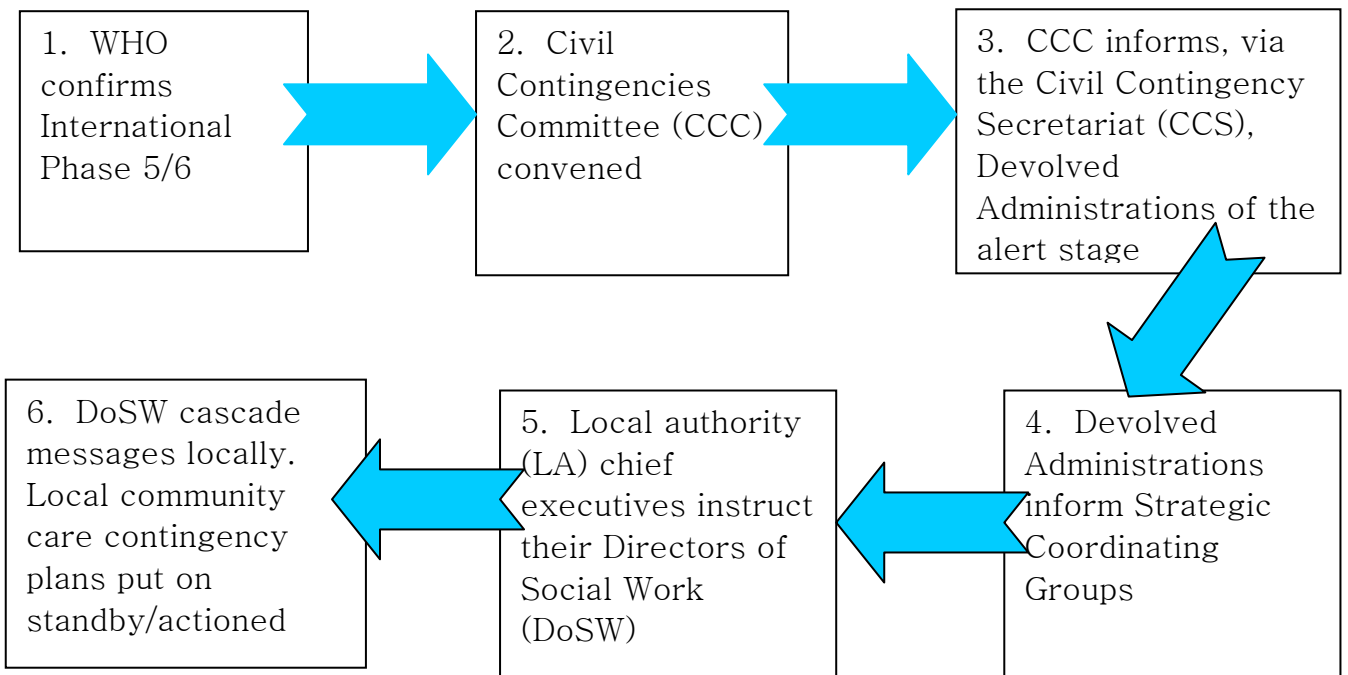
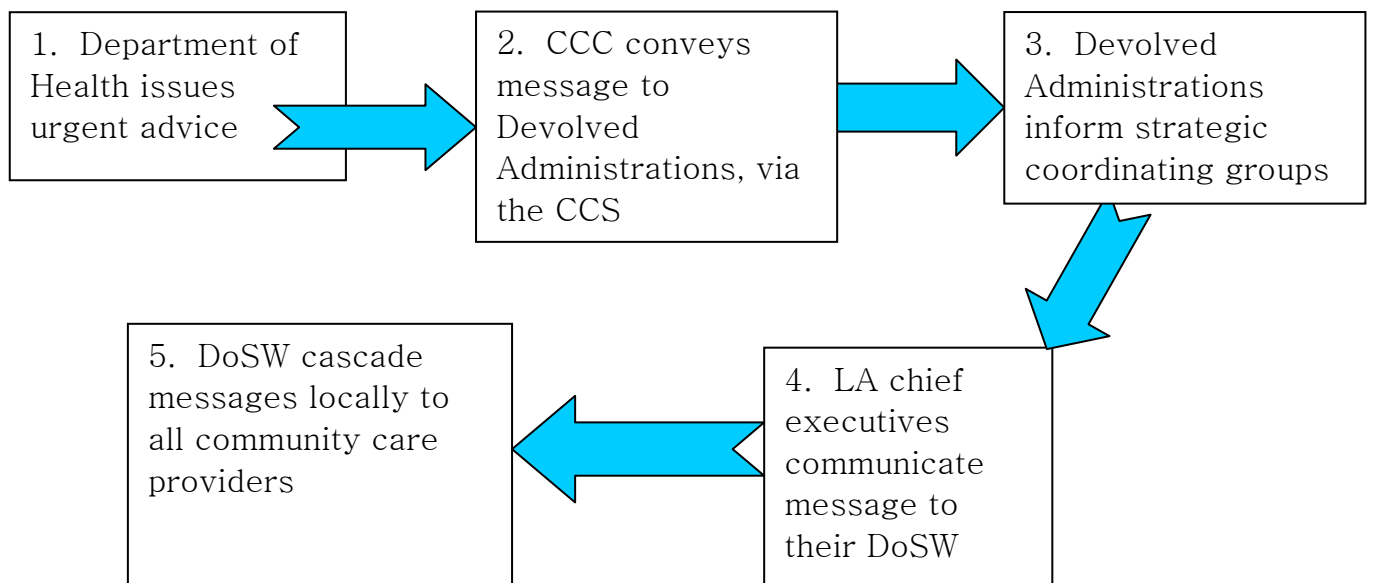


Figure 3: information flows – communicating key messages during the pandemic period



56. The Scottish Government will contact community care provider representatives and umbrella organisations to help disseminate key messages to community care providers through their networks; however, the primary responsibility for ensuring that key messages reach providers remains with the Directors of Social Work. Similarly, Directors responsible for education and children's services will be responsible for communicating key messages to schools and group childcare facilities. Guidance on the role of the Directors responsible for education and children's services has been produced by the Scottish Government. Directors of Social Work (if different) are encouraged to refer to this guidance in order to be aware of the role of the Directors responsible for education and children's services will be performing during a pandemic. Directors responsible for children's services and the Directors of Social Work (if different) should agree between them what roles each Director will perform during a pandemic in order to avoid any overlap or issues being missed.

57. It may be helpful for community care providers to be able to access a central source of information about pandemic preparedness in their local area, e.g. the content of the local authority contingency plan. Directors of Social Work may wish to consider how their local authority can best ensure that their local providers have access to useful and up-to-date information to aid them in their planning and preparedness, e.g. information on the authority's website.

58. Local authorities will also need to consider how they convey messages locally, particularly during pandemic alert Phase 6. Some local authorities operate a text messaging service to disseminate certain key messages.

Care Commission

59. The Care Commission maintains a register of all community/social care services registered with it under the Regulation of Care (Scotland) Act 2001. The information is available on their website (*Care Services* on menu bar, then *Care Services List* on left hand menu; or direct link here -

http://www.carecommission.com/index.php?option=com_content&task=view&id=24&Itemid=45

NHS Boards

60. NHS Boards are responsible for developing, maintaining and testing robust, resilient and integrated local response plans within national guidelines and in conjunction with partner agencies. NHS Boards also provide a health input to Strategic Co-ordinating Groups. Each NHS Board has a pandemic influenza plan which has been submitted and reviewed by the Scottish Government and operational level planning is progressing in all areas. The plans can be found at www.scotland.gov.uk/pandemicflu. As part of their contingency planning NHS Boards, working with Community Health Partnerships (CHPs), also have a responsibility to consider the impact of pandemic outbreak on the primary care sector as most of the assessment, treatment, care and support will be outside hospital settings.

61. In the event of a pandemic, NHS Boards, assisted by CHPs and other agencies, will co-ordinate the health response in their area, provide advice and information, working within the current national guidelines and responding in a coherent, effective, co-ordinated and ethically appropriate way. They will also collate and report information related to the health services and the outbreak to the Scottish Government.

Voluntary sector organisations not providing ‘core’ community care services

62. The voluntary sector is a key provider of services in community care, with many organisations providing a wide range of operational support to ease the pressure on statutory responders.

63. The voluntary and community sector may be able to help support the response to pandemic influenza at a local level. Local authorities, with their local partners, will need to consider how to involve voluntary organisations in their area with whom they do not usually have business arrangements. Examples of organisations that may be able to offer assistance include the Salvation Army, Women’s Institute, and WRVS as well as small, local self-help groups, community groups and faith-based organisations and places of worship.

64. Such organisations may be able to support a response by:

- putting in place initiatives for ‘good neighbour’ schemes
- providing a useful route in some areas for access to hard-to-reach individuals and groups, such as travellers, asylum seekers, homeless people, people with mental health problems/learning disabilities and those with little or no English or understanding of the state system
- helping in the communication of key messages, information and advice both before and during a pandemic, eg through websites, their volunteers, shops, etc
- contributing valuable information and expertise to aid local pre-pandemic preparations and simulation exercises
- helping to provide social support to maintain sufferers in a community setting or assisting those suffering from stress, anxiety or grief.

65. Voluntary sector support should be coordinated via designated officer for contingency planning in community care (see paragraph 54).

66. Community care organisations will also need to understand that voluntary organisations themselves are likely to be under pressure and limited in their capacity to provide additional help and services during the pandemic period. There are limited numbers of volunteers available and the pandemic will affect them too, not only in terms of the number of volunteers who may actually catch the virus but also in their willingness to become involved due to the fear of catching it. Organisations benefiting from the support

of volunteers will need to ensure that they have adequate briefing, training, skills and personal protection for the role they are expected to perform. They should also ensure that volunteers are properly indemnified for insurance purposes.

Employers, Trades Unions and other staff or professional organisations

67. Working together, employers; trades unions and other staff or professional associations have a significant role to play in preparing for and responding to a pandemic by educating and informing the workforce, promoting measures that reduce the spread of infection, helping to maintain essential services and minimising social disruption.

Private and independent sectors

68. In addition to providing community care services, many private and independent sector organisations are responsible for providing supplies and services that are critical to maintaining community care services, particularly in the area of protective clothing, etc. Planning to ensure the maintenance or even expansion of these supplies and services, as far as is possible, is an essential part of developing effective response arrangements as part of a joined-up approach with the health service.

Community care providers (statutory, voluntary and private sector)

69. Community care providers will need to ensure that they plan for how they will maintain their services and ensure that people relying on them are not left unsupported during a pandemic. As far as is possible, they should plan in consultation with service users and carers and other key local organisations. Some providers may wish to undertake joint planning with other local care providers to explore risk sharing and pooling arrangements.

Community and individual responsibility

70. Well-prepared and informed communities and their leaders can play a major role in supporting the response to and recovery from an influenza pandemic. Community networks can be particularly effective in such areas as disseminating information, providing reassurance and identifying/supporting those who are particularly at risk, and should therefore be fully involved in developing response plans. Involvement of community networks and key local leaders in planning and providing a response will be particularly important for people who are harder to reach through normal channels; these include some homeless people, some ethnic groups, travelling communities and some migrant workers.

71. The cooperation of individual members of the public and their willingness to follow advice, to take responsibility for their own health and to support each other are likely to be critical determinants of the overall success of the response.

Planning principles

Ethical considerations

72. In preparing for and responding to an influenza pandemic, governments, policy makers, public and private sector organisations, professional leaders, clinicians, health workers and many others involved in the caring professions and/or leadership roles will face difficult decisions and choices that may impact on the freedom, health and in some cases the prospects of survival of individuals. Many people are also likely to face individual dilemmas and tensions between their personal, professional and work obligations. Given the expected levels of additional demand, capacity limitations, staffing constraints and potential shortages of essential medical material, hard choices and compromises are likely to be particularly necessary in the fields of health and community care.

73. People are more likely to accept the need for and the consequences of difficult decisions if these have been made in an open, transparent and inclusive way. National and local preparations for an influenza pandemic should therefore be based on widely held ethical values, and the choices that may become necessary should be discussed openly as plans are developed so that they reflect what most people will accept as proportionate and fair. At the request of the Department of Health, an independent committee with cross-UK representation has developed an ethical framework to inform the development and implementation of health and social care (community care) and public health response policy. The systematic use of the principles it contains can act as a checklist to ensure that all the ethical aspects have been considered at all levels.

74. The *ethical framework for the response to pandemic influenza* is available at www.dh.gov.uk/pandemicflu.

Key planning assumptions

75. The precise characteristics and impact of an influenza pandemic will only become apparent as the virus emerges. Therefore, some assumptions and presumptions of its likely response in a number of key areas are necessary to describe the impact the Government is currently planning for. For more information refer to the Scottish Framework for Responding to an Influenza Pandemic.

76. The use of common assumptions and presumptions for planning across all public and private sector organisations avoids confusion and facilitates integrated preparation. Given the uncertainties, these should be regarded as working estimates rather than predictions, and response arrangements must be flexible enough to deal with a range of possibilities and capable of adjustment as they are implemented. Provided that the origin of a pandemic is outside the UK, emerging surveillance data might also allow the use of real-time modelling to confirm and/or refine these assumptions and presumptions.

77. Some key planning assumptions for community care are set out below. Comprehensive planning assumptions are available in the Scottish Framework for Responding to an Influenza Pandemic. Some of these assumptions are based on a

uniform attack rate across all age groups. Whilst they should assist in impact assessments and developing contingency plans, the attack rate may not be uniform across all age groups, so plans will need to retain flexibility to adapt as information emerges.

78. In previous pandemics, the overall UK clinical attack rate has been of the order of 25% to 35%, compared with the usual seasonal influenza range of 5% to 15%. Cumulative clinical attack rates of up to 50% of the population in total are possible spread over one or more waves of around 15 weeks, each some weeks or months apart. If they occur, a second or subsequent wave could possibly be more severe than the first.

79. In Scotland, there are around 2,000 “excess winter deaths” each year. There is a clear link between “excess winter deaths” and the level of influenza activity¹. During a pandemic, assuming a clinical attack rate of 25%, the number of excess deaths due to influenza in Scotland may be between 5,100 and 31,700. However, if the clinical attack rate is as high as 50%, the number of excess deaths is likely to be between 10,200 and 63,700.

80. The actual extent (clinical attack rate) of illness will only become evident as person-to-person transmission develops, but response plans should recognise the possibility of a clinical attack rate of up to 50% in a single-wave pandemic.

Geographical spread

81. You may wish to note the following points about how an influenza pandemic can spread:

- once a pandemic is declared (WHO Phase 6 – see paragraph 94 for more detail on the WHO phases), even if – as seems likely – it originates abroad, a pandemic will probably have reached the UK within a month
- from arrival in the UK, it will take a further one to two weeks until sporadic cases and small clusters occur across the whole country that will act as initiators of local epidemics
- the pandemic may occur in one or more waves

¹ Excess Winter Deaths, 2006, General Register Office for Scotland, www.gro-scotland.gov.uk/statistics/publications-and-data/excess-winter-deaths/index.html

Severity and extent (clinical attack rate) of illness and death

82. You may wish to note the following planning assumptions for the severity and extent of an influenza pandemic:

- all ages are likely to be affected, but children and otherwise fit adults could be at relatively greater risk, particularly if older people have some residual immunity from previous exposure to a similar virus earlier in their lifetime
- although the potential for age-specific differences in the clinical attack rate should be noted, they are impossible to predict, and a uniform attack rate across all age groups is assumed for planning purposes
- **up to 50%** of the population may show clinical symptoms of influenza over the entire period of a pandemic and up to 25% of these people may develop complications
- **up to 2.5%** of those who become symptomatic may die
- **up to 22%** of influenza cases can be expected to occur **during the peak week** of a pandemic wave

Infectivity and mode of spread

83. Influenza can infect people and spread amongst the population in the following ways:

- influenza spreads through the respiratory route by droplets of infected respiratory secretions when an infected person talks, coughs or sneezes
- it may also spread by hand/face contact (nose, mouth or eyes) after touching a person or surface contaminated with infectious respiratory droplets
- finer respiratory aerosols (which stay in the air for longer and are therefore more effective at spreading infection) may occur in some circumstances such as during the use of nebulisers, some dental procedures etc
- people may be infectious between 24 and 48 hours before the onset of symptoms and are highly infectious for 4 or 5 days from the onset of symptoms (longer in children and those who are immunocompromised)
- children have been shown to secrete virus for longer and at higher levels than adults
- some people can be infected without showing symptoms, and may shed (excrete) the virus and therefore be able to pass on the infection
- the incubation period is in the range of one to four days (typically 2-3)

- without intervention, and with no significant immunity in the population, historical evidence suggests that one person infects about two other people on average (the R_0 or 'basic reproduction number'). This number is likely to be higher in communities such as prisons, care homes or boarding schools

Health and community care demand

84. An influenza pandemic will place an increased demand on health and community care organisations. You may wish to note the following:

- all health and community care organisations will need to adapt and reorganise to provide treatment, care and support for the large numbers likely to suffer from Influenza or its complications whilst maintaining other essential care
- most health and community care will need to be delivered in a community setting, with hospital capacity protected and preserved for the most seriously ill who are likely to benefit
- given a 50% clinical attack rate, demand for hospital admission can be expected to increase by as many as 440 new cases per 100,000 population per week at the peak and will exceed available hospital capacity
- given a 50% clinical attack rate, demand for critical care beds could rise up to 110 per 100,000 population per week at the peak and would exceed available capacity
- up to 4% of those who are symptomatic may require hospital admission if sufficient capacity were to be available
- those who become symptomatic will be advised to stay at home and make telephone contact with health services for initial assessment
- most patients will be treated at home with antiviral medicines initially
- according to the 2001 Census, in Scotland over 60,000 people care for a relative or friend for between 20 and 49 hours per week, and almost 116,000 people provide care for a relative or friend for over 50 hours per week. Many of these informal carers will be infected during the pandemic period and alternative community care may need to be provided for those they care for. Of course many community care staff are also carers

Note: for more information on planning presumptions you may wish to refer to additional planning presumptions contained in A Scottish Framework for Responding to an Influenza Pandemic.

Impact on workforce

85. We anticipate that an influenza pandemic will have a significant effect on the health and community care workforce. The full details of this are at the 'Managing staff absences' section at paragraphs 97-102. For instance:

- up to 50% of the workforce may require time off at some stage over the entire period of the pandemic, (with individuals absent for a period of seven to ten working days)
- additional staff absences are likely to result from such things as care responsibilities, family bereavement, or practical difficulties in getting to work
- the Scottish Government may advise schools and group childcare settings in an area to close in order to reduce the spread of infection among children, meaning that some staff may need to stay off work in order to care for their children

Vaccination and antiviral drugs

Pandemic-specific vaccination

86. Vaccination is widely used in the UK to offer protection against the seasonal influenza strains most likely to be circulating that particular year. As a pandemic will result from the emergence of a new or modified strain, these routine vaccines are unlikely to offer protection. It is not possible to develop a matching vaccine until the emerging influenza strain has been identified. The Government has finalised advanced supply contracts with manufacturers to make sufficient supplies of a matching vaccine available as soon as it is developed and is also working actively with the international community and pharmaceutical industry to speed development, testing and licensing.

87. However, it may take four to six months before an effective vaccine is available and considerably longer before it can be manufactured in sufficient quantities for the entire population given that international demand will be high. Realistically, it is therefore unlikely that a specific vaccine will contribute much to dealing with the initial wave of a pandemic – unless its evolution, or the effectiveness of early control measures, result in a significantly slower developing pandemic than anticipated.

88. For planning purposes, the presumption should be that a mass pandemic vaccination campaign during the first pandemic wave is unlikely, but may contribute to reducing the impact of subsequent waves if they occur.

89. For information about pre-pandemic vaccination, refer to the Scottish Framework for Responding to an Influenza Pandemic.

Antiviral medicines

90. Antiviral drugs can be used to treat certain viral infections, including influenza. The existing UK stockpile allows for the treatment of all symptomatic patients at clinical attack

rates of up to 25% and arrangements to make antivirals rapidly available are a critical part of the health response.

91. Although the targeted and effective use of antiviral medicines or other definitive pharmaceutical interventions is an important countermeasure, they may be in limited supply. When used to treat seasonal influenza, antiviral medicines reduce the length of symptoms (by around a day) and usually their severity, as long as they are started within two days of the onset of symptoms. Whilst it is impossible to predict whether antiviral medicines will be equally effective against a new or modified pandemic virus, it is reasonable to anticipate a similar effect and associated substantial reductions in severe morbidity.

Supporting access to antivirals and vaccines

92. The current community care model for pandemic planning proposes that people identify, in advance of a pandemic, friends or family who could collect medicines on their behalf should they fall sick.

93. For more information about the effect and use of anti-virals and vaccines refer to the Scottish Framework for Responding to an Influenza Pandemic.

How will key messages be communicated during a pandemic?

World Health Organisation (WHO) international phases and UK alert levels

94. WHO is responsible for declaring the various international phases of a pandemic according to the following model:

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 within limited foci or delay 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.

- 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

- 6 Increased and sustained transmission in general population

Minimise the impact of the pandemic

UK alert levels

- 1 Virus/cases only outside the UK
- 2 Virus isolated in the UK
- 3 Outbreak(s) in the UK
- 4 Widespread activity across the UK

Minimise the impact of the pandemic

95. This model describes the progression of an influenza pandemic starting from the identification of a new virus strain and ending with widespread activity in the UK. The six phases allow for effective communication of the worldwide situation and enable governments, and other relevant organisations, to adopt an incremental approach to preparedness planning.

96. Strategic Co-ordinating groups will be mobilised to lead the local response in Scotland see diagram on page 15

Specific issues to be considered by community care organisations

Managing staff absences

97. The level of staff absence from work during a pandemic will depend significantly on the nature of the pandemic virus when it emerges. The impact of a pandemic on absenteeism in community care is likely to be severe. Not only will staff be ill but the profile of the workforce is such that some people will be absent from work due to the need to care for children and/or other family members who are ill with influenza. Employers should consider whether their policy on absence is clear to staff so that they are aware of the boundaries.

98. In addition, schools and early years group childcare facilities may be advised to close during the pandemic period in order to reduce the spread of the virus amongst children, or may close because of staff shortages. This is likely to compound staff shortages in community care, as many members of the workforce have young children and parents will need to care for their children or find substitute care. The Scottish Government produced guidance called [Planning for a Human Flu Pandemic – Guidance for Schools, Childcare and Children’s Services in Scotland](#). Because such closures will have huge impact on the workforce planners are advised to consider the guidance when making assumptions about staffing levels. Planners should check with Directors responsible for education and children services what the approach should be to taking appropriate local decisions about if/when to close schools and early years group childcare facilities.

99. The planning assumptions set out below are based on current knowledge, analysis of past pandemics, published evidence and scientific modelling. Organisations should ensure that their business continuity plans have the flexibility to accommodate the expected levels of staff absence. Local authorities should ensure that all contracts have clauses that require business continuity plans.

100. During a pandemic, staff will be absent from work if:

- a) they are ill with influenza. Numbers in this category will depend on the clinical attack rate. Up to 50% of the workforce may require time off at some stage over the entire period of the pandemic, with individuals absent for a period of seven to ten working days. Absenteeism should follow the pandemic profile with an expectation that it will build to a peak lasting for two to three weeks, when between 15% and 20% of staff may be absent due to having influenza, and then decline. Modelling suggests that small organisational units (5 to 15 staff) or small teams within larger organisational units are likely to suffer higher percentages of absenteeism due to having influenza – up to 30–35%
- b) they need to care for children or other dependants who are ill with influenza
- c) they need to care for (well) children due to local school closures (in light of July 2006 guidance from the Scottish Government Education Department which advises

schools and childcare settings to plan for possible closure on a regional basis during a pandemic). Regardless of whether or not the Government advises schools to close, it is likely that some schools will have to close due to shortages of staff or parents not being willing to send their children to school

- d) they have non-influenza medical problems
- e) their employers have advised them to work from home
- f) they decide to absent themselves for other reasons, eg family bereavement, other psychosocial impacts, fear of infection, or practical difficulties in getting to work.

101. Contingency planning should allow flexibility and include a strategy for coping with widespread staff shortages – our aim must be not to leave people without essential care during the pandemic phase.

102. Community care organisations should consider taking the following measures during the planning stage:

- estimating the number and categories of staff needed to maintain a satisfactory (rather than ideal) level of care for the service as a whole and/or for a single service user or a small group of service users
- identifying a network of people who would be prepared to work in an ancillary care capacity during a pandemic. These could include:
 - other service users
 - relatives and friends of service users
 - retired staff
 - local students and trainees in the sector
 - people within the organisation currently undertaking back-office tasks, e.g. some administrative staff
 - local voluntary or faith groups
 - disclosure checked staff working in the education and leisure sectors
 - student volunteers (16 years and upwards) from schools or colleges that have been closed.

If such networks or 'volunteer pools' can be identified, providers will need to consider how they can be equipped and trained to undertake their roles, eg shadowing of staff, volunteer work placements, cross-training between existing staff, etc

- considering suitability of replacement staff (specific communication skills/expertise/cultural understanding – eg is gender an issue for certain groups or individuals?).
- involving the main employment agencies providing temporary community care staff locally
- agreeing risk-sharing/staff-pooling arrangements and protocols with other local organisations

Occupational health and staff welfare issues

103. People are the most important resource in maintaining community care support for those who need it. Staff who know that they are valued and supported during a pandemic will be more likely to maintain their goodwill and commitment during periods of extreme pressure. Some measures providers may consider taking during planning to support the welfare of their staff include:

- being proactive in providing staff with, or helping staff to access, information relevant to their own health before and during a pandemic (eg posting advice on the latest developments on the local authority website)
- implementing a non-punitive sick leave policy for managing staff who have symptoms, or a confirmed case, of influenza. If staff members suspect that they may have the symptoms of pandemic influenza they should be instructed to stay away from work until reviewed by a doctor or other healthcare worker and told otherwise. Please note that it may not be possible to arrange a review by a doctor or healthcare worker prior to return to work unless the employer's occupational health scheme allows for this.
- agreeing with staff that, where possible, those who have had and recovered from pandemic influenza (and may have therefore acquired antibodies which might guard against future infections) will most likely be the first managers called upon to offer personal care as they will themselves be healthy and able to care for ill people and will also be unable to infect healthy people
- where possible, putting in place plans to safeguard the health of staff who are at high risk of complications of pandemic influenza, eg pregnant women, people with chronic conditions, other immunocompromised persons. This could include informing them about their medical risk and offering them alternative low-risk duties or consideration for administrative leave until pandemic influenza has abated in the community. This would need to be handled very sensitively as in the usual course of events managers and colleagues would not necessarily know a member of staff's personal health information. Considerable thought needs to be given to protecting personal data – particularly if someone is, say, HIV positive or from an ethnic group experiencing higher prevalence of certain conditions such as hepatitis

- considering home working for administrative staff who would be of most benefit if they continue with their administrative duties rather than be transferred to a caring role
- agreeing in advance, and seeking the wide support of staff for, measures limiting time off during the pandemic whilst meeting staff needs for essential rest and recuperation
- identifying local mental health, faith-based or other voluntary sector resources for counselling of staff during a pandemic to help them deal with issues such as management of grief and fear
- developing procedures to support staff in the resolution of ethical dilemmas arising during the course of their work
- where appropriate, developing a strategy for accommodating and feeding staff who might be on-site for prolonged periods
- developing a strategy to accommodate and support staff who have unavoidable responsibilities to care for children or older people.

Health and safety legislation – protection in an occupational setting

104. In a pandemic setting, employers still have a duty to provide a safe place of work for their workers: they are required to maintain safe working systems and implement protective measures based on a local risk assessment, taking account of the Control of Substances Hazardous to Health Regulations 2002 as appropriate. A risk assessment should be completed to consider whether the employee's work activity increases the risk of exposure beyond that of community-acquired exposure and if so, control measures proportionate to this should be implemented.

105. Consultation, jointly conducted risk assessments by employers, staff and their representatives and documented procedures during the planning phase, can help ensure that employees are well educated and informed. Joint risk assessments can also assist in identifying and exploring any subjective perceptions of risk, the opportunities for more flexible working arrangements, and training requirements to help cover staff absences. Identifying those staff with co-morbid conditions or other factors that may put them at higher risk may also allow proportionate individual precautions. Authorities should note that they are responsible for the health and safety of any volunteers appointed during a pandemic, and for ensuring that the correct health and safety practices are in place for any organisation contracted to provide additional support.

106. Making temporary changes to working practices, eg reducing close face-to-face contact, providing physical barriers to transmission, enhancing cleaning regimes, ensuring that the necessary protective equipment is available, having hand washing, waste disposal and other hygiene facilities in place and actively promoting these and other similar measures, can help to encourage and maintain attendance at work during the response phase. Further guidance for employers is available on the Health and Safety Executive (HSE) website at www.hse.gov.uk/biosafety/diseases/influenza.htm .

Training and education for staff

107. A workforce that is well-informed and trained is likely to manage the additional pressures and challenges arising during a pandemic. Topics for staff education and training should include:

- good hygiene practices to limit the spread of the virus as far as possible
- general information about pandemic influenza, including information about vaccination and antiviral drugs
- infection control strategies for influenza, including respiratory hygiene/cough etiquette, hand hygiene and other precautions, specific training for cleaners and their roles in helping reduce the spread of infection
- specific training for telecare and community alarm call centre staff in helping to identify and support people isolated at home
- opportunities such as job shadowing to help prepare staff and volunteers to take on additional roles and responsibilities in the short term to cover staff absences
- how to respond to ethical dilemmas
- how best to train duty and on-call staff, eg whether or not this is best done face to face.

Infection control and personal hygiene

108. Once efficient person-to-person transmission is established, preventing an influenza pandemic developing is unlikely to be possible as most people are likely to be exposed to the virus at some stage during normal activities. In order to protect others and reduce the spread of infection, anyone with influenza-like symptoms should stay at home, minimise social/family contact and go out only if absolutely necessary (eg for medical care) until symptoms have resolved. Those who are not symptomatic should continue normal activities and can reduce – but not eliminate – the risk of catching or spreading influenza by avoiding unnecessary close contact with others and adopting high standards of personal and respiratory hygiene.

109. Applying basic infection control measures and encouraging compliance with public health advice are likely to make an important contribution to the UK's overall response.

Simple measures will help individuals to protect themselves and others. The necessary measures include:

Hand Hygiene

- Washing hands frequently with soap and warm water to reduce the spread of the virus from the hands to the face, or to other people, particularly after coughing, sneezing, blowing your nose or disposing of tissues. Making sure children follow the above advice
- Washing hands before, and after, contact with clients on leaving the care setting.
- An alcohol hand rub or hand towelettes containing a soap/detergent solution can be used instead of soap and warm water if access to a sink is restricted.
- Hand hygiene should be performed even if disposable gloves have been worn for any contact as described above.

Coughing/Sneezing

- Covering the nose and mouth with a tissue when coughing or sneezing
- Disposing of dirty tissues promptly and carefully – bagging and binning them

Environment

- Ensure patient/client's immediate environment is clean and not contaminated with respiratory secretions
- Cleaning frequently touched hard surfaces (eg kitchen worktops, door handles, television controls) frequently using warm water and detergent or normal cleaning product

Others

- Crockery/Utensils should be washed in the normal way with hot soapy water (or in a dishwasher).
- Laundry that may be contaminated, for example clients' clothing and bedding, should be washed in the usual way, as per local policy.
- Avoiding crowded gatherings where possible, especially in enclosed spaces
- If someone is symptomatic (has pandemic influenza) and it is essential to go out, they should consider wearing a disposable face mask to protect others

110. Adopting such measures can help mitigate the overall health and wider impact of a pandemic by lowering the clinical attack rate and slowing its development, thereby spreading peak demand and enabling services to respond more effectively.

The use of face masks and respirators

111. Surgical face masks or respirators (masks that incorporate a filter) provide a physical barrier against the influenza virus provided that they are of an appropriate type, are worn correctly, changed frequently, removed properly, disposed of safely and used in combination with good universal hygiene behaviour. Face masks can be used to help

protect those who may, for example, be at occupational risk from close or frequent contact with symptomatic patients and by those who are symptomatic to avoid contaminating others if they have no choice but to leave their home, though significant communication, supply, logistic and training aspects would need to be addressed. Disposable masks or respirators should generally only be worn once, for no longer than the time recommended by the manufacturer, and then discarded in an appropriate receptacle.

112. Although the perception that wearing a face mask in public places may be beneficial is widely held, there is little actual evidence of proportionate benefit from widespread use. The Government will not therefore be stockpiling facemasks for general use. If individuals who are not symptomatic choose to purchase and wear facemasks in public places, they should be worn properly and disposed of safely to reduce infection spread. Wearing masks at all times is not practical; so decisions in occupational settings must take account of the degree of risk associated with particular occupations or activities and be based on joint risk assessments carried out by employers and staff representatives.

113. Although further clarification and guidance on the use of face masks may become available in due course, the planning presumptions should be that anyone who is ill with influenza like symptoms will be advised to stay at home. The general wearing of face masks in public places by those who do not have influenza symptoms will not be recommended and the Government will not supply facemasks for that purpose. Judgements on respiratory protection in specific occupational or other settings will need to be based on joint risk assessments. Guidance to employers is available via the Health and Safety Executive website at www.hse.gov.uk/biosafety/diseases/influenza.htm

Emergency short-term breaks

114. It is estimated that there are over 60,000 people caring for a relative or friend for between 20 and 49 hours per week and almost 116,000 people providing care for a relative or friend for over 50 hours per week. There is likely to be a marked increase in demand for emergency short-term breaks for service users where their 'informal' carers have contracted the disease. A substantial number of community care employees are likely to be informal carers too.

115. Local authorities with community care services responsibilities will need to consider, plan and prioritise for how they may meet this increased demand, with a view to people remaining in their own homes if possible.

Supporting access to antivirals and vaccines

116. The current community care model for pandemic planning proposes that people identify, in advance of a pandemic, friends or family who could collect medicines on their behalf should they fall sick. Whilst community care services will not have a direct responsibility for the distribution of antivirals and/or vaccines to people using services, they could play a key role in advance of a pandemic by supplementing primary care in their arrangements.

Identification and referral of individuals with pandemic influenza to health services

117. Individuals in receipt of community care services presenting symptoms of pandemic influenza should approach health services in the same way as the rest of the general population. For many people who cannot do this directly, neighbours, community care staff and families will need to be particularly vigilant. However, unless an individual is presenting particularly severe symptoms or is developing complications, they should be advised to contact the National Flu Line Service.

118. A widespread public awareness campaign will be initiated to inform the public of when and how to contact local health services.

119. In preparation for widespread activity (UK alert level 4), the Government will activate and publicise a flu information line. The Flu Information Line will be available from WHO phase 5 to provide public information, updates and access to literature and at UK alert level 2 (WHO Phase 6) to provide initial patient assessment and, where necessary, access to anti-virals. This will be maintained until the impact of the pandemic subsides and there is no threat of further waves. Further information on the National Flu Line Service is outlined in the Scottish Framework for Responding to an Influenza Pandemic,

Pandemic planning in different community care settings

120. Whilst some issues, such as managing staff absences, will be generic to all community care settings, each setting will have service-specific issues to take account of in its plans. This section sets out what some of those service-specific issues may be and how providers may start to address these. Services which are required to register with the Care Commission should consider what is required in the context of that registration and discuss any proposals or issues with the Commission.

Care homes

121. There is likely to be pressure on all care homes and intermediate care facilities to operate at full capacity during a pandemic. Temporary admissions to care homes are rarely likely to be ideal and should not be the first option. Therefore, care in the person's usual home should be encouraged and offered wherever possible unless there are complications.

122. Other aspects of maintaining a minimum level of service within the care home will also need to be planned, eg:

- continuity of meals provision
- continuity of other essential supplies/maintenance, eg cleaning of linen etc
- possible plans to house some workers on-site to enable extended shifts and minimise travelling from outside.

123. It may be sensible for care homes to 'pair up' with other care homes in the area and agree staff sharing arrangements to mitigate staff shortages where possible. In reality, however, we expect each service to concentrate on keeping the service for which it is immediately responsible running.

Home care

124. Given the additional pressures on both hospitals and care homes, many more people are likely to need to be supported at home. This will raise specific issues for additional carer support in the home setting and lead to an increased demand for domiciliary care services. Care providers are likely to have to arrange for some people to be supported at home at short notice and may need to develop reciprocal arrangements with other care providers.

125. Some assistive technologies and community equipment, eg community alarms, telecare, grab rails etc, may help people to manage in the short term in their own homes.

126. A number of other services that support people in the community are also likely to be affected; these include meals on wheels and home shopping schemes, without which people are likely to go without essential food and drink.

127. Domiciliary care providers will need to prioritise their services and staff and perhaps postpone some services, eg some general cleaning, and replace them with basic personal care, infection control, ensuring access to food etc.

128. When pandemic influenza is in their locality, home care agencies will need to consider contacting their clients before undertaking home visits to determine whether people within the household have influenza-like symptoms.

129. If service users have pandemic influenza, agencies should consider:

- discussing with the service users the postponing of non-essential services
- assigning staff who have already contracted and recovered from the influenza
- staff being designated to care for either influenza or non-influenza individuals wherever possible.

Day care

130. Day care centres play a vital role in helping to provide additional support to vulnerable people living at home. They can enable people to remain at home without the need for a full-time carer. They can help support carers and enable them to continue working or take breaks, and they provide a vital lifeline for many vulnerable people, reducing their social exclusion and enabling them to have wider contact with others and participate in meaningful activities.

131. However, day care services will have to consider the point at which the need to protect staff and the people attending day care outweighs the benefits to people of attending. For planning purposes, it may be sensible to recommend that, during the

pandemic phase, the provision of day care should cease and staff available for work should be redeployed elsewhere, eg to support domiciliary care services, to support usual day care attendees at home or join peripatetic networks.

Self-directed support (direct payments)

132. Local authority self-directed support services will need to ensure that individuals are not left without support if their staff become ill with influenza. Support services should consider the role their local centres for independent living can play.

Legal issues

Suspension of statutory services

133. Under the Civil Contingencies Act 2004, local authorities are required to plan for the continuing performance of their functions in the event of an emergency. Whilst it will be desirable for local authorities to maintain normal levels of service, this is likely to be impossible in the event of a pandemic. Therefore, all local authorities will need to review their services and take a risk-based approach towards which services are the most essential and therefore must continue, and which services might be reduced or even stopped during the pandemic period. However, decisions of this nature must be taken within existing legal and ethical frameworks.

Disclosure Scotland and Protection of Vulnerable Groups checks

134. Staff will be required to work flexibly when the pandemic hits Scotland. Staff may be required to cover additional tasks and, in particular, office-based staff may be required to take on caring roles.

135. Proposals in the Protection of Vulnerable Groups (Scotland) Bill lay the foundations for the creation of a new vetting and barring scheme for people working with children and protected adults. This new scheme, which is likely to be implemented from late 2008 onwards, will replace the existing Disqualified from Working with Children list (the DWCL list) and will introduce, for the first time in Scotland, a list of those unsuitable to work with adults. The new vetting and barring scheme will replace enhanced disclosure checks for those who work with children or protected adults to create a centralised and continuously updated system of pre-employment vetting and referral-based barring. This new scheme will be delivered in Scotland by an Executive Agency of which Disclosure Scotland (who carry out Disclosures check now under the Police Act 1997) will be part. The Agency will access the equivalent lists from elsewhere in the UK.

136. Among the new features that the scheme will introduce, will be a system of continuous updating, and in time once an individual has entered the scheme, employers will be able to view a short scheme record via an online facility. This feature in particular will improve the speed and responsiveness of the current system and, in the event of a pandemic, will make it easier for employees to move between jobs as circumstances dictate. This new scheme mirrors the Safeguarding Vulnerable Groups Act 2006 which introduces a similar vetting and barring scheme covering England and Wales.

137. In the event of an influenza pandemic occurring before implementation of the new scheme, and where staffing levels in relation to community care are adversely affected, care service providers will still need to ensure that any arrangements put in place to deal with this ensures that individuals charged with looking after vulnerable people have been properly disclosure checked. Providers should consider with the Care Commission what this means for their service.

138. More generally the Scottish Government could consider issuing directions pursuant to Section 1(2)(a) of the Regulation of Care (Scotland) Act 2001. Such directions could instruct the Care Commission to ensure that people working to provide essential community care services are able to operate as flexibly as possible to avoid staffing gaps, and to ensure that services are maintained to the requisite level in order to protect the health and wellbeing of service users.

Performance management

139. All local authorities will be assessed against the requirements of the Civil Contingencies Act 2004 through normal management audit arrangements.

140. Community care services are regulated by the Care Commission under the Regulation of Care (Scotland) Act 2001 and its associated regulations. During the pandemic period, it may be necessary to suspend routine Care Commission inspections of community care services. In part, this will be due to the widespread disruption to services that an outbreak will cause and in part it will be for preventative and logistical reasons. Restricting visits to community care environments will help to minimise the spread of disease, whilst logistically it may be difficult for inspectors to travel for such visits as unnecessary travel will be discouraged during the pandemic period.

141. The Care Commission is prepared to take a flexible approach to inspection during the pandemic period and will work with the Scottish Government to develop appropriate arrangements based on a risk management approach.

142. The Care Commission inspection regime for operation during the pandemic period will be placed on its website at the time a pandemic occurs.

Recovery Phase

143. As the impact of the pandemic subsides and it is considered that there is no threat of further waves occurring, the UK will move into the recovery phase. Although the objective is to return to pre-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, on-going demands, backlogs, staff and organisational fatigue and continuing supply difficulties in most organisations. Therefore, a gradual return to normality should be anticipated and expectations shaped accordingly. Plans at all levels should recognise the potential need to prioritise the restoration of services and to phase the return to normal in a managed and sustainable way.

Other available support and guidance

144. The following publications are available online at the Scottish Government's website: <http://www.scotland.gov.uk/Topics/Health/health/AvianInfluenza/PandemicFlu>

Scottish Framework for Responding to an Influenza Pandemic

Explaining pandemic flu: A guide from the Chief Medical Officer

Community care/Health Care

Planning for pandemic influenza in adult community care: guidelines for community care staff

Guidance on the Provision of Healthcare in a Community Setting in Scotland

Education Department

Planning for a Human Flu Pandemic – Guidance for Schools, Childcare and Children's Services in Scotland [Legislation]

Pandemic Flu: Schools, Nurseries and Children's Services: Information for Parents

Other useful support and guidance

The ethical framework for the response to pandemic influenza

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073179

World Health Organisation

http://www.who.int/csr/disease/avian_influenza/en/

Best practice examples and other resources at the Social Care Pandemic Influenza Network, www.socialcarepandemic.org.uk

Useful websites

www.ukresilience.info/ccact/index.shtm

www.hse.gov.uk/biosafety/diseases/pandemic.pdf

Checklists

General issues/prompts for planners

- Plan local simulations
- Draw up frequently asked questions and answers and display them wherever the public are likely to go. Include in all local authority communications
- Allocate and publicise clear lines of responsibility and authority – devolved as locally as possible – to enable quick and robust decision making
- Institute a process of contemporaneous recording regarding decisions taken and why
- Identify deputies for key decision-making personnel, including Directors of Social Work and senior management team
- Establish good neighbour networks, building on existing links in communities/localities
- Establish a staff hotline
- Educate staff and carers in identifying and reporting/referring people in confused states arising from infection
- Advertise low-level tasks volunteers and the relevant charities could help with (eg caring for pets, shopping), as well as requirements for more intensive support
- Plan for likely impact on out-of-hours teams
- Get local media involved
- Consider how to keep payment systems going. Plurality of providers makes this a real issue in community care

Workforce issues

- Communicate messages about how to keep yourself well and how to self-care when ill
- Consider how to handle the cancellation of planned leave
- Plan across sectors with the full involvement of trade unions
- Map skills and profile existing health and community care workforce, including commitments and locations
- Collaborate with employers outside health and community care
- Consider regional agreements, particularly as pandemic is likely to occur in waves in different areas and how feasible this is
- Train staff in infection control and basic physical care. They will need regular refresher training
- Identify in advance the work patterns that staff will need to follow to combine home and work responsibilities
- Work with your health colleagues, as accident and emergency staff will need awareness and guidelines about dealing with people with mental health problems or learning disabilities, migrant workers, asylum seekers, homeless people and tourists
- Establish pairing/buddying arrangements between services and establishments
- Consider terms and conditions issues (eg overtime/Working Time Directive, special leave and certification)
- Identify staff to work from home
- Consider verifying the identity of casual/voluntary staff
- Match level of risk to level of vulnerability in the use of checked/unchecked staff
- Learn lessons from seasonal influenza. Talk to providers about this
- Recruit volunteer drivers. This may be especially important in rural areas

Planning for people with mental health problems

- Convene a multi-agency planning group including service users and stakeholders from the health, housing and voluntary sectors
- Create a comprehensive map of services
- Consider any specific issues for people from black and minority ethnic communities
- Establish clear arrangements for stocking, prescribing and collecting medication.
- Ensure priority drugs are identified
- Work with the local police force to ensure clear arrangements (eg for provision of a place of safety)
- Create and keep updated lists of approved community workers
- Establish a contact point for carers
- Create a list of prompt questions for staff
- Consider arrangements for older people with mental health problems
- Consider specific arrangements for people with additional issues such as learning disabilities
- Create a pool of peripatetic staff, drawing across agencies and sectors and including retired staff
- Consider the fact that some volunteers may not have the appropriate skills and experience to cope
- Compile charts showing where staff are usually employed and agree reallocations during a pandemic
- Establish operating instructions for services – which to close, which to remain open
- Allocate individuals to make judgements on:
 - safety issues for staff and service users
 - staffing levels

– the relevant qualifications of staff on each shift

- Draw up clear guidance and support for staff
- Ensure that records are up-to-date and address both priorities and risks for individuals
- Consider an open access centre to deal with emotional and psychological issues such as fear, anxiety etc
- Produce self-help leaflets
- Work with GPs to establish what each practice will be able to deal with
- Draw up care plans to include contingency arrangements either to increase or to reduce support as required
- Draw up care plans to identify any heightened risks of self-harm or harm to others in the event of a pandemic
- Consider arrangements to reduce or close non-essential services and increase capacity of crisis teams
- Collaborate with leisure and education departments and the private leisure industry to reduce social isolation
- Establish arrangements whereby service users can be contacted over the telephone rather than in person
- Where possible, reduce the number of personnel visiting an individual
- Expand the remit of all staff if necessary
- Set up a specific mental health helpline (consider engaging the voluntary sector to do this)
- Develop user support and good neighbour schemes
- Identify and clearly communicate the priorities for inpatient treatment and what supporting resources will be available
- Ensure that short-term assessment places are available
- Increase locally held records on patients that indicate how services should be safely delivered
- Ensure that rationing criteria are open, clear and consistent with national guidelines

- Consider where facilities and resources can be pooled across agencies and sectors
- Consider how to access secure services
- Acknowledge longer-term consequences such as the likely need for an increase in talking therapies, bereavement counselling etc
- Agree any role for the voluntary sector in the administration or monitoring of medication

Community services

- Establish a database/map of priorities (drawn from care plans)
- Consider how you can plan to introduce more flexibility
- Draw up a priority list of core activities
- Step up verbal messages but consider the access needs of deaf and deafblind people in communicating these messages
- Use local and community radio to communicate daily messages
- Undertake modelling work based on planning assumptions from [*A Scottish Framework for Responding to an Influenza Pandemic*](#)
- Ensure contracts include business continuity plans
- Plan which services are to be kept open/which are to be closed and at what stage
- Start planning now to expand the use of telecare etc
- Highlight the expectations in guidelines for maintaining care records
- Plan the use of short-term care

Issues to note

Issues for working with black and minority ethnic groups

- Some small specific services may be vulnerable
- Communication issues
- Understanding of where to go for help if members of these groups have influenza
- New people arriving in the country need to get information, so a one-off communication exercise is not sufficient
- Different approaches/rituals concerning illness and death
- If a pandemic starts in South East Asia it is likely to have a significant impact on communities of South East Asian origin here
- Minority ethnic communities may be scapegoated and seen as 'carriers'
- Need to work through existing networks, leaders and meeting places
- Need to build on established ways of reaching some isolated groups (eg tuberculosis and hepatitis outreach services)

Issues for working with homeless people and highly mobile populations

- Definitions (eg rough sleepers), including those with and without some contact with services
- Communication links with housing authorities for those who are temporarily homeless and in short-term accommodation
- Difficulties of penetrating the culture of some mobile populations such as travellers and migrant workers from Eastern Europe
- 'Invisible' population of illegal immigrants
- Risk of certain parts of society, eg those people who are visibly homeless or migrant workers, being scapegoated as responsible for the spread of influenza
- Low access to healthcare; poor self-care

- A proportion of homeless people will have mental health problems and/or substance misuse issues – culture of self-neglect
- People newly released from prison but with no fixed abode
- Communication strategy – make it clear that a pandemic is different to seasonal influenza
- Difficulties in identifying deceased
- Vulnerability of young people who are care leavers and on the street
- Surge of demand on hostel places
- Scoping and mapping – these groups will need different responses from the ‘mainstream’ population
- Supply of prescription medicines such as methadone

Working with care homes providers

- Need to plan residential care as part of its community – by looking at the wider resources
- Point/person to contact for advice
- Hygiene training and awareness
- Involve residents (where possible) and families in planning
- Map of provision, what it offers and what it could offer in an emergency
- Daily monitoring of capacity and sickness levels by a dedicated council official
- Staff-sharing schemes, including managers
- Admission criteria during a pandemic – decision-making powers
- Minimum staffing levels
- Daily living – need to balance restrictions to reduce spread against risk of social isolation
- Potential for relatives to stay in the home or locally
- Deployment of staff amongst ill/well residents
- Best use of those who have recovered and are now immune

- Support to small independent operators
- Status and deployment of staff, including Disclosure checks etc
- Expectations regarding care records – prioritise those who are ill, detail the specific issues to record
- Strategy for use of short-term care

Acronyms

CPA Comprehensive Performance Assessment

CC Care Commission

GP General practitioner

HSE Health and Safety Executive

SCG Strategic coordination group

WHO World Health Organization

WRVS An organisation formerly known as the Women's Royal Voluntary Service

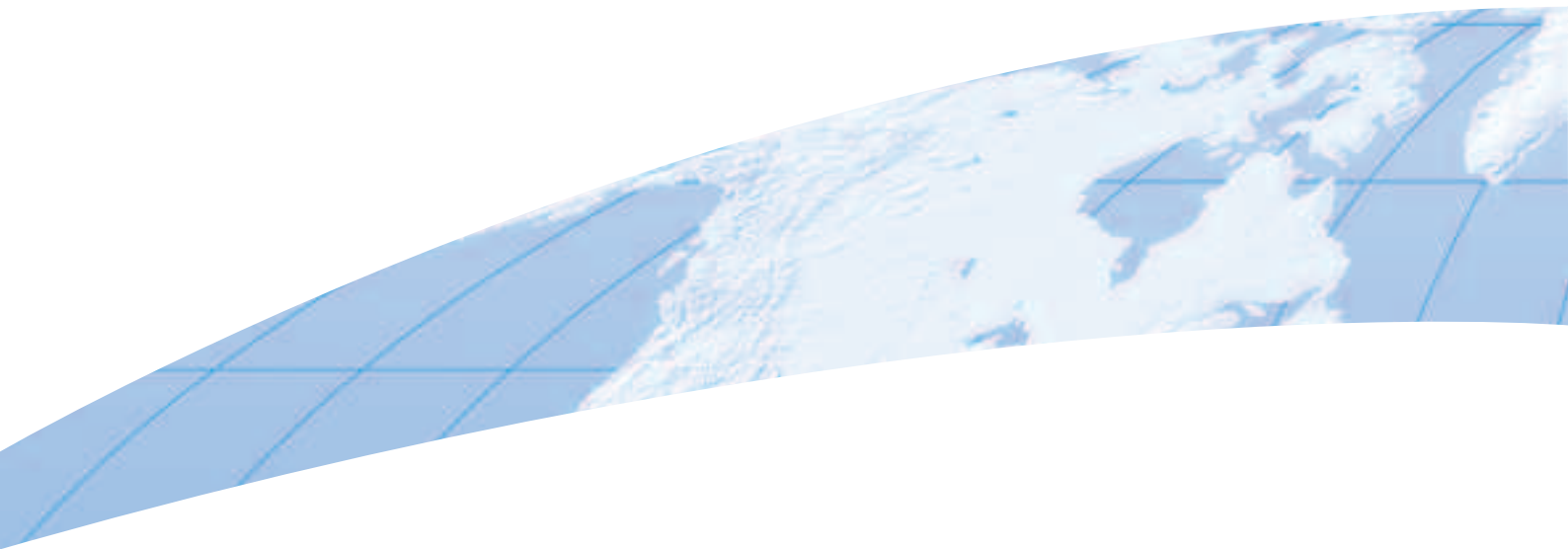
Glossary

Antiviral medicine	A type of medicine used to treat viral infections such as influenza.
Attack rate	The cumulative percentage (or proportion) of a population infected over a specified period of time, for example during an epidemic.
Clinical attack rate	The cumulative percentage (or proportion) of a population infected and showing symptoms over a specified period of time.
Containment	Measures to limit the spread of infection from an affected area.
Director of Social Work	This is intended to cover Director of Social Work/Chief Social Work Officer in every case, but for brevity's sake we do not spell this out.
Epidemic	The widespread occurrence of significantly more cases of a disease in a community or population than expected over a given period of time.
Face mask	A disposable face mask that provides a physical barrier but no filtration.
Hand hygiene	Thorough, regular hand washing with soap and warm water, or with alcohol-based products containing an emollient that do not require the use of water, to remove dirt and germs at critical times, eg after touching potentially infected people/objects and before touching others or eating.
Incubation period	The period from entry of infection to the appearance of first symptoms.
Infectivity	The extent to which a given micro-organism infects people (or animals), ie the ability of the organism to enter, survive and multiply in people and cause disease.
Malaise	general bodily discomfort/feeling of unease
Outbreak	A sudden appearance of, or increase in, cases of a disease in a specific geographic area or population, eg in a village, town or closed institution.
Pandemic	A worldwide epidemic – an influenza pandemic occurs when a new strain of influenza virus emerges which causes human illness and is able to spread rapidly within and between countries because people have little or no immunity to it.
Phase	Any of the stages leading up to a pandemic, as defined by WHO in its global classification. The phases, which run from 1 to 6, are used as a trigger for escalating planning so that the response is proportionate to the risk.
Reproductive number (Ro)	The average number of secondary infections resulting from each individual case – the 'basic' reproductive number is the number of secondary cases in a fully susceptible population without intervention. It measures the degree of transmissibility of an infection.

Reciprocity	<p>The principle of reciprocity means if people are asked to take increased risks, or face increased burdens, during a pandemic, they should be supported in doing so, and the risks and burdens should be minimised as far as possible.</p> <p>Some people, including health and social care staff, may face very heavy burdens in trying to help us through a pandemic; it is important to think about how to minimise those burdens.</p>
Surge capacity	The ability to expand provision beyond normal capacity to meet transient increases in demand, eg to provide care or other services above usual capacity, or to expand manufacturing capacity to meet increased demand.
Surveillance	The continuing scrutiny of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action.
Symptomatic	Showing symptoms of disease or illness.
Shed	excreting or casting off the virus through their secretions eg having the virus in their body and in their body fluids and sneezing. This sneeze would contain mucus droplets with the live virus which leaves the body in the mucus droplet through the process of sneezing ie the body excretes this virus or sheds the virus.
Transmission	Any mechanism by which an infectious agent is spread from a source or reservoir (including another person) to a person.
UK alert level	The UK alert level system is triggered once WHO declares Phase 6 on its international scale. Escalation through the four UK alert levels is related to the spread of pandemic influenza in the UK, rather than internationally.
Wave	The period during which an outbreak or epidemic occurs either within a community or aggregated across a larger geographical area. The disease wave includes the time during which the disease occurrence increases, peaks and declines back towards baseline.

The Scottish Government
Primary and Community Care Directorate

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This document is also available at www.scotland.gov.uk/pandemicflu

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