Department of
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AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

PANDEMIC INFLUENZA

GUIDANCE ON PREPARING MENTAL HEALTH SERVICES IN NORTHERN IRELAND

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1 Introduction

Context

1.1 Influenza pandemics are natural phenomena that tend to occur two or three times each century. Pandemics arise when a new influenza virus emerges and spreads rapidly across the world with widespread epidemics in countries. The severity of a pandemic varies but in the last century, there were three pandemics: the 'Spanish flu' of 1918/19, in which between 20 and 40 million people worldwide died (with peak mortality rates in people aged 20 to 45); the 'Asian flu' of 1957/58 and the 'Hong Kong flu' of 1968/69. While the pandemics in 1957/58 and 1968/69 were much less severe, they also caused significant illness levels (mainly in the young and the old) and an estimated 1 to 4 million deaths between them.

1.2 Another pandemic is highly likely to occur. However, there is uncertainty about the timing and the impact. This uncertainty poses a challenge to planners and providers however, by having preemptive, coordinated and robust plans in place, the impact of a pandemic can be reduced and recovery of services hastened.

1.3 Mental health services are critical public services that should be maintained, as far as possible, during a pandemic. They aim to help people manage mental health disorders and problems by providing assessment, care, treatment, support and guidance for people who are affected by mental ill health. Mental health services are provided across a spectrum of user groups, such as children and adolescents, adults of working age and older people. In addition, they include services for people who have learning disabilities, misuse substances or who require forensic mental health services.

1.4 It is estimated that one in four people experiences a mental health problem during their lifetime. Further estimates from the *National Service Framework for Mental Health* (1999) indicate that one in six people of working age will have a mental health problem - most often anxiety or depression - while at any one time about one in 250 people with have a psychotic illness (e.g. schizophrenia or bipolar affective disorder). General practitioners see a range of patients of all ages who have mental health problems or mental disorders. However, only a small proportion of these are referred to specialist mental health services, and most people with mental health problems are cared for in a community setting. Out of every 100 people who consult their GP with a mental health problem, nine are referred to specialist services

for assessment and if necessary, treatment. Some people with severe and enduring mental illness will continue to require care and support from specialist services.

1.5 Reflecting the diverse needs of people with mental health needs, mental health services are provided as part of primary and secondary care as well as within the independent and voluntary sectors. Services include acute inpatient care, community care services, rehabilitation services, residential care centres, and day hospitals and drop in centres. An additional point to note is that like other chronic conditions, people with minor mental health problems who usually receive their care from primary care should continue to do so during a pandemic. This should be acknowledged in pandemic flu plans as prevention against all mental health problems becoming the domain of mental health services during a pandemic. Such an increase in demand would overwhelm the services.

1.6 There is evidence to show that major incidents including epidemics of infectious disease cause distress and anxiety. People who are already vulnerable to mental disorder (e.g. depression) may require additional support and/or care, and there may be relapses among those people who have serious mental health disorders. It is likely that some groups may be more affected by an influenza pandemic than others. It is crucial that when planning for pandemic flu, the dependency of users groups on mental health care is considered and essential services are sustained throughout the period of the pandemic. The impact of a pandemic may also mean that more people may experience mental health problems and disorders, such as depression, for the first time. Such an increase in demand will occur at a time when resources are limited (for example because of higher than usual staff sickness levels) and both specialist mental health and other health services are under tremendous strain. It is essential therefore, that there are coordinated, robust plans in place to ensure that mental health services are able to respond effectively.

Purpose

1.7 The purpose of this guidance is to assist mental health service providers in developing their plans for responding to an influenza pandemic. The arrangements described do not cover planning for or the response to seasonal influenza outbreaks, avian influenza (e.g. A/H5N1) or any other animal influenza infection.

1.8 The guidance consists of general contingency advice for planners. It is not intended to offer detailed operational guidance for responding to an

influenza pandemic. Instead, this document details a regional approach, setting out the key planning assumptions and principles, roles and responsibilities that should inform the development of local plans.

1.9 The emphasis throughout the document is on business continuity and maintaining access to services and treatments for users throughout the pandemic phase. For any one group of service users, there may be a number of providers and these partners must work together. Furthermore, guidance for primary care providers and their partners focuses on the provision of healthcare within the community setting. In particular, the guidance advocates supporting the public to self-care and enabling symptomatic patients to access care from their own home as far as possible. Guidance on mental health services should be mindful of these planning arrangements.

1.10 This guidance has been written in conjunction with the *Northern Ireland Contingency Plan for Health Response for an Influenza Pandemic*. Staff should be made aware of *Responding to Pandemic Influenza: The ethical framework for policy and planning*. Copies of these frameworks are available online at www.dh.gov.uk/pandemicflu.

Aims

1.11 The main aims of this framework are as follows:

- To encourage the development of effective and resilient local response plans to an influenza pandemic
- To minimise the impact of pandemic flu on local mental health services
- To minimise the impact of pandemic flu on people who have mental health problems
- To develop measures to maintain essential mental health services and access to pharmaceuticals and treatments
- To cope with the additional burden pandemic influenza will place on mental health services
- To promote partnership working and integrated local response plans, e.g. with social care services and primary care
- To provide timely, consistent and authoritative public advice and information, which is also sensitive to the importance of preventing people with mental health problems and disorders from being discriminated against or socially excluded during a pandemic

Audience

1.12 This guidance is primarily intended for those preparing mental health service providers for an influenza pandemic. It is also of relevance to staff and providers of mental health services in the voluntary and private sectors. Additionally, it will be of interest to other stakeholders including primary and secondary care.

1.13 It should be noted that this contingency plan has been written for the current arrangement of Boards and Trusts. The Board refers to the relevant Health and Social Services Board until the Regional Health and Social Care Board is operational from April 2009.

2 The current context for influenza pandemic planning for trusts

Potential impact of an influenza pandemic on services

2.1 It is difficult to predict the precise impact that an influenza pandemic will have on the NI population. The effects of an influenza pandemic would depend on a number of factors including the characteristics of the virus, the severity of the illness it causes and its clinical attack rate. However, the impact of an influenza pandemic is likely to be intense and sustained, affecting the whole country. Services may become quickly overwhelmed for the following reasons:

- the increased workload of patients with influenza and its direct complications arising from influenza
- the additional burden on peoples health caused by distress, anxiety and bereavement
- the particular needs for infection control facilities and equipment
- depletion of the workforce and pool of informal carers due to the direct or indirect effects of influenza on themselves and/or their families
- pressure on social services and primary care, which impacts upon the interface between these services and mental health services
- delays or difficulties in dealing with medical conditions other than influenza, and strain on critical care in hospitals
- logistical problems caused by the possible disruption of supplies, utilities and transport
- the longer term macroeconomic effects of an influenza pandemic on the local (and global) economy
- pressure on mortuary facilities, possibly exacerbated by delays in death registration and funerals

2.2 To respond to the demands for services during a pandemic, mental health service providers will have to find innovative approaches for delivering many aspects of care including staffing and assessment of patients. It is crucial that they plan with other local and regional stakeholders so that they can respond in a co-ordinated, effective and ethically appropriate way for an influenza pandemic.

2.3 Many of the issues that are relevant to contingency planning for an influenza pandemic are common to other emergencies and will already have been addressed as part of the usual contingency planning. However, most emergency plans are based on the short-term escalation of services, whereas, an influenza pandemic will have a

sustained impact on demand, affecting most areas simultaneously. This will require different planning responses. Additionally, service providers should be aware that a pandemic may occur over more than one wave and response plans will need to cover this possibility. The recovery period after a wave could be used to restock and prepare for possible subsequent waves.

Key planning assumptions

2.4 **Uncertainty about extent and severity of influenza pandemic**

The epidemiology of an emergent influenza pandemic virus and its clinical behaviour cannot be predicted with certainty. In previous pandemics, the overall UK clinical attack rate has been in the order of 25% to 35% compared with the usual seasonal range of 5% to 15%. As the actual extent of illness will only become evident as human-to-human transmission develops, response plans should be sufficiently flexible to deal with the range of possible attack rates, clinical impact and mortality assumptions as outlined in the *Northern Ireland Contingency Plan for Health Response for an Influenza Pandemic*. This recognises the possibility of a clinical attack rate of up to 50% in a single wave pandemic and so this should be reflected in local response plans. An influenza pandemic can occur either in one wave or in a series of waves, weeks to months apart. To inform preparedness planning, a temporal profile based on the three pandemics that occurred in the 20th century and current transmission models was constructed. This predicts the national profile of a single wave to last 15 weeks. Local epidemics might be over more quickly (six to eight weeks). See the *Northern Ireland Contingency Plan for Health Response for an Influenza Pandemic* for further information on the severity and extent of an influenza pandemic.

2.5 **Care in the Community**

The national response to an influenza pandemic relies upon the provision of care in the community. Most health and social care should be delivered outside of hospital settings, which will be reserved for those who are most seriously ill and most likely to benefit. Influenza patients who are unable to access secondary care will need to be cared for in their own home or in a residential setting as far as possible, and where required and appropriate, care taken to them. Advising those who are ill with the influenza virus to stay at home and to self care (if they are able to) or access care from their own home, is likely to be the most practical and effective way of slowing or limiting the general spread of infection.

Users of mental health services presenting symptoms of pandemic influenza should approach health services in the same way as the rest of the general population. This includes accessing antiviral treatment and pandemic influenza-related information via the National Flu Line service. However, for many people that cannot do this directly, their families, neighbours, mental health staff, social services staff and

volunteers will need to be particularly vigilant and may need to arrange access to services on their behalf.

2.6 **Impact on the workforce**

Up to 50% of the workforce may require time off at some stage over the period of the pandemic. (A wave can constitute 15 weeks and waves can be weeks or months apart). Individuals are likely to be absent for 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 from the workforce may be absent and then decline. Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependents, family bereavement, practical difficulties in getting to work and caring for children, whose schools or playgroups may have been closed. See Chapter 5 and the forthcoming pandemic influenza human resource guidance for advice on how services can mange the impact of staff shortages.

Key planning principles

2.7 As well as ensuring that response plans are informed by consistent national planning assumptions, it is also important that mental health services plan according to the same planning principles. The *Northern Ireland Contingency Plan for Health Response for an Influenza Pandemic* outlines the following:

- Joint working and integrated planning between all key agencies
- Flexible planning to deal with a range of possible scenarios and clinical attack rates
- Flexible thinking in bolstering local staff capacity
- Building on normal delivery models (as far as possible)
- Advising and enabling symptomatic influenza patients to remain at home
- Facilitating rapid access to antiviral medicines
- Reducing routine activity but continuing to make critical and core care available

2.8 Local response plans for mental health services will also need to consider the following two principles:

- People with mental health problems should receive the same degree of support and protection as other members of the population at home, as residents or as in-patients.
- In preparing for and responding to an influenza pandemic, mental health staff will face difficult choices and decisions that may affect the care provided for service users. This will be especially true during the pandemic when capacity limitations, staff and supply shortages and possible increased demand may result in compromised care. Response plans and arrangements should adopt measures that maintain public confidence and balance individual care with the priority to reduce illness and save most lives

in a way that is fair. Responding to Pandemic Influenza: The ethical framework for policy and planning can help staff with the consideration of ethical aspects at all levels. Furthermore, 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 manner.

Sensitivity to local needs

2.9 Planning for an influenza pandemic should reflect the needs of the local population, including the population demographics, ethnic structure and geographic dispersion of residents. This will be particularly important for communications and access to services and treatment.

3 The impact of pandemic influenza on mental health services

Mental health response to pandemic influenza

3.1 In the event of an influenza pandemic, the key role of the mental health service providers is to ensure that core mental health services are maintained and provided at safe levels. This includes inpatient care and care provided in the community. Early in the planning stages, mental health service providers should consider what are deemed to be essential activities and develop appropriate models of care to ensure they can be maintained. Reduced numbers of staff will affect maintenance of services, and local plans should consider the minimum numbers of staff who are required to run a service and which staff could be redeployed to priority services and areas. Patient prioritisation is another important matter, and although plans should aim to minimise disruption to mental health services as far as possible, it is likely that some routine or non-urgent procedures may need to be delayed, suspended or delivered by alternative means during a pandemic.

3.2 Mental health service providers will face specific challenges during a pandemic, for example, as some inpatient environments, particularly those that provide care in security, are closed, there is a risk of more rapid spread of influenza in both patients and staff. In the 1957 pandemic, some residential schools (which were closed environments) had attack rates of up to 90%, and often whole schools were affected within a fortnight. Their welfare is also dependent on the continuing supply of psychopharmacological agents that are necessary for many to maintain their mental health. The need to provide speedy diagnosis and care for patients who present at hospital emergency departments or to primary care with mental health-related symptoms will continue despite an influenza pandemic.

3.3 Contingency plans should include infection control measures to minimise the spread of influenza in residential establishments. This is based on the assumption that it will not be possible to move those people with significantly challenging behaviours, or who prevent risks to themselves or others, to different settings. Plans should also contain explicit agreements on how resources will be prioritised and on how vulnerable individuals will be identified in order to help them take appropriate precautions against infection and to provide support should they develop influenza. The potential for areas of clinical risk to increase during a pandemic (for example, as a result of reduced staff numbers) should also be considered.

Key Roles and responsibilities

Partnership working

3.4 Inter-partnership working between mental health service providers, primary and secondary care is essential in ensuring that people with mental health problems and mental disorders have their needs met as well as possible during a pandemic. Users of mental health services are likely to be users of social services and other health services. Some mental health services are provided by voluntary organisations. A portion of these is provided under commission from Health and Social Services Boards and Trusts but others operate independently. These services should be factored into local contingency plans and collaboration on the development of their own flu plans is important. Decisions about service provisions should not be made unilaterally as decisions in one area will have knock on effects on other services and sectors. For example, if an acute trust decided to close a day centre for older people in order to provide extra bed capacity for younger patients of the trust, this could result in additional strain on community services. Such a decision should only be made jointly in discussion with the relevant bodies.

3.5 The overall responsibility for influenza pandemic preparedness within the community rests with primary care so representatives from mental health service providers should be included in local primary care pandemic planning committees or resilience forums. When developing plans to prepare for and respond to an influenza pandemic, Trusts should ensure that there are good partnership/multi-agency working and communication arrangements between themselves and other stakeholders. Mental health service providers should ensure that the views of partners have been taken into account during their development of plans to minimise the risk of making planning assumptions that are not sustainable during the pandemic.

Trust Responsibilities

3.6 Each Trust should have a clinically led internal management steering and planning group to ensure that robust plans and preparations are

being made. As a minimum, the membership of the group should include the following representation:

- Influenza pandemic preparedness lead
- Emergency planner
- Infection control lead
- Clinical lead with representation from in-patient care and community care as appropriate
- Nursing lead
- Pharmacy lead
- General management
- Pharmacy
- Health Protection Agency
- User/carer representatives

3.7 Within the Trust, the Chief Executive and the board should take overall control of the preparations for responding to an influenza pandemic. Whilst it may be appropriate to delegate the task of detailed planning and preparation, the Chief Executive and the board should retain an active interest in progress by regularly monitoring and reviewing the plans and ensuring that they are tested. Regular testing of plans and use of simulations are critical for ensuring that the response is as smooth as possible in the actual event of a pandemic.

3.8 Ideally, mental health service providers should have an appointed pandemic flu lead. This role can be undertaken by an emergency planner. The Pandemic Influenza lead should ensure that robust response plans are in place and are based upon the information and approach outlined in this guidance. They will also be required to ensure that planning is an integrated activity and that all plans are regularly updated and tested. Any gaps, areas of concern and actions identified through the planning process should be taken forward, and regular updates provided to the trust Board.

3.9 The decision to declare a pandemic will be taken by WHO. Unless the pandemic originates in the UK, there will be no cases in the UK at this point (UK alert level 1). When the pandemic arrives in the UK, the UK government will alert level 2, escalating this to levels 3 and 4 as the pandemic spreads throughout the country. See the *Northern Ireland Contingency Plan for Health Response for an Influenza Pandemic* for more details on alert levels. These decisions will be cascaded at this point to trusts via the Health and Social Services Boards. Mental health service providers should ensure that they have robust systems capable of receiving and acting on a decision to declare an influenza pandemic. When planning for an influenza pandemic, mental health service providers in trusts should have nominated individuals in charge who can activate the trust's response. These people should be easily contactable and there should be adequate means of communicating each decision to frontline and other hospital staff.

Communications

3.10 In an influenza pandemic, it is vital to have robust reporting pathways within the mental health service providers so that decision makers can be provided with the information they require to take action. It is also important that decisions and information can be cascaded effectively to frontline staff. So that decisions continue to be made, command and control plans should allow for the possibility that the people who are in positions of authority could become ill. Mental health service providers are advised to develop action cards, which describe the actions to be taken by staff at different stages of the flu pandemic and can be used by staff during a flu pandemic. This will help to facilitate effective delegation.

3.11 Good communication with the public before, during and after an influenza pandemic is vital. A national public awareness campaign will be initiated to inform the public about key pandemic-related issues, including advice on how to protect themselves and others from contracting influenza and what to do if they become symptomatic. Primary care services have a responsibility for cascading and supporting national messages and for adding local advice and information. Mental health service providers should ensure that their communications systems for pandemic influenza are developed in conjunction with primary care services and that the channels and mechanisms for cascading routine and urgent information are tested. There is a huge element of uncertainty regarding pandemic influenza and communication mechanisms should be developed that are able to function despite information being incomplete. During the pandemic, it is essential to inform people who use mental health services that contingency care arrangements are in place. This information should be as clear and concise as possible to avoid misinterpretation and panic. Vague timelines such as “closed until further notice” should be avoided if possible. Consideration should be given to the communication mediums most appropriate to the needs of service users, eg providing easy to read material for learning disability groups.

Antiviral drugs

3.12 Antiviral drugs can be used to treat certain viral infections including influenza. The existing UK stockpile of Oseltamivir (Tamiflu) allows for the treatment of all symptomatic patients (where they are able to take the first dose within 48 hours of onset of symptoms) at clinical attack rates of up to 25%. Symptomatic patients can access antiviral medicine via the National Flu Line service. If a person thinks that they are symptomatic with the pandemic influenza virus, they should contact the National Flu Line service as the first port of call. After being assessed in accordance to the national clinical algorithm and if found to be eligible for antiviral treatment, the caller will be authorised to receive antiviral medicine and advised to ask a family member/friend/carer to collect their antiviral medication from a local collection point for them. If

a caller has higher-level needs (ie complications or more complex or urgent healthcare needs), they will be referred to another healthcare service/professional for further advice and care.

3.13 Mental health service providers will need to work closely with primary care services to ensure that the population they serve get access to antivirals if symptomatic. Like other members of the public, patients who receive mental health care in their communities will be expected to access antivirals via the National Flu Line service and to ask a relative/friend/carer to collect their antiviral medicines from a local collection point. If it is anticipated that some people with mental health problems or mental disorders may have difficulty in using the National Flu Line, then it may be necessary to provide assistance on a local level. Community mental health teams should be alerted to all individuals who are assessed as needing help in gaining access. Voluntary organisations and district nurses may also help.

3.14 Mental health service providers will also need to liaise with Trusts to establish how inpatient and secure units will receive antiviral medicines from the national stockpile.

3.15 Tamiflu™ can be taken in conjunction with drugs prescribed for mental disorders. If there are concerns about the possible contraindications of antiviral drugs with drugs already prescribed for a particular condition, clinicians can consult the British National Formulary. Recent studies in Japan found a possible association between Tamiflu and increased levels of suicide. To date, there is no evidence of a causal link. Nevertheless, mental health service providers should be aware that it is possible that Tamiflu might heighten risk of suicide in suicidal patients and should refer to best practice guidelines in preventing suicides.

Vaccination

3.16 Vaccination is widely used in the UK to offer protection against the seasonal influenza strains that are the most likely to be circulating in any particular year. However pandemic influenza will result from a new or modified strain, and the routine vaccinations are unlikely to offer protection. It is not possible to develop a vaccine for pandemic flu until the influenza strain has been identified. Once vaccine production has started, it is likely to take over 12 months to receive delivery of the full quantity of vaccine. The presumption, for planning purposes, should therefore be that a pandemic vaccination during the first pandemic wave is unlikely, but it may contribute to reducing the impact of subsequent waves if they occur. Once vaccines are available in the UK, they will be distributed through general practices. However, there may be instances in which people with mental health problems are not registered with a general practitioner or may have difficulties accessing GP services. Mental health service providers should agree with primary care services prior to the pandemic on how vaccinations of mental health patients and staff will be carried out. Within secure units and other in-patient care, it may be necessary to identify mental health

staff who can administer vaccinations or agree for an outside vaccination team to give the vaccines on the premises.

3.17 Pre-first wave immunisation with an influenza vaccine that is related but not specific to the pandemic strain might offer some limited, but nonetheless useful, protection. Currently, the UK has very limited stocks of A/H5N1 vaccine purchased specifically for the protection of healthcare workers. Pre-pandemic vaccination may be initiated based on national and international expert advice and delivery may primarily be the responsibility of employers.

Other medicines

3.18 Antibiotics are the most effective means of treating the secondary bacterial complications of influenza, but these should be prescribed appropriately. Advice from the Health Protection Agency will help determine the organisms most likely to cause complications. The Department of Health, Social Services and Public Safety is reviewing available stock levels and options for enhancing these levels.

Promotion of self-care

3.19 Promoting ways in which people can care for themselves will be crucial in encouraging the public to look after its health and to take the necessary steps to avoid contracting and spreading the influenza virus. Self care will also be critical in supporting those who are symptomatic with influenza to care for themselves at home or within residential settings. Promoting self care will enable primary care services to focus on those with more urgent or critical healthcare needs. There is a national strategy for communications that encourages the public to engage in self care prior to and during a pandemic. Further information on health communication in a pandemic is available at www.dh.gov.uk/pandemicflu .

3.20 If health services are to remain as functional as possible, the public will need to follow advice on protecting themselves and their families, complying with public health measures and when and how to seek medical advice or care. Mental health service providers have a role to play in encouraging and supporting staff, service users and the local population to care for themselves where they are able to do so. There will be difficulties in communicating with some users of mental health services. Groups that could be particularly vulnerable include: older people, children, people with an addiction, addicts, homeless people and people who are a danger to themselves. Some service users may also have addictions that complicate prevention and communication regarding influenza and self care. It cannot be assumed that vulnerable groups are able to comprehend or comply with advice on self care. Forms of communication that do not rely solely on written communication should be designed and utilised. These include face to

face communication or use of interactive websites to communicate information. It may be appropriate to reproduce information on self care in easy to read formats for younger people, people with learning disabilities and people with sensory impairments.

3.21 In secure units, one-to-one education with a staff member whom people know can be of benefit. Messages on self care should be simple and clear, and should include basic infection control advice such as on the use and disposal of tissues.

Implications for Mental Health Order

3.22 The Mental Health (Northern Ireland) Order (1986) provides legal safeguards for patients including various mechanisms for appealing against detention. The Mental Health Review Tribunal hears appeals from patients who are detained under the Order. There are certain timescales in which these appeals should take place. An influenza pandemic could delay these timescales, which are set out under domestic law and the European Court of Human Rights, as it may not be possible to convene tribunals to hear appeals. Tribunals could be held via teleconferencing links but the patients would still need to be examined in person. Gaining access to staff during an influenza pandemic could be an issue.

3.23 The Mental Health (Northern Ireland) Order 1986 also sets out certain safeguards relating to certain treatments, such as psychosurgery (which is very unlikely to be required urgently during a pandemic), Electro Convulsive Therapy and implantation of hormones for the control of male sexual drive. ECT may be required urgently. The Order requires ECT to be given by consent (although patients who need ECT urgently may not have the capacity to give consent) or by second opinion. There is a provision for giving urgent treatment pending arrival of a second opinion. However, if there is a problem getting the second opinion, there could be an issue around whether or not to continue ECT as urgent treatment until the second opinion is obtained.

3.24 The Mental Health Commission has two key statutory duties: Monitoring of the Mental Health Order as it relates to detained patients and second opinions relating to certain forms and durations of treatment. Mental Health Commissioners carry both of these functions. Second opinions are provided by a panel of consultant psychiatrists appointment by the Mental Health Commission. This arrangement offers a degree of flexibility which could enable the Mental Health Commission to respond readily within reasonable constraints in a pandemic.

3.25 Liaison with the Northern Ireland Ambulance Service in the planning stages is important with regard to the use of emergency services during a pandemic in the detention of people under the Mental Health

Order. Ambulance services are likely to be restricted. There is also the possibility that the Mental Health Order may be misused because there may not be community services to help those at risk and so people may end up being detained. There will be a need of an emergency assessment facility that is not in a hospital so doctors are not at risk of flu.

3.26 There is no legislative provision under which the death of a person detained under mental health legislation must be reported to a coroner. This would continue during a pandemic.

3.27 As a result of these various problems with access to assessments, opinions and tribunals, throughout a pandemic, staff of mental health services may be placed in a position whereby making decisions in the best interest of their patients may contravene the law. Staff may fear litigation and, as a result, may not come to work or refuse to carry out procedures. It is crucial that mental health service providers issue guidance to their staff on how to operate during a pandemic. This guidance should be developed prior to the pandemic.

4 Key challenges in managing mental health services

Access to clinical skills relating to physical health

4.1 A pandemic is likely to place immense strain on all healthcare services. It is unlikely that psychiatric in patient and residential care services will be able to transfer patients with significant physical health needs to acute trusts. Furthermore, access to primary care will also be limited. Psychiatric services may be required to cope with patients who are suffering from influenza and its complications. They may also be required to deal with patients with other physical health needs that arise during a pandemic and who would, ordinarily, have required referral or transfer to another healthcare facility. Psychiatrists, trainee psychiatrists, registered mental health nurses and other staff may need to work outside or extend their normal role, although they should continue to work within their scope of competence and receive adequate training and supervision. It is important that action is taken prior to a pandemic to improve staff capabilities and capacities in delivering physical healthcare. Mental health service providers should consult the guidelines *Pandemic flu: clinical management of patients with an influenza-like illness during an influenza pandemic* from the British Infection Society, British Thoracic Society and the Health Protection Agency when thy develop the assessment and clinical management skills of their staff.

4.2 Training is likely to comprise of basic and enhanced skills training. For training at a basic level, Trusts should consider training staff in

recognising and managing common healthcare emergencies. In particular, staff should have a grounding in diagnosing and managing influenza and the methods for limiting its spread. All professional staff in mental health services are likely to require update and refresher courses on basic physical healthcare including assessment and examination techniques, common complications of influenza, hand-washing and clinical cleanliness skills. Starting basic training in advance of a pandemic is good practice as it helps to build capacity and develop guidelines and confidence in them.

4.3 In community settings, it is likely that, from a clinical perspective, the key skills required for handling influenza pandemic cases will include:

- emergency care
- basic nursing care
- medicine management
- infection control
- venous access
- basic respiratory care/monitoring
- supporting self care
- care of older people
- prescribing and pharmacy
- social care

4.4 In forensic services and inpatient care, it is likely that, from a clinical perspective, the key skills required for handling pandemic influenza cases will include:

- emergency care
- critical care skills
- basic nursing care
- medication handling
- infection control
- venous access
- basic respiratory care/monitoring
- advanced respiratory support/monitoring
- advanced nursing care
- pharmacy
- counselling

4.5 Non-clinical key skills will also be required during an influenza pandemic and these include:

- catering
- food handling
- maintenance and engineering
- transport
- records handling
- information technology
- logistics/stores handling/requisitions

- finance
- security
- linen handling
- waste disposal – clinical and non-clinical
- telephony/call handling
- chaplaincy and other religious support facilities

Maintenance of access to medicines

4.6 Similar to people suffering from other conditions, such as diabetes, users of mental health services who rely on drugs for their treatment (eg antipsychotics, antidepressants and methadone replacement) will need continual access to their drugs throughout a pandemic. Recent crises, such as Hurricane Katrina in New Orleans, have demonstrated that maintenance of access to pharmaceuticals is paramount. It was found that the requirement for pharmaceuticals increased dramatically. This included an increase in the number of people in Louisiana who required treatments and maintenance treatments for addictions.

4.7 Continuing access to medicines for mental health problems or mental disorders requires a local response. Primary care services should co-ordinate access to pharmacy provision and include the requirements of people who use mental health services in their planning. These plans should incorporate the probability that some community pharmacies will close due to staff absences and the fact that the global distribution chain is quite fragile, with orders for medicines only coming in a month in advance of stocks being supplied. Mental health service providers and primary care service providers should liaise to ensure standardisation of policies across the area with regard to maintaining supplies of a selected range of psychiatric medicines during a pandemic.

4.8 There are certain drugs that may require additional contingency planning. For example, there may be problems regarding clozapine, which is used to treat treatment resistant schizophrenia. This treatment reduces white blood cell count and regular monitoring is required. Access to phlebotomy and laboratories could be affected by staff absences. Mental health service providers should identify in their plans the drugs that are commonly prescribed and which require additional contingency planning. This should be done with a view to putting in place arrangements to ensure their safe continuing availability and usage during a pandemic.

4.9 Mental health service providers should consider the possibility of an influenza pandemic occurring sooner rather than later, and seek reassurance from suppliers that they have robust contingency plans in place in order to continue supplying their services in a prolonged emergency. Even if suppliers can give such assurances, the generalised effect of the emergency will impact upon their resilience. Mental health service providers should explore with primary care

whether there is a need to stockpile some supplies, especially if suppliers cannot provide adequate assurances or if items are of particular critical importance.

4.10 The Department of Health, Social Services and Public Safety is reviewing the available stock levels of both influenza specific medicines (including medicines used to treat illness associated with the complications of influenza) and non influenza medicines. It is working with the pharmaceutical sector and others to enhance stocks, increase supply chain resilience and consider options for enhancing stock levels. In order to ensure, as far as possible, that people have access to the medicines they need, it is proposed that, once an influenza pandemic is declared by WHO, amendments to medicines and related legislation will be brought into force for the duration of the pandemic. These changes are being taken forward at a National level and are outlined in the forthcoming *Proposals to amend medicines and associated legislation during an influenza pandemic*. If the proposals are accepted, they will include:

- Protocols for the mass supply of key influenza related medicines
- New powers of emergency medicines supply for pharmacists
- Powers for dispensers to repeat ongoing prescriptions without recourse to a doctor
- Access to over the counter medicines and healthcare products. This would authorise supply of a limited list of medicines on the health service, without a doctor's prescription and free of charge. These schemes would be for the group of people who are exempt from prescription charges and would otherwise have made an appointment with a GP to obtain a prescription.

4.11 Provision of influenza-related medicines to people who have mental disorders should follow consent procedures and common law.

4.12 The principles of consent to assessment and treatment of influenza are no different from the principles that relate to other health conditions. When the treatment concerns conditions other than the mental illness being treated, the patient must give consent if they are able to do so. If the patient does not have the capacity to give consent, then it will be lawful to give treatment that is in the patient's best interests.

Excess demand for mental health services

4.13 There is some evidence that major events or crises raise psychosocial morbidity in terms of mental health. The most common short term responses are distress and bewilderment. In the medium to long term, people who are exposed to major incidents may show more sustained psychosocial responses and some may develop mental disorders that include anxiety and depression, and post-traumatic stress conditions. In the particular instance of an influenza pandemic, people will suffer grief arising from bereavement. It is likely that an influenza pandemic

may place additional requirements on local services at a time when resources and services are strained.

4.14 The requirements for communities for services and treatments are likely to vary. It is expected that there would be short, medium and long term effects. In the short term, people will behave as they would do in any crisis. People will be distressed and this will almost certainly place a burden on services. Such distress is not a mental disorder and most people recover from it once the strain is removed. Many people may seek bereavement counselling. These demands are likely to fall, first, on primary care, community services and voluntary agencies. These kinds of problem are not normally the domain of mental health and other trusts that deliver specialist mental health services. When working with partners in developing pandemic influenza plans, any assumptions regarding intervening to assist people who are distressed or bereaved should be clarified. Experience of the staff of palliative care services at hospices and relevant voluntary agencies may be of help. Thought should also be given as to how certain services and practitioners might be trained to deliver psychological first aid after the peak of a wave has passed.

4.15 Additionally, in the medium and long term, a pandemic may precipitate more serious mental disorders. Some people may suffer anxiety and/or depressive disorders consequent on a pandemic. People who are vulnerable to serious mental illnesses may relapse. Also, people are likely to continue to develop mental disorders that are not directly or indirectly connected with the pandemic. Thus the caseloads of mental health services in both primary and secondary care are likely to include new service users as well as existing users. Therefore, it is also possible that more requests for help will be made both during a wave of a pandemic and in its aftermath. This will be at a time when mental health services will have a limited capacity to respond.

4.16 It is difficult to estimate the likely increase in demand. There is also conflicting evidence on demand for drugs and therapies from other events. Some studies indicate that there are no changes to prescriptions for antidepressants while others suggest a 15% increase in demand for drugs.

Continuity of Care

4.17 During a pandemic, people with mental health problems or mental disorders will continue to rely on mental health services. This includes existing service users and people who become ill during the pandemic, irrespective of whether or not they have influenza. There will be a group of people whose care will be compromised due to staff absences or other effects of a pandemic. It may be difficult to sustain certain people on intensive care packages in the community during the pandemic. Eligibility criteria for care during a pandemic should be

transparent and applied in a consistent and equitable way that reserves capacity for those in greatest need.

4.18 In primary care, essential primary mental health care should continue to be provided. Many vulnerable people are treated within the community, and it is imperative that they receive support throughout the duration of the pandemic. Community psychiatric nurses have an important role as patients' advocates to primary care services. Since primary care will be severely depleted, roles as advocates may need to be balanced against the needs of essential mental health services. Alternative arrangements for advocacy, such as using current volunteers or befriending systems, could be made.

4.19 People with severe mental illness and/or learning disabilities have high rates of physical morbidity and are at risk of social exclusion and discrimination. Some pose a risk to themselves. Only a small proportion pose a risk to others, most often their carers or families. Crises need to be anticipated and prevented and, if a crisis does occur, the patient involved requires prompt and effective help. This includes timely access to appropriate and safe mental health placements or hospital beds that are as close to home as possible. During a pandemic, such access will be affected and limited.

4.20 A large number of service users, such as people who have a learning disability, rely on family members or friends. These informal carers or caregivers are a vitally important group within mental health care because they carry such a large burden of responsibility. Mental health service providers should identify the carers within their areas who are looking for patients who are most at risk or dependent upon continuing care and make contingency plans if possible. Caregivers will be trying to cope during the pandemic and will require support. There may also be a requirement for new carers. Provision of information to informal carers on how they can both protect themselves from contracting influenza and support/care for a service user with influenza will be critical. This includes advice on what to do in the event of an outbreak, how certain services should be accessed and hygiene and infection control measures. It is likely that there will be a marked increase in demand for emergency short-term care for service users when their informal carers fall ill. This will be a difficult challenge during a time when capacity and staffing are limited. Mental health service providers should liaise with local authorities to plan and prioritise how they may meet this increased demand, with a view to people remaining in their own homes if possible. Specific care plans may need to be written (e.g. what particular patients like to eat, etc). This will help enable straightforward passing of care from carer to health professional, or between health professionals.

5 Pandemic planning for a range of different mental health service settings

Mental health care in the community

5.1 A large proportion of mental health care is provided within primary care and in the community. During a pandemic, provision of primary care will be restricted. This will have an impact on the level of services that are available to the users of mental health services. There is a mix of people in the community with mental health problems or mental disorders and not all are the responsibility of primary care. Some are maintained in the community by mental health teams. There is a danger that, without overt discussion on a patient-by-patient basis, these users may be overlooked or be assumed to be the responsibility of primary care during a pandemic. When planning in advance of a pandemic, it is necessary to identify the people who are at risk of their care being disrupted during a pandemic and who could, quite possibly, increase their demand or use of the services at a time when the services are already strained. Robust risk assessments with set criteria for individuals may need to be developed. Within vulnerable groups, there may be individuals who are functioning better than others. Therefore, identifying individuals rather than groups may be useful in helping to reduce demand on services, and appraisal of people's changing needs should be kept up to date.

5.2 Mental health services within the community are co-ordinated by community mental health teams, crisis teams and outreach teams. During a pandemic, each will have an enhanced role in ensuring that essential health and support services are provided and are in place for service users. There may be additional workload requirements. These can include:

- Work resulting from the earlier discharge of service users from inpatient and residential settings, and the corresponding additional support needs of those services users
- supporting emergency departments in removing and assessing patients who present there and who require mental health services or other forms of less specialised psychosocial intervention
- working closely with GP practices, community pharmacists, social services departments and other services as appropriate, to identify the long-term support requirements of people caught up in the pandemic and their families and friends, and arranging for onward referral into mainstream services, but only if needed

5.3 There is a risk that anyone with a mental health problem will be referred back to mental health services. They may be discriminated against and their physical health may not be cared for within primary or secondary care as it would be in normal circumstances. Community health teams should act as facilitators for people with mental health problems to have access to physical health care within primary care.

When planning for an influenza pandemic, patients with high dependency care needs and people who are likely to relapse during a pandemic should be reviewed and the management of their cases brought up to an optimum level. This should help reduce the impact of a pandemic upon their mental health state.

5.4 As the pandemic peaks, there may be an increase in the numbers of people in the population who are suffering from anxiety, depressive disorders or post-traumatic condition. New users of services will require intervention from community services, especially if primary care services are limited.

5.5 Community mental health teams are likely to have to prioritise their work according to demand, urgency of need and staff availability. Flexibility in work and practices may be required. The capability of systems to share information on caseloads and priorities between the staff of community mental health teams and between community mental health teams and other services and the robustness of these systems should be tested in pandemic simulations.

5.6 As far as possible, teams should try to ensure that care packages continue during the pandemic, despite staff sickness in the different agencies involved. Teams should work with social care teams in identifying any vulnerable patient groups who may be at risk of not receiving a service during a pandemic. Information on the different services and agencies involved in meeting each person's needs should be communicated between the organisations. This can help to identify those people who are vulnerable to services being reduced or to staff absences. Carers are as likely as the rest of the population to contract influenza or develop other illnesses. Sickness among carers will leave vulnerable people without their normal care at home. Teams should be aware of the level of support within a person's home.

5.7 Should community mental health teams become overwhelmed, particularly as a consequence of staff absences, the teams may have to consider delivering services in different ways, merging teams and prioritising which service users receive home visits. For example, it may be possible to carry out assessments over the phone for non-priority cases or where a service user is known to have the influenza virus. Self-help materials may have to be provided in lieu of personal visits. Planning could also explore the possibility of social care services and voluntary groups supporting delivery of care. Community mental health teams may be able to aid vulnerable people in taking appropriate precautions against infection and provide advice on self-care, should they develop influenza.

5.8 It is important that the gatekeeping role by crisis or home treatment teams is maintained as far as possible during a flu pandemic. Such teams are the link between inpatient care and the community and are

often the first point of call for assessment for treatment at home or in hospital.

Forensic Services and Other In-patient Services

Infection Control

5.9 There are two main challenges facing inpatient services that include secure forensic facilities: preventing the influenza virus from entering the premises, and stopping the virus from spreading widely once it has been introduced. The influenza virus tends to spread rapidly in closed communities such as secure units and residential settings. The virus is likely to enter the wards via asymptomatic staff, visitors or patients who are incubating the virus and, by the time the symptoms manifest, many patients and staff on a ward could have been exposed already. Infection control measures are of the utmost importance. This is especially so when it is not possible to move those people whose behaviour is seriously disturbed or challenging to other settings. In many units, patients have their own rooms, and decisions to instigate further isolation may need to be taken. The separation of influenza patients from non-influenza patients should be carried out as far as possible. Admissions during a pandemic may also have to be restricted to essential admissions (i.e. those detained under the Mental Health Order or considered to be at high risk). With regard to visitors, there should be visiting policies that help to contain the spread of the virus. Visiting should be reduced as much as possible, other than for those people for whom a visit is essential or required by law. It is advisable to avoid transportation as far as possible once people have contracted the virus.

5.10 **Staff matters**

The following matters are of importance in ensuring that mental health services are as resilient as possible:

- Staff will require access to personal protective equipment (PPE) and additional training in infection control and hygiene matters. Collaboration with primary care service providers, hospitals and local authorities may be necessary to determine access to stockpiles of PPE.
- As previously stated, general nursing and physical health skills will be required of staff. This should be addressed prior to a pandemic. Plans should include allocating someone with physical health skills to each ward during the pandemic.
- Staff capacity will be reduced due to staff sickness and absence for other reasons and staff may have to be redeployed. Flexible rotas and changes to staff shifts may need to be introduced and workload prioritised. When required, non-emergency activities could be suspended in order to free up capacity and staff.

- Disruption to transport links may affect staff members' journeys to work, and could also prevent them from returning home. It may be necessary to provide areas of rest and refreshment facilities and the means for staff to maintain contact with their families. When planning, geographical areas where staff live should be identified and, if possible, accommodation for staff identified where they are unable to travel to and from home.
- It may not be possible to hire agency staff during a pandemic due to the demand on their resource. Discussions with agencies with regard to their business continuity and pandemic influenza plans should be carried out in advance of a pandemic.

5.11 **Management of patients**

The following points should be considered when planning for the management of patients during a pandemic:

- Measures need to be in place to keep patients safe and secure, despite staff shortages
- Patients may need to be shown images of people with PPE in advance so that they are not frightened by staff wearing PPE
- Business continuity plans will also have to consider that the current reliance on emergency services during crises may be affected during a pandemic, and alternative agreements will need to be sought. Death certificates may have to be issued in-house
- Forensic services (low, medium and high security) pose an additional management problem in that some patients who are on restriction orders imposed under mental health legislation. Court appearances and procedures may be affected
- Where inpatient beds are located in hospitals, mental health service providers should link with the hospital to address the particular needs of the patients of the mental health service. For example, there may be an issue around providing secure accommodation, or hospitals may be under pressure to close wards in order to use the beds for other patients
- Discharging patients from general psychiatric wards to the community may be difficult during an influenza pandemic. It will be necessary to evaluate the risk of discharge to the patient and to others compared with the influenza risks of remaining as inpatients and any loss of liberty that might be involved. This would include assessing the level of support at home for those who are ready to be discharged, and the capability of community services to provide care when their workloads have already been increased by the influenza pandemic.
- During the pandemic, prison inmates may develop mental illness and may be moved to a high-security unit for a period. There could be a problem with discharging the prisoners back to prison if influenza has broken out in the prison or if the prisoner has developed influenza-like

symptoms. Mental health service providers should liaise with prisons to agree in advance a course of action should this situation arise.

Other Services

5.12 While all mental health services face general challenges, as outlined in Chapters 4 and 6, and many of the issues specified in the sections on community care and inpatient care are common to all, there are also specialised services for specific groups of people or circumstances. These are:

- Child and adolescent mental health services
- Mental health services for mothers and their babies
- General psychiatry services for people of working age
- Mental health services for older adults
- Day and emergency care
- Learning disability services
- Alcohol and drug services
- Psychotherapy services
- Rehabilitation and recovery services
- Eating disorder services

5.13 When planning for an influenza pandemic, all mental health and learning disability services for people of all ages should be included in the plans of mental health service providers. Otherwise, there is a risk that these services could be among the first to be closed, and mental health service providers are urged to develop business continuity plans for each service component. Mental health service providers should try to maintain normal services for as long as possible and then activate a proportionate response to the pandemic. Joint working and integrated planning with local authorities and HSC partners are necessary to ensure that complementary business continuity plans and models of care are developed. Training of staff and carers in using PPE and adopting strict hygiene measures should also be undertaken. Above all, decision-making should reflect the local needs and preferences of the population and the impact upon healthcare staff workload elsewhere in the community.

5.14 There are specific issues relating to some of the services listed above. They are as follows:

5.15 **Day and emergency care**

Day care and emergency (or crisis support) care play a vital role in helping to provide additional services for vulnerable people at home. Day care provides a vital lifeline for many people by reducing their social exclusion and helping them to have wider contact with others. Both day care and emergency care support informal carers by enabling them to take breaks or continue working. Mental health

service providers will have to discuss the impacts of possible closure of day care with other partners.

5.16 It is likely that there will be an increased demand for emergency care (including crisis and hospital-at-home services) during a pandemic as carers fall ill with influenza. This may happen at a time when ambulance services are strained due to staff absences. Plans should incorporate actions that can be reasonably achieved during the peak of the pandemic.

Mental health services for mothers and their babies

5.17 Mental health services for mothers and their babies are usually provided in wards in a general hospital. Women can be referred from the community or from maternity hospitals and can be suffering from pre- or post-natal depression. The aim is to ensure that they and their babies are cared for in a safe environment. During a pandemic, there will still be a need for this service, and joint planning with acute hospitals will be needed in advance of a pandemic for how to continue to provide these services.

5.18 **Mental health services for older adults**

The impetus is to keep residential and nursing homes running. Services, such as home care and day care may be affected by a shortfall in staffing. Changes to services (e.g. provision of sandwiches instead of serving hot meals) will need to be considered. Voluntary groups that specialise in helping older people should be included in local planning. Inter-agency work and communication is essential.

5.19 **Learning disability services**

People with learning disabilities often have physical disabilities and are cared for within the community or in voluntary or independent learning disability homes. Many service users have 24 hour community support provided for them by health and social services. Such services will be quickly affected where small numbers of staff are relied upon to deliver the services. Robust business plans will be essential to ensure that the service is able to function as long as possible. Partnership contingency planning will be vital particularly where small staff teams are providing 24 hour essential care to dependent service users. Often, adults with learning disabilities are cared for by an elderly patient or by other informal carers. Patients should be identified in advance of a pandemic and plans put in place for continuity of care in the event that the parent (or other carer) falls ill or dies.

5.20 Alcohol and drug services

In the event of staff absences that affect delivery of treatments, it is important that alternative arrangements are developed to prevent patients from relapsing. Access to and availability of services may need to be restricted to a limited number of sites. There may be problems regarding continuing the provision of methadone replacement or maintenance treatments for people who have an addiction. There is also evidence from the Hurricane Katrina situation in the United States, that a crisis can interrupt supply of illegal drugs. This could lead to an increase in the number of people suffering withdrawal symptoms and they could cause a surge demand at alcohol and drug services.

5.21 Rehabilitation and recovery services

In trying to minimise impact on impairment, rehabilitation and recovery services may need to reduce their intake of new patients but should maintain essential services as far as possible.

5.22 Eating disorders services

A particular problem for eating disorders services which requires consideration at the planning stage is weighing up the risk of referring patients to institutions in which they are to be fed with the risk of them coming into contact with pandemic flu. Consideration would also need to be given to whether or not people who require admission for refeeding should remain at home when they are at risk of being at dangerously low weights that may fall further. Decisions will have to be made on a case-by-case basis.

6 Mental Health Service Providers and Business Continuity

Business continuity plans

6.1 A phased approach consisting of immediate and recovery plans is recommended when developing business continuity plans. The aim should be to try to maintain normal services for as long as possible and then activate a proportionate response to the pandemic. Mental health service providers should decide early on in the planning process which of their mental health services are considered 'core' or 'essential' and which services could be scaled down or delivered differently during a pandemic. Such decisions should be made using services' business continuity plans and bearing in mind the projected staff absence of up to 50% at some stage during the period of the influenza pandemic. All services should consider the implications of staff absence at a time when workload and pressure on services may be at their highest. Modified models of care should be developed to incorporate staff absences, patient prioritisation and surge management. Business continuity plans should be reviewed, updated and tested regularly.

6.2 Business continuity issues are similar to those faced by hospitals. There will be difficulties in staffing services due to staff sickness or absences. New ways of working will have to be considered – e.g. phone contact to follow up patients in the community rather than community psychiatric nurse visits. Working practices should be flexible during a pandemic in order to minimise the spread of disease and to continue to provide essential care despite staffing shortages. Social services, primary care services and mental health service providers should have consistent local policies regarding ways of working.

Training and support

6.3 A workforce that is well-informed and trained is likely to manage the additional pressures and challenges arsing during a pandemic. Infection control and occupational health should work together to ensure that staff education and training starts as early as possible with regard to good hygiene practices to limit the spread of the virus; and general information about pandemic influenza, including information about vaccination and antiviral drugs. The message that staff who are ill with influenza should stay at home should be communicated as early as possible. Training is necessary for all staff in relation to the recognition of pandemic influenza symptoms and infection control measures. Early detection and treatment of staff and patients presenting with influenza symptoms will be essential to prevent the spread of infection to other members of the team. Key messages on the availability of vaccine and antivirals and the use of PPE should also

be communicated. *Guidance for Pandemic Influenza: Infection Control in Hospitals, Community and Primary Care Settings* is helpful regarding the use of PPE, the deployment of staff who may have been exposed to influenza and the staffing of units where patients are particularly vulnerable to the effects and complications of influenza.

6.4 Deployment of staff may result in staff working in environments or roles different from their usual activities. This has potential risks for both the staff member and patients. Appropriate training for working in settings or roles that are different from usual will be required. Plans should be developed to ensure that reallocated staff who are working in fields beyond their normal realm have appropriate supervision. The wider health and safety of all staff need to be considered, especially where they are redeployed and working in unfamiliar roles/areas.

6.5 A sustained event such as an influenza pandemic is likely to affect the resilience and stamina of staff in mental health service providers. Staff may also find it difficult to cope with family bereavement or the loss of patients.

Staffing and staff capacity

6.6 Up to 50% of the workforce could be absent at some stage over the course of a pandemic. As a minimum, organisations should ensure that they plan for handling staff absence rates of 15% to 20% over the two- to three-week peak of a pandemic (and up to 30% for smaller organisations). Absence due to influenza is likely to be seven to ten working days. A proportion of staff will be absent due their caring responsibilities, bereavement and other psychosocial impacts; practical difficulties in getting to work; or problems with childcare. However, there need to be sufficient human resources available to run essential mental health services. Therefore, planning to maximise the use of available staffing levels should be a key focus for influenza pandemic preparedness. A register can be developed to establish the skill mix of staff and to identify staff with skills and experience in physical health care. Furthermore, mental health service providers should develop a risk assessment grid or framework that shows the likelihood of particular events occurring against the degree of impact they would have. This could include scenarios with different levels of staff absence, timings for closing areas and deploying staff. These scenarios should be tested in advance of a pandemic.

6.7 The pool of staff should be considered in advance of an influenza pandemic. It is recommended that a register of reserve staff be drawn up prior to a pandemic. Staff will fall into the following groups:

- People who are performing tasks that will be essential during a pandemic (clinical and non-clinical)
- People who are performing tasks that will be non-essential during a pandemic (clinical and non-clinical)
- Managerial

- Voluntary
- External contractors
- Other reserve staff pools (retired, etc)

6.8 Key elements to consider in relation to planning for these staff groups are:

- Normal operational staffing levels
- Minimum staffing levels required to maintain a satisfactory level of care
- Mapping of directly employed staff groups
- Mapping of reserve staff, including agency workers and volunteers
- A skills audit (to help establish the pool of clinical and non-clinical skills available during a pandemic)
- Current management of sick leave and other staff absences from work
- Ethical and professional obligations of staff during an influenza pandemic
- Contracted hours and the European Working Time Directive
- Occupational Health
- Health and safety
- Restriction of deployment of potentially infected staff, reserve staff and volunteers
- Regulatory issues
- Indemnity
- Certification
- Criminal Records Office assessment of staff, reserve staff and volunteers

6.9 Employers may need to draw on a range of sources to supplement existing staff in the case of absence. Extra staff could be drawn from workers who have recently retired, local students or trainees in the sector, local voluntary or faith groups and staff working in non-essential services. There may be problems to resolve regarding security clearance. During the pandemic, if there is not enough time for security or Criminal Records Office clearance, newly retired staff or volunteers may have to be deployed to do background work e.g. cleaning rather than having patient contact. Reserve staff if trained prior to a pandemic can be used as a ‘physical other’ to avoid lone worker scenarios. Some of these issues could be resolved prior to a pandemic by drawing up a register of reserve staff.

6.10 When using temporary staff or deploying currently employed staff to help keep core services running, consideration will need to be given to the roles in which they can be employed, the training and supervision requirements associated with this and how these requirements are to be delivered in an emergency situation. Arrangements for travel to work and childcare will also need to be considered. Fear of influenza may be a confounding factor. Staff who are not ill should be encouraged to continue to work, while those who are symptomatic

should stay at home to limit spread of the virus. Staff can be reassured by methods such as helping them to have confidence in PPE and providing facilities for them to call home to tell their families that they are alright. Education on how influenza is transmitted and how they can protect themselves should be delivered prior to any pandemic and reinforced once the pandemic occurs.

6.11 All staff may need to review the way they work during a pandemic, with a view to them becoming more flexible, as regular duties may be altered to take account of service priorities. Administrative staff may have to work from home or may be transferred to duties in certain forms of patient care. Clinical staff with desk or administrative duties may be shifted to ward duties. Local planning should involve human resource staff and trade unions in relation to changes in duties. *Responding to Pandemic Influenza: The ethical framework for policy and planning* may also be of use. Risks to staff and patients should be mitigated if possible. For example, staff at high risk of influenza complications (e.g. pregnant women or those who have pre-existing respiratory disease) may need to be reallocated to duties in which they are less exposed.

6.12 In order to reduce the impact of an influenza pandemic on staffing levels, mental health service providers should consider the steps needed to ensure that employees who are ill or think they are ill with influenza are positively encouraged not to come into work. This may involve reviewing current personnel policies. Mental health service providers will also need to have systems in place for identifying staff who have influenza-like symptoms before they arrive at work. They will also need to have arrangements in place for handling staff who become ill with influenza-like symptoms while at work. Once staff have recovered from pandemic influenza, it may be appropriate to use these staff to look after patients with pandemic influenza, provided that the health and safety needs of such staff are taken into account.

The role of the voluntary and independent sector

6.13 The voluntary and independent sectors may be able to help support the response to pandemic influenza at a local level. Mental health service providers along with local authorities and primary care service providers, will need to consider how to involve voluntary organisations in their area with which they do not usually have business arrangements, e.g. the Salvation Army, St John Ambulance, local self-help groups and faith-based community groups or charities. These organisations can help by:

- Communicating key messages, information and advice both before and during a pandemic
- Making links with vulnerable or isolated individuals
- Supporting vulnerable or isolated individuals by facilitating the collection of antivirals on their behalf
- Putting in place initiatives for ‘good neighbour’ schemes

6.14 Both the voluntary and independent sectors should be involved in the planning and coordination of roles via local primary care service providers, pandemic committees or local resilience forums. Some medium-security services may be provided by the independent sector, and this sector will need to develop pandemic influenza and business continuity plans. Mental health service providers should identify local voluntary groups in advance. Some voluntary groups provide helplines, and it is important that the messages they put out are consistent so as not to conflict with the National Flu Line Service. Closer ways of working and the enhanced role of the voluntary sector in providing services alongside mental health service providers during a pandemic should be agreed in advance. Additionally, there should be agreement on what roles volunteers could undertake. Note that voluntary organisations will also be affected by pandemic influenza and may be limited in their capacity to provide additional help and services.

Equipment and supplies

6.15 Early in the planning stages, core equipment requirements should be established and their availability in a crisis considered. Provision of supplies and services by private or independent organisations will be affected during an influenza pandemic. Particularly at the peak of the pandemic, supplies of consumables and utility supplies (such as catering and the cleaning of linen in secure units) are likely to be compromised. There may be particular problems with the distribution of PPE, food and medicines. There could be problems in inpatient and secure units regarding the continuation of services from domestic and auxiliary services. Possible fuel shortages may impede staff attendance and the delivery of supplies. Although the continuation of supplies is being examined nationally, mental health service providers should consider what the key supplies are, and local plans should be able to maintain these supplies. Planning should explore the effects of different scenarios and develop appropriate response arrangements. It may be necessary to discuss with suppliers whether or not they have robust business continuity plans, and investigate if there is a need to stockpile some items while remaining dependent on the delivery of others during a pandemic. Mental health service providers will need to link with primary care service providers and hospitals with regard to their access to stockpiles of PPE.

Recovery

6.16 A single wave pandemic profile with a sharp peak provides the most prudent basis for planning. However, second or subsequent waves have occurred in some previous pandemics, often weeks or months after the first wave. While the first priority at the end of the first wave will be to develop recovery plans and restore mental health services to their original capacities, plans must assume that some regrouping may be necessary in anticipation of future waves. Ongoing constraints on

supplies and services may also continue to place pressure on mental health services. Second or subsequent waves may be more or less severe than the first wave. DHSSPS will issue guidance to inform health plans following its review of the first wave and the availability of countermeasures.

6.17 As the threat of further waves subsides, 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 a number of factors, including demand for services, backlogs, staff and organisational fatigue and supply difficulties. Therefore, a gradual return to normality should be anticipated and expectations shaped accordingly. Trust plans should recognise the potential need to prioritise the restoration of services and to phase the return to normality in a managed and sustainable way.

6.18 Restoration of normal working will include:

- Assessment of the clinical and non-clinical workforce that is available to return to work
- A phasing-in period to allow the resumption of normal services, depending on the residual skills and resources available
- Psychological services for staff to enable them to restore their resilience
- Recruitment, although this will be at a potentially difficult time due to the nature of the work, sensitivities around the loss of staff and a potentially competitive environment
- Ensuring that buildings are adequately cleaned, sanitised and otherwise made ready for resumption of normal service

6.19 Mental health services are likely to experience persistent secondary effects for some time. There may be increased demand for continuing care from people such as:

- Patients whose existing illnesses have been exacerbated by influenza (e.g. people with severe learning disabilities may be particularly vulnerable to the secondary effects of influenza)
- People who suffer from potential medium- or long-term health complications

6.20 In addition there may be a backlog of work resulting from the postponement of treatment for less urgent conditions.

6.21 The reintroduction of performance targets and normal care standards should recognise the loss of skilled staff and their experience. Most services will have been working under pressure for prolonged periods and are likely to require rest and continuing support. Facilities and essential supplies may also be depleted and resupply difficulties might persist. Impact assessments will therefore be required.