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and Public Safety**

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AN ROINN

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Pandemic Influenza

Human Resources

Guidance for the Health and Social Care Trusts

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1 Introduction

1.1 The Department of Health Social Services and Public Safety is in the process of preparing for a possible outbreak of pandemic influenza. In November 2007, the Department of Health and the Cabinet Office published *Pandemic flu: A national framework for responding to an influenza pandemic*, which was based on expert scientific advice, World Health Organization (WHO) guidelines and the best available information. This document is available on the Department of Health website at www.dh.gov.uk/pandemicflu. This good practice guidance provides specific advice to the Health Service on human resources requirements in the event of a pandemic. It supplements and should be read alongside other guidance on pandemic flu, which is available on the DHSSPS website: http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

1.2 The Board refers to the Health and Social Care Board which became operational from April 2009. The following sets of supporting guidance are also available at

http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

> *Northern Ireland Contingency Plan for Health Responses to an Influenza Pandemic*

> *Pandemic influenza: Guidance on preparing acute hospitals in Northern Ireland*

> *Pandemic influenza: Guidance for Northern Ireland Ambulance Service and their staff*

> *Planning for Pandemic Influenza in Personal Social Services*

> *Pandemic influenza: Guidance on preparing mental health services in Northern Ireland*

1.3 This human resources guidance should be read in conjunction with these other sets of guidance (listed above). The guidance covers Northern Ireland only; separate guidance based on similar principles has been developed for England, Scotland and Wales. 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 of the order of 25 to 35 percent. The actual extent of illness will only become evident as person-to-person transmission develops, but a clinical attack rate of up to 50 percent is possible. The pandemic may last for up to three to five months, depending on the season, and there may be subsequent waves, weeks or months apart.

1.4 Local planning for an influenza pandemic is well under way across the health and social care sector. While the pattern of development of a pandemic in Northern Ireland cannot be absolutely predicted, it is most likely that it would spread over a matter of weeks, and not necessarily uniformly, in the initial phase. It is therefore important that the Board and Trusts determine the impact on human resources in light of the development of the pandemic locally.

1.5 This guidance deals in more detail with the workforce and human resource issues that may arise in a pandemic. It is designed to give an overall framework for local organisations to build on and work within, and should be read alongside the overall pandemic influenza planning documents. This good practice guidance provides a brief overview of pandemic flu, how it is transmitted and the recommendations with reference to human resource management within boards and trusts. Further information on the likely nature and spread of an influenza pandemic can be found in chapters 4 and 5 of *Northern Ireland Contingency Plan for Health response for an Influenza Pandemic*, available at the DHSSPSNI website:

www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm.

1.6 This guidance is aimed primarily at HSC Trusts and the social care sector both independent and private. It is also of relevance to social care organisations. We are aware that, in practice, many healthcare workers work either alongside their social care colleagues or in a complementary fashion both within services and with individuals. The text makes references to social care organisations where appropriate.

1.7 The Northern Ireland Ambulance Service HSC Trust may face particular challenges during a pandemic. For example, staffing pressures on ambulance services are likely to be intense and they are less able than other sectors to draw on other staff. Ambulance services will need to review working arrangements and training.

1.8 This guidance also covers cooperation with the independent sector and general practice, although its recommendations on employment policy do not directly apply to non-HSC employers.

1.9 An ethical framework for the response to pandemic influenza, designed for use by planners and strategic policy makers, is now available on the DHSSPS website:

http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm.

This sets out seven substantive principles and a principle of good decision-making which should be used in developing local policies. In the context of human resources policy, the implications of the principles of minimising harm, working together, keeping things in proportion, flexibility and reciprocity are of particular relevance. Professional codes will also be especially important and the General Medical Council (GMC) is currently updating its guidance on Good Medical Practice during a pandemic. Professional guidance will also be issued for pharmacy, which will take into account the consultation on legislative changes that may need to be made to medicines and associated legislation

1.10 This framework was developed by a stakeholder working group made up of representatives of the Department of Health, Health and Social Care Trusts (HSC's), regulatory bodies, NHS and local government employers and trade union representatives. It has been developed on a partnership basis and it is recommended that discussions on these issues at local level should also be conducted on this basis. Agreements on frameworks and protocols on staffing issues should be reached with local staff-side representatives. Discussions will still need to take place with individuals with regard to any measures that impact on their circumstances, for example changes in hours of work, changes in shifts worked or changes in location.

Context

1.11 Influenza is a highly infectious viral illness that has the capacity to spread rapidly. A pandemic is likely to occur when a new influenza strain emerges and it will spread rapidly because people will not have any natural resistance to it. It is impossible to predict the scale, severity and impact of a pandemic, but it is anticipated that it will affect the entire country and that up to half the population could develop the illness. There could also be more than one wave of the pandemic. For further guidance on this issue, '*Northern Ireland Contingency Plan for Health Response to an Influenza Pandemic*' released 25/11/2008. This document is available at:

http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

1.12 An influenza pandemic in Northern Ireland would be a major challenge to the operation of HSC Trusts. This guidance is designed to provide a framework for local decisions on employment issues. It aims to address some key issues and answer some common questions, while recognising the unpredictable nature of the challenge. The HSC Trusts have extensive experience of successfully dealing with a range of disasters and emergencies, and this experience will assist in response to an influenza pandemic. An influenza pandemic is, however, likely to be more sustained and widespread than other types of emergency. For example, the duration of the demand for healthcare and the levels of staff absence and stress on staff may be unprecedented. The scope for mutual aid between Trusts is also likely to be less than in previous emergencies as the pandemic is likely to spread rapidly and affect most of the country. There is also a strong possibility of more than one wave of the pandemic. This guidance does not deal in detail with issues concerning the organisation of services during a pandemic, as this is dealt with elsewhere. It looks at the workforce issues that may arise in the event of a pandemic. Other relevant websites are referred to in Annex C.

1.13 In general, Trusts should seek to operate within its existing employment principles during a pandemic, although with modifications as suggested throughout this guidance. In particular, Trusts will need to draw on a range of staff to offset the impact of absence, asking staff to work flexibly and to take on new roles during a pandemic. The Trusts will seek to focus only on essential work during a pandemic in order to maximise the number of staff available to deal with the pandemic. Staff may therefore need to be redeployed to other work.

1.14 Organisations will need to have clear leadership during a pandemic. The Health and Social Care Board and trust Chief Executives need to have overall responsibility for dealing with this challenge, and therefore there should be a lead director on each board responsible for implementation of their local pandemic strategy. There will also be staff with specific emergency planning responsibilities. Workforce planning for a pandemic needs to be linked to existing planning arrangements.

1.15 An influenza pandemic will place great demands on all staff. For example, they may be asked to undertake new tasks and deal with increased demands. They may also be worried about their own health and safety. In line with the principle of reciprocity, employers should seek to provide as much support as possible to their employees. For example, employers have a legal responsibility to maintain health and safety even in an emergency. Employers must take reasonable steps to protect staff health and safety, provide clear communication on risks and take a supportive view of those staff who have caring responsibilities (see section on absence management). This issue is covered further in the section on staff support.

1.16 This guidance has been developed with the support of Trade Union representatives. Partnership working will be the key to successful relationships during an influenza pandemic. Local staff representatives should be fully engaged in preparations for a pandemic; there should be local discussion of the range of issues identified in this guidance and there may need to be special arrangements for liaison during the pandemic.

1.17 The guidance is split into three sections: before, during and after the first wave of a pandemic.

2 Before a Pandemic

2.1 Preparation for an influenza pandemic is already well under way in most areas. The main workforce issues that Trusts are beginning to prepare for now are:

- mapping their workforce
- communicating with staff
- identifying the likely impact on staffing
- consulting staff organisations at a local level
- developing delivery awareness training for staff.

Mapping the Workforce

2.2 In order to tackle a pandemic, it will be necessary to take pragmatic decisions to sustain services. For example, organisations may need to redeploy staff into different roles or locations, or ask them to work in new ways. Organisations may also need to call on professionals who are not currently working to assist if existing staff are absent. In order to make the most effective use of resources, trusts may therefore need to supplement existing information that they hold on staff, as recommended in the guidance for acute hospitals. Many trusts will already have begun this process. Protocols on security of personal data should be observed.

2.3 It may be useful to have a Memorandum of Understanding between organisations at the local level. This could cover how they will pool resources during a pandemic, redeployment of staff and suspension of non-essential work. There are already examples of this type of agreement in London and other areas. Many organisations will already have developed their own local policies on emergency planning and/or pandemic planning and these should take account of this guidance.

2.4 As a minimum, it is recommended that organisations seek to gather data on certain areas, while operating within the framework of the Data Protection Act and other HSC specific information guidance. This should cover:

> details of staff arrangements for travelling to work, as staff with lengthy or complex journeys are perceived as being at high risk of not being able to attend because of transport problems.

In addition, it may be useful to collect information from staff on whether they would be willing to work at another hospital nearer to their home. Staff could also be asked if they could provide lifts or are willing to share transport with

colleagues. Employers should also consider the benefits of assisting with transport if practicable.

> staff contact details, especially mobile phone numbers, for use in an emergency

> whether staff have dependants, especially school-age children or other dependants for whom they would need to care. During a pandemic, these staff may face major difficulties in attending work if, for example, schools are closed as a means of protecting children. It is currently intended that decisions on this will be taken locally by each Education Board working with local schools.

> staff who have skills that could be used during a pandemic. In particular, organisations should seek to identify those staff who have such skills but are not using them in their current work role. These staff could be trained up in a relatively short period through refresher training. For example, most hospital medical staff will have generic skills in addition to their specialty and could be redeployed if their current work were to be suspended, as may happen with elective surgery. Particular attention should be given to skills that will be in high demand such as respiratory support skills. Staff could also be trained up to deal with pandemic-specific tasks such as the administration of vaccines and other medicines. Specialist skills will continue to be needed to deal with emergencies and some ongoing long-term conditions during the pandemic. Experience suggests that, in the main, staff are best used in areas they are familiar with. Where staff do work at a new location, they will still need an induction.

2.5 The guidance for acute hospitals gives some indication of the areas where pandemic-related skills will be needed, e.g. in respiratory medicine. Organisations should seek to build up as detailed a picture as possible of the skills of their staff. Medical directors will need to assess likely capacity and need for skills. Plans are also being developed to create 'surge capacity' to allow flexibility in meeting demand. The Minister will decide upon the suspension of targets during a pandemic. Much will depend on the circumstances and impact of a pandemic, e.g. whether certain regions are being affected more than others and the pressures being created by the additional demands.

2.6 The HSC Trusts will need to operate within the framework of the Data Protection Act in the collection and use of this data. The information will need to be collected in a way that allows it to be kept up to date, as it is likely to change. Staff will need to be reassured that this information is being used only for planning purposes and not for any other purposes. It should be held securely.

2.7 In addition, organisations should identify workforce issues such as the health and safety of contractors and their staff, who maintain essential services such as cleaning and IT systems and who are likely to be exposed to risk of infection. Contractors should be asked to ensure that they can provide adequate staffing during a pandemic and there should be contingency plans to address critical areas, e.g. by redeploying HSC staff to assist contractors. Trusts should also map the range of services commissioned from non-Trust providers and include this in their planning. Other independent contractors such as dentists and pharmacists also need to be included in planning. Independent sector facilities may be used to boost capacity under agreed arrangements.

2.8 There will also be a need to assess the impact on other local partners, such as independent sector providers, and voluntary agencies. In particular, the impact on nursing and care home providers should be taken into account. It will be in the interests of the Trusts to seek to maintain these services in order to prevent admission of residents, and this may require the sharing of staff and other resources. The Trusts should work with local independent sector providers to assess the impact on care homes. This may be especially challenging because of the large number of small owner-operated care homes. An operational and strategic framework: Planning for pandemic influenza in adult social care is available at:
<http://www.dhsspsni.gov.uk/planning-for-pandemic-influenza-in-pss-guidance-for-pss-providers.pdf>.

2.9 HSC Trusts will also wish to encourage and support independent contractors in mapping the skills and resources available (identifying where there are gaps or risks) and in coordinating the available staffing resources and skills to bolster and support those services that will be critical in the event of a pandemic. This will include general practice, community pharmacy and out-of-hours services, as these will represent 'pinch points' in the delivery of services and in the management of demand during a pandemic. Single-handed general practices, for example, should be encouraged and supported to enable them to 'buddy up', e.g. to share staff and resources with other practices during a pandemic. Trusts will need to provide support to practices to enable effective planning. Within this, the levels of staffing available and role of other independent contractors and how they are best utilised need to be considered. The issues affecting services in the community are covered more fully in the guidance on community services. Guidance on pharmacy is being developed alongside forthcoming guidance for other independent contractors such as dentists.

Communication with Staff

2.10 There is likely to be a great deal of concern among staff about the potential risks of pandemic influenza. It is therefore recommended that trusts develop local communications plans to address these fears. Trusts should ensure that:

- > staff are briefed about the key facts about pandemic influenza, e.g. how it spreads, risks of infection and infection control methods, and the role of antivirals and vaccines

- > relevant clinical staff will be available to deal with queries.

2.11 Trusts should develop their plans with local staff-side representatives and involve them fully in communication around the issues. Local plans need to be responsive to and triggered by escalating alert levels. A range of national communication material is already available. Employers should identify as communications officer an individual whom staff trust and should provide this person with appropriate training and support. Many trusts will have professional communications staff who should be fully involved.

Identifying the Likely Impact on Staffing

2.12 Depending on a pandemic's clinical attack rate (the percentage of the population affected), the impact on Trusts will vary in intensity. A pandemic may involve one or more waves of around 15 weeks each, spread some weeks or months apart. The cumulative clinical attack rate could be up to 50% as the worst case scenario. Further information on the potential impact is available in the *National framework*, available at :
http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

2.13 An influenza pandemic will affect Trust staffing in four ways:

- > HSC staff may themselves become infected, which is likely to lead to an unprecedented level of sickness absence during a pandemic

- > some staff may have fears of being infected while at work and, in particular, of passing on the infection to their families and friends

- > stress levels will be high because of pressures on staffing

- > staff with caring responsibilities may be adversely affected by local measures, such as closure of schools. As a result, these staff may have to stay at home to care for dependent children and, in other cases, staff may be caring for partners or other dependants, such as older relatives.

2.14 Trusts should identify in their employee support services (in some organizations clinical care coordinators) a lead role for clinical care/carer support to keep staff informed about local childcare/carer arrangements. There may be some scope for changing working times to allow parents to share childcare. Additional problems may be caused where staff are unable to travel to work because of local transport problems, such as lack of fuel or staff shortages. Transport operators are optimistic that they will be able to continue to provide a good service during a pandemic.

2.15 Up to 50% of the workforce may require time off because of caring responsibilities (for young children or other dependants) at the peak of a pandemic. Individuals may be absent for seven to ten working days. Local planners should refer to planning assumptions in the *'Northern Ireland Contingency Plan for Health Response to an Influenza Pandemic'* but are advised to make their own risk assessments.

2.16 The Government is likely to issue advice, but the decision to close schools and early years childcare facilities will be taken at a local level, and close liaison with Trusts will therefore be important. This measure is designed to limit the spread of the pandemic. It will have a major impact on services such as HSC Trusts where many staff have childcare responsibilities. Nurseries may also be closed.

Monitoring Absence

2.17 Organisations will need to have robust information systems, which will enable them to track the levels of absence during a pandemic. Systems should allow employers to track absence that is due to influenza, identify areas that are most affected and provide necessary information. As noted above, absences could be for seven to ten days.

2.18 Current systems for reporting absence should be reviewed and clear guidance issued to staff on reporting arrangements. Where a member of staff is complaining of influenza-like symptoms, they should be sent home. In order to assist with planning, and to provide appropriate support, human resources departments will need systems for keeping in contact with staff who are absent due to sickness. Employers should be as supportive as possible. People who are confirmed as having had pandemic flu and having recovered should have developed some immunity, depending on whether/how the virus mutates or changes. Deploying staff on return from sickness leave will need to be considered at the time of the pandemic and the information available on the virology. Overall sickness reporting arrangements are being reviewed. Many trusts have indicated that they plan to extend self-certification arrangements. Discussions are taking place to review statutory requirements and the current seven day limit.

Sources of Staffing

2.19 Because of the anticipated levels of absence, it will probably be necessary to consider a number of different sources to maintain staffing.

Internal Redeployment

2.20 The main method of responding to absence will be internal redeployment. HSC services during a pandemic will be reduced to the provision of essential care, and therefore some work such as elective surgery is likely to be suspended. Staff working in these areas could be moved to deal with the pandemic. Local agreements on movement of staff will need to be reviewed to support a more flexible approach during a pandemic. There are some potential obstacles to redeployment of staff during a pandemic:

> Staff may not have the right skills, which should be addressed by the skills audit and, where practicable, via retraining. In some cases, staff may need to refresh their knowledge or work alongside colleagues. For example, most specialist medical staff will have had general training, which means that they can also provide general medical care in a hospital setting. Ongoing training programmes could be reviewed to incorporate elements aimed at pandemic related skills. Patients with pandemic influenza will often have other conditions or complications and so a range of skills will be needed. Non-clinical staff will also be essential to provide support and maintain services. It is therefore vital that these staff are fully involved in planning for the pandemic. Records should be maintained which set out dates of training so that employers can decide if staff training is recent enough or whether refresher training is needed. Some employers are using appraisal systems to maintain this data.

> Staff may not be in the right location. Provided that it does not compromise infection control, staff can be asked to relocate as necessary, taking personal circumstances into account. The needs of the situation may have to supersede the need to be in the usual work locations. Travel to work issues should be assessed and transport provided. Existing local agreements on relocation may need to be reviewed to allow for changes of location. As far as practicable, redeployment should be voluntary, as it would increase stress if staff were moved away from their families during this period. Staff should get appropriate support and should only be asked to take on tasks within their competence. The Nursing and Midwifery Council (NMC) statement on this issue is attached at Annex A.

> Some managerial, administrative and clinical staff, especially those with a clinical background, could also be redeployed if work not related to a pandemic is suspended. They may need specific training in the area to which they are to be redeployed. The skills audit should be used to identify these skills.

> It may not be practicable to redeploy staff in some circumstances, e.g. into the ambulance service or other specialist areas such as mental health. Most social care staff will probably still be needed in social care.

> Where staff travel to work is disrupted, staff may ask to work at a more convenient location, which may be that of a different employer. Local discussions on this should take place. Where this happens, staff will need to be clear on local procedures.

> Staff may have a high level of concern about being moved to deal with pandemic influenza patients. Therefore, timely and accurate communication to staff on minimising the risks during a pandemic will be critical to local human resources strategies. Trusts should negotiate flexibility clauses with trade unions at a local level. In the event of a pandemic, staff may be asked to carry out other duties as requested in their scope of competence.

2.21 It is important that all employers in an area work together to tackle the challenges of a pandemic. The HSC Trust will have strategic overview and the overall coordinating role but, at the local level, individual employers should seek to reach agreement on sharing resources, including staff, during a pandemic. Where practicable, local protocols or Memoranda of Understanding should be agreed in advance of a pandemic. Universities should be approached to assess whether clinical academics could be utilised to provide support during a pandemic.

Bank Staff

2.22 Most trusts operate some form of internal staff bank. These staff can be called on to work additional hours during a pandemic. Existing full-time and part-time staff could also be asked to work additional hours. Both groups will, however, also be affected by pandemic related absence and so may not provide as much additional cover as anticipated. There should be discussion with local staff-side representatives on this. See also the section on the Working Time Regulations.

Sharing Staff Between Organisations at Local Level

2.23 Local agreements should be considered to support the sharing of staff between organisations at a local level. Staff moving between employers should be seconded on existing terms and conditions. Transfer needs to be undertaken in a planned way to ensure that resources are allocated most effectively. Such moves should, wherever possible, be voluntary and take account of individual skills and personal circumstances balanced against the needs of the service.

2.24 Where there is a high degree of disruption to the journeys of staff, it may be beneficial to allow individual staff to work at another HSC facility nearer their home as long as this is practical. This should be agreed with the current employer, and there will need to be good communication to ensure that such staff go to where they are most needed and that their ordinary employer knows where they are working. It should be treated as temporary secondment to ensure that staff are covered for indemnity purposes. Staff will need an induction at their new work area.

Drawing on Non-HSC Sources of Staffing

2.25 At some point, there may be a need to supplement current Health and Social Care staff with others. For example, the British Medical Association's (BMA's) Retired Members Forum has offered to assist, and work is under way on how this can best be organised. For the time being, employers should concentrate on building up their own local pool of potential employees who could be called on to assist, focusing initially on retired staff.

2.26 The Department of Health (England) is also working with regulatory bodies to tackle the issue of restoring staff to the register in order to allow them to practice. The GMC and the NMC have indicated that they would seek to readmit eligible individuals as rapidly as possible. For the NMC, this means nurses and midwives who meet the standards for entry on the register. See Annex C for details of relevant websites. Discussions in this area are continuing, including on whether changes could be made to registration arrangements to support this.

Working with Other Sectors

2.27 The HSC Trusts will need to work closely with the social care sector, including home care services, to maintain services and provide support after discharge. Trusts and the Board should work together to assess what areas of work could be suspended during a pandemic to allow for flexible use of resources and staff. In particular, service providers need to consider whether services such as day care centres, libraries and other community facilities should remain open. Nurseries, Sure Start and other childcare facilities are likely to be closed, which may release some staff to assist those being cared for at home. There may be scope for redeploying staff between the sectors.

2.28 In the event of a pandemic, Health and social care staff who work in the community will be dealing with the additional pressure of caring for more people in their own homes.

2.29 Health and social care staff will no doubt be in a position to take on additional or different tasks in these circumstances. It is therefore important that Trusts and the Board plan for deployment of the overall workforce working, for example, on intermediate and integrated care of older people. Where possible, Trusts and the Board should come to clear agreements in advance, involving frontline staff and their representatives. There should be a communications lead between trusts and the Board.

2.30 In the event of a pandemic, it is important that organisational and procedural differences do not become barriers to joint planning and working. It is particularly important to remember that the independent sector employs large numbers of the social care workforce, particularly those working directly with individuals in their own homes and in care homes. The sector is diverse, ranging from small providers to large national ones.

2.31 Terms, conditions, vetting procedures, levels of training and qualifications and registration requirements vary among professions, sectors and employers. Employers will need to recognise this and address it in drawing up their plans.

Building up a local pool

2.32 As noted above, staff who have recently left the service (e.g. retired staff) are likely to be the most effective group to call on for the local pool. Employers will be familiar with these staff and their skills should be relatively up to date. If not still registered, they can be restored to the register relatively easily. As an initial step, all staff who leave employment from now on, whether due to retirement or for other reasons, should be approached and asked if they would be willing to assist during a pandemic. Employers should keep in contact with these staff and consider offering refresher training at appropriate intervals, as is done for staff on maternity leave. It may also be necessary for employers to assist with registration fees. Regulatory bodies such as the GMC, NMC and the Pharmaceutical Society of Northern Ireland (PSNI) can already restore staff quickly to their respective registers. The potential need for emergency re-registration arrangements is being kept under review.

2.33 HSC Employers and the BMA's Retired Members Forum are working with the medical Royal Colleges to develop a possible database of retired medical staff whose details could be made available to trusts in the event of a pandemic. These retired staff would be able to provide additional medical capacity, which the service could draw on. A range of issues would need to be considered, including payment of registration fees, how quickly people can be restored to the register and other administrative issues. The Home Office has also recently consulted on plans for retired GPs to take on a role in certifying death and further advice will be issued on this proposal.

2.34 The Trusts may be able to call on assistance from healthcare staff currently employed in a range of other employment:

> The Trusts work with a range of independent providers. During a pandemic, some of these independent providers may have staff who could work in Trusts, as some of their normal work is likely to be suspended. For example, independent sector treatment centre providers may not be doing their ordinary work. Local independent providers should be involved in local planning. Private hospitals may also be affected and able to release their staff and offer their facilities on a voluntary basis. The Trusts should work closely with independent providers on this issue.

> Graduate healthcare professionals who have not been able to secure employment could also be contacted, though not as a substitute for substantive employment.

> Professionals who provide temporary staffing to trusts will face the same staffing issues as the Trusts during a pandemic and will therefore only have capacity to provide additional temporary staffing to organisations that have current contracts with them.

> If educational institutions are closed to limit the spread of the pandemic, educational and academic staff (including those based in deaneries) could also assist, e.g. by providing professional supervision and other support for healthcare students. (The potential role of healthcare students is discussed in paragraph 2.45.) The use of healthcare students needs to be carefully considered and properly supervised. Healthcare students should not be used as substitute staff.

2.35 Where additional staff are employed to help cope with a pandemic this would usually be on a temporary basis. A draft contract for use with temporary staff is at Annex B. While there are likely to be additional pressures and depleted staff to process applications, there would still be a requirement for all additional staff – including temporary staff – to be checked with AccessNI. When additional staff are being considered, they should be asked if a check to the level required has already been obtained for their normal position and what that position is. AccessNI has business continuity and contingency plans in place, which it will regularly monitor to meet the pressures during a pandemic. AccessNI has stressed that decisions about eligibility for checking any position (paid or unpaid) would need to be taken by the potential employer in line with relevant legislation and the usual criteria (e.g. position, level of contact and supervision with children or vulnerable adults). Changes to legislation requiring pre-employment vetting checks or the exercise of legislative powers at the Department's disposal will be implemented as necessary. AccessNI should be informed if it is planned to submit applications solely to cope with a pandemic situation, over and above the numbers normally submitted. That will help AccessNI to ensure that appropriate resources can be deployed.

2.36 Members of the public are likely to volunteer to help during a pandemic and could provide invaluable additional support in non-clinical roles, e.g. support services, general assistance and providing basic information under supervision. Employers may find it useful to work with existing volunteer organisations such as St John Ambulance. Volunteers will need to undergo a health check and be Access NI checked, with appropriate references taken up. Retired staff and volunteers should be required to attend a special induction or health and safety training session to ensure that the trust complies with its legal obligations. Volunteers are not normally paid, although expenses should be met. Employers need to be clear about the remit of volunteers during a pandemic.

2.37 Volunteers will need some form of honorary contract adapted for specific purposes of pandemic flu.

2.38 Changes to legislation by the Department of Health, England to allow emergency registration, e.g. of doctors, may be considered if necessary. As this legislation applies throughout the four countries, Northern Ireland will follow suit. This would allow for increased capacity in the medical workforce of doctors who may have never registered in N.I., final year medical students and retired doctors

with lapsed registration. The registration would be temporary and would cease once the pandemic (and any aftermath) is considered to be over.

Primary Care and Community Services

2.39 The National Pandemic Flu Line service will be activated to provide people with access to information and antiviral medicines where they require them. The information function of the National Flu Line will be activated at WHO Phase 5, to provide the public with access to information, including pandemic-related advice, situation reports and daily updates, and a pandemic literature request function. This advice line will also direct individuals to the Northern Ireland advice line. At WHO Phase 6, UK alert level 2, the National Flu Line service will be expanded to provide assessment and access to antiviral medicines for symptomatic patients. NHS Direct will have a lead role in the setting up and management of this service. Both functions will remain operational until the impact of the pandemic and the threat of further waves subside. Various operational and technical solutions are being looked at to determine how the service will be staffed. Although it is anticipated that some of the National Flu Line service will be supported by automated technology and non-clinical staff, clinical skills will also be required (to handle non-routine calls). However, as there is only a finite pool of clinical resources in the system, it will be important for Trusts to work with NHS Direct to identify which clinical resources from the healthcare team could be used to support NHS Direct in administering the National Flu Line service or its core non-influenza business in the event of a pandemic.

General practice

2.40 An agreement has now been reached on the operation of the General Medical Services contract in the event of a pandemic in line with assurances given by ministers. This guidance only covers Trust employers and their staff.

2.41 Trusts and general practices need to work together to ensure adequate staffing during a pandemic. Trusts may also need to provide additional support, especially for smaller practices, and will need to keep in close contact. For example, it is recommended that the Trust may be best placed to employ and allocate GP locum staff to sustain services. These staff would then be covered by Trust indemnity insurance. It is not envisaged that Trusts would take over the running of practices unless services could not be sustained in other ways. However, in some cases, Trust community staff could be seconded into practices if this was felt to be effective. The role of services provided directly by Trusts, such as walk-in centres, should be kept under review. General practices will also

need to work closely with local authority social services departments to maintain support for patients in the community.

Educational and Training Issues

2.42 It is anticipated that a pandemic could severely restrict the availability of educational provision. For example, educational institutions could close as a public health measure or due to staff absence or redeployment of educationalists. The cohort of students affected will still need to be dealt with effectively. Depending on when a pandemic strikes, this could affect more than one cohort of students. The GMC is therefore considering which steps to take to safeguard the interests of medical students. Parallel issues will also arise for other types of student as clinical placements may not be practicable during the height of the outbreak.

2.43 The GMC is also considering how best to deal with the graduation of final year medical students. One option would be to allow final year students to be given a provisional graduation without taking their final exam. They would be given a form of registration and could work under supervision, therefore being available to help sustain services. These steps would only be taken when the pandemic had reached a level where this approach would be beneficial. Students would need to work under clinical supervision and within their scope of competence. Transitional arrangements for the operation of the Foundation Training Programme would then be required. The GMC is continuing to work on policy proposals in this area and there will need to be further discussions with stakeholders.

2.44 The Department of Health is currently working on changes to legislation to enable emergency registration. The NMC is considering its processes for completing the registration process in the event of an interruption to the normal procedures resulting from pandemic influenza.

2.45 Employers would also need to consider how best to deploy medical and other clinical students if it is feasible and beneficial to do so. It is recognised that higher education institutions providing health professional training will need to agree these protocols and this is best done at local level. Medical and other students already carry out a range of tasks and could therefore provide a variety of assistance during a pandemic. They would supplement rather than substitute clinical staff. The level at which students could work will depend on the competencies they have at each stage of their studies. Expectations of the role of students during a pandemic would depend on the stage, experience and level of competence. If students are to contribute outside their programme, it must be appropriate to the level of knowledge, skill and experience as well as the supervision available and the degree of complexity. For example, final year

medical students could probably assist to a higher degree. Where students were carrying out work related tasks, they should be issued with 'honorary contracts' to ensure that they are covered by indemnity insurance and health and safety rules. In addition, where duties are substantial and sustained, some form of payment would be appropriate. Supervision will be essential and educational clinicians could assist with this as they will not be undertaking their normal work.

2.46 There will also be an issue of how to manage the rotations for postgraduate medical trainees, e.g. in their foundation years. In the event of a flu pandemic of serious proportions being declared, the Medical Dental and Training Agency (NIMDTA) has indicated that it would favour an embargo on rotational moves for trainees during the height of the emergency, both to reduce the spread of infection and also reduce the training burden on Trusts. Deanery human resources staff will need to work with local employers on this issue.

Working with the Independent Sector

2.47 One of the issues that needs to be taken into account in the event of a pandemic is how independent sector providers may be affected. Independent sector providers of elective medical and health care will, like Trust providers in this area, probably have their work suspended during a pandemic. Their staff, or Trust staff seconded to them, could therefore become available for use by the health service. As these staff are already in employment and have been Access N.I. checked, they would be an extremely useful reserve for the Trusts to draw on. Independent providers should therefore be involved in workforce planning at a local level and, where possible, agreements should be reached in advance to support use of these staff, e.g. via secondment. Indemnity arrangements can be set up at the local level via the appropriate employer and/or Trust. Local arrangements should be developed as appropriate.

2.48 Some services provided to Trusts by the independent social care sector will need to be maintained during a pandemic, for example, care homes, nursing homes and domiciliary care services. The providers then have the main responsibility to maintain services, but the Trusts need to make contingency plans to sustain these facilities. . For further information refer to DHSSPS;Planning for Pandemic Influenza in Personal Social Services at: <http://www.dhsspsni.gov.uk/planning-for-pandemic-influenza-in-pss-guidance-for-pss-providers.pdf>.

2.49 During a pandemic, it will be in the interests of the Trusts and social care services that residential care and nursing homes' services for older people are maintained. This may include use of Trust and social care staff during a pandemic. Protocols will need to be developed for support that may be needed,

for example community nurse visits. The Trusts need to support homes providing nursing and long-term care. The large number of small homes will be a particular challenge. Trusts in particular should seek to 'map' staffing in homes in order to identify risk areas.

Mental Health Services

2.50 Institutional mental health services will face particular issues during a pandemic. Long-term residential facilities will need to be kept open to avoid the admission of residents to hospital. As in other facilities, this will be a staffing challenge as these units are likely to be affected by staff absence and it may not be practicable to deploy staff from other health areas into mental health units. If non-residential facilities are closed as an infection control measure, there may be some scope to redeploy mental health staff into acute facilities. Non-residential facilities may need to be closed to limit the spread of infection. Guidance on preparing mental health services in England can be found on the Department of Health website at: www.dh.gov.uk/pandemicflu. In addition, a range of specific mental health issues have been identified including the need to review the operation of some legislation, for example aspects of the Mental Health Act.

2.51 Efforts should be made to identify mental health units that can be paired to support one another during a pandemic. There will need to be close cooperation between the Trusts and the independent sector as they are major providers in this sector, especially of long-term and residential care. The issue of medical services in other institutional settings, such as prisons and detention centres, needs to be taken into account. Trusts have overall responsibility for healthcare in these settings and will need to work with the relevant organisations to ensure that staffing is maintained. The workforce in these institutions may feel at risk and need additional training and support.

2.52 During a pandemic, residents with influenza and/or other acute conditions may require admission to an acute hospital but, wherever possible, treatment should occur on site to limit infection risks. Acute hospital staff will need familiarization and appropriate training. Non-registered staff in mental health units can be trained to undertake some tasks in order to use staff most effectively during absences, but will need access to clinical supervision and support.

3 During a Pandemic

3.1 A range of human resource issues will emerge during a pandemic. The key will be to build resilience prior to the pandemic and to maintain morale and motivation over a sustained period. It is essential that close contact is maintained with staff-side colleagues and that a partnership working approach is adopted. Discussion on likely issues with local staff-side representatives should take place at an early stage. Staff and their representatives should be kept fully informed during the process and the issue should be approached on a partnership basis at local level.

Absence Management

3.2 HSC Trust experience suggests that the vast majority of staff will approach the pandemic in a spirit of cooperation and commitment. Employers should seek to support and sustain morale during the pandemic, and absence management will need to be handled with care and sensitivity.

3.3 Staff who display symptoms should be sent home and advised not to work until fully recovered. Infected staff would be paid under normal sick pay arrangements. Staff should notify their employer using agreed local procedures. It will be vital to track absence trends and be able to monitor absence levels within and across employers to get an accurate picture of the impact of the pandemic. Statutory sickness certification arrangements are being kept under review. Employers will want to review their local procedures.

3.4 The decision to close schools will have a major impact on Trust staff, as many have school-age children. There may be some scope for support via local networks of childcare coordinators or cooperation between parents, though this is likely to be limited due to fear of infection. Home working and home-based working may be a feasible response for a small number staff, though communications networks are likely to be under pressure.

3.5 It is recommended that employers should support staff with caring responsibilities of children in the event of pandemic-related school closures. The nature of the support offered could vary, for example a combination of paid and unpaid leave building on existing carers' leave provision. Staff should be treated consistently and fairly. Similar principles should be followed in relation to other dependants, such as disabled or older relatives. Such a positive approach will demonstrate employers' commitment to supporting staff in a highly stressful period. There may be advantages in having similar provisions across nearby employers. It is recommended that this issue is discussed in advance with local staff-side representatives.

3.6 Employers will need to balance the need to sustain the service with the pressures that will fall on staff who have childcare and other caring responsibilities. It is, however, unrealistic to expect that staff with caring responsibilities will not be affected by the closure of schools and/or nurseries.

3.7 The length and nature of such provision is a matter for local determination, although there is an expectation that, during a pandemic, employers will utilise carer's leave policies.

3.8 Another potential issue will be the non-attendance of staff due to fear of infection. Trust staff have a very high level of commitment to caring for patients but there may be a high level of anxiety about pandemic influenza, resulting in some staff being unwilling to attend work for fear of putting themselves or their family at risk. Initially, efforts should be made to convince staff to attend, e.g. by direct approaches from clinical colleagues.

3.9 Information and accurate risk communication for staff are key to avoiding rising levels of anxiety in the workforce. It should be stressed that staff who are not dealing directly with symptomatic patients are not at high risk. The Health Protection Agency (HPA) has guidance on this issue.

3.10 Employees will have no right to refuse to attend work during a pandemic, unless there is a clear health and safety risk. The employment contracts of staff will oblige them to treat patients and refusal to do so may put them in breach of their contracts. Employers should, however, acknowledge the level of anxiety that an influenza pandemic is likely to generate and seek to persuade rather than penalise. It is unlikely to be feasible to take disciplinary measures during the pandemic and the view of the staff-side representatives should be sought before any such action is taken. It is also the case that the professional codes that apply to many Trust staff also make clear that staff have an obligation to provide care to those in need. It is anticipated that, in line with Trust traditions, staff will work in an exemplary manner and planning should be based on this principle. Employers also have an obligation to ensure the safety of staff and the measures taken in this respect should help reassure them.

Disciplinary Issues

3.11 Although agreed local disciplinary procedures will remain in place during a pandemic, trusts should take a supportive approach to recognising that instances of error may be greater than normal. Systems that allow for rapid learning from adverse incidents and sharing of information will be vital. The GMC has indicated that, provided the doctor acts in good faith within their skill and competence, it would not usually anticipate a disciplinary issue to emerge. This subject will be covered further in forthcoming guidance from the GMC on *Good Medical Practice*. Similarly, reference should also be made to *The Code: Standards of conduct, performance and ethics for nurses and midwives*, which covers issues such as conduct, performance and ethics, as do codes for other professional groups. Staff will also be guided by *Responding to pandemic influenza: The ethical framework for policy and planning* (available at www.dh.gov.uk/pandemicflu) on the decisions they will take during a pandemic. Reckless behaviour (e.g. disregard of relevant codes or conduct which places patients at risk) does of course still need to be dealt with as appropriate, even during a pandemic. Conduct does need to be seen in context and account taken of pressure on staff.

Indemnity and Litigation

3.12 Trusts cannot prevent patients from pursuing legal action, but should reassure staff that they will provide appropriate support in such circumstances. Staff should also be reassured that normal indemnity arrangements in respect of clinical and social care negligence will continue to apply during

In accordance with existing guidance, staff should continue to take reasonable steps to maintain patient/client records.

Staff should also seek to operate within the principles of the ethical framework (see above), as this will be seen as the governing set of principles during a pandemic.

> Where staff or students are asked to work outside their normal role, they must continue to work within their scope of competence and receive adequate training and supervision. Students in particular should be properly supervised. Registered staff should be guided by their professional codes, e.g. for medical staff, the forthcoming statement on *Good Medical Practice* from the GMC and for nurses and midwives, see Annex A.

> Employers and managers also need to be aware of their responsibility to make adequate provision for health and safety even during a pandemic, as they will be expected to continue to take reasonable steps to safeguard staff.

Conduct which places staff, patients or the public at risk

3.13 While taking a balanced approach, employers and managers should identify conduct that places staff, patients or the public at risk and deal with it **fairly and robustly**. Disciplinary procedures will remain in place and cannot be altered unilaterally. However, it may be useful to reach local agreements that make provision for staff to be suspended, if necessary, during the pandemic period pending investigations, as conducting hearings during the pandemic is unlikely to be practicable. This would be without prejudice in the interests of patient safety, so for example it may be necessary to use suspension to remove staff from the workplace pending an investigatory process. Local managers should be briefed on how to approach these issues.

Working Flexibly

3.14 Any pandemic may lead to a need for staff to take on new roles or work in unfamiliar situations. The following guiding principles should be observed:

> The training of non-registered staff to take on some tasks so as to free up registered staff for other duties should be discussed with local staff-side organisations, and appropriate protocols should be followed. Taking on additional tasks should follow training and be under some form of supervision or, if this is not practicable, some other clinical support. It should not set a precedent for longer-term role changes, as issues that staff face during a pandemic are very different from the usual ones.

> The NMC has developed a statement based on its existing code of practice, which sets out the general principles that should guide registered nursing staff in carrying out their role during a pandemic. This states: *'Registrants will not be professionally compromised provided they are competent (and have been assessed as such) to carry out any practice being requested of them. They remain answerable at all times for their actions or omissions.'* (See Annex A.) Regulatory bodies have indicated that they would take into account the context of staff undertaking unfamiliar duties in stressful conditions. Staff can refuse to undertake duties if they are outside their competence.

> The Health Professions Council has also indicated that it would expect registrants to carry out roles as necessary within their competence.

> Employers must therefore ensure that staff are competent before any duties are delegated to them. The Knowledge and Skills Framework is useful for assessing staff for skills and training needs. Some specific training programmes are being developed in relation to a potential pandemic. Appropriate supervision and support should be developed though it is recognised that this may not always be to the level applied normally.

> However, there are currently legal restrictions on some roles, e.g. who can prescribe, and it is currently intended that these will remain in operation. For example, employers will need to operate the system of Patient Group Directions (PGDs) and train as many staff as possible to undertake this role. Protocols on this will need to be developed locally and operate within current legislation. The current legislation on prescribing is being looked at by the Pharmacy Working Group to see if it needs to be changed to assist in tackling a pandemic.

> The GMC is continuing to develop its advice on the principles that should guide medical staff during a pandemic, and this will be issued in due course. It will be based on the existing code of *Good Medical Practice* and will take into account the ethical framework for dealing with pandemic influenza. This guidance should be published before the end of 2008.

3.15 As far as practicable, employers should identify, in advance of a pandemic, any tasks that may need to be taken on by staff on a flexible basis, so that appropriate training can be offered. During the pandemic itself, emergency situations may arise which need to be dealt with on a case-by-case basis, balancing the needs of patients against any risks in asking staff to take on unfamiliar roles.

Human Resources Policies

3.16 HSC Trusts terms and conditions of service will remain in place and it is not intended to use powers to alter employment legislation. The operation of human resources policies will need to be reviewed in the light of the pressure on the service. Regional guidance cannot anticipate all scenarios that may occur, but it may be useful for local organisations to develop their response to the following framework of principles in discussion with local staff-side organisations.

> All non-statutory functions should be assessed to see if they can be postponed for the duration of the pandemic. For example, undertaking appraisals will probably be impractical, so the dates for performance reviews will need to be amended and interviews postponed, as may study leave provision.

> The operation of review under the Knowledge and Skills Framework may also need to be postponed. Agreement may need to be reached in the regional joint negotiating forum on how this affects pay progression if the pandemic continues for an extended period.

> It may be necessary to limit annual leave to sustain services, although there should not be a blanket ban on leave. Time away from work is essential for health and morale. Requests for leave should therefore be considered on their merits, as it is important to allow staff to recuperate from the intense pressure of a pandemic. Pre-booked leave should be allowed unless there are exceptional circumstances.

> As noted previously, the operation of disciplinary procedures will also need to be amended. Conducting investigations and hearings is likely to be impracticable at the height of a pandemic. Suspension will need to be used as a precautionary measure pending return to more normal conditions. Agreement with staff-side organisations will be needed on these issues, especially over timescales and union representation arrangements.

> As discussed, reporting arrangements for sickness absence should also be reviewed to balance the need to monitor absence with the capacity to do so. Some employers may make arrangements to extend self-certification. Staff who have experienced influenza may have resistance but should not be pressurised to take unnecessary risks.

> There will be a need for the AccessNI to continue carrying out pre-employment screening checks in the run up to a pandemic, especially on staff taken on to assist who have not been previously checked to the level required

Terms and Conditions

3.17 In general, the HSC Trusts intend to maintain normal terms and conditions during a pandemic, but some areas may need to be changed:

> Shift patterns and other working arrangements may need to be revised, although unsocial hours provisions and payments will remain in force. This means that staff should be paid at the appropriate rate.

> It will, however, be necessary to take a flexible approach at a local level on some key issues such as the implementation of the Working Time Regulations (WTRs) (see below). More staff may be needed at nights and weekends.

> Staff employed on a temporary basis should be paid at the appropriate rate, ie Agenda for Change terms, where a job covered by the national job evaluation scheme is being undertaken, or other local terms as applicable. A draft model contract for flexible workers taken on during an influenza pandemic is given at Annex B.

Working Time Regulations

3.18 The key area where major changes to current practice will be made is in relation to the Working Time Regulations (NI) 1998. The WTRs will remain in force but the application of the regulations will need to be reviewed during an influenza pandemic. Legal advice to the Department of Health indicates that the night work limits (including the limit for special hazards), right to rest periods and rest breaks under the regulations do not apply where the worker's activities are affected by taking account of these exemptions to the WTRs:

> an occurrence due to unusual and unforeseeable circumstances, beyond the control of the employer, or

> exceptional events, the consequences of which could not have been avoided despite the exercise of all due care by the employer.

3.19 Notwithstanding the legal position on exemptions, it is recommended that employers engage in discussions with a view to reaching agreement on how the

WTRs will be applied. In the event of any dispute, it would be for the courts and/or enforcement authorities to decide whether action taken by an employer was justified in taking account of the exemptions in the WTRs. Regulation 23 of the WTRs also allow for exemptions to certain rules by collective (employer and independent trade union) or workforce agreements. Most employers in the NHS have local agreements that apply the WTRs. Some already allow 'opt outs' for some staff. It is recommended that agreements should be reviewed to allow more flexibility on the night work limits, right to rest periods and rest breaks. In particular, where staff work beyond the length of shifts laid down in the regulations, Health and Safety Executive N.I. (HSENI) advice is that 'wherever possible an equivalent period' of compensatory rest should be taken before the next shift begins. These provisions remain in force. Rest breaks will also still be necessary if staff are to function effectively and employees need to be advised to take breaks in order to maintain safety. Discussions should take place with local staff-side organisations on these issues to seek agreement on policy at local level. For example, on working hours, a 17 week reference period is probably adequate though the reference periods can be extended to up to 26 weeks or a maximum of 52 weeks by agreement.

3.20 However, there may be some staff for whom such an approach is not practicable even with a 52 week period as, due to their specialist skills, they are likely to be in heavy demand, for example medical, maintenance and IT support staff. In addition, senior staff may be required to be available to provide guidance. In these cases, it may be necessary to ask individual staff to voluntarily waive their right to not work more than 48 hours a week to allow for flexibility. It is recommended that this provision should only be used in exceptional circumstances.

3.21 It is envisaged that, even during a pandemic, extending to a 52 week reference period should allow sufficient flexibility and excessive working hours should be avoided. These staff would need to be approached at the earliest stage practicable once the need for them to work longer hours is identified. This 'opt out' should be for the duration of a pandemic only and should not be applied unless necessary. In some cases, staff may already be operating under opt-out provisions. Staff should not be subject to any detriment if they choose not to comply with this request and inducements cannot be offered. It is accepted that this approach creates practical problems but it appears to be the best option within the regulations. Employers should start to identify such staff now although the opt-out waivers should not be offered until a pandemic is under way. This approach should be used sparingly but is allowed under the regulations. In any event, the use of such opt-outs should be discussed with local staff-side representatives

3.22 The culture of the Health and Social Care has traditionally been for voluntary working of as many hours as necessary during an emergency. Unlike other emergency situations in the recent past such as the 7 July bombings in

London, a pandemic could last for many months. Excessive working hours cannot be a safe practice in such circumstances and managers have a responsibility to communicate this message to clinical colleagues. Senior managers should also seek to observe these provisions. In particular, the hours worked by staff involved in interventions, operating equipment and key decision-taking should be monitored to avoid excessive working even during a pandemic.

3.23 In addition, staff should be reminded of the risks of driving when over-tired. Similar considerations will apply for independent contractors though they are not directly covered by the legislation.

Health and Safety

3.24 The health and safety precautions to be taken during a pandemic can be found on the HPA and HSE websites (see Annex C). As the aim is for all symptomatic people to receive antivirals, it is not currently planned to give priority to healthcare employees when distributing antivirals, although this will be kept under review. These issues need to be explained to staff to secure their support and avoid damaging morale. Clinicians are best placed to explain these issues. Info available in 'Northern Ireland Contingency Plan for Health Response to an Influenza Pandemic' released 25/11/2008. This documents is available at: http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm along with additional Health and Safety info.

3.25 The current stockpile of antivirals is intended to be used to treat all symptomatic patients where they are able to start taking the course within 48 hours of the onset of symptoms. In the event of a pandemic of similar proportions to those that occurred in the 20th century, the stockpile is large enough to treat all those who fall ill, so prioritisation should not be required. However, frontline health and social care staff and those in clinical 'at risk' groups for seasonal influenza will be given initial priority if the clinical attack rate proves higher. This strategy will be reviewed in the light of information about the virus and its impact emerging from the early stages of a pandemic. Staff with symptoms should use the National Flu Line.

3.26 The DHSSPS has a small stockpile of a pre-pandemic vaccine, which would be offered to staff with direct patient contact, if there was a close enough match between the vaccine strain and the emerging pandemic strain. It is important to remember that a pandemic virus could be so different from pre-pandemic strains that this vaccine might not offer any benefit. Any pandemic specific vaccine is not likely to be available until at least four months after the onset of a pandemic. The eligibility of staff for vaccination will be determined in due course, based on a

clinical assessment of the staff groups that could be at risk. It will not be restricted to health service employees, but based on clinical risk/benefit for all health and social care staff in direct contact with symptomatic patients.

3.27 Employers have the same duty of care to their staff during a pandemic as in other circumstances, and should take reasonable steps to safeguard the health and safety of staff. Employers must consult with recognised health and safety representatives about health and safety issues around pandemic planning.

3.28 The HPA and the HSE are producing detailed guidance on key issues (see Annex C for web addresses). At local level, employers should set up arrangements to address health and safety concerns. Occupational health services should be able to provide counselling and other support services. A range of security issues may arise during the pandemic, particularly in relation to the safety of ambulance staff and staff working in accident and emergency areas. Staffing for these areas needs to be taken into account.

3.28 Local occupational health and safety committees will have a key role to play in developing a partnership approach at local level. They should consider the planning arrangements that may be adopted at local level and help to communicate messages for staff. There may also be a need to develop appropriate arrangements during a pandemic for quick exchange of information and communication. Access to trusted and impartial advice will be vital.

Staff Support

3.29 Maintaining staff morale and motivation will be essential during a pandemic. The HSC Trusts have an exemplary record in sustaining services in emergency and stressful situations and responding to emergencies. An outbreak of pandemic influenza will, however, create sustained pressure lasting weeks and possibly months. Experience from the severe acute respiratory syndrome (SARS) outbreak suggests that tackling staff fears will be vital. Clear communication from trusted sources, honesty and open discussion of fears have been shown to be the most effective methods of sustaining morale. Electronic communication methods may need to be used to reduce risks, but face-to-face meetings will also have a key role in sustaining group morale. Staff who are seen as impartial such as chaplains may have a key role here.

3.30 In practical terms, trusts should seek to ensure that they have some 24-hour catering and other facilities for staff working on site. The possibility of sleeping in accommodation should also be evaluated as some staff might need to stay on site for extended periods. Arrangements could be made with local hotels for

accommodation. Staff should be able to use communication systems to maintain contact with families and trusts should ensure that staff have access to phone and email for personal use. Counselling services and religious facilities may be in high demand due to the stress caused by a pandemic. Staff may also need a means of exploring ethical concerns and getting support for making decisions. Employers should also, where appropriate, provide accommodation and transport. Occupational health services will be in high demand at all stages of the pandemic.

4 After the First Wave

4.1 International experience suggests that, after the first wave of a pandemic, it will be vital to allow staff sufficient time and space to recover. However, the possibility of subsequent pandemic waves has to be kept in mind and preparations should be made to cope with such an eventuality. It is recommended that there should be a formal way of recognising the contribution staff make in this challenging period.

4.2 It is anticipated that it will take considerable time for the service to return to normal. Once the pandemic is officially over, those staff who have been working beyond contracted hours should be given compensatory leave. Annual leave requests should be reviewed. The waiver provisions of the WTRs will need to be rescinded, reference period calculations undertaken where applicable and appropriate compensation considered. Any disciplinary or grievance issues will need to be followed up, taking into account the circumstances that prevailed during the pandemic and learning from any adverse events.

4.3 It is likely that demand for occupational health, counselling and staff support services may increase when the pandemic is over. Sickness absence levels may also continue to be higher than normal as stress related and other repressed conditions emerge. Emotional stresses may also come to the surface. There may be particular needs, such as bereavement counselling. Some staff may suffer post-traumatic stress and trusts should put in place mechanisms for dealing with this.

4.4 Staff are likely to be tired and may need some time before they can return to ordinary performance, and this should be taken into account. It is essential to sustain morale during this period and learn any lessons from the first wave of a pandemic. It is not clear at what stage ordinary HSC working would resume and in particular when targets would be reimposed. However, organisations do need to plan to be able to resume normal working within two to three months of the end of a pandemic.

Glossary

BMA – British Medical Association, the doctors’ professional organisation established to look after the professional and personal needs of their members. The BMA represents doctors in all branches of medicine all over the UK.

Access N.I. - the organisation that carries out statutory employment checks on Health Service staff.

GMC – General Medical Council, the regulatory body for doctors. The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

GMS contract – General Medical Services contract, the contract governing payment to GPs for services to the NHS.

HPA – Health Protection Agency, whose role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other Arms Length Bodies, the Department of Health and the Devolved Administrations. The Agency was established as a special health authority (SpHA) in 2003.

HSENI – the Health and Safety Executive Northern Ireland which protects people’s health and safety by ensuring that risks in the changing workplace are properly controlled. HSE conducts and sponsors research, promotes training, provides an information and advisory service, and submits proposals for new or revised regulations and approved codes of practice.

MOU – Memorandum of Understanding, agreement at local level within a health and social care economy.

NHS - Professionals – NHS body supplying temporary staff to NHS organisations.

NISCC - Northern Ireland Social Care Council

NMC – Nursing and Midwifery Council, the regulatory body for nurses and midwives.

PGD – Patient Group Direction, a written instruction for the sale, supply and/or administration of a named medicine for a defined clinical condition.

RPSGB – Royal Pharmaceutical Society of Great Britain, the professional and regulatory body for pharmacists.

WTRs – Working Time Regulations (NI) 1998, which implement the European Working Time Directive into law. Employers should assess the likely impact of pandemic influenza on their workforce. Employers should carry out a skills audit of their workforce and identify any gaps that could be filled. Employers should ask employees for a range of data, which would assist in contacting staff during a pandemic and identify those most at risk of being unable to attend work. Employers should assess how staff could be redeployed if normal working were suspended. Employers should work with local staff-side organisations on workforce issues that will arise during a pandemic and there will need to be discussion with individuals on issues such as changes in hours of work, changes in shifts worked or changes in location. Employers should set up a reserve pool of staff that could be drawn on in the event of a pandemic. Employers should ask all staff who retire from now on whether they would be available to assist during a pandemic. Employers should work with local staff-side organisations to develop protocols on treatment of staff that are absent during a pandemic. In particular, employers will need local, agreed policies developed in line with national guidance on the treatment of staff who are absent due to childcare or other caring responsibilities and for those who are off sick due to influenza. Employers should seek to increase the number of staff with key skills needed during the pandemic, especially prescribing and respiratory medicine. Employers should work with local partners to make arrangements to assist during a pandemic and, in particular, arrange for staff to be deployed to assist in at-risk areas such as nursing and care homes to help prevent hospital admissions. Trusts should work with GPs and community pharmacy services to ensure that primary care services can be sustained, in particular to support single-handed GP practices, and ensure that arrangements are in place for deploying locums.

Summary of Recommendations

The following applies to all Health and Social Care organisations:

Managers will need advice on how to handle disciplinary and grievance issues in the event of a pandemic.

Agreed communication arrangements and mechanisms for meeting with staff need to be in place.

Employers will need to have plans to concentrate their staffing on sustaining essential services and providing support for vulnerable groups.

Employers will need arrangements for providing support to staff during this difficult period.

Employers will need to identify those staff who will need to be asked to sign waivers under the WTRs and have in place arrangements to monitor their working hours and maintain health and safety.

Employers need a policy to deal with the potential for more than one wave and for a 'recovery period' after the end of a pandemic.

Annex A

Nursing and Midwifery Council statement on the role of registered nursing staff during an influenza pandemic

The Nursing and Midwifery Council (NMC) is the UK regulatory body for nurses and midwives. Its primary aim is to protect the public. The NMC is required by the Nursing and Midwifery Order 2001 (SI 2002/253) (the Order) to keep a register of practitioners eligible to work in the UK, and to set standards for education, training and conduct for those on the register (registrants). Currently, there are more than 682,000 nurses, midwives and specialist community public health nurses on the register.

The Order also requires the NMC to establish, and keep under review, effective arrangements to protect the public from registrants whose fitness to practice is impaired.

1. Scope of practice for nurses, midwives and specialist community public health nurses ('registrants')

The Code: Standards of conduct, performance and ethics for nurses and midwives (2008) informs the professions of the standards of professional conduct and provides a benchmark for practice. There is no legal definition of a nurse or specialist community public health nurse. However, only a registered midwife with a current Intention to Practice (ITP) can provide care or advice to a woman in relation to her pregnancy, whether antenatally, intranatally or postnatally. Midwives can extend their scope of practice to provide nursing duties if they are competent to do so. All registrants are expected to practice within their competency level and acknowledge the limitations of their professional practice. If faced with any aspect of practice that is either outside their area of registration or beyond their competency level, they must seek supervision or advice from a competent practitioner. In accordance with *The Code* all registrants are accountable for their actions or omissions regardless of advice or guidance given by another professional. As such, registrants are able to extend their scope of practice, within the healthcare legal framework, but must ensure that they have the knowledge and skills to do so in a competent manner. If competency levels are not adequate, support and supervision must be sought from a competent practitioner. If working outside their normal area or scope of practice, registrants must consider their duty of care to the public. Their first consideration in all activities must be in the interests and safety of the patient/client. Registrants will

not be professionally compromised provided they are competent (and have been assessed as such) to carry out any practice being requested by the employer. They remain answerable at all times for their actions or omissions.

Medicines legislation is very specific about the administration of medications under Patient Group Directions (PGDs). Registrants **must not** delegate the administration of these medications; only the registrant identified on the PGD documentation can supply and administer them.

2. Registration

Nurses who are not registered with the NMC **cannot** work as registered nurses in the UK. They can, however, be utilised in a supportive capacity. If unregistered nurses are utilised in this way, their role must be clearly identified in order to protect the public. Employers and managers are responsible for checking whether their employees are registered with the NMC. Further information on how to do this can be found on the Confirmation Services page of the NMC website at www.nmc-uk.org

3. Students

Students of nursing and midwifery are required to undertake the approved curriculum of the programme they join and to complete that programme in five years full time or seven years part time. Any minor modification to their programme can be made by the higher education institution but, where these modifications impact on regulatory requirements, the matter would need to be referred to the NMC. Students should remain on their programme whenever possible but, where contingency plans are activated, the action taken should not disadvantage them. Within contingency planning, where the situation is deemed safe and appropriate, it would be appropriate for students to participate in the giving of care as long as they are considered competent to do so. Similarly, they must be provided with an appropriate level of supervision depending on their stage of training and the care they are providing. Should the experience not be considered suitable or safe, the decision should be taken to remove students from the situation until it is considered safe or appropriate for them to return. The usual approach would be for this time to be used for study. It would be unacceptable for students to be temporarily removed from the programme and utilised as healthcare assistants. Should the student wish to work in a voluntary capacity as a healthcare assistant in their own time, or apply for a role as such, they have the right to do so as a member of the general public. However, they should not feel compelled to undertake this role.

Annex B

Flexible worker contract of engagement

Name of HSC Trust:

Address:

Introduction

The purpose of this contract is to provide short-term temporary assistance for **[insert name of HSC trust]**, hereafter referred to as 'the trust', during the pandemic influenza outbreak. This is a fixed-term contract for a specific purpose – to provide additional service to the trust for the duration of the influenza pandemic. The duration of this contract will be determined with reference to advice from the DHSSPS Chief Medical Officer. This document sets out your terms of engagement as a flexible worker and forms the terms of your contract of engagement with the trust. Outside of this contract, for the specific purpose of dealing with the influenza pandemic, there is no contractual relationship between you and the trust. And you shall not be regarded as having been taken into the employment of the trust.

(A) Name:

[Title] [First Name] [Surname]

(B) Address:

[Address 1]

[Address 2]

[Address 3]

[Address 4]

[Postcode]

(C) Region/Nurse ID/Doctor GMC Registration Reference Number (where applicable):

(D) Post: **Flexible worker**

(E) Person accountable to: **As designated by the trust**

(F) Rate of pay: Payment will be made weekly/monthly (delete as applicable)

1. Term of your engagement

The trust may decide at any time to end your engagement to work under this contract of engagement. However, such notification must be given in writing. The trust shall endeavour to give reasonable notice and, as a minimum, will give one day's notice or payment in lieu. Employees shall also give reasonable notice. The trust may terminate this contract of engagement without notice for gross misconduct or as otherwise determined. The requirement to give notice is not taken to prevent either party waiving their right to notice.

2. Job role and description

During the period of this contract, you are engaged as **[insert job title according to job held]** to carry out duties within your competence as determined by the trust. Your duties and responsibilities will vary according to your job title, level of experience and qualifications/competencies. The trust shall have regard to relevant job descriptions such as those produced under Agenda for Change or at local level but will not be limited by them. Appropriate training will be provided to enable you to undertake duties as required. These responsibilities should not be regarded as exclusive or exhaustive and may need to be amended from time to time in the light of clinical/service requirements at the trust.

3. Place of work

The trust at the following location(s): **[insert as applicable]**. You may be required to work at other locations.

4. Accountability

On a day-to-day basis, you will be accountable to a designated manager or other member of staff.

5. Hours of work

As a flexible worker, you will have no set hours unless agreed otherwise. You may be asked to consider entering into a binding agreement waiver (opt out) consenting to hours in excess of 48 per week in accordance with the Working Time Regulations 1998. It is the trust's duty generally to monitor your working hours, including hours that you work for an employer other than the trust and in any other employment you may hold with any trust/employer (for instance under a full-time contract of employment). Therefore, you agree that you will inform the trust of:

> any other work you carry out for any other person, firm or employer other than the trust

> any other work you carry out which means you may not comply with working time rest requirements (i.e. 11 hours' break in every 24 hours, and 2 days in any 14-day period)

> the days on which you carry out such other work

> the hours that you work for such other person, firm or employer and the times at which you carry out such work. Any opt-out agreement you sign will be subject to the proviso that you are able to deliver safe patient care. The trust shall monitor working hours and seek to avoid any risk to health and safety from excessive working.

6. Absence due to sickness

You are required to notify the trust immediately if you are unable to attend the trust due to ill health. The following provision will apply if sickness absence occurs after the start of this contract. You will not be eligible for occupational sick pay unless employed continuously for the relevant qualification period. **If you are unable to work due to contracting pandemic influenza, the trust will seek to re-employ you once you are fit to return to work, subject to work being available.**

7. Medical fitness

The trust reserves the right to require you to attend a medical examination carried out by an occupational health practitioner and/or a medical practitioner nominated by the trust in order to assess your fitness to work. The outcome of any medical examination will be disclosed to the trust. Failure to attend such medical examination may prevent you from undertaking this role.

8. Smoking policy

Smoking is prohibited on all premises except in designated areas.

9. Disciplinary procedure

During the course of this contract of engagement, you will be subject to the provisions of the relevant disciplinary procedure in the event that a disciplinary issue arises. A copy of the trust disciplinary procedure is available from the human resources department.

10. Grievance procedure

During the course of this contract of engagement, should you have any complaint or grievance then this will be dealt with by raising the matter with your manager.

11. Rehabilitation of offenders

You are required to inform the trust of any criminal investigations, prosecutions or convictions against you at the point at which you are engaged and in the course of your registration as a flexible worker. You are advised that the roles you may carry out during this contract of engagement are exempt from the provisions of Section 4(2) of the Rehabilitation of Offenders Act 1974. You are not entitled to withhold information about any criminal convictions which for other purposes are 'spent' under the provisions of that Act. Any failure to disclose such convictions may result in disciplinary action or termination of this contract of engagement.

In the event that the trust applies to the Criminal Records Bureau for a disclosure, you agree that you will cooperate with and consent to any such application.

12. Health and safety

While working with the trust, you have a duty to take reasonable care to avoid injury to yourself, patients and others at your place of work and to cooperate with the trust in meeting its obligations towards the safety of its workers, patients and others throughout the pandemic influenza outbreak and its obligations under health and safety legislation. If, during the contract of engagement, you are involved in an accident or incident (whether or not it is affected by the pandemic) or injure yourself or a colleague at work, you must inform your designated manager at that particular location immediately. Personal injury details must be entered in the accident book immediately and the necessary local accident report form completed. **The trust will comply with relevant advice on health and safety measures to minimise the spread of pandemic influenza.**

13. Confidentiality

You are required to observe the strictest confidence regarding any information relating to the work of the trust, their patients/clients and employees. 'Confidential information' includes but is not limited to information relating to the trust received by you during this contract of engagement as a flexible worker relating to patients, personal information, budgeting and financial information, and information in respect of which the trust owes a duty of confidentiality to a third party. You are required to not disclose any confidential information, either during or after your engagement with the trust, unless expressly authorised to do so by the trust or required in the proper performance of your duties or as required by law. This obligation will cease only when such information comes into the public domain other than through unauthorised disclosure by you. Failure to comply with these requirements will be treated as an act of gross misconduct. These requirements are without prejudice to the rights to make a protected disclosure as set out in the Public Interest Disclosure Act 1998 (as amended from time to time).

14. Professional qualification

If you are engaged in an area of work which requires membership of a professional body in order to practice, it is a condition subsequent of this contract of engagement for you to maintain membership of such a professional body. It is also your responsibility to comply with the relevant body's code of practice as laid down from time to time. You are required to advise the trust if your professional body in any way limits or changes the terms of your registration or practice.

Failure to remain registered or to comply with any relevant code of practice may result in the termination of this contract of engagement or disciplinary action.

If you are required to hold registration with a particular professional body, the trust may require you, on demand, to provide documentary evidence of your registration with that professional body.

15. Personal particulars

While working under this contract of engagement, you are required to notify the trust of any changes in your personal circumstances including changes to your name, address or telephone number, or eligibility to work in the UK. If you are employed by another employer, you must inform the trust of any suspension or disciplinary action taken against you by them. You must also inform the trust of any referrals or fitness to practice restrictions by your professional bodies. If you leave your employment with your substantive employer, you must inform the trust, and equally if you take up employment with another NHS employer, then you must disclose that too. You are required to wear your photo identity badge while working under this contract of engagement.

16. Loss of personal effects

While working at the trust, you are advised that no liability can be accepted for any loss or damage to personal property while on any of the trust's locations. You are advised to provide your own insurance cover.

17. Uniforms

You may be provided with items of clothing or identification by the trust. Any such items shall remain the property of the trust. The uniform must be worn correctly and at all appropriate times. All articles of uniform or identification must be returned to the trust on termination of this contract of engagement.

18. Data protection

You agree that the trust can process any data about you, including sensitive personal data for the purposes of the Data Protection Act, for the purpose of:

- > complying with legal obligations
- > management, including (but without limitation) the administration of any benefits
- > safeguarding the safety of patients and staff in the trust
- > any other general purpose of the trust.

19. Equal opportunities

The trust is committed to provide equal opportunities. You are therefore required to comply with the equal opportunities and/or dignity at work policies of the trust. In the event that you fail to comply with the relevant policies and/or commit an act of discrimination and/or harassment during this contract of engagement, on the basis of an individual's gender (including gender reassignment), age, race, nationality, ethnic or national origin, disability, religion, beliefs or sexual orientation, you will be subject to the disciplinary procedure and disciplinary action may be taken against you.

20. General conditions

You are subject to such terms and conditions of service and procedures as are notified to you from time to time. As a temporary worker, you will have a pro rata entitlement to annual leave which is reflected in your hourly rate of pay. You will be covered by the NHS indemnity insurance policy.

21. Changes in terms of engagement

These will be determined by the trust as necessary and will be notified to you separately.

22. Redundancy provisions

You will not be entitled to redundancy payments arising from this employment and will be notified of pension arrangements.

23. Leave

As a temporary worker, you will have a pro rata entitlement to annual leave which is reflected in your hourly rate of pay.

Acceptance of the terms and conditions of engagement

I confirm that I have read the entire terms and conditions of this contract of engagement and accept them.

Signed

[Title] [First Name] [Surname]

Date

Signed

For and on behalf of the trust **[insert name and position held]**

Date

Annex C

Website Links

There is a range of links which employers may find useful. The main site for all Department of Health pandemic influenza guidance is:

www.dh.gov.uk/pandemicflu

General guidance produced by the Health and Safety Executive for employers and employees to use if the Chief Medical Officer declares an influenza pandemic within the UK:

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

General emergency planning guidance:

http://www.dhsspsni.gov.uk/index/phealth/php/infectious_diseases/pandemicflu.htm

www.ukresilience.gov.uk/pandemicflu.aspx

www.nhsdirect.nhs.uk/articles/article.aspx?articleId=1303

www.preparingforemergencies.gov.uk

www.preparingforemergencies.gov.uk/emergency/060710_revised_pandemic.pdf

Access N.I.

www.accessni.gov.uk/

General Medical Council:

www.gmc-uk.org

The Health Protection Agency website gives more guidance:

www.hpa.org.uk/infections/topics_az/influenza/pandemic/default.htm

Northern Ireland Health and Social Care Council:

www.niscc.info

Nursing and Midwifery Council:

www.nmc-uk.org

Royal Pharmaceutical Society of Great Britain:

www.rpsgb.org.uk

The Regulation and Quality Improvement Authority:
www.rqia.org.uk