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PLANNING FOR PANDEMIC INFLUENZA IN PERSONAL SOCIAL SERVICES

GUIDANCE FOR PERSONAL SOCIAL SERVICES PROVIDERS IN THE STATUTORY AND INDEPENDENT SECTOR

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1. INTRODUCTION

- 1.1 “Most experts believe that it is not a question of whether there will be another severe influenza pandemic, but when” (The Chief Medical Officer, Department of Health 2002 in the UK National Plan). A pandemic (worldwide epidemic) of influenza remains a very real threat. Health experts, including the World Health Organisation (WHO), have warned that a pandemic is inevitable and have advised public services to begin planning accordingly. We have a rare opportunity to enhance our preparedness in all areas including how we continue to support vulnerable people. Social services providers will play an integral role in the community response to a pandemic and this guidance will help planners in developing and enhancing local preparations.
- 1.2 The uncertainty surrounding timing and impact is one of the main challenges for planners and providers. An effective response needs to take account of this uncertainty and will require the co-operation of a wide range of organisations as well as the active support of the public. Experience suggests that a consistent and co-ordinated response will not only help to reduce the impact of such an outbreak but will also speed recovery.
- 1.3 Social Services is a major public service. At any one time, some 190,000 children and adults in Northern Ireland will be relying on services provided by, or through, Personal Social Services. Although it is impossible to predict which groups of people will be most affected by influenza - the peak mortality rate in the 1918-19 “Spanish” influenza was in persons aged between 20 and 45 – it is very likely that some groups may be more affected than others. Children and otherwise fit adults could be at relatively greater risk, as older people may have some residual immunity from previous exposure to a similar virus earlier in their lifetime. Alternatively, certain older people could be significantly affected and may be at greater risk of serious complications and, as such, are likely to place a greater strain on health and social services.
- 1.4 Therefore, it is essential that health and social services boards¹, social care trusts and other social services organisations put in place robust plans to ensure the continuity of business during the event of an outbreak of pandemic influenza. Plans will need to be flexible and responsive, as the impact of the pandemic will vary depending on the group most affected.
- 1.5 People assessed as being in need of social services should not be left without sufficient levels of care and support. During a pandemic it is likely

¹ Responsibilities currently with HSSBs will change as a consequence of the Review of Public Administration and when new structures are agreed. See page 16 for HSSB and HSCT responsibilities. The Board refers to the relevant HSSB until the Regional Health and Social Care Board is operational from April 2009.

there will be additional demand from those not usually in need of care services. This could include people who would, under normal circumstances, be cared for in hospital but who may need supporting in the community due to the volume of additional people needing acute hospital care during the pandemic. It is also likely to include additional short-term emergency care for people ordinarily supported at home by their friends or relatives (carers) to cover the period their carer is ill with pandemic influenza.

- 1.6 Strong leadership, efficient internal organisation and co-ordination, effective communication and clear lines of accountability will be key to meeting the unique challenges faced by social services in preparing for and responding to a pandemic.
- 1.7 Leadership will be needed at all levels in all organisations. People will be making decisions and, in many cases, will have very little time for deliberation or consultation. This will not only affect senior staff; frontline staff will be faced with dilemmas and problems on a daily basis. You should ensure that staff are aware of *The ethical framework for the response to pandemic influenza* www.dh.gov.uk/pandemicflu and how this should affect their behaviour and actions in the event of a pandemic. Local planning needs to recognise this and introduce measures that will support staff and people using their services. An example is the need for staff to record their thinking and decisions as they happen, or as soon afterwards as possible.
- 1.8 Throughout this guidance, we encourage multi-agency planning. We discuss the ability to share and redeploy staff within and between organisations, and across sectors. The prime focus for staff in each service will be to concentrate on keeping the service they are immediately responsible for running.
- 1.9 **Current position**
- 1.10 This guidance is designed to assist health and social services boards, health and social care trusts, social services managers, organisations and staff in the statutory, private and voluntary sectors in planning a response to an influenza pandemic.
- 1.11 Planners should be aware that the information available on pandemic influenza changes rapidly. Guidance is therefore continually being revised. It is important that planners ensure they work to the latest information, including any guidance referred to within this document. It is important to emphasise that during a pandemic some elements of the planned response are likely to be initially implemented in the face of incomplete information or in the context of an evolving picture of the disease and its impacts. Therefore, assumptions and response measures need to be reviewed and where necessary changed as the pandemic evolves and further information becomes available or the impacts are better understood.

- 1.12 It is the intention that this guidance is used as a resource aimed at supporting health and social services in pandemic planning. This guidance will be on the DHSSPS website alongside the revised *Northern Ireland Contingency Plan for Health Response for an influenza pandemic. (DHSSPS Oct 2008)*
- 1.13 This framework is primarily aimed at:
- health and social care trusts
 - managers and staff and providers of social care services in the statutory, voluntary, and private sectors together with their key partners.
- 1.14 The aim is to:
- put in place robust local plans to respond to an influenza pandemic and minimise its impact on local social services and the people who use them, taking into account *Responding to pandemic influenza: the ethical framework for policy and planning*
 - limit mortality as far as possible
 - support and complement other local contingency plans e.g. those for health and education services
 - develop measures to help maintain essential social services and cope with the additional burden pandemic influenza will place on these services
 - minimise social and economic disruption.
- 1.15 This guidance accompanies the UK government's revised framework *UK Health Departments' A National Framework for Responding to an Influenza Pandemic. www.dh.gov.uk/pandemicflu* The national framework provides the overall framework for the UK's response to an influenza pandemic as well as detailed information about pandemic influenza, its likely impact and current planning assumptions. Other guidance which should be considered by social service providers includes:
- *Northern Ireland Contingency Plan for Health Response for an influenza pandemic. (DHSSPS Nov 2008)*
 - *Guidance on Preparing Acute Hospitals in Northern Ireland (DHSSPS Nov 2008)*
 - *Guidance on Preparing Mental Health Services in Northern Ireland (DHSSPS Nov 2008)*
 - *Guidance for Northern Ireland Ambulance Services (DHSSPS Nov 2008)*
 - *Planning for a Human Pandemic Influenza. Guidance for schools in Northern Ireland (Department of Education Sept 2006)* and parallel *Guidance for Nursery Schools in Northern Ireland (DE Sept 2006)*.
 - *Pandemic influenza. Human resources guidance for the NHS (DH Aug 08)**

- 1.16 This guidance is for Northern Ireland only. Parallel guidance is being issued by the Department of Health, the Scottish Executive, and the Welsh Assembly Government.

*DHSSPS Guidance in the event of Pandemic Influenza will be available early 2009

2. WHAT IS PANDEMIC INFLUENZA?

- 2.1 Influenza is a familiar infection in the UK, especially during the winter months. The illness, caused by an influenza virus, can be mild or severe and can lead to death.
- 2.2. Pandemic influenza is different from ordinary influenza because it occurs when a new influenza virus emerges into the human population and spreads from person to person worldwide. It may be that some groups of people are likely to be more susceptible than other groups, especially those such as older people and those with certain health conditions such as heart or chest disease. Observing good practice on personal hygiene is important to help reduce the spread of the virus (see paragraph 6.12 entitled "Infection Control and personal hygiene").
- 2.3 As it will be a new virus, it is likely that the entire population will be susceptible because no one will have any immunity to it. Therefore, it will attack healthy adults as well as older people and other potentially vulnerable groups. The lack of immunity in the UK population will mean that the virus has the potential to spread very quickly between people. This will result in many more people becoming severely ill with additional pressure on social services.
- 2.4 The circumstances exist now for a new virus to emerge and spread worldwide. Although a pandemic has not yet started, experts warn that it could be soon.

Signs and symptoms of influenza

The most significant symptoms are the sudden onset of:

- fever
- cough

Other symptoms

- headache
- tiredness
- aching muscles

- sore throat
- chills
- runny nose, sneezing
- loss of appetite

Incubation period (time between contact with the virus and onset of symptoms)

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

Infectious period (how long you are infectious to others)

- 2.6 People are most infectious to others soon after they develop symptoms, though they can continue to shed virus for usually up to five days after the onset of symptoms (this extends to seven days in children).
- 2.7 It is sometimes stated that patients are infectious shortly before they develop symptoms; however, the evidence for this is limited. Spread from a person before they develop symptoms has rarely been recorded, though experimental studies have shown that some people start shedding low doses of virus in the 24 hours before symptoms occur. Some people can be infected without showing symptoms and, as they may shed the virus, be able to pass on the infection.

How is pandemic influenza caught and spread to others?

- 2.8 Pandemic influenza is spread from person to person by close contact. Please refer to the section called "Infectivity and mode of spread" for more details, at paragraph 4.12. Here are a few examples of how this infection can be spread:
- Infected individuals can pass the virus to others through large droplets when coughing, sneezing and even talking within a close distance (usually 3 feet or less).
 - You can pass on the virus by direct contact with an infected individual. Shaking or holding hands with an infected individual followed by touching your own mouth, eyes or nose without first washing your hands with soap and water will also allow the virus to spread to you.
 - You can spread the influenza virus when environmental and inanimate objects, such as door handles and light switches become contaminated with the virus. Once again, if a person touches these objects and then touches his/her mouth, eyes or nose without first washing their hands with soap and water, their chances of catching the virus increase.

2.9 Key messages to the public on becoming ill

2.10 The key messages to those who have influenza-like symptoms are:

- Stay at home
- Don't spread it around
- Telephone the National Flu Line service

2.11 Training and education

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

3. THE IMPACT OF PANDEMIC INFLUENZA ON PERSONAL SOCIAL SERVICES

THE SOCIAL SERVICES RESPONSE TO PANDEMIC INFLUENZA

- 3.1 In the event of an influenza pandemic, social services will be under particular strain. Social services support people who are likely to suffer disproportionately from the impact of the pandemic in its early phase. It is also likely that it will severely affect other services, such as transport.
- 3.2 The disparate nature of social services means that planning for an outbreak of pandemic influenza will arguably be more challenging in this sector than in many other sectors. Social services cover a wide range of services for a wide range of user groups including care provided at home, care provided in care homes and in day/drop in centres, as well as services such as adoption and fostering, meals on wheels, home care, personal assistant schemes and adult placement schemes.
- 3.3 Many of these services are not provided directly by statutory social services but by voluntary, and private sector organisations. Some are provided under commission by the statutory sector but many operate on an entirely private/independent basis. However, all forms of social services will need to be factored into local contingency plans, and not just those services provided directly or indirectly through health and social care trusts.

What impact will pandemic influenza have on social services?

- 3.4 It is impossible to predict the precise impact pandemic influenza will have on the UK population, much less its impact on social services. Much will depend on the characteristics of the virus, its clinical attack rate, the severity of the illness it causes and the resulting case fatality rate.
- 3.5 Given the highly uncertain nature of a pandemic, we cannot know in advance the scale of the disruption it will cause and whom it will most affect. All health and social services are likely to experience severe pressure. The impact of a pandemic will not be uniform over the wave or across regions; it may take the form of a rising tide, depending on the attack profile. Any age-specific differential attack rate will affect the overall impact. If working-age adults are predominantly affected, this will have a more direct impact on provision of services and business continuity, whilst illness in very young children and older people is likely to have an indirect impact and will present a greater burden on health and social services.

3.6 Key challenges in managing social services

3.7 To meet the key challenges, careful co-ordination, robust leadership and effective multi-agency working will be essential. Local planners should follow the eight key principles outlined in *The ethical framework for the response to pandemic influenza* when developing their responses to those challenges (also covered at paragraphs 4.1 to 4.3). These are:

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

3.8 Key challenges in managing social services include:

- Maintaining social services in the community with reduced staff, including all the services that are not about direct care but that form an essential lifeline for some people e.g. family support and protection, safeguarding vulnerable children and adults, meals on wheels, shopping schemes, transport services, provision of community equipment, community alarm services, telecare etc
- Recognising and planning for individuals and groups that may be particularly at risk and hard to reach, such as children in need, some people with mental health problems, gypsies and travellers, homeless people, and rough sleepers as well as some black and minority ethnic communities
- Managing the inevitable additional demand placed on already overstretched local social services and health services. Additional pressures on acute hospital beds created by pandemic will likely necessitate all but the most critical clinical cases to be cared for outside the hospital setting
- Ensuring that the necessary lines of communication exist to communicate essential national, regional and local messages on pandemic planning
- Ensuring that messages are clear, so that organisations from a diverse range of social services across all sectors (statutory, voluntary, and private) can respond to them
- Additional pressures on time needed to support care home and hostel residents and people cared for in their own homes when they have influenza
- Sustaining people with complex disabilities who have intensive care packages in the community, including those using their own personal assistants

- Providing emergency short-term care for people looked after at home by family and other carers for the period their carer is ill
- Maintaining appropriate safety and infection control measures that ensure that people's quality of life is maintained as far as possible and that they continue to be appropriately safeguarded
- Ensuring business continuity.

3.9 Directors of Social Services (DSS) have a particularly crucial role in co-ordinating the planning and response of social services. They should begin by holding a scoping exercise involving other social services departments and stakeholders, to ensure that their plan will include all actual and potential service users. They may need to consider the costs involved in managing an influenza pandemic. We are particularly concerned that individuals or groups that are already disadvantaged or at particular risk should be fully considered and planned for.

Examples of these might be:

- people with mental health problems
- people who are homeless or living in temporary or insecure accommodation
- people with communication difficulties e.g. deaf and deaf/blind people
- some black and minority ethnic communities
- isolated and older disabled people living alone
- gypsies and travellers
- migrant workers
- older carers of adults
- people with learning difficulties.

3.10 In addition to planning for these groups, DSS should give thought to how some of these groups will need to be protected from negative public opinion or stigmatisation if they are perceived as posing a particular threat to public health. For example, the perception may be that influenza is more prevalent amongst homeless people, and as such other groups may be reluctant to come into contact with them at local co-ordination centres or other public facilities. Some checklists for DSS and others to consider when planning and thinking about the scope of their responsibilities, are contained on Annex 1 of this document.

3.11 **Key planning considerations**

3.12 Health and social care trusts will be responsible for co-ordinating the social services response to pandemic influenza locally, in the context of the wider responsibilities under the Civil Contingencies Act 2004.

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

- 3.14 Response arrangements should be based on strengthening and supplementing normal delivery mechanisms in so far as is possible. To be effective they will need to be developed on an integrated multi-agency basis with risk sharing and cross-cover between organisations where possible, supported by strong local leadership and co-ordination when implemented.
- 3.15 Local advice and information should complement wider national messages.
- 3.16 Health and social care trusts should start now to work with local providers to ensure they have robust business continuity plans in place and that these are appropriately reflected in commissioning arrangements. Having strong relationships with all local providers including those in the independent sector is key to managing an influenza pandemic.
- 3.17 **Carers**
- 3.18 Disruption is likely to be less severe if individuals with responsibility for caring for others know what to expect and what to do in the event of an outbreak. Up to date and authoritative information should be available to these individuals. This should include advice on where carers can go to for help if they feel unable to cope anymore due to increased demands arising from an influenza pandemic.
- 3.19 **People using social services**
- 3.20 It is essential to reassure people who use services that contingency care arrangements may need to be in place. This may include relying more heavily on families and carers if normal care arrangements are disrupted by the onset of pandemic influenza. Eligibility criteria for care during a pandemic should be transparent and applied in a consistent and equitable way that reserves capacity for those in the greatest need. *The ethical framework for the response to pandemic influenza* developed for the UK by the Committee on Ethical Aspects of Pandemic Influenza (CEAPI) will be important here.
- 3.21 **KEY ORGANISATIONAL AND INDIVIDUAL ROLES AND RESPONSIBILITIES**
- 3.22 Planning for and responding to the health, social care and wider challenges of an influenza pandemic requires the combined and co-ordinated effort, experience and expertise of all levels of government, public authorities/agencies and a wide range of private and voluntary organisations. Preparations require the active support of communities and critically, that individuals take personal responsibility for protecting their

health, supporting each other and contributing to disease containment efforts.

To ensure an effective response, each organisation needs to understand its responsibilities, plan adequately, prioritise its efforts and take pro-active steps to ensure the continuity of its services as far as that is possible.

This section describes the roles and responsibilities of the main health and social care participants in Northern Ireland.

3.23 The UK Central Government

3.24 The primary responsibility for developing preparedness plans for and an effective operational response to major emergencies in the UK rests with local organisations. However, given the national scale, complexity and international dimensions of a pandemic, strong central government coordination, explicit guidance and support will be critical at the planning and response phases.

3.25 DHSSPS and the Chief Medical Officer

3.26 The Department of Health Social Services and Public Safety (DHSSPS) is the lead Health Department in Northern Ireland in responding to an influenza pandemic. It also has overall responsibility for developing and maintaining Northern Ireland's contingency preparedness for the health and social care response and establishing stockpiles of countermeasures to support that response.

In the event of a pandemic, DHSSPS will initiate and direct the Northern Ireland response, providing specialist advice and information to ministers, other government departments and responding organisations. It will also be responsible for the effectiveness of the health response, procuring a suitable vaccine, securing and distributing supplies of medical countermeasures, and leading and co-ordinating health and social care activity in Northern Ireland. In order to provide a health focal point and reporting channel the Department would activate its Regional Health Command Centre in response to an increased threat level. The Centre will link with Health Boards and Trusts in Northern Ireland, Civil Contingencies Policy Branch (OFMDFM) who will facilitate the cross-government response, Department of Health in London, Department of Health and Children in Dublin, the Devolved Administrations, the Health Protection Agency through CDSC (NI) and the Civil Contingencies Committee (through CCPB).

The Department's Chief Medical Officer (CMO) will act as Northern Ireland's principal source of public health advice and information. The CMO will also give strategic and tactical health policy direction, form a central focal point for clinical advice and expertise and provide leadership for health professionals and the HSS Boards and HSC Trusts.

DHSSPS takes the lead in regional contingency planning for pandemic influenza and is represented in national UK pandemic planning structures by its Senior Medical Officer/Consultant Epidemiologist with lead responsibility for communicable diseases. Pandemic planning work is progressed through a core DHSSPS pandemic planning group, which has six sub-groups each charged with taking forward various streams of work. Each HSS Board and HSC Trust has an identified 'Flu Lead' who meet regularly as a group and oversee planning for their respective organisation.

3.27 Specialist advice

3.28 The Chief Medical Officer will receive specialist advice on the health response from the UK National Influenza Pandemic Committee which consists of clinical, scientific and other experts drawn from a range of relevant organisations and agencies. The Government's Chief Scientific Adviser, the Pandemic influenza Scientific Advisory Group and other expert committees also inform and support this work. The Department's Senior Medical Officer/Consultant Epidemiologist provides the conduit between UKNIPC and NIPICC (see para 3.25)

3.29 DHSSPS Minister and co-ordination of the pandemic response

3.30 A Ministerial Committee (MISC 32), comprising Ministers from across government departments and the devolved administrations, oversees and coordinates national preparations for an influenza pandemic. In the event of an increased threat (i.e. at WHO phase 4 or above) and during the pandemic, the Government's dedicated crisis management mechanism – the Civil Contingencies Committee (CCC) - would be activated in support of the lead UK government department. The CCC will direct central government activities, co-ordinate the wider response, make key strategic and tactical decisions on the countermeasures required and determine national priorities. The CCC will be guided by input from central departments and agencies and from local responders through Regional Civil Contingencies Committees (RCCCs) and the devolved administrations. It will work with the national News Coordination Centre to maintain public confidence.

3.31 Planning for the non-health aspects is co-ordinated across Northern Ireland Government Departments and other key organisations by the Civil Contingencies Group, Northern Ireland (CCG(NI)), chaired by the Office of the First Minister and Deputy First Minister (OFMDFM) through a Pandemic Influenza sub group and a Pandemic Fatalities Management sub-group. Departments liaise closely with key stakeholders within Northern Ireland and with equivalent Departments in the UK. The Civil Contingencies Policy Branch within OFMDFM is also represented on the UK MISC32 Pandemic Working Group, and CCG (NI) provides regular updates on planning to the Head of the Northern Ireland Civil Service and Permanent Secretaries Group.

3.32 Northern Ireland shares a land border with the Republic of Ireland and NI Departments maintain liaison with their opposite numbers in the Republic of Ireland to ensure that Pandemic Influenza planning issues are discussed and co-ordinated as far as possible.

3.33 Regional Health Command Centre (RHCC)

3.34 The Regional Health Command Centre will be chaired by the Chief Medical Officer and will include key personnel from within DHSSPS and Health Boards and Trusts. RHCC will come into effect during WHO phase 6. Once RHCC is convened it will become the lead command and control body to guide the health response during the period of pandemic activity. The RHCC operates at a strategic (gold) level and will have the following role:

- To protect and safeguard the health of the population of Northern Ireland.
- To minimise, and if possible, contain the spread of pandemic influenza.
- To ensure treatment of patients with influenza.
- To direct all appropriate Health and Social Care resources.
- To brief and provide information to Boards and Trusts.
- To provide advice to Ministers, CMG/CEMG and the NIIMC.
- To liaise with other UK health Departments and the Department of Health and Children (Republic of Ireland).
- To provide information to Cabinet Office/BR as required through CEMG/CMG.edical

3.35 Northern Ireland Pandemic Influenza Control Committee (NIPICC)

3.36 The Northern Ireland Pandemic Influenza Control Committee will be comprised of a range of key health professionals including a Deputy Chief Medical Officer and Senior Medical Officer from the Department, epidemiologists, Directors of Public Health, Consultants in Communicable Disease Control and virologists. NIPICC should be the lead control committee for WHO Pandemic Phases 3-5. During that time NIPICC will determine if any interventions or guidance is needed. NIPICC will advise on when RHCC should be convened. Once RHCC has been convened, NIPICC will remain as operational support to RHCC. During this period NIPICC may be asked to review and revise where appropriate any guidance issued by UKNIPC or to advise on the potential effectiveness of control measures. This would occur at WHO Phase 6, UK Alert Level 3 and 4.

The role of NIPICC will be to:

- Provide expert advice to CMO and the RHCC on all issues relating to the influenza pandemic in Northern Ireland

- Provide advice and guidance to HSS Board and HSC Trust Pandemic Control Teams
- Use the epidemiological information gained from regional, national and international monitoring to inform prevention and control measures
- Consider scientific data and advise RHCC on its implementation for Northern Ireland
- Appropriately adapt National guidance for pandemic flu management within the Northern Ireland context
- Monitor the surveillance systems and reporting arrangements to ensure robust and up to date information is available
- Assess the effectiveness of control measures and make recommendations for change where necessary
- Advise DHSSPS on public and professional communications

3.37 Public health advice at National level

3.38 At National level the Health Protection Agency (HPA) is the lead agency responsible for providing public health advice to the health service and supporting all aspects of the public health response to an influenza pandemic. At local level this role is fulfilled by CDSC (NI). The HPA has a key role in international and national surveillance and intelligence gathering, informing public health policy development, contributing to global efforts to prevent or detect the emergence of a new virus and supporting HSS Boards and HSC Trust planning at all levels. In any period of heightened alert and as a pandemic develops, the HPA nationally and CDSC (NI) locally will provide:

- Reference virological and microbiological services
- Coordination and advice on the investigation and management of early cases and contacts
- Detailed epidemiological data on the emerging virus (from WHO phases 4 -6 UK alert level 2) and aggregate data thereafter
- Data for national decisions such as choice of vaccine or antiviral strategy
- Expertise and advice to the health service through local and regional teams
- Coordination of the collection and publication of UK-wide influenza surveillance data.
- A real-time modelling capability

3.39 Regional and local health planning and response

3.40 At operational level, planning and response in the health and social care sector is delivered at regional and local levels through the following key players:

3.41 Health and Social Services Boards (HSSBs)

3.42 Health and Social Services Boards will² play a key part in ensuring a strong public health input into contingency planning for an influenza pandemic at regional level. The Director of Public Health (DPH) in each Board area may devolve all or part responsibility to a Consultant in Communicable Disease Control who will be a member of the public health team in that Board area. HSS Boards have designated pandemic flu co-ordinators to ensure the development, maintenance and testing of effective and integrated health response plans in their areas. In the event of an influenza pandemic, HSS Boards will be responsible for the general oversight and co-ordination of the health and social care response and for ensuring the most effective deployment of available resources in their area. They will also provide health advice and information to local multi-agency planning partners, act as reporting links to RHCC, collate and forward monitoring information, provide a communication link and support media handling and the provision of public information.

3.43 Health and Social Care Trusts (HSCTs)

3.44 HSCTs are responsible for assessing local risk and supporting and monitoring the development of integrated health and social care response plans. Trusts should ensure they have adequate contingency plans within their own area of work. Some Trusts also have responsibility for developing specific arrangements to maintain and support patients in a community setting. Through a designated pandemic influenza lead, HSCTs provide a health and social care input to local multi agency planning partners, co-ordinate plans with those of the parent HSSB and ensure that social care and other key partners are fully involved.

In the event of a pandemic, HSCTs will co-ordinate its local health and social care response, provide advice and information, collate and report information to the parent HSSB and make contingency arrangements for the distribution of antiviral medicines and delivery of vaccination programme if required.

3.45 Primary Care

3.46 The Primary Care sector in Northern Ireland is directly responsible for the provision of a wide range of health and social care services. Primary Care should support local planning arrangements and develop internal contingency arrangements for responding to the additional demands whilst maintaining essential health care throughout an influenza pandemic. Plans should pay particular attention to the projected requirement for significant surge capacity, patient transport, redeployment of staff at short notice, staff protection and strict infection control. Plans should also consider general practice continuity arrangements, and the development of inter-

² Responsibilities currently with HSSBs will change as a consequence of the Review of Public Administration and when new structures are agreed.

practice multi-professional planning and mutual aid in the primary/community care setting.

3.47 Directors of Social Services

3.48 Directors of social services (DSS) will have ultimate responsibility for planning and co-ordinating the social services response at a local level. Planning the social services response should take full account of the impact of such events as the closure of schools and childcare facilities and other services involving the users of social services. DSS will play a key role in cascading messages from the centre and in ensuring all social services providers within their trust area are aware of and involved in local contingency plans.

3.49 As part of their overall strategic co-ordination of plans DSS's will need to ensure that local contingency plans do not make unfounded and unrealistic assumptions that other areas will have spare capacity to assist them in providing services during the pandemic period. This should be done as part of their commissioning and contracting arrangements.

3.50 Directors should also be in regular dialogue with directors of public health and their emergency planners to establish the social services implications for existing contingency planning arrangements and to determine what is required of them and their teams in the influenza preparedness phase (WHO phases 3-5). It is important that there is a clear relationship and consistency between the plans for health and social services. Directors will also need to work closely with the DHSSPS, Health and Social Care Boards (HSSB) and Directors of Public Health.

3.51 Providers of Personal Social Services

3.52 All Social service providers will need to ensure that they plan for how they will maintain their services and ensure that people relying on their support are not left unsupported during a pandemic. These plans should be developed in conjunction with the overall social services contingency plans and, as far as is possible, they should be developed in consultation with service users and carers and other key local organisations. Some providers may wish to undertake joint planning with other local care providers to explore risk sharing and pooling arrangements.

3.53 It may be helpful for social service providers to be able to access a central source of information about pandemic preparedness in their local area, e.g. the content of the overall social services contingency plan. Directors of Social Services may wish to consider how their social services can best ensure that their local providers have access to useful and up-to-date information to aid them in their planning and preparedness, e.g. information on websites. Health and social care trusts will also need to consider how they convey messages locally, particularly during pandemic alert Phase 6.

3.54 Voluntary, Community and Private Sector Organisations

- 3.55 Voluntary, community and private sector organisation will be key in supporting the response to pandemic influenza at a local level. Health and social care trusts need to establish links with and include these organisations in their planning.

Voluntary, community and private organisations offer a wide range of skills and experiences and membership often includes retired professionals. Many are routinely engaged in the provision of services to very vulnerable sections of the community and will therefore need to develop their own service continuity arrangements for a pandemic. Some also respond to emergencies as an integral part of their role and have personnel, expertise and facilities that could assist in providing surge capacity and support for statutory responders. Each can offer specific contributions - providing social support to maintain sufferers in a community setting, assisting those experiencing stress, anxiety and grief, staffing telephone help lines or supplementing health and social care resources.

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

Organisations benefiting from the support of volunteers will need to ensure that they have adequate briefing, training, skills, personal protection and indemnity for the role that they are expected to perform.

3.56 Business sector organisations

- 3.57 Business sector organisations are increasingly responsible for the provision of many essential services and the manufacture, supply and distribution of items critical to the response to an influenza pandemic and to minimising its social and economic effects. Planning to ensure the maintenance of supplies and services as far as that is possible is an essential part of developing effective response arrangements. Sector-specific emergency arrangements to build resilience and develop effective response frameworks are already required, and plans are in place in most key sectors. Those frameworks should recognise the unique nature of the disruptive challenges that an influenza pandemic is likely to present. A

wider community of industrial and commercial organisations also plays a direct role in maintaining social normality and will want to minimise potential losses from disruption to business and promote a return to normality as soon as possible.

3.58 DHSSPS and the Regulation and Improvement Authority (RQIA)

3.59 DHSSPS receives advice and information on all regulated social care providers in accordance with Part 2 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. DHSSPS proposes to ensure RQIA send information on an annual basis to all DSSs so that they are aware of all providers within their local areas. In the event of an escalation in WHO alerts (phase 5 onwards see section 5 of this guidance), DHSSPS in conjunction with RQIA will disseminate up-dated information relating to registered providers on a regular basis.

3.60 DHSSPS has also considered its contingency plan for a major event such as pandemic influenza (see the revised *Northern Ireland Contingency Plan for Health Response for an influenza pandemic Nov 2008*.) This is in recognition of the likely pressures on regulated services and in managing its own staff absences. It is considering the risks alongside the need to be proportionate and reasonable in the light of circumstances. It is also taking account of the legal implications in the light of key differences between England, Wales and Northern Ireland in regulations governing particular services. (See paragraphs 6.29-6.31).

3.61 Employers, Trades Unions and other staff or professional organisations

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

3.63 Telephone Helpline/Health Information

3.64 During a pandemic, demand for health information will increase significantly. A national 'flu line' will be established to deal with calls from the public seeking advice, help and information. Symptomatic callers will be directed to the appropriate tele co-ordination centre for health assistance.

3.65 Individual and social responsibility

3.66 Every part of society must prepare for a pandemic and will be part of the response. However well response plans are prepared and implemented, the overall effectiveness of the Northern Ireland response will ultimately depend heavily upon the co-operation of individuals and their willingness

to follow advice, take personal responsibility for their health and accept social responsibility for supporting each other. Pandemic plans must ensure that people's expectations of services are realistic and if they are being asked to take increased risks or face increased burdens that they are supported in doing so and that those risks and burdens are minimised as far as possible.

In inter pandemic years, individuals should keep themselves informed, practice good hygiene habits and ensure that they are routinely vaccinated against seasonal influenza and pneumonia if in a designated category. Should the threat increase, they should follow public health advice and consider how they and dependents might prepare for such socially disruptive effects as potential school closures, shortages and travel constraints. Where possible, individuals should take active steps to put in place self help measures in case of influenza and to ensure continuing care for existing health conditions. They should also ensure that they have supplies of normal home remedies and other basic necessities, explore the potential for support from family and friends not resident with them ('flu friends') and consider how they might be able to assist others.

In the pandemic alert and pandemic stages, increased fear and apprehension are natural and individuals should listen carefully to government advice and instructions made available in the media, on the internet and in printed material. They should also familiarise themselves with local arrangements for accessing health and social care support - including antivirals - and follow public health advice and instructions. It is particularly important that anyone suspecting influenza like symptoms should stay at home if ill and make telephone contact with health services through the National Flu Line Service rather than attending surgeries, hospitals or other health establishments.

4 KEY PLANNING PRINCIPLES AND ASSUMPTIONS

4.1 ETHICAL CONSIDERATIONS

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

- 4.3 People are more likely to accept the need for, and the consequences of difficult decisions if they have been made in an open, transparent and inclusive way. Therefore, national and local preparations to respond to an influenza pandemic should be based on widely held ethical values. Choices that may become necessary should be discussed openly as plans are developed so that they reflect what most people will accept as proportionate and fair. Staff at all levels will be required to make difficult decisions without wider consultation. Staff must ensure they record these decisions.
- 4.4 The Department of Health, in consultation with UK interests including Northern Ireland, has developed an ethical framework to inform national health and social services policy. The systematic use of the principles it contains can act as a checklist to ensure that all the ethical aspects have been considered at all levels. Local planning processes should also seek to encompass ethical values, ensuring that difficult decisions and choices are approached in an open and inclusive way *Responding to Pandemic Influenza. The Ethical Framework*

Key Planning Assumptions

- 4.5 The precise characteristics and impact of an influenza pandemic will only become apparent as the virus emerges. Therefore, some assumptions and presumptions of its likely response in a number of key areas are necessary to describe the impact the UK Government is currently planning for. These are included in the Pandemic Influenza guidance specific to each subject. For more information, please see the *National Framework*.
- 4.6 The use of common assumptions and presumption for planning across all public and private sector organisations avoids confusion and facilitates integrated preparation. Given the uncertainties, these should be regarded as working estimates rather than predictions, and response arrangements must be flexible enough to deal with a range of possibilities and capable of adjustment as they are implemented. Provided that the origin of a pandemic is outside the UK, emerging surveillance data might also allow the use of real-time modelling to confirm and/or refine these assumptions and presumptions.
- 4.7 Some key planning assumptions for social care are set out below. Comprehensive planning assumptions are available in *Pandemic influenza: A national framework for responding to an influenza pandemic*. Some of these assumptions are based on a uniform attack rate across all age groups. Whilst they should assist in impact assessments and developing contingency plans, the attack rate may not be uniform across all age groups, so plans will need to retain flexibility to adapt as information emerges.
- 4.8 In previous pandemics, the overall UK clinical attack rate has been of the order of 25% to 35%, compared with the usual seasonal influenza range of 5% to 15%. Cumulative clinical attack rates of up to 50% of the population

in total are possible, spread over one or more waves of around 15 weeks, each some weeks or months apart. If they occur, a second or subsequent wave could possibly be more severe than the first.

4.9 During a pandemic, assuming a clinical attack rate of 25%, the number of excess deaths due to influenza in the UK may be between 55,500 and 375,000. However, if the clinical attack rate is as high as 50%, the number of excess deaths is likely to be between 111,000 and 750,000. The fatality rate is assumed to be in the range of 0.4% to 2.5%.

4.9.1 The actual extent (clinical attack rate) of illness will only become evident as person-to-person transmission develops, but response plans should recognise the possibility of a clinical attack rate of up to 50% in a single-wave pandemic. See Table 1 below which shows the range of possible excess deaths based on various permutations of case fatality and clinical attack rates, based on the Northern Ireland population

TABLE 1 RANGE OF POSSIBLE EXCESS DEATH WITHIN N.I

Overall case fatality rate	Clinical Attack Rate 25%	Clinical Attack Rate 35%	Clinical Attack Rate 50%
0.4%	1700	2400	3400
1.00%	4300	6000	8600
1.50%	6500	9000	12900
2.50%	11000	15100	21600

4.10 Geographical spread

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

- Once a pandemic is declared (WHO Phase 6 – see paragraph 5.1 for more detail on the WHO phases), even if – as seems likely – it originates abroad, a pandemic will probably have reached the UK within a month.
- From arrival in the UK, it will take a further one to two weeks until sporadic cases and small clusters occur across the whole country that will act as initiators of local epidemics.
- The pandemic may occur in one or more waves.

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

4.12 You may wish to note the following points about the severity and extent of an influenza pandemic:

- All ages are likely to be affected, but children and otherwise fit adults could be at relatively greater risk, particularly if older people have some residual immunity from previous exposure to a similar virus earlier in their lifetime.

- Although the potential for age-specific differences in the clinical attack rate should be noted, they are impossible to predict, and a uniform attack rate across all age groups is assumed for planning purposes.
- **Up to 50%** of the population may show clinical symptoms of influenza over the entire period of a pandemic and up to 25% of these people may develop complications.
- **Up to 2.5%** of those who become symptomatic may die.
- **Up to 22%** of influenza cases can be expected to occur during the **peak week** of a pandemic wave.

4.13 Infectivity and mode of spread

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

- Influenza spreads through the respiratory route by droplets of infected respiratory secretions which are produced when an infected person talks, coughs or sneezes.
- It may also spread by hand-to-face contact after touching a person or surface contaminated with infectious respiratory droplets.
- Finer respiratory aerosols (which stay in the air for longer and are therefore more effective at spreading infection) may occur in some circumstances.
- People are highly infectious for four to five days from the onset of symptoms (longer in children and those who are immunocompromised) and may be absent from work for up to 10 days.
- Children have been shown to shed virus for longer and at higher levels than adults.
- Some people can be infected without showing symptoms, but may nevertheless shed the virus, and therefore be able to pass on the infection.
- The incubation period is in the range of one to four days (typically two to three).
- Without intervention, and with no significant immunity in the population, historical evidence suggests that one person infects about 1.4 to 1.8 people on average (the R_0 or 'basic reproduction number'). This number is likely to be higher in communities such as prisons, residential homes or boarding schools.

4.15 Health and social care demand

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

- All health and social services organisations will need to adapt and reorganise to provide treatment, care and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care.

- Most health and social services will need to be delivered in a community setting, with hospital capacity protected and preserved for the most seriously ill who are likely to benefit.
- Given a 50% clinical attack rate, demand for hospital admission can be expected to increase by as many as 440 new cases per 100,000 population per week at the peak and will exceed available hospital capacity.
- Given a 50% clinical attack rate, demand for critical care beds could rise up to 110 per 100,000 population per week at the peak and would exceed available capacity.
- Up to 4% of those who are symptomatic may require hospital treatment if sufficient capacity were to be available.
- Those who become symptomatic will be advised to stay at home and make telephone contact with health and social care services for initial assessment.
- Most patients will be treated at home with antiviral medicines initially.
- According to the 2001 Census, in Northern Ireland over 185,000 people, equating to 11% of the population care for a relative or friend. Of these, 60% are providing care between 1-19 hours per week, 15% providing care between 20-49 hours per week and 25% are providing care for more than 50 hours per week. Many of these carers, who may not be known to social services, will be infected during the pandemic period and alternative social care may need to be provided for those they care for. Of course many social services staff are also carers.

Note: For more information on planning presumptions you may wish to refer to additional UK Planning presumptions contained in '*A National framework for responding to an influenza pandemic*' [table 2] and also paragraph 9.3.2.

4.17 Impact on workforce

4.18 We anticipate that an influenza pandemic will have a significant effect on the health and social care workforce. The full details of this are at the 'Managing staff absences' section at paragraph 6.1. For instance:

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

4.19 VACCINATION AND ANTIVIRAL DRUGS

4.20 Pandemic-specific vaccination

4.21 Vaccination is widely used in the UK to offer protection against the seasonal influenza strains most likely to be circulating that particular year. As a pandemic will result from the emergence of a new or modified strain, these routine vaccines are unlikely to offer protection. It is not possible to develop a matching vaccine until the emerging influenza strain has been identified, and the UK Government is working actively with the international community and pharmaceutical industry to speed the development, testing and licensing of vaccines and secure the earliest possible supply.

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

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

4.24 For information about pre-pandemic vaccination, refer to section 7.2 of the National framework.

4.25 Antiviral medicines

4.26 Antiviral drugs can be used to treat certain viral infections, including influenza. The existing UK stockpile allows for the treatment of all symptomatic patients at clinical attack rates of up to 25% and arrangements to make antivirals rapidly available are a critical part of the health response.

5 HOW WILL KEY MESSAGES BE COMMUNICATED DURING A PANDEMIC?

5.1 The World Health Organisation (WHO) international phases

5.2 The World Health Organisation (WHO) is responsible for declaring the various international phases of a pandemic according to the following model:

Table 2: WHO international phases and UK alert levels

WHO international phases		Overarching public health goals
Inter-pandemic period		
1	No new influenza virus subtypes detected in humans.	Strengthen influenza pandemic preparedness at global, regional, national and sub-national levels. Minimise the risk of transmission to humans; detect and report such transmission rapidly if it occurs.
2	Animal influenza virus subtype poses substantial risk.	
Pandemic alert period		
3	Human infection(s) with a new subtype, but no (or rare) person-to-person spread to a close contact.	Ensure rapid characterisation of the new virus subtype and early detection, notification and response to additional cases. Contain new virus or delay its spread to gain time to implement preparedness measures, including vaccine development. Maximise efforts to contain or delay spread, to possibly avert a pandemic and to gain time to implement response measures.
4	Small cluster(s) with limited person-to-person transmission but spread is highly localised, suggesting that the virus is not well adapted to humans.	
5	Large cluster(s) but person-to-person spread still localised, suggesting that the virus is becoming increasingly better adapted to humans.	
Pandemic period		
6	Increased and sustained transmission in general population. UK alert levels 1 Virus/cases only outside the UK 2 Virus isolated in the UK 3 Outbreak (s) in the UK 4 Widespread activity across the UK	Minimise the impact of the pandemic

5.3 This model describes the progression of an influenza pandemic starting from the identification of a new strain and ending with the declaration of an international pandemic. The six phases allow for effective communication of the worldwide situation and enable Governments, and other relevant organisations, to adopt an incremental approach to preparedness planning.

5.4 As it is impossible to predict with any certainty how quickly the virus will spread, it is essential that contingency plans are developed now, as from WHO Phase 4 onwards, organisations will need to be ready to put their plans into practice.

5.5 The UK phases

5.6 For UK planning purposes, WHO Phase 6 (the pandemic period) has been divided in the UK and the extent of its spread. The WHO Plan recognises additional national subdivisions from Phase 2 onwards, according to whether a country is affected itself, has extensive travel/trade links with an affected country, or is not affected. The UK phases are as follows:

- **Alert level 1** Cases only outside the UK (in a country or countries with or without extensive UK travel/trade links)
- **Alert level 2** New virus isolated in the UK
- **Alert level 3** Outbreak(s) in the UK
- **Alert level 4** Widespread activity across the UK

5.7 Information flows – cascading information locally

5.8 It will be the responsibility of health and social services chief executives and directors of social services to communicate key messages to the social services field, including all private sector and voluntary providers.

5.9 Once WHO Phase 5 has been confirmed, the Department of Health will convene the National Influenza Pandemic Committee (UKNIPC). This is an expert body whose role is to provide specialist advice to the Government throughout the duration of the pandemic, and inform the Civil Contingencies Committee and Secretariat. The Secretariat will then be responsible for cascading messages at a regional and local level.

5.10 Under the Civil Contingencies Act 2004 in Northern Ireland, there will be strategic co-ordination of the response to emergencies at a local level, including pandemic activity. The strategic co-ordination will involve key front-line responders, including social services chief executives. Once WHO Phase 5 has been confirmed, the Civil Contingencies Secretariat (CCS) will inform the DHSSPS who in turn informs the HSCT Chief Executives

- 5.11 The health and social services chief executives will be expected to inform their directors of social services who will be responsible for communicating messages to all care homes, domiciliary care agencies and other voluntary and private sector care providers in their area. To ensure DSSs have up to date lists of all local providers, DHSSPS in conjunction with RQIA will share this information with each DSS. DHSSPS will continue to provide updates as/when the UK moves through the WHO international phases.
- 5.12 The same communication process will apply when Phase 6 is confirmed and the UK four point alert system is triggered. A similar model will operate throughout the duration of the pandemic period (Phase 6), when the Government may need to convey urgent messages or advice to local organisations (see figures 1 and 2). As well as communication via these models, the Government will also use the media to communicate more general messages.

Figure 1: Information flows - Communicating the alert stages of a pandemic

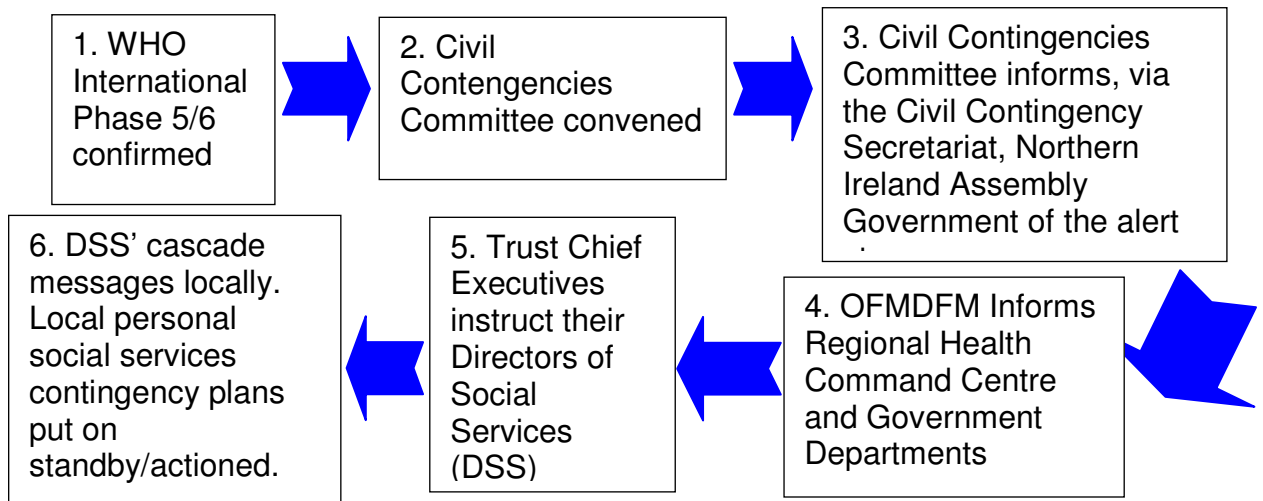
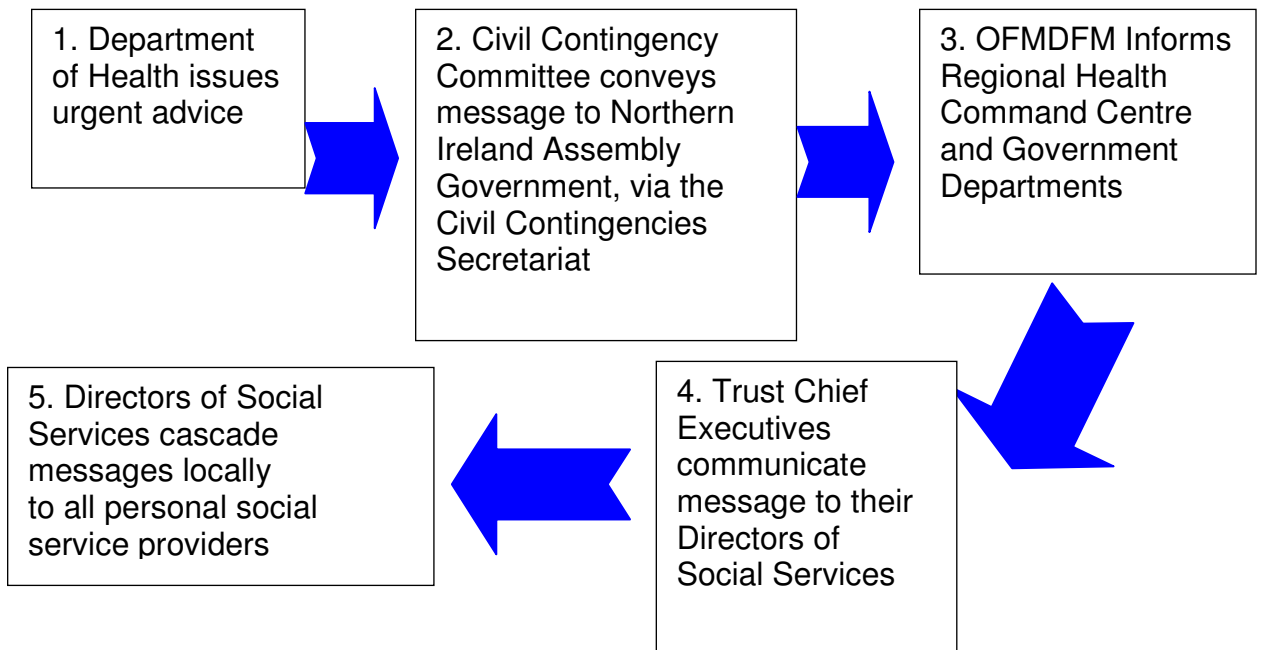


Figure 2: Information flows - communicating key messages during the pandemic period



6 SPECIFIC ISSUES TO BE CONSIDERED BY PERSONAL SOCIAL SERVICES IN CONTINGENCY PLANNING

MANAGING THE DEPLOYMENT OF THE WORKFORCE, INCLUDING STAFF ABSENCES

- 6.1 The level of staff absence from work during a pandemic will depend significantly on the nature of the pandemic virus when it emerges. The impact of a pandemic on absenteeism in social services is likely to be severe. Not only will staff be ill but the profile of the workforce is such that some people will be absent from work due to the need to care for children and/or other family members who are ill with influenza. Employers should consider whether their policy on absence is clear to staff so that they are aware of the boundaries.
- 6.2 In addition, schools may be advised to close during the pandemic period in order to reduce the spread of the virus among children, or because of staff shortages. This is likely to compound staff shortages in social services as many members of the workforce have children of school age and parents will need to care for their children, or find substitute care. The Department for Education for Northern Ireland has produced guidance for schools and other settings where children are cared for because school closures will have a huge impact on the workforce planners are advised to consider the guidance when making assumptions about staffing levels www.deni.gov.uk . The guidance gives more information about when schools are likely to be closed. As a general guide, schools may be asked to close at an early stage of the pandemic. Planners should check with the Department of Education what the approach should be to taking decisions about when/if to close schools. In addition, any advice on closures would also affect early year's group child-care facilities. Planners should factor this in to its effect on the workforce.
- 6.3 The planning assumptions set out below are based on current knowledge, analysis of past pandemics, published evidence and scientific modelling. Organisations should ensure that their business continuity plans have the flexibility to accommodate the expected levels of staff absence. Health and social care trusts should ensure that all contracts have clauses that require business continuity plans.
- 6.4 During a pandemic, staff will be absent from work if:
- a. they are ill with influenza. Numbers in this category will depend on the clinical attack rate. Up to 50% of the workforce may require time off at

some stage over the entire period of the pandemic, with individuals absent for a period of seven to ten working days. Absenteeism should follow the pandemic profile with an expectation that it will build to a peak lasting for two to three weeks, when between 15% and 20% of staff may be absent due to having influenza, and then decline. Modelling suggests that small organisational units (5 to 15 staff) or small teams within larger organisational units are likely to suffer higher percentages of absenteeism due to having influenza, up to 30-35%;

- b. they need to care for children or other dependants who are ill with influenza;
- c. they need to care for (well) children due to local school closures (in light of 2006 guidance from the Department for Education Northern Ireland which advises schools and childcare settings to plan for closure when the pandemic reaches their area. Regardless of whether or not the Government advises schools to close, it is likely that some schools will have to close due to shortages of staff or parents not being willing to send their children to school);
- d. they have non-influenza medical problems;
- e. their employers have advised them to work from home;
- f. they decide to absent themselves for other reasons, e.g. family bereavement, other psychosocial impacts, fear of infection, or practical difficulties in getting to work.

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

6.6 Social services organisations should consider taking the following measures during the planning stage:

- estimate the number and categories of staff needed to maintain a satisfactory (rather than ideal) level of care for the service as a whole and/or for a single service user or a small group of service users.
- identify a network of people who would be prepared to work in an ancillary care capacity during a pandemic. These could include:
 - other service users
 - relatives and friends of service users
 - retired staff
 - local students and trainees in the sector
 - people within the organisation currently undertaking back-office tasks e.g. some administrative staff
 - local voluntary or faith groups
 - Access NI and Protection of Childcare and Vulnerable Adults checks for those working in the education and leisure sectors

- student volunteers (16 years and upwards) from schools or colleges that have been closed.
- if such networks or “volunteer pools” can be identified, providers will need to consider how they can be equipped and trained to undertake these roles e.g. shadowing of staff, volunteer work placements, cross training between existing staff etc.
- consider suitability of replacement staff (specific communication skills/expertise/cultural understanding e.g. is gender an issue for certain groups or individuals?)
- involve the main employment agencies that provide temporary social care staff locally.
- agree risk-sharing/staff pooling arrangements and protocols with other local organisations.

6.7 Occupational Health and Staff Welfare Issues

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

- being proactive in providing staff with, or helping staff to access, information relevant to their own health before and during a pandemic (e.g. posting advice and the latest developments on the social services website).
- implementing a non-punitive sick leave policy for managing staff that have symptoms, or have a confirmed case, of influenza. If staff members suspect that they may have the symptoms of pandemic influenza they should be instructed to stay away from work until reviewed by a doctor or other healthcare worker and told otherwise. Please note that it may not be possible to arrange a review by a doctor or healthcare worker prior to return to work unless the employer’s occupational health scheme allows for this.
- agreeing with staff, that where possible, those who have had and recovered from pandemic influenza (and may have therefore acquired antibodies which might guard against future infections), will most likely be the first managers call upon to offer personal care, as they will themselves be healthy and able to care for ill people and also unable to infect healthy people.
- where possible, putting in place plans to safeguard the health of staff that are at high risk for complications of pandemic influenza e.g. pregnant women, people with chronic conditions, other immunocompromised persons. This could include informing them about their medical risk and offering them alternative low risk duties or consideration for administrative leave until pandemic influenza has abated in the community. This would need to be handled very

sensitively as, in the usual course of events; managers and colleagues would not necessarily know staff's personal health information. Considerable thought needs to be given to protecting personal data—particularly if someone is say HIV positive or of an ethnic group experiencing higher prevalence of certain conditions such as hepatitis.

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

6.9 Health and safety legislation – protection in an occupational setting

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

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

6.12 Making temporary changes to working practices, e.g. reducing close face-to-face contact, providing physical barriers to transmission, enhancing cleaning regimes, ensuring that the necessary protective equipment is available, having hand washing, waste disposal and other hygiene facilities in place and actively promoting these and other similar measures, can help to encourage and maintain attendance at work during the

response phase. Further guidance for employers is available on the Health and Safety Executive (HSE) website at www.hse.gov.uk/biosafety/diseases/influenza.htm.

Training and education for staff

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

- good hygiene practices to prevent the spread of the virus as far as possible
- general information about pandemic influenza including information about vaccination, anti-viral drugs
- infection control strategies for the control of influenza, including respiratory hygiene/cough etiquette, hand hygiene and other precautions, specific training for cleaners and their roles in helping reduce the spread of infection
- specific training for telecare and community alarm call centre staff in helping to identify and support people isolated at home
- opportunities such as job shadowing to help prepare staff and volunteers to take on additional roles and responsibilities in the short term to cover staff absences
- how to respond to ethical dilemmas
- how best to train duty and on-call staff, e.g. whether this is best done face to face
- Infection control and personal hygiene.

6.14 INFECTION CONTROL AND PERSONAL HYGIENE

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

6.16 Applying basic infection control measures and encouraging compliance with public health advice are likely to make an important contribution to the UK's overall response. Simple measures will help individuals to protect themselves and others. The necessary measures include:

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

- washing hands frequently with soap and warm water to reduce the spread of the virus from the hands to the face, or to other people, particularly after blowing your nose or disposing of tissues
- making sure children follow this advice
- cleaning frequently touched hard surfaces (e.g. kitchen worktops, door handles) frequently using a normal cleaning product
- avoiding crowded gatherings where possible, especially in enclosed spaces.

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

6.18 The use of face masks and respirators

6.19 Surgical face masks or respirators (masks that incorporate a filter) provide a physical barrier against the influenza virus providing they are of an appropriate type, are worn correctly, changed frequently, removed properly, disposed of safely and used in combination with good universal hygiene behaviour. Face masks can be used to help protect those who may, for example be at occupational risk from close or frequent contact with symptomatic patients and by those who are symptomatic to avoid contaminating others, if they have no choice but to leave their home, though significant communication, supply, logistic and training aspects would need to be addressed. Disposable masks or respirators should generally only be worn once, for no longer than the time recommended by the manufacturer, and then discarded in an appropriate receptacle.

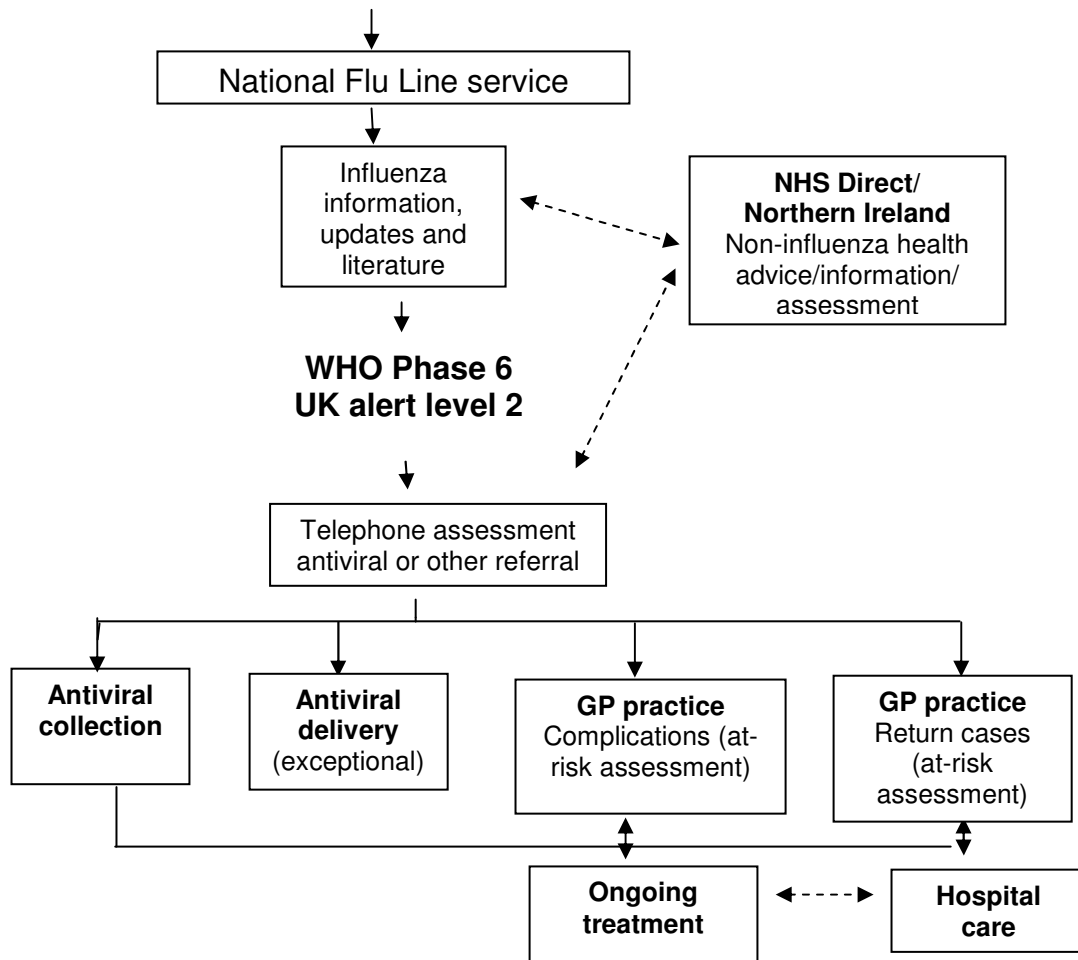
6.20 Although the perception is that wearing a facemask in public places may be beneficial is widely held, there is little actual evidence of proportionate benefit from widespread use. The Government will not therefore be stockpiling facemasks for general use. If individuals who are not symptomatic choose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

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

6.22 Identification and referral of individuals with pandemic influenza to health services

- 6.23 Individuals in receipt of social services presenting symptoms of pandemic influenza should approach health services in the same way as the rest of the general population. For many people that cannot do this directly, neighbours, social care staff and families will need to be particularly vigilant. However, unless an individual is presenting particularly severe symptoms or is developing complications, they should be advised to contact the National Flu line.
- 6.24 A wide spread public awareness campaign will be initiated to inform the public of when and how to contact local health services. In preparation for widespread activity (UK alert level4), the Government will therefore activate and publicise a National Flu Line Service to divert requests for general information and switch calls from symptomatic patients automatically to the local influenza co-ordination centre covering the area from which the call originates. The National Flu Line Service will be available from WHO Phase 5 to provide public information, updates and access to literature and a separate National Flu Line will be available from UK alert level 2 to provide initial patient assessment and, where necessary, access to anti-viral. That facility will be maintained until the impact of the pandemic subsides and there is no threat of further waves. However, where possible social services providers, particularly those in contact with individuals alone in their own homes (e.g. social workers, domiciliary care staff, community alarm providers) should ensure they are aware of and able to pass on these key messages to the people they care for.
- 6.25 Figure 3 shows the proposed model of care during a pandemic from a patient's perspective.

Figure 3: Who Phase 5



Local influenza collection centres

6.26 The DHSSPS has established a pharmaceutical supply line work group comprising the HSSB's, Trusts and Pharmaceutical supplies to develop central guidance to help local planning of a longer-term solution. The aim is to ensure that we:

- have all-Northern Ireland coverage
- can deliver antiviral within a set time frame
- have robust storage and distribution arrangements
- make best use of information technology (IT)

6.27 LEGAL ISSUES

6.28 Suspension of statutory services

6.29 Under the Civil Contingencies Act 2004 health and social care trusts are required to plan for the continuing performance of their functions in the event of an emergency. Whilst it will be desirable for health and social

care trusts to maintain normal levels of service, this is likely to be impossible in the event of a pandemic.

6.30 Therefore, all health and social care trusts will need to review their services and take a risk-based approach towards deciding which services are the most essential and therefore must continue, and which services might be reduced or even stopped during the pandemic period. However, decisions of this nature must be taken within existing ethical and legal frameworks.

6.31 Access NI and Protection of Children and Vulnerable Adult checks

6.32 Staff will be required to work flexibly when the pandemic hits the UK. Staff may be required to cover additional tasks and, in particular, office-based staff may be required to take on caring roles provided they had the necessary competencies and there had been some assessment of their competencies and skills.

6.33 AccessNI enables organisations in Northern Ireland to carry out Enhanced Disclosures on those individuals they propose to employ in a regulated or care position as required by the Protection of Children & Vulnerable Adults (NI) Order 2003 (POCVA). An Enhanced Disclosure provides a check against relevant disqualification lists and criminal history information. The current NI disqualification lists are as follows:

- The Disqualification from Working with Children (DWC (NI)) List which contains the names of those individuals found unsuitable to work in a regulated position with children;
- The Disqualification from Working with Vulnerable Adults (DWVA (NI)) List which contains the names of those individuals found unsuitable to work in a care position with adults
- The Unsuitable Persons (UP List)

Disqualified individuals must **not** be employed in regulated or care positions.

6.34 New safeguarding legislation – the Safeguarding Vulnerable Groups (NI) Order 2007 laid the foundation for the creation of a new vetting and barring scheme for people working with children and vulnerable adults. The new scheme, to be implemented late 2009, will replace POCVA and Department of Education’s Regulations. Employers will be able to check whether or not an individual is a member of the scheme via an online facility. This feature, in the event of a pandemic, will make it easier for employees who are members of the scheme to move between jobs as circumstances dictate.

6.35 In the event of an influenza pandemic occurring before implementation of the new safeguarding arrangements, and where staffing levels in relation

to social services are adversely affected, the DHSSPS will consider the way forward.

6.36 PERFORMANCE MANAGEMENT AND INSPECTION

6.37 The Civil Contingencies Act 2004 gives a Minister powers to require the provision of information about actions taken by Category 1 or 2 responders. There are no proposals to use these powers at the moment and the government will rely on current good practice in performance management and on established audit and regulatory bodies to assess performance.

6.38 The RQIA is also responsible for the regulation (which includes registration and inspection) of establishments and agencies delivering health and social care services including children's homes, day care settings, independent clinics, independent hospitals and independent medical agencies, nursing homes, nursing agencies, residential care homes, residential family centres and domiciliary care agencies

6.39 During the pandemic period, it may be necessary to consider a proportionate approach to routine RQIA inspections of social care functions. In part, this will be due to the widespread disruption to services that an outbreak will cause and in part it will be for preventative and logistical reasons. Restricting visits to social care environments will help to minimise the spread of disease, whilst logistically it may be difficult for inspectors to travel for such visits as unnecessary travel will be discouraged during the pandemic period.

6.40 RQIA is prepared to take a flexible approach to inspection during the pandemic period and will develop appropriate arrangements based on a risk management approach. It is recognised that regulation has an important role in the continuity of services and the protection of vulnerable people. RQIA's inspection regime for operation during the pandemic period will be placed on its website at the time a pandemic occurs.

6.41 PANDEMIC PLANNING IN DIFFERENT SOCIAL SERVICES SETTINGS

6.42 Whilst some issues such as managing staff absences will be generic to all social services settings, each setting will have service specific issues to take account of in their plans. Leaflets to support and inform staff about infection control are available. This section sets out what some of those service specific issues may be and how providers may start to address these. The checklists on annex 1 pages 47-51 also provide advice relevant to specific services and groups.

6.43 Care at home

6.44 For both children and adults there will be a need to prioritise referrals and assessments in dealing with those in need of protection and those at risk.

There will also be the need to consider visits to those children and some adults where there are statutory visiting requirements. This should be based on a risk assessment at the time.

6.45 Residential Care Homes - Adults

6.46 There is likely to be pressure on all residential facilities to operate at full capacity during a pandemic. The need for short-term breaks and the policy to maintain people in the community as far as possible may result in increased temporary admissions to care homes, although this is rarely likely to be ideal and should not be the first option. Therefore, care in the person's usual home should be encouraged and offered wherever possible, unless there are complications.

6.47 Other aspects of maintaining a minimum level of service within the care home will also need to be planned e.g.

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

6.48 It may be sensible for care homes to "pair up" with other care homes in the area and agree staff sharing arrangements to mitigate staff shortages where possible. In reality, however, we expect each service to concentrate on keeping running the service for which they are immediately responsible. In addition, in some social services area there are schools that provide accommodation for children, some of which have significant special needs. The Department of Education provides guidance to these schools and appropriate links should be made in local planning.

6.49 Residential Care Homes - Children

6.50 Residential children's homes should continue to function during a flu pandemic as they would usually be the only residence for the children and young people who depend on this service. It is therefore particularly important that plans are in place to enable the home to function safely and reduce the risk to children, young people and staff. *Para 6.35 & 6.36 also apply.*

6.51 Child Protection Services

6.52 HSC Trusts will need to ensure that staff are able to continue to discharge their statutory duties in relation to child protection services.

6.53 Home Care

6.54 Given the additional pressures on both hospital and residential care, many more people are likely to need to be supported at home. This will raise specific issues for additional carer support in the home setting and an

- increased demand for domiciliary care services. Care providers are likely to need to arrange for some people to be supported at home at short notice and may need to develop reciprocal arrangements with other care providers.
- 6.55 Some assistive technologies and community equipment e.g. community alarms, telecare, grab rails etc may help support people to manage short term in their own homes. A number of other services that support people in the community are also likely to be affected; these include meals on wheels and home shopping schemes without which people are likely to go without essential food and drinks.
- 6.56 Domiciliary care providers will need to prioritise their services and staff and perhaps postpone some services e.g. general cleaning services and replace them with basic personal care, infection control, ensuring access to food etc. This will need to be taken into account in planning and contracting arrangements.
See UKHCA Pandemic influenza Guidance for Homecare Providers 07
- 6.57 When pandemic influenza is in the community, home care agencies will need to consider contacting their clients before undertaking home visits to determine whether people within the household have influenza like symptoms.
- 6.58 If service users have pandemic influenza, they should consider:
- discussing with the service user postponing non-essential services
 - assigning staff who have already contracted and recovered from the influenza
 - staff being designated to care for *either* influenza *or* non-influenza individuals wherever possible.
- 6.59 Day Care**
- 6.60 Day care centres play a vital role in helping providing additional support to vulnerable people living at home. They can enable people to remain at home without the need for a full time carer. They can help support carers and enable them to continue working or take breaks and they provide a vital lifeline for many people, reducing their social exclusion and enabling them to have wider contact with others and participate in meaningful activities.
- 6.61 However, day care services will have to consider the point at which the balance between protecting staff and the people attending day care outweighs the benefits to people attending. For planning purposes, it may be sensible to recommend that, during the pandemic phase, the provision of day care should cease and staff available for work should be redeployed elsewhere e.g. to support domiciliary care services, or to support usual day care attendees at home.

6.62 Emergency short-term care

- 6.63 With an estimated (Source: 2001 Census Northern Ireland) 11% of the population caring for a relative or friend there is likely to be a marked increase in demand for emergency short-term care for service users where their carers have contracted the disease.
- 6.64 Health and social care trusts will need to consider, plan for and prioritise how they may meet this increased demand with a view to people remaining in their own homes, if possible.

6.65 Direct payments users

- 6.66 Social services direct payments support services will need to ensure that direct payment users are not left without support if their staff become ill with influenza. Support services may want to consider the role their local centres for independent living can play.

Available Support, Guidance and Information

Information which has already been produced on pandemic flu includes:

DHSSPS website

There is a section on pandemic flu on the DHSSPS website at <http://www.dhsspsni.gov.uk/index/phealth/pandemicflu.htm>. The site includes Northern Ireland's Health Pandemic Influenza Contingency Plan and information for the public and health professionals. Travel advice, information on food safety and links to relevant organisations are all included on the site.

Pandemic flu fact sheet

The fact sheets were distributed to GP surgeries and pharmacies and are available on the DHSSPS website.

Frequently asked questions

This is also available on the DHSSPS website.

Public information leaflet

'Pandemic flu, important information for you and your family' was distributed to GP surgeries and pharmacies and HSS Boards and HSC Trusts.

Useful websites for Northern Ireland

<http://new.NorthernIreland.gov.uk/topics/health/protection/communicable-disease/flu/?lang=en>

www.dh.gov.uk/en/pandemicflu/index.htm

www.ukresilience.info/ccat/index.shtm

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

www.ukhca.co.uk/flu/

www.scie.org.uk Caring in a crisis: The contribution of a social care to emergency response and recovery

www.scottishexecutive.co.uk/pandemicflu Guidance for infection control in residential setting for children and vulnerable young people

www.ukresilience.info/ccact/index.shtm (for managing civil emergencies)

www.accessni.gov.uk

www.dhsspsni.gov.uk/svg

www.rqia.org.uk

Cascading information

In the event of a pandemic flu outbreak happening now, immediate actions would be communicated quickly and accurately to key health and social care service workers, other organisations (other government departments, emergency services, private sector bodies and international partners) and the public. Information would be cascaded as follows:

The Secretary of State for Health, on the advice of the CMO, England, will convene the UK National Influenza Pandemic Committee, which advises all UK Health Departments. DH will inform the Devolved Administrations and the Civil Contingencies Committee.

The response to an influenza pandemic would be on a UK-wide basis. At a national level, two way strategic communications will involve central Government Departments, the Devolved Administrations and all other agencies and organisations involved in the response, including the health protection organisations and NHS at all levels and international agencies.

In Northern Ireland, an inter-agency response will be set up to ensure there is:

- Effective internal communication systems across Government Departments and agencies involved in assessing, directing and co-ordinating the response.
- Providing regular and timely information to health and social care professionals
- Constantly updating DHSSPS website to allow 24-hour access to information
- Ensure appropriate information is available for use by Northern Ireland Health Emergency helpline operators

General issues/prompts for planners

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

Workforce issues

- Communicate messages about how to keep yourself well and how to self-care when ill
- Consider how to handle the cancellation of planned leave
- Plan across sectors with the full involvement of trade unions
- Map skills and profile existing health and social care workforce, including commitments and locations
- Collaborate with employers outside health and social care
- Consider regional agreements, particularly as pandemic is likely to occur in waves in different areas and how feasible this is
- Train staff in infection control and basic physical care. They will need regular refresher training
- Identify in advance the work patterns that staff will need to follow to combine home and work responsibilities
- Work with your health colleagues, as accident and emergency staff will need awareness and guidelines about dealing with people with mental health problems or learning disabilities, migrant workers, asylum seekers, homeless people and tourists

- Establish pairing/buddying arrangements between services and establishments
- Consider terms and conditions issues (e.g. overtime/Working Time Directive, special leave and certification)
- Identify staff to work from home
- Consider verifying the identity of casual/voluntary staff
- Match level of risk to level of vulnerability in the use of staff
- Learn lessons from seasonal influenza. Talk to providers about this
- Recruit volunteer drivers. This may be especially important in rural areas.

Planning for vulnerable service users

- Convene a multi-agency planning group including service users and stakeholders from the health, housing and voluntary community and private sectors
- Create a comprehensive map of services
- Consider any specific issues for people from black and minority ethnic communities
- Establish clear arrangements for stocking, prescribing and collecting medication.
- Ensure priority drugs are identified
- Work with the local police force to ensure clear arrangements (e.g. for provision of a place of safety)
- Create and keep updated lists of approved social workers
- Establish a contact point for carers
- Create a list of prompt questions for staff
- Consider arrangements for older people with mental health problems
- Consider specific arrangements for people with additional issues such as learning disabilities
- Create a pool of peripatetic staff, drawing across agencies and sectors and including retired staff
- Consider the fact that some volunteers may not have the appropriate skills and experience to cope
- Compile charts showing where staff are usually employed and agree reallocations during a pandemic
- Establish operating instructions for services – which to close, which to remain open
- Allocate individuals to make judgements on:
 - safety issues for staff and service users
 - staffing levels
 - the relevant qualifications of staff on each shift
- Draw up clear guidance and support for staff
- Ensure that records are up-to-date and address both priorities and risks for individuals
- Consider an open access centre to deal with emotional and psychological issues such as fear, anxiety etc
- Produce self-help leaflets
- Work with GPs to establish what each practice will be able to deal with

- Draw up care plans to include contingency arrangements either to increase or to reduce support as required
- Draw up care plans to identify any heightened risks of self-harm or harm to others in the event of a pandemic
- Consider arrangements to reduce or close non-essential services and increase capacity of crisis teams
- Collaborate with leisure and education departments and the private leisure industry to reduce social isolation
- Establish arrangements whereby service users can be contacted over the telephone rather than in person
- Where possible, reduce the number of personnel visiting an individual
- Expand the remit of all staff if necessary
- Set up a specific mental health helpline (consider engaging the voluntary sector to do this)
- Develop user support and good neighbour schemes
- Identify and clearly communicate the priorities for inpatient treatment and what supporting resources will be available
- Ensure that short-term assessment places are available
- Increase locally held records on patients that indicate how services should be safely delivered
- Ensure that rationing criteria are open, clear and consistent with national guidelines
- Consider where facilities and resources can be pooled across agencies and sectors
- Consider how to access secure services
- Acknowledge longer-term consequences such as the likely need for an increase in talking therapies, bereavement counselling etc
- Agree any role for the voluntary sector in the administration or monitoring of medication.

Community services

- Establish a database/map of priorities (drawn from care plans)
- Agree how assessment policies for children (UNOCINI) and Adults (NISAT) will operate
- Consider how you can plan to introduce more flexibility
- Draw up a priority list of core activities
- Step up verbal messages (but consider the needs of deaf and deaf/blind people in communicating these messages)
- Use local and community radio to communicate daily messages
- Undertake modelling work based on planning assumptions from *Pandemic influenza: A national framework for responding to an influenza pandemic*
- Ensure contracts include business continuity plans
- Plan which services are to be kept open/which are to be closed and at what stage
- Start planning now to expand the use of telecare etc
- Highlight the expectations in guidelines for maintaining care records
- Plan the use of short-term care.

Home Care Services

- Involve home care providers in training, including hygiene training and awareness and guide providers on how to manage deaths in their leading role in making arrangements
- Map and identify capacity of the homecare sector to offer assistance in an emergency, and operate a memorandum of understanding with the sector so as to set out terms of work in a crisis situation
- Offer support to small independent providers who may struggle with minimum staffing levels in event of pandemic
- Consider guidance on the status and deployment of staff, including criminal record checks as appropriate to Northern Ireland
- Consider how to balance restrictions against risk of social isolation for homecare service users.

Issues for working with black and minority ethnic groups

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

Issues for working with homeless people and highly mobile populations

- Definitions (e.g. rough sleepers), including those with and without some contact with services
- Ensure communication links with housing organisations for those who are temporarily homeless and in short-term accommodation
- Consider the difficulties of penetrating the culture of some mobile populations such as travellers and migrant workers from Eastern Europe
- Consider the 'invisible' population of illegal immigrants
- There is a risk of certain parts of society, e.g. those people who are visibly homeless or migrant workers, being scapegoated as responsible for the spread of influenza
- This group has low access to healthcare and poor self-care
- A proportion of homeless people will have mental health problems and/or substance misuse issues – there is a culture of self-neglect

- Consider people newly released from prison but with no fixed abode
- Establish a communication strategy – make it clear that a pandemic is different to seasonal influenza
- Consider the difficulties in identifying the deceased
- Parish councils in farming areas should consider the issues of groups of migrant workers
- Consider the vulnerability of young people who are care leavers
- Consider the surge of demand on hostel places
- Consider scoping and mapping – these groups will need different responses from the ‘mainstream’ population
- Ensure that there is a supply of prescription medicines such as methadone.

Working with residential care providers

- Consider the need to plan residential care as part of its community – by looking at the wider resources
- Establish a point of contact/contact person for the dissemination of advice
- Update hygiene training and awareness
- Involve residents (where possible) and families in planning
- Set up a map of provision, including what it offers and what it could offer in an emergency
- Plan for the daily monitoring of capacity and sickness levels by a dedicated social services official
- Establish staff-sharing schemes, including managers
- Consider admission criteria during a pandemic – who has decision-making powers?
- Agree on minimum staffing levels
- Consider daily living – need to balance restrictions to reduce spread against risk of social isolation
- Consider the potential for relatives to stay in the home or locally
- Consider the deployment of staff amongst ill/well residents
- Consider the best use of those who have recovered and are now immune
- Offer support to small independent operators
- Consider the status and deployment of staff, including relevant checks etc
- Make clear the expectations regarding care records – prioritise those who are ill, detail the specific issues to record
- Develop a strategy for use of short-term care.

ACRONYMS

CCA	Civil Contingencies Act 2004
CCC	Civil Contingencies Committee
CCO	Civil Contingencies Committee Officials
CCDC	Consultant in Communicable Disease Control
CCS	Civil Contingencies Secretariat
CDSC (NI)	Communicable Disease Surveillance Centre (Northern Ireland)
CEMG	Central Emergency Management Group
CMG	Crisis Management Group
CEPU	Central Emergency Planning Unit
CMO	Chief Medical Officer(s)
CO	Cabinet Office
COBR	Cabinet Office Briefing Room
COSHH	Control of Substances Hazardous to Health (Regulations) '02
DAs	Devolved Administration(s)
DARD	Department of Agriculture and Rural Development
DH	Department of Health (London)
DHSSPS	Department of health, Social Services and Public Safety
DPH	Director of Public Health
EWRS	Early Warning and Response System (of the European Network for Communicable Diseases)
NIPCC	Northern Ireland Pandemic Influenza Control Committee
OFMDFM	Office of the First Minister and Deputy First Minister
HPA	Health Protection Agency
HSSB	Health and Social Services Board
HSCT	Health and Social Care Trust
ICT	Infection Control Team
MISC	Ministerial Committee
NISAT	Northern Ireland Single Assessment Tool
RHCC	Regional Health Command Centre
UNOCINI	Understanding the Needs OF Children In Northern Ireland
UKNIPC	United Kingdom National Influenza Pandemic Committee

GLOSSARY

Antiviral medicine - A type of medicine used to treat viral infections such as influenza.

Attack rate - The cumulative percentage (or proportion) of a population infected over a specified period of time, for example during an epidemic.

Clinical attack rate - The cumulative percentage (or proportion) of a population infected and showing symptoms over a specified period of time.

Containment - Measures to limit the spread of infection from an affected area.

Epidemic - The widespread occurrence of significantly more cases of a disease in a community or population than expected over a given period of time.

Face mask - A disposable face mask that provides a physical barrier but no filtration.

Hand hygiene - Thorough, regular hand washing with soap and water, or with alcohol-based products containing an emollient that do not require the use of water, to remove dirt and germs at critical times, e.g. after touching potentially infected people/objects and before touching others or eating.

Incubation period -The period from entry of infection to the appearance of first symptoms.

Infectivity - The extent to which a given micro-organism infects people (or animals), i.e. the ability of the organism to enter, survive and multiply in people and cause disease.

Outbreak - A sudden appearance of, or increase in, cases of a disease in a specific geographic area or population, e.g. in a village, town or closed institution.

Pandemic - A worldwide epidemic – an influenza pandemic occurs when a new strain of influenza virus emerges which causes human illness and is able to spread rapidly within and between countries because people have little or no immunity to it.

Phase - Any of the stages leading up to a pandemic, as defined by WHOM in its global classification. The phases, which run from 1 to 6, are used as a trigger for escalating planning so that the response is proportionate to the risk.

Reproduction number (Ro) - The average number of secondary infections resulting from each number (Ro) individual case – the 'basic' reproduction number is the number of secondary cases in a fully susceptible population without intervention. It measures the degree of transmissibility of an infection.

Shed/Shedding virus – Excreting, releasing or casting off the infectious particle (virus).

Surge capacity - The ability to expand provision beyond normal capacity to meet transient increases in demand, e.g. to provide care or other services above usual capacity, or to expand manufacturing capacity to meet increased demand.

Surveillance - The continuing scrutiny of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action.

Symptomatic - Showing symptoms of disease or illness.

Transmission - Any mechanism by which an infectious agent is spread from a source or reservoir (including another person) to a person.

UK alert level - The UK alert level system is triggered once WHO declares Phase 6 on its international scale. Escalation through the four UK alert levels is related to the spread of pandemic influenza in the UK, rather than internationally.

Wave - The period during which an outbreak or epidemic occurs either within a community or aggregated across a larger geographical area. The disease wave includes the time during which the disease occurrence increases, peaks and declines back towards baseline.