DRAFT

NHS SCOTLAND

Influenza Pandemic Preparedness

Guidance for Health and Social Care Services in Scotland

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Document Purpose	To enable NHS Boards and Health and Social Care Partnerships to work together to address the challenges of planning and preparing for an influenza pandemic.
Description	Guidance setting out the range of issues to be addressed in local plans, and highlighting the respective roles and remits of statutory health and social care organisations.
Superseded Documents	Health and Social Care Influenza Pandemic Preparedness and Response (DH 2012)
Action required	NHS Boards, Local Authorities, Health and Social Care Partnerships should ensure that local joint health and social pandemic flu plans appropriately reflect the content of this document.

Contents

Foreword

Better preparedness for an influenza pandemic will mitigate its impact.

The threat landscape has proved to be increasingly complex and varied. However the threat of an influenza pandemic remains at the top of the threat list because of its likelihood to severely disrupt services.

If the wide range of major incidents recently – cyber, terrorism, severe weather – have highlighted two simple facts: what was once unthinkable is now reality, and that preparedness is key to survival and success. Simply put, the latter underlines that being at the ready significantly reduces crisis impact.

The severe weather in February 2018, so-called 'Beast from the East' incident, demonstrated the business continuity impact of loss of staff on health and social care services. Lessons from that period should assist with planning for an influenza pandemic, which although it will be insidious, is likely to have longer impact and far more reaching consequences.

The integration and interdependence of health and social care services highlights the importance of organisations planning and preparing together. Mutual understanding of expectations and challenges and how they may change over the duration of a pandemic situation should enhance the resilience of both sectors.

I urge NHS Chief Executives and Chief Officers of Health and Social Care Partnerships to take account of this guidance in the process of producing joint plans for Pandemic Influenza.

Scottish Government

Executive Summary

Influenza Pandemic Preparedness provides guidance for health and social care organisations in Scotland in the context of pandemic influenza being the top national risk in the UK. It enables organisations to understand the challenges of a pandemic and their roles and responsibilities during various phases.

The document highlights that pandemic planning is taking place at a UK level, with the four UK nations working together to update the UK Influenza Pandemic Preparedness Strategy 2011, on which this guidance is based. It also emphasises key messages from recent national pandemic flu exercises – of agencies planning together to enable an integrated response; and further developing plans to respond to significant increases in demand for services.

Reflecting the particular integrated health and social care landscape in Scotland, this document sets out an expectation that NHS Boards and Health and Social Care Partnerships (HSCP) work closely together to develop scalable plans and enhance each other's as well as the overall resilience of their respective sectors.

Sections 1 to 4 explain the strategic context and the approach to be adopted in Scotland, and the dynamics of pandemic influenza. Section 5 sets out the legal framework that underpins the responsibilities of NHS Boards and HSCPs.

Sections 6 highlights the responsibilities of particular organisations in planning and preparing for a pandemic, and Section 7 explains how a national response will be coordinated. The roles and responsibilities of particular organisations, and what is required of them is outlined in Section 8. The importance of Business Continuity planning (Section 9) is clearly underlined with a checklist (Annex C) to support organisation's preparedness. The specific issues that require consideration, from taking action to minimise the spread of infection to planning for an increase in demand, are highlighted in Section 10.

Annexes A and B explain in detail the roles and remits of the range of health and social care organisations.

1. INTRODUCTION

1.1. The UK National Risk Register 2017[1] identifies pandemic flu as the highest risk facing the nation. The Influenza A H1N1 (commonly known as 'Swine flu') pandemic in 2009/10 was mild by historical standards and the threat of a new and far more serious pandemic remains.

1.2 Influenza (commonly known as 'flu') is a widespread and familiar infection, especially during the winter months. Illness caused by the influenza virus is usually relatively mild and self-limiting. However, some groups of people such as older people, young children and people with certain medical conditions, may be more at risk of severe infection or even death.

1.3. Pandemic flu is different from seasonal influenza. It occurs when a new flu strain emerges in the human population and spreads from person to person worldwide. As it is a new virus, the entire population is susceptible as very few people have immunity to it. Therefore healthy adults, as well as older people, young children and those with existing medical conditions, may be affected. The lack of immunity in the population means that the virus has the potential to spread very quickly from person to person, leading to more people becoming severely ill and potentially many more deaths.

1.4. Pandemic flu can strike at any time and has no seasonal linkage. A rapid integrated response, coordinated across the health and social care sectors, and the agencies involved in the Resilience Partnership, will help to minimise societal impact.

1.5 This guidance document is aimed at supporting health and social care services in Scotland to meet the strategic objectives set out in the UK Pandemic Preparedness Strategy 2011[2]. These are to:

- Be prepared to respond to any future influenza pandemic and any new emerging infections;
- Minimise the potential impact of a future influenza pandemic on health and social care services;
- Minimise the potential impact of a pandemic on society and the economy;
- Instil and maintain trust and confidence amongst health and social care organisations, the professionals who work in them, and the public in our ability to respond to pandemic influenza;
- Be active global players working with the World Health Organisation (WHO) and the European Centre for Disease Prevention and Control, including supporting international efforts to detect the emergence of a pandemic and early assessment of the virus by sharing scientific information; and to
- Regularly review research and development needs in pandemic influenza, in collaboration with research partners, to enhance our pandemic preparedness.

[1] https://www.gov.uk/government/collections/national-risk-register-of-civil-emergencies
[2] https://www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic

2. THE STRATEGIC APPROACH IN SCOTLAND

This section highlights the aims and objectives which underpin the planning and response arrangements in Scotland.

Strategic approach

2.1. The UK Influenza Pandemic Preparedness Strategy 2011 underpins the strategic approach that Scotland and the other UK nations will adopt to planning for and responding to the demands of an influenza pandemic. This should ensure that local and national organisations work together to develop appropriate response arrangements.

2.2 Over the last five years, Scotland has developed a robust strategy landscape that is predicated on the ambition of, as far as possible, managing patients at home or in a homely setting, and minimising length of stay in hospital when inpatient care is required. Furthermore, all health and social care provision should as far as possible involve the service user in a process of shared decision-making, and unnecessary waste and variation should be avoided.

2.3 These tenets are captured in the following strategies:

- Health and Social Care Delivery Plan – December 2016[3]
- Realizing Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016[4]
- Six Essential Actions of Unscheduled Care[5]
- Pulling together: transforming urgent care for the people of Scotland: The Report of the Independent Review of Primary Care Out of Hours Services – Nov 2015[6]
- National Clinical Strategy[7]
- Taking Care to the Patient, the Scottish Ambulance Service 2020 Vision[8]

2.4 These strategies promote a culture within services that is person-centred, safe and effective, and which minimises health inequalities across the population.

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3 https://beta.gov.scot/publications/health-social-care-delivery-plan/

4 https://beta.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/

5 https://www.gov.scot/Topics/Health/Quality-Improvement-Performance/UnscheduledCare/6-Essential-Actions-To-Improving-Unscheduled-Care

6 https://www.gov.scot/Resource/0048/00489938.pdf

7 https://www.gov.scot/Resource/0049/00494144.pdf

8 http://www.scottishambulance.com/UserFiles/file/TheService/Publications/Strategic%20Plan_Online%20pdf.pdf

Principles

2.5 It is uncertain when a new influenza virus might appear. Until it emerges and affects a significant number of people, it will not be possible to identify the key features of the disease, the groups most affected, or to assess the effectiveness of clinical countermeasures. Given this, the three main principles that will underpin planning and preparedness in Scotland are:

- **Precautionary** – Plan for an initial response that reflects the level of risk based on information available at the time, accepting that uncertainty will initially exist;
- **Proportionality** – Plan to be able to scale up and down in response to the emerging epidemiological, clinical and virological characteristics of the virus and its impact at the time.
- **Flexibility** – Plan for the capacity to adapt to local circumstances that may be different from the overall UK picture, for instance in 'hotspot' areas.

Aims and objectives

2.6 In line with the UK Influenza Pandemic Preparedness Strategy 2011, Scotland has adopted a 'Defence in Depth' approach to influenza pandemic planning and response, which aims to reduce the proportion of the population that may develop influenza or become critically ill by:

- **Promoting work during the inter-pandemic period** to strengthen preparedness arrangements and increase resilience in the UK;
- **Maintaining surveillance**, in collaboration with national and international partners, to detect the emergence of a novel virus strain or any illness attributable to it. Monitoring the spread and assessing the impact of the virus, identifying the groups most at risk of severe illness and death and monitoring the uptake, effectiveness and safety of the various clinical counter-measures including vaccination when available;
- **Reducing risk of transmission** and infection by applying individual and community infection control measures and assisting self-care by providing public advice, information and messages promoting good respiratory and hand hygiene;
- **Reducing illness, complications and minimising deaths** of symptomatic individuals through rapid access to health assessment, providing antiviral medicines promptly where they are needed, providing specialist treatment as appropriate and providing other effective treatment including antibiotics for those suffering from secondary bacterial infections; and
- **Protecting the public through preventing** transmission of the virus, when possible and appropriate, through pandemic specific vaccination.

3. PANDEMIC PHASES

This section explains the five phases of a pandemic as described in the 2011 UK Influenza Pandemic Preparedness Strategy

3.1 The nature of a pandemic is that it evolves and potentially includes multiple waves of illness. Therefore various indicators are used to define the five phases set out in the 2011 UK Influenza Pandemic Preparedness Strategy (Detection, Assessment, Treatment, Escalation and Recovery), as illustrated in Figure 1 below (NB. These are distinct from the WHO phases).

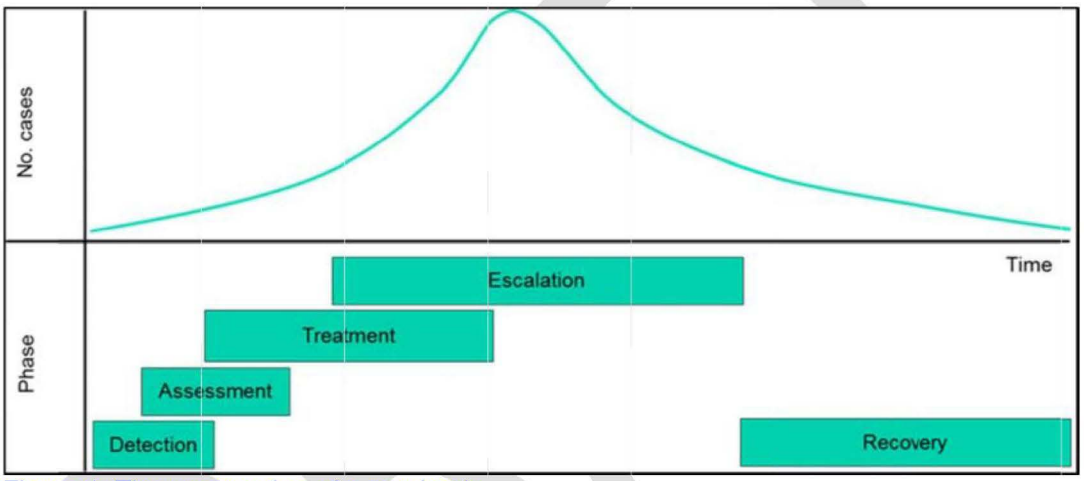

Figure 1: The progression of a pandemic

3.2 These phases of a pandemic as outlined in Figure 1, which may not follow in strict order, are intended to reflect the likely level of demand placed on services as the number of people infected increases, and the public health impact.

3.3 **Detection** would commence when a pandemic is declared by the World Health Organisation (WHO), or earlier if an influenza-related Public Health Emergency of International Concern is declared by WHO. The focus of response activities by WHO and national Public Health agencies / NHS Public Health specialists during the Detection phase will be:

- Intelligence gathering from countries already affected;
- Enhanced surveillance within the UK;
- The development of diagnostics specific to the new virus; and
- Dissemination of information to the public and professionals.

3.4 The move to the **Assessment** phase would occur when the first patient with the pandemic strain of influenza is identified in the UK. The focus of Public Health agencies during this phase will be on:

- Collection and analysis of detailed clinical and epidemiological information on early cases, which will inform early estimates of the impact and severity of the pandemic; and
- Reducing the risk of transmission and infection with the virus within society by actively identifying, self-isolating cases and providing treatment as necessary.

3.5 **The Detection and Assessment phases form the initial response to the pandemic** and may be relatively short. These phases may be combined depending on the speed of transmission of the virus in society.

3.6 The initial response to the pandemic will be followed by the **Treatment** phase, as it will not be possible to curtail the spread of the pandemic strain of influenza once it has occurred in Scotland. During the Treatment phase, healthcare services will focus on:

- Continuing to treat individual cases as they occur within the population;
- Population level treatment and support, including the assessment of individuals (particularly those in the at risk groups)[9] and distribution of anti-viral medicines, via the National Pandemic Flu Service (if it is activated);
- Enhancement of the healthcare services to manage an increasing number of people infected;
- Consideration of advanced public health measures (including 'population distancing' strategies such as school closures) to limit the spread of the disease; and
- Developing a vaccine for the specific strain of influenza causing the pandemic.

3.7 In the event of a severe prolonged pandemic, and progression to the **Escalation** phase, the pressures on services and wider society may be extreme. The focus of health and social care organisations at this stage of a pandemic should be on adjusting service delivery to accommodate increasing demand, including:

- Implementing pre-planned arrangements to increase service capacity in response to a sudden increase or surge/ spike in demand;
- Prioritising service delivery and triage with aim of maintaining essential services;
- Revising service thresholds to respond to demand, acuity and service availability; and
- Implementing resilience measures and implementing contingency plans.

3.8 Following the peak of the pandemic, as the number of new infections decline, there will be a continued focus on Treatment activities, followed by a move into the **Recovery** phase. The focus of this phase will be on steadily returning services to normality and 'business-as-usual', reviewing the organisational response to the pandemic and the lessons, while simultaneously preparing for a potential resurgence of the pandemic (a second "wave").

[9] Children and young people, frail elderly, and those with long term conditions

3.9 Influenza pandemics can occur in multiple waves and while Recovery activities are on-going it is important that health and social care organisations individually and collectively with resilience partners ensure preparedness for any future waves of pandemic activity. Debriefing reports and other relevant sources of information should be used to identify relevant single/multi-agency lessons and improvements.

3.10 Each phase of a pandemic poses its own capacity and capability challenges for health and social care organisations. These will be dependent upon the characteristics of the new virus and whether the impact on local or national services is low, moderate or high. Given the unpredictability of any influenza pandemic it is not possible to quantify likely numbers of cases or hospitalisations. Much may depend on other pressures at the time of the pandemic such as winter pressures, co-existing viral outbreaks, public reaction and media coverage, all of which may add to increased pressure on organisations.

3.11 To ensure preparedness for every eventuality during the various phases of a future pandemic, health and social care organisations should incorporate sufficient flexibility in resilience / contingency plans to enable them to respond effectively as the pandemic progresses. In the early stages of a pandemic, when information about the virus and its impact is still emerging, national Public Health agencies i.e. Public Health England and Health Protection Scotland, will undertake modelling exercises to determine the likely impact of the new virus and support the appropriate levels of preparedness.

4. PLANNING DIMENSIONS

This section explains the various planning dimensions and how services should plan to address them.

4.1 The various dimensions of planning for a pandemic are generally the same as those for other public health emergencies and adverse incidents. They are:

- *Uncertainty*. There may be little or no information available initially so rapid gathering and sharing of reliable data will be important to inform the response;
- *Speed*. In local areas the increase in demand for services can develop rapidly, requiring an agile and coordinated response;
- *Profile*. Media pressure and public demand for information will be intense, requiring frequent, consistent and coherent communications;
- *Cross-sector*. The response will require a range of organisations to work collectively and across boundaries to support each other and understand how any changes to services may potentially impact on each other's capacity and capability; and
- *Local hotspots.* The demand in each area may not be uniform; with different geographic areas may be under pressure at different times, requiring effective information exchange and plans that are flexible.

4.2 However, the *duration* of an influenza pandemic may be much longer than other emergencies, potentially lasting several months. Therefore, a sustained and resilient response will be necessary.

4.3 Health and social care services should be prepared to accommodate the demands and consequences of different types of pandemics, ranging from a mild pandemic with a (generally speaking) low impact on services (such as the 2009 H1N1 pandemic) to a severe prolonged pandemic such as the H1N1 "Spanish Flu" pandemic experienced in 1918.

4.4 Influenza pandemic planning in the UK[10] is based on an assessment of the 'reasonable worst-case', derived from experience and scientific analysis of influenza pandemic and seasonal influenza in the 20th and early 21st centuries. However the uncertainties in any pandemic mean that the reality of a pandemic may differ from the planning assumptions, and plans will need to be flexible and adaptable to respond to changing circumstances.

[10] https://www.gov.uk/guidance/pandemic-flu

Planning assumptions: health and social care services

4.5 The planning assumptions used in this guidance are consistent with those outlined in the UK Influenza Pandemic Preparedness Strategy 2011, which is extant.

4.6 During a pandemic, the assumptions on which to base the response will be updated in the light of emerging knowledge about the developing scenario. Despite this unpredictability, there are some key assumptions that will help to inform planning:

- A pandemic is most likely to be caused by a new subtype of the Influenza A virus but plans could be appropriately adapted and deployed for any epidemic infectious disease.
- An influenza pandemic could emerge at any time of the year anywhere in the world, including in the UK. Regardless of where or when it emerges, it is likely to reach the UK very rapidly and, from arrival, it will probably be a further one to two weeks until sporadic cases and small clusters of cases are identified/recognised as occurring across the country.
- The potential scale of impact, risk and severity from related secondary bacterial infection and clinical risk groups affected by the pandemic virus will not be known in advance.
- It will not be possible to completely stop the spread of the pandemic influenza virus in the country of origin or in the UK, as it will spread too rapidly and too widely.
- Initially, pandemic influenza activity in the UK may last for up to three to five months, depending on the season. There may be subsequent waves of activity of the pandemic virus weeks or months apart, even after the World Health Organisation has declared the pandemic to be over.
- Following an influenza pandemic, the new virus is likely to persist as one of a number of seasonal influenza viruses. Based on observations of previous pandemics, subsequent winters are likely to see increased seasonal flu activity compared to pre-pandemic winters.

4.7 Healthcare services should continue to prepare to provide advice and treatment for up to 30% of all symptomatic people in the usual pathways of primary care. Between 1-4% of symptomatic patients could require hospital care, depending on the severity of illness caused by the virus. Of these, up to 25% may require critical care.

4.8 Staff absence is likely to follow the wider community profile. In a widespread and severe influenza pandemic affecting 50% of the population, between 15-20% of staff might be absent on any given day during peak weeks. However, these figures may be reduced by the impact of antiviral and antibiotic countermeasures depending on the effectiveness of these measures.

4.9 A summary of the planning assumptions in a reasonable worst case scenario is outlined below:

Up to 50% of the population could experience symptoms of pandemic influenza over one or more pandemic waves each lasting 15 weeks.
30% of all symptomatic people may need to access primary care.
1-4% of symptomatic people may require hospital treatment.
25% of hospital patients may require critical care.
15-20% of staff may be absent on any given day during peak weeks.
2.5% of those with symptoms may die as a result of influenza, if no treatment proved effective.

Planning Assumptions for Excess Deaths

4.10 In terms of planning for excess deaths, the Cabinet Office's 2011 "Preparing for Pandemic Influenza - Guidance for Local Planners"[11] states that although the Reasonable Worst Case scenario identifies that up to 2.5% of those who are symptomatic may die, given the relatively low likelihood of a virus with both a high attack rate and severe disease, and against which medical countermeasures are ineffective, it was agreed that local planners should focus on ensuring that robust arrangements are in place for managing excess deaths in a lower range (approximately 0.4-0.5% of the population), possibly over as little as a 15 week period and perhaps half of these over three weeks at the height of the outbreak. The possibility remains however that a future pandemic may result in deaths above this range. Such circumstances may require the local response to be augmented with short term measures to manage an exceptional situation, such as additional temporary body storage, facilitated by central government.

Flexible/scenario planning

4.11 Three interdependent factors influence the impact of the new virus on all services:

- The characteristics of the disease;
- Available service capacity, and
- The behaviour of the population.

4.12 The situation remains complex. For example, if an influenza pandemic occurs at a time of existing high demand on health and social care services, e.g. winter, even an influenza virus that produces mild clinical symptoms may have a high impact on some aspects of service provision.

11 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

5. LEGAL FRAMEWORK

This section highlights the key relevant legislation underpinning the overall response to pandemic influenza.

The Civil Contingencies Act

5.1 **The Civil Contingencies Act 2004**[12] (CCA) and the Civil Contingencies Act 2004(Contingency Planning)(Scotland) Regulations 2005 set out a single framework for civil protection across the UK, including responding to public health emergencies. They require that organisations designated as Category 1 and Category 2 responders demonstrate that they can respond to a range of incidents, including public health emergencies, while maintaining business-as-usual.

Designated Responders

5.2 Under the CCA, Category 1 responders are those organisations at the core of an emergency response, and in Scotland include:

- Local Authorities (LAs)
- All Territorial NHS Boards; and
- Scottish Ambulance Service

5.3 Category 2 responders have a lesser set of duties and they will be less involved at the core of the planning, but they will be heavily involved in providing the expertise or specialist resource of their sector during incidents through cooperation in response and / or the sharing of information. Within NHS Scotland, they include:

- NHS National Service Scotland – The Health Board that incorporates Health Protection Scotland (HPS)[13].

5.4 Category 1 responders will be at the forefront of a response to a public health emergency, such as an influenza pandemic. They are required to: assess risk; have emergency and business continuity plans in place; have in place arrangements to warn, inform and advise the public in the event of an emergency, and to co-operate with each to enhance co-ordination and efficiency. The latter of these duties is discharged through the Regional Resilience Partnerships[14].

[12] http://www.legislation.gov.uk/ukpga/2004/36/contents

[13] Health Protection Scotland will become part of Public Health Scotland. An estimate of the timing of the vestment date is currently listed as December 2019

[14] https://www.readyscotland.org/ready-government/legislation/

Health and Social Care Partnerships

5.5 The **Public Bodies (Joint Working)(Scotland) Act 2014** places a duty on Integration Authorities to develop a strategic plan for the delegated functions and budgets under their control. Unlike Integration Authorities, Health and Social Care Partnerships (HSCPs) are not statutory bodies. These have been developed in each Integration Authority to create an identity for successful integration of health and social care staff from the council and Health Board into a single, coherent delivery entity. Each HSCP is led by a Chief Officer, supported by a senior management team, and is the operational and delivery arm of integration, bringing together staff from the relevant Health Board and Local Authority to support integrated working.

5.6 As 'delivery entities' of the local NHS Board and Local authority, HSCPs are not categorised as 'responders' under the CCA.

5.7 In this guidance, where integrated health and social care is being delivered, we refer to 'health and social care partnerships', to include community health services, social work and independent and third sector care providers.

5.8 It is important that NHS Boards and Local Authorities develop a memorandum of understanding with their local HSCP(s) to clarify mutual roles, responsibilities and discharge of functions under the CCA.

5.9 Under the **Social Work (Scotland) Act 1968**[15], Local Authorities (LAs) have a duty to assess a person's community care needs and decide how to meet their needs and manage any risks. Any assistance should be based on an assessment of the person's care needs and should take account of their preferences. In addition under Section 22 of the Children (Scotland) Act 1995, LAs have a duty to safeguard and promote the welfare of children in their area who are in need[16].

5.10 Each Integration Authority is required to produce a strategic commissioning plan that sets out how it will plan and deliver services in their area over the medium term, using the integrated budgets under their control.

5.11 Since implementation of the Public Bodies (Joint Working)(Scotland) Act in 2016, all social work services for adults have been commissioned via a strategic plan through the Health and Social Care Partnerships. Some HSCPs also include children and criminal justice services within their responsibilities.

5.12 **The Public Health etc. (Scotland) Act 2008** sets out the public health duties of Scottish Ministers, NHS Boards and Local Authorities. Scottish Ministers have a duty to protect public health i.e. to protect the community from infectious disease, contamination and any other hazards that constitute a danger to human health. This includes the prevention of, control of, and provision of a public health response to such disease, contamination or other hazards.

[15] http://www.legislation.gov.uk/ukpga/1968/49/contents
[16] https://www.legislation.gov.uk/ukpga/1995/36/contents

5.11 The Act also established a framework and timeframes for registered medical practitioners and diagnostic laboratories to notify the Health Protection Team of diseases, organisms or health risk states.

5.12 Under **the Equality Act 2010**[17], health and social care organisations must consider the needs of all individuals - staff and patients - and how they may be affected when developing policy, service delivery plans and procedures[18]. They must, under the UK **Human Rights Act (1998)**, also take into account a range of factors including the dignity of individuals receiving treatment and care; end of life considerations; prioritisation of treatments and transparency in relation to decision-making when delivering services.

5.13 In the context of their duties under Equalities and Human Rights legislation, health and social care organisations must undertake an appropriate level of impact assessment of key plans and protocols to ensure they do not perpetuate existing inequalities.

[17] Equality Act 2010, http://www.legislation.gov.uk/ukgpa/2010/15/contents
[18] Preparing for Emergencies- Guidance for Health Boards in Scotland: Annex on Equalities, Human Rights and Resilience Planning, Scottish Government, 2013.

6. PLANNING AND PREPAREDNESS IN SCOTLAND

This section highlights the roles of various agencies in planning and preparing for pandemic influenza

National Level

6.1 In Scotland the Scottish Government has the lead role for planning at national level to mitigate the risk from, and manage the response to, a future influenza pandemic. It will work closely with the other UK administrations to ensure a co-ordinated approach to preparedness for various pandemic scenarios and impacts.

Local Level

6.2 Territorial NHS Boards and Local Authorities, as Category 1 responders under the Civil Contingencies Act 2004, are responsible for pandemic influenza planning, preparedness and response at local level in relation to health and social care. Some of these responsibilities will in practice be discharged by the local Health and Social Care Partnership(s), the extent of which should be outlined the mutually agreed memorandum of understanding (see paragraph 5.8).

Multi-Agency Planning

6.3 As previously indicated, local organisations are primarily responsible for planning for and responding to any major incident (see CCA paragraph 5.1), including an influenza pandemic. Multi-agency planning, through the Resilience Partnerships, is key to developing and delivering an integrated response to an influenza pandemic.

6.4 Individual organisations are responsible for planning and preparedness for influenza pandemic. Accordingly pandemic preparedness plans should be developed by all organisations. However multi–agency collaboration is required so that

- Cohesive / integrated plans are developed for every phase of a pandemic;
- Best use is made of resources to deliver the best possible outcomes for the locality;
- Plans are based on best practice and learning from across the sectors;
- Organisations can exercise their plans with partners, testing assumptions and promoting mutual understanding of roles, capabilities and potential challenges.

Resilience Partnerships

6.5 The Resilience Partnerships (RP) have a collective responsibility to plan, prepare and communicate in a multi-agency environment[19].

6.6 RPs should promote cross-sector work to put in place multi-agency and integrated plans that are sufficiently flexible and scalable to respond to a mild, moderate or severe pandemic. The plans should be based on commonly agreed (planning) assumptions.

6.7 As Health and Social Care Partnerships (HSCPs) are integrated operational entities responsible for delivering joined-up primary, community and social care services, they will have a key role to play in planning for and responding to an influenza pandemic that is different to those of the NHS Board and Local Authority. Therefore it is important that RPs take active steps to ensure that local HSCPs are fully involved in all relevant multi-agency arenas in relation to influenza pandemic preparedness.

An Evidence-based approach

6.8 National and local planning for (and the response to) a future influenza pandemic will at all times be informed by the best available scientific (microbiological, epidemiological and modelling) evidence provided by government appointed independent bodies such as Public Health England (PHE), Health Protection Scotland (HPS), Scientific Advisory Group For Emergencies (SAGE, see paragraph 8.4) and the Joint Committee on Vaccination and Immunisation (JCVI).

6.9 Prior to, and at the outset of, a future pandemic there will be uncertainty about:

- The effects of the pandemic strain of influenza;
- The impact of the pandemic strain on society and health & social care services;
- How a future pandemic may progress.

Therefore, scientific, clinical and professional advice will be key to planning for and directing the response at both a national and local level.

6.10 At all times the advice provided by the national advisory bodies, and the response by health and social care agencies should be:

- Evidence-based or based on best practice in the absence of evidence
- Based on ethical principles
- Based on established practice and systems as far as possible
- Co-ordinated at local and national levels.

[19] https://www.readyscotland.org/ready-government/legislation/

7. COORDINATION

This section highlights national and cross-government arrangements that will coordinate a response to an influenza pandemic.

Local and National Coordination

7.1 The response to a future influenza pandemic will be coordinated by the Scottish Government Resilience Room (SGORR)[20]. SGORR provides a focal point for the Government's response and an authoritative source of advice for local responders.

7.2 In the event of a pandemic, Scottish Government will establish a Cross-Government Pandemic Co-ordination Centre (PCC) to support the SGORR infrastructure in view of the potentially significant cross-sectoral impacts. One focus for the PCC will be to streamline reporting requirements and information requests to local organisations.

7.3 Figure 2 illustrates the coordination arrangements in Scotland for incidents of national significance and the relationship with the UK Government's Cabinet Office Briefing Room (COBR).

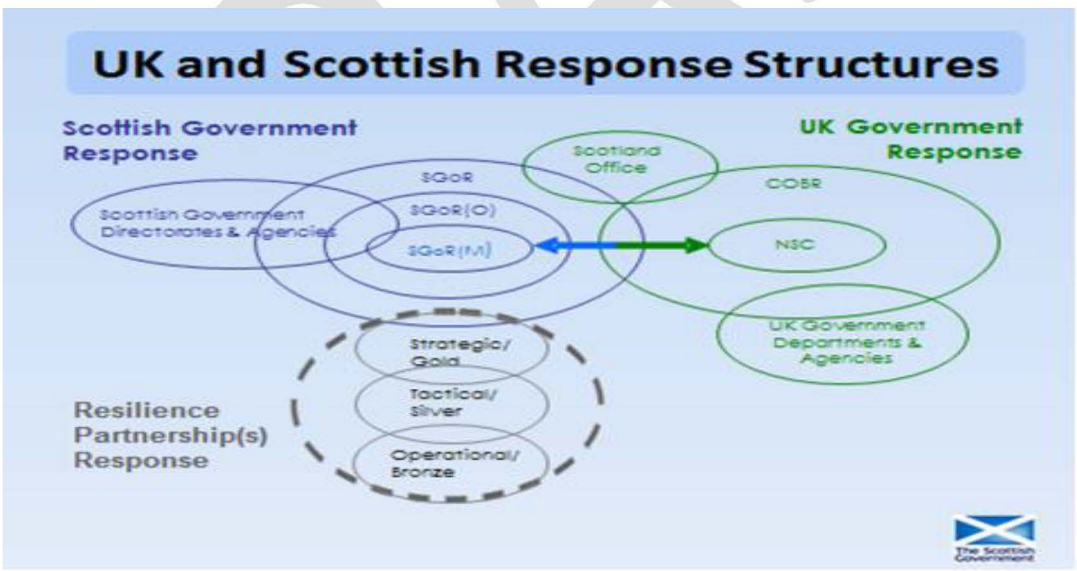

Figure 2. UK and Scottish Response Structure

[20] https://www.readyscotland.org/media/1410/preparing-scotland-hub-updated-published-version-august-2017.pdf

8. PREPAREDNESS AND RESPONSE

This section provides an overview of the role and responsibilities of health and social care organisations in ensuring preparedness for an influenza pandemic.

Roles and Responsibilities

8.1 The function and responsibilities of health and social care services in relation to pandemic preparedness and response will naturally vary according to their role. Annex A highlights in more detail the actions expected of each organisation during the phases of an influenza pandemic: Preparing, Detection/Assessment, Treat/Escalate and Recovery (see Figure 1, section 3.1).

8.2 During an influenza pandemic, it is expected that health and social care services will continue to ensure that, in line with the Quality Ambitions[21], services they provide are

- Person-centred
- Safe, and
- Effective.

Scottish Government

8.3 The Scottish Government (SG), although not a designated responder under the CCA, has a key role in civil protection and resilience. When the scale or complexity of an incident is such that it would benefit from central government coordination or support, SG will actively collaborate with the UK Government and activate its emergency response arrangements through the Scottish Government Resilience Room (see figure 2) to ensure that national responses are consistent in approach. The role of SGoRR will vary according to the nature, scale and impact of an incident.

Cross-Government coordination of advice during a response

8.4 During response to an influenza pandemic, a UK Scientific Advisory Group for Emergencies (SAGE[22]) will be established to ensure that coordinated, timely scientific and/or technical advice is made available to support decision-making across UK Government and the Devolved Administrations. The scope of SAGE will be determined by decision-makers at national level; it will vary as the pandemic responses progress through the Treatment, Escalation and towards the Recovery phase.

[21] http://www.gov.scot/resource/doc/311667/0098354.pdf
[22] https://www.gov.uk/government/groups/scientific-advisory-group-for-emergencies-sage

NHS Boards

8.5 NHS Boards should have effective plans in place to ensure they are fully prepared for the various phases of a future influenza pandemic. All activities in relation to planning and preparedness should be undertaken with the local HSCP(s) and the Resilience Partnerships so that there is a multi-agency, integrated health and social care response.

8.6 The challenge for NHS Boards in an influenza pandemic situation will be to provide care to patients with pandemic influenza as well as those who are not infected.

8.7 The Board's Executive-level Director with responsibility for resilience should ensure that:

- The NHSScotland Standards for Organisational Resilience[23], which includes specific standards on pandemic preparedness and response, are met; and
- There is active engagement with the local HSCP(s) as a means of ensuring whole system planning, preparedness and response.
- The work is undertaken with the Local Authority and the HSCP to develop a mutually agreed, joint Memorandum of Understanding that clearly sets out expectations of each organisation during a pandemic situation.

8.8 As NHS Boards manage the contracts with General Practitioners and other independent primary care contractors (i.e. Dental Practitioners, Pharmacies, Optometrists), they should develop and agree robust and up-to-date business continuity plans with these services, to withstand the impacts of an influenza pandemic. NHS Board should also develop robust and up-to-date business continuity plans for Primary Care Out of Hours Services to withstand the impacts of an influenza pandemic and agree these plans with the relevant services.

8.9 NHS Board's pandemic plans should demonstrate how the organisation will respond effectively to various levels of demand depending on whether the impacts of the pandemic are mild, moderate and severe. Plans should specifically address:

- **Service provision**: How will core services be maintained and continue to be delivered safely; What additional services may be required and how they will be delivered?
- **Patient Flow:** What arrangements will be implemented with local HSCPs to maintain patient flow?
- **Patient transfers**: What arrangements will be put in place to ensure the safe management of patient transfers between primary, secondary and community services?
- **Mutual aid**: What type of mutual aid might be required and what arrangements have been made with organisations who could provide it (where practical)?
- **Mortuary capacity**: What arrangements have been made to access additional capacity, if necessary?
- **Business continuity**: Do BC plans adequately reflect how potential disruptive challenges will be addressed so that services continue to be provided and adapted both between pandemic waves and how services will be returned to business-as-usual after the pandemic?

[23] https://www.readyscotland.org/ready-government/nhsscotland-resilience/preparing-for-emergencies/

- **Workforce issues:** How will workforce challenges be addressed? What a arrangements will be implemented to support staff? (see section on Human Resources)
- **Supply chain issue:** What arrangements will be put in place to ensure the continuations of supplies (food, medication, equipment etc.) and services?
- **Communications plan:** What arrangements will be put in place to ensure effective and proactive communication and engagement with staff, partner agencies and with the public; and
- **Financial impacts**: How will financial impacts on internal services and those of the local HSCP(s) be identified and addressed during a prolonged pandemic situation?
- **Death Verification and Certification**: Guidance is available to support local planning and response. [24][25]

8.10 Preparing For Emergencies – Guidance for Health Boards in Scotland[26] and the NHSScotland Standards For Organisational Resilience set out what NHS Boards should do to prepare for emergencies and enhance organisational resilience. These documents may also be of interest to Local Authorities and Health and Social Care Partnerships.

NHS National Services Scotland

8.11 Health Protection Scotland (HPS), as part of NHS National Services Scotland, has a duty under the CCA (it is designated a Category 2 responder) to assist the NHS and Local Authorities during national incidents with a public health dimension. HPS collaborates with Public Health England to ensure the UK's preparedness for, and response to, a future influenza pandemic. HPS is responsible for surveillance and health protection advice during a pandemic within Scotland; it will collaborate with Public Health England who will lead on UK surveillance activities. HPS will:

- Co-ordinate the national health protection activity and facilitate an effective public health response by:
- Leading the investigation, risk assessment and management of cases in liaison with the NHS boards
- Produce and disseminate educational material and infection control guidance to reduce transmission of pandemic influenza
- Support communication leads by providing information for action
- Support the Scottish Health Protection Network in implementing the deployment of the pandemic specific vaccine and work with PHE and others to evaluate its effectiveness and the effectiveness of other clinical countermeasures
- Facilitate research addressing urgent pandemic influenza issues

Further information on Surveillance activities during a pandemic situation are outlined in Annex B.

[24] https://www.gov.scot/Resource/0051/00517361.pdf
[25] https://www.gov.scot/Resource/0051/00517361.pdf
[26] http://www.gov.scot/Resource/0043/00434687.pdf

NHS 24

8.12 NHS 24 would play a key role in a pandemic response. In the initial stages of a pandemic, it would work alongside primary care services in assessing patients and to stream them to territorial board patient facing services, community pharmacies, SAS, and self-care, as appropriate.

8.13 Should the National Pandemic Flu Service (NPFS)(see section 10) be activated (on the basis of rising demand for primary care services), NHS 24 will continue to play this role for patients who require face to face assessment, following an initial call to the NPFS. During a pandemic, NHS 24 will be focussed on identifying the need for urgent medical assessment and directing patients to a GP practice or other healthcare service for additional advice or treatment.

8.14 NHS 24 also has a key role to play in:

- enabling self-care through the provision of information on NHS Inform
- using its messaging platforms to promote health messages
- keeping the public informed about the progression of the pandemic

8.15 To support their pandemic response, NHS 24, alongside HPS, would also establish the Scottish Flu Response Centre (SFREC). As well as leading on the patient assessment roles noted above (which would be accessed through the normal NHS 111 contact number), the SFREC remit would also include:

- contacting those who have been identified by HPS as having been in contact with confirmed cases
- In the initial stages, assisting NHS territorial boards in the management of contacts of confirmed cases

8.16 During the assessment phase, SFREC NHS 24 call handlers are trained to carry out contact management: phoning contacts of cases and referring them for issue of antiviral prophylaxis and/or a clinical assessment as appropriate.

Local Authorities

8.17 Local Authorities (LAs) are designated Category 1 responders under the CCA. Like NHS Boards they have a duty to plan for and respond to public health emergencies, including an influenza pandemic.

8.18 LAs also have a duty to assess adult's and older people's community care needs and decide whether to arrange any services and to safeguard and promote the welfare of vulnerable groups in their area.

8.19 LAs should undertake work with the local NHS Board and HSCP to develop a mutually agreed, joint Memorandum of Understanding that clearly sets out expectations of each organisation during a pandemic situation.

8.20 Like the local NHS Board, LAs should also have in place corporate influenza pandemic plans for the organisation that set out it will respond to the various pandemic scenarios

and the associated impacts. Local Authority planning and response considerations will be very similar to those outlined for NHS Boards.

Health and Social Care Partnerships

8.21 In the event of an influenza pandemic, the number of people in the community requiring support, either as a direct result of influenza or because of underlying conditions, is expected to increase. Much of the burden of this increase in vulnerable persons in the community is expected to fall on Health and Social Care Partnerships (HSCP). Assistance from the independent, voluntary and third sector will be important to supporting these individuals during the pandemic.

8.22 HSCPs, as delivery partners to NHS Boards and Local Authorities, are responsible for delivering primary, community and social care services. As such, they should be actively involved in local influenza pandemic multi-agency planning and preparedness arenas. They will have a key role in ensuring that effective arrangements are in place for the various impacts of an influenza pandemic and the delivery of safe and joined-up health and social care services in the community.

8.23 HSCPs should work in partnership with the NHS Board and Local Authority(ies) to agree their respective responsibilities (see paragraph 5.6). In this context they should develop influenza pandemic plans that correspond to those of their partner organisations, and work with other agencies via the Resilience Partnership to ensure that their plans are appropriately integrated and consistent.

Primary Care

8.24 In accordance with their remit for sustaining the delivery of primary care/ general medical services, HSCPs should ensure its pandemic plans cover the contribution/role of local GP practices and community pharmacies and agree these plans with those services – to include:

- arrangements for GP practices to work in clusters where possible;
- agreement of plans with the GP Out-Of-Hours Service, Scottish Ambulance Service and NHS 24;

Social Care

8.25 All forms of social care will be impacted by a future pandemic. This includes those provided by the HSCP or external providers, and funded by the Partnership or via self-funding arrangements. HSCPs should therefore ensure that contingency plans are developed by all social care providers to take into account the needs of people receiving such services.

8.26 HSCPs should take action to ensure that the local social care system will be flexible, adequately prepared and appropriately resilient (i.e. having business continuity arrangements in place) to meet the demands of a moderate or severe pandemic over a sustained period when service provision may be adversely impacted.

8.27 Using the agreed planning assumptions (see section 4) for the area, HSCP lead professionals should work with social care / framework providers in the area to:

- Identify arrangements for monitoring increasing/changing care needs and impacts on the care sector during various phases of a pandemic;
- Develop the local care sectors' response to providing safe care to vulnerable individuals;
- Agree inter-provider relationships and the type and level of assistance might be provided by mutual agreement between the HSCP and other providers;
- Identify triggers and processes for assistance with meeting demand for social care and to facilitate effective patient flow through acute/secondary care services;
- Develop models of stepped / flexible care to manage capacity and meet additional demand for (residential care and home care) services;
- Implementing alternative admission and discharge criteria to/from social care, and encompassing processes;
- Develop arrangements for monitoring workforce impacts;
- Ensure all care providers have robust up-to-date business continuity plans (see section 9) and contingency arrangements for their services;
- Advise individuals with self-directed support arrangements to have contingency plans built into their care plans in the event that their carers /personal assistants or commercial care agencies are adversely affected by the pandemic. It should be made clear that any support by the HSCP or other relevant agencies will be dependent on the availability of suitably qualified staff and other workforce demands at the time.

8.28 Through their commissioning arrangements, HSCPs will have well-established relationships with independent and third/voluntary sector care ('framework providers') providers in their area and good information on how the capabilities of these organisations may be utilised during a moderate or severe pandemic to provide additional practical support for vulnerable individuals or groups by,

- Creating local support networks to collect /deliver medicines ("flu friends"); and
- Collecting shopping and basic supplies for persons unable to do so themselves.

8.29 The Scottish Government publication The Voluntary Emergency Responders Guide[27] provides information on the capabilities of national voluntary sector organisations that can provide assistance during emergency situations.

[27] https://www.readyscotland.org/ready-government/engaging-with-the-voluntary-sector/

9. BUSINESS CONTINUITY

This section highlights what organisations should do to mitigate the impact of potential disruptions on services.

Business Continuity Management

9.1 All health and social care organisations should have in place robust business continuity management arrangements and flexible and responsive business continuity plans. These will help ensure that the impact of any disruptions on services will be minimised. In the event of an influenza pandemic, organisations will have a key role to play in reducing the risk to staff and service users' health and safety as far as possible, as well as maintaining essential services.

9.2 Given the highly uncertain nature of an influenza pandemic, there will be no advanced warning of how serious it will be and who will be most affected; it is therefore important that plans are developed which can address a range of scenarios.

9.3 An influenza pandemic is different from other major incidents / business continuity disruptions. Its effects will be prolonged, multiple locations could be affected simultaneously and its impacts can be immediate. Therefore, planning processes should consider the dynamic nature of a pandemic as part of an organisation's overall strategy.

9.4 Effective Business Continuity Management (BCM) requires senior management engagement and clearly defined decision-making processes so that decisions regarding governance and compliance with regulatory-driven requirements can be taken without delay. BCM is also essential to ensuring there is comprehensive:

- Situational awareness and identification of forward looking capabilities
- Awareness of the challenges ahead
- Executable goals and objectives
- Application of experience / lessons from past successes ('lessons-learned').

Business Continuity Plans

9.5 Business Continuity (BC) /contingency plans should:

- Assess and mitigate the impact of the pandemic on services and service users;
- Identify plans to manage workforce absence and disruption to travel;
- Measures to control the spread of infection;
- Identify plans for a potential loss of suppliers of services, medication and equipment;
- Identify how the needs of service users with acute illness might be met at home or in care homes if they cannot be admitted to hospital; and

- Identify agreed partnership / service-sharing arrangements with other providers in the local area.

A checklist to assist health and social care organisations with business continuity planning and preparedness is attached as Annex C.

9.6 Business Continuity plans are generally focussed on recovery of utilities and facilities ('bricks and mortar' type structures). However, in a pandemic situation, the human component is critical. Therefore it is important that pandemic BC plans take account of:

- **Loss of staff** which could occur for several reasons – sickness, caring for sick relatives, school closures, fear of contamination at the workplace; and,
- **Communication and information flows** vertically and horizontally throughout the organisation. This means that consideration should be given to the use of common terminology within the organisation and with all external partners and service users that is understood by everyone.

9.7 In order to be prepared to respond to and manage the consequences of a pandemic in a timely manner, organisations should:

1. Undertake a business impact assessment to identify which elements of the service are likely to be impacted, and how any risks can be mitigated.
2. Rethink the basis (i.e. risks) on which their BC Plan was originally developed.
3. Focus on developing their ability to maintain functionality while operating at reduced capability, until it can return to normal operational capacity.
4. Develop surveillance and control-and-coordination arrangements to monitor the impact of the pandemic, the effectiveness of their BC plan, and to liaise with partners, and
5. Exercise their BC plan and train staff at all levels in the organisation to understand and implement the plan. A BC plan will not be effective unless it is properly tested and understood.

9.8 Given the potential duration of an influenza (flu) pandemic, BC planning for all operational activity will be important in underpinning resilience in the health and social care sectors.

Business Continuity and Contingency Planning

9.9 As a condition of their registration with the Care Inspectorate, care providers[28] are required to state how they will provide for the health and welfare of service users, and to have robust Business Continuity (BC) managements arrangements, underpinned by effective governance and decision-making processes and plans/contingency arrangements to enable them to continue providing safe care and mitigate the effects of disruptive incidents. These BC management arrangements and plans should be outlined in the providers' contracts.

9.10 As part of the commissioning / contracting process, HSCPs should ensure that service providers have robust and up-to-date business continuity plans in place.

[28] Care services as defined in PSR (Scotland) Act 2010 s. 47: https://www.legislation.gov.uk/asp/2010/8/section/47

10. SPECIFIC ISSUES

This section highlights specific issues that require careful consideration to ensure an effective response to and preparedness for an influenza pandemic.

Minimising the spread of infection

10.1 Measures to minimise the spread of infection both in the population and care setting during an influenza pandemic include implementation of infection control measures in care settings, including the use of Personal Protective Equipment (PPE) and provision of advice to the public and clinical countermeasures (see section 10.8).

Infection control in the care setting

Infection control procedures

10.2 Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) are specified in the National Infection Prevention and Control Manual (NIPCM)[29], and should be implemented during all phases of an influenza pandemic e.g.:

- Hand Hygiene
- Respiratory and Cough Hygiene
- Patient Placement (isolation/cohorting)
- Personal Protective Equipment (PPE), including use of Respiratory Protective Equipment (RPE)
- Safe Management of the care environment and equipment (including linen and blood and body fluid spillages)
- Safe Disposal of Waste (including sharps)

10.3 Some treatment services may require to be rescheduled and non-urgent services may be reduced if there are shortages of staff and specialist consumables.

Respiratory Protective Equipment (RPE)

10.4 RPE i.e. Fluid Repellent Surgical Facemask (FRSM) and Filtering Face Piece (FFP) Respirator may be required:

A Fluid Repellent Surgical Mask (FRSM) should be worn by care staff when working in close proximity (within one metre) to someone with symptoms of influenza;

[29] http://www.nipcm.hps.scot.nhs.uk

A FFP3 Respirator should be worn when performing care procedures that have the potential to generate infectious aerosols such as intubation, extubation, bronchoscopy and dental procedures. In addition, in an Intensive Care Unit (ICU) where patients with pandemic influenza are being managed in an open (multi-bed) unit, all staff and visitors should wear an FFP3 respirator at all times. If the patient(s) is isolated in a single room then only those entering the room should wear a FFP3 respirator.

10.5 A Filtering Face Piece Class 3 (FFP3) is the recommended standard of respirator for use in an influenza pandemic. Only these types of respirator are held in the national stockpile for use in a pandemic.

10.6 It is important for all staff that may be required to wear a FFP3, are fit-tested and trained in their use.[30][31].

National Stockpile of Personal Protective Equipment (PPE) and other consumables

10.7 The Scottish Government has a centrally-held stockpile of PPE (and RPE) and a range of consumable products which may be in short supply during an influenza pandemic. This is to ensure that health and social care services are provided with adequate supplies to enable them to continue to function effectively. More detailed information on the stocks held and how health and social care organisations can access them will be made available in the event of a pandemic.

[30] http://www.nipcm.hps.scot.nhs.uk
[31] http://www.hse.gov.uk/respiratory-protective-equipment/fit-testing-basics.htm

Clinical Countermeasures

10.8 An influenza pandemic will inevitably place substantial pressures on health services. Clinical countermeasures such as antiviral medicines, vaccines and antibiotics may reduce the severity of illness in individuals, lessen the number of deaths resulting from an influenza pandemic and ease pressure on care services.

Access to Antiviral medicines and treatment

National Stockpile

10.9 The Scottish Government, like the other UK administrations, holds stockpiles of antiviral medicines sufficient to treat up to half of the population in the event of a high impact pandemic (the modelled 'reasonable worst case' pandemic scenario).

10.10 At the beginning of a response to an influenza pandemic, a proportion of the national stockpile of antiviral medicines will be distributed to identified geographical locations across Scotland in varying quantities to meet local needs. This will supplement the small stocks held by local NHS Boards. These arrangements will be underpinned by robust distribution and stock control systems.

10.11 Antiviral medication may also be available via the National Pandemic Flu Service (NPFS), if/when it is set up, to reduce the pressures on the NHS – primary care and emergency departments – as the pandemic develops.

Antiviral Medicines

10.12 For maximum treatment benefit, antiviral medicines need to be taken within seven days of symptom onset and ideally within 48 hours. Arrangements for providing rapid assessment and access to antiviral medicines have been developed on the basis of providing treatment within this timescale.

10.13 The two antiviral medicines recommended for the treatment of influenza in the UK are, oseltamivir (Tamiflu) and zanamivir (Relenza), both neuraminidase inhibitors. They are primarily used for treating symptomatic individuals and national protocols for their supply and administration have been developed on the basis of expert clinical advice.

10.14 In certain situations, where individuals with a serious underlying condition or who are pregnant have been in close contact with an infectious person, clinical judgement will determine the level of prophylaxis against infection and to reduce the risk of life-threatening illness.

10.15 During a pandemic, it is likely that the National Pandemic Flu Service (NPFS) – (see below) will be mobilised and will become the main route to authorise antivirals medicines. Until it is mobilised, GPs and other clinicians will be able to prescribe antiviral medicines as normal.

Antibiotics

10.16 Secondary bacterial infections may be a significant cause of death during an influenza pandemic as a result of secondary complications. Therefore the national stockpile contains sufficient levels of those antibiotics most likely to be useful in treating influenza pandemic related complications. They would be made available only if there was clear evidence of shortages in the medicines supply chain in primary or secondary care at

the time. Information on accessing the stockpile would be issued by the Scottish Government's Chief Pharmaceutical Officer at the appropriate point in time.

Pandemic Specific Vaccine

10.17 It will take at least four to six months from the start of a pandemic for a pandemic specific vaccine (PSV) to become available. Scottish Government will notify the NHS Boards when a PSV is available for use. Thereafter, NHS Boards will be responsible for encouraging its uptake by frontline health and social care staff as a strategy for improving the resilience of the services they provide.

The National Pandemic Flu Service

10.18 The National Pandemic Flu Service (NPFS) is a UK internet and phone based facility that will allow members of the public to be assessed and authorised antiviral medicines if appropriate. It is aimed at:

- reducing pressure on primary care services;
- enabling people with flu like symptoms to remain at home;
- enabling rapid self-assessment, providing care advice, and antiviral authorisation; and
- providing an additional source of data relating to trends in activity and profile of people assessed as suffering from pandemic symptoms.

10.19 The Scottish Government will authorise the mobilisation of the NPFS in Scotland, following expert assessment of the level of pressure on services and the impact of the pandemic at the time.

10.20 NPFS assessment is based on a clinical algorithm that has been developed by clinical experts. It will be updated to take account of the nature of the flu pandemic. It is focussed on identifying the need for urgent medical assessment and directing patients to a GP practice or other healthcare service for additional advice or treatment. If the assessment of the patient indicates that they should receive antiviral medicine an authorisation number (instead of a prescription) will be issued. The patient's representative (their 'Flu Friend')[32], not the symptomatic individual, can then attend an Antiviral Collection Point (ACP) to collect the antiviral medicines.

10.21 Children aged two years or over can be assessed by the NPFS using a clinically based paediatric triage protocol and referred for antiviral medicines if appropriate[33], although those at risk of suffering complications of influenza may be referred to a suitably qualified health professional/practitioner if needed.

10.22 Prior to NPFS mobilisation, antiviral medicines will be made available through primary care. Once a decision has been made to mobilise the NPFS, the lead time for it to become operational is three weeks, during which time arrangements for implementation of antiviral collection points in all local areas will need to have been completed. The increasing demand placed on services during this three week period will be managed through NHS escalation processes.

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[32] "Flu Friend" - A friend, relative or neighbour who could help someone who falls ill by collecting medicines and other supplies so the person with flu does not have to leave home and possibly spread the virus.

[33] Children under this age will be assessed by a GP or suitably qualified health professional/practitioner

Antiviral Collection Points

10.23 Antiviral Collection Points (ACPs) are designated places in the community where antiviral medicines can be collected on behalf of a symptomatic person, on presentation of the person's valid authorisation.

10.24 The purpose of an ACP is to:

- Enable symptomatic patients to remain at home but still gain rapid access to antiviral medicines if necessary via a flu friend; and
- Minimise the impact on primary care and secondary care services, so that they can retain their operational capacity for the assessment of patients with non-influenza illnesses.

10.25 NHS Boards, in collaboration with the local Health and Social Care Partnerships (HSCP) will be required to assess population requirements using national planning assumptions to inform decisions regarding the number and location of ACPs at a local level, and risk assess potential sites. Operational responsibility for the ACPs will rest with the HSCP, supported where necessary by the NHS Board.

10.26 As GPs (except in some rural locations by agreement with the NHS Board) and hospitals (except for inpatients) will not retain or dispense antiviral medicines to the public, their premises should not be used as ACPs. 10.29 The NHS Board and the HSCP must assure the governance arrangements for all ACPs and ensure that the staff who will be called upon to assist in the ACP are appropriately trained in the storage and supply of medicines, safe systems and processes, reporting mechanisms and relevant security issues.

Community Pharmacies As Primary Antiviral Distribution Points

10.27 The establishment and running of ACPs would be a resource intensive exercise at a time where pressure on existing resource may be significant. Many stakeholders have therefore expressed a preference for arrangements which would enable community pharmacies to be used as the primary distribution route in their Board area, where this is the local preference (it may not be in specific locations). The Scottish Government is therefore working with relevant stakeholders to agree systems to enable this to happen and will update Boards and others in due course.

Demand and Capacity

10.28 During an influenza pandemic, the level of demand for health and social care services is likely to be greater than the most severe winter pressures projections. Services, especially those in the 'hotspot' areas, are likely to be under considerable, sustained pressure even if the impacts are mild or moderate.

Patients with existing illnesses (respiratory, immuno-compromised and other co-morbidities), long term / chronic conditions and frail elderly are more likely to have complications from influenza pandemic; this will place an additional burden on services.

Guiding principles

10.29 Seven guiding principles should be considered when planning for an increase in demand and capacity. They are common to health and social care services:

- The care that can be given to people when resources are stretched should be maximised;
- Plans should be consistent with the overall aim of preserving and maintaining essential services;
- Changes to services and clinical / care standards should be incremental and should reflect changes in local demand and the resources that are available;
- Changes should be consistent with the established ethical principles;
- Plans should take a whole-system approach and encompass primary, community and secondary care;
- Plans should support the attainment of strategic objectives at each stage of a pandemic;
- Implementation of this guidance should be coordinated at a strategic level by health and social care organisations to ensure consistency of interpretation and effect.

Organisations must also be aware of their legal duty to involve / inform patients/ service users in the development of their plans and their Equality duty.

Key elements

10.30 In developing demand and capacity systems during an influenza pandemic, there are three interrelated elements to consider:

- the physical aspects of creating extra capacity, i.e. creating space, providing staff, supplying resources and/or managing the process;
- prioritising services to release capacity;
- prioritising patients and clinical interventions to control demand.

10.31 These three elements will be present to a greater or lesser extent along a spectrum of actions, depending on the magnitude of the challenge and the resources available.

Increasing Capacity

10.32 Capacity management involves 'four Ps': Processes, Premises, Providers and People. Each of these components should be considered individually, as well as how they would operate together:

- **Processes** – There should be clear arrangements for command, control and coordination. Systems changes, such as staffing levels, require planning so that any changes can be implemented easily and quickly during a pandemic.

- **Premises** – Hospitals should be able to make significant expansions in their acute bed capacity and double the provision of critical care beds within a one-to two-day period. In primary care, extra capacity could be created for additional clinical contact opportunities through the suspension of other health promoting/ chronic disease management clinics. As far as possible, non-flu patients should access and receive care in the ways in which they would do so in 'normal' circumstances (e.g. practice-based care). Influenza patients will need to be supported to remain at home, for example through home visiting and telephone assessment. Expansion of community hospital and continuing care capacity should also take place where possible.

- **Providers/provisions** – Health and social care organisations should consider what their key vital supplies are and what is likely to be required to meet the surge in demand for emergency care/support. They should make provision for these items well in advance of the pandemic. However, certain commodities such as blood and blood components cannot be stockpiled, and reference should be made to national plans. Plans should be put in place to commission additional capacity from third sector/independent providers and models of (stepped) care should be agreed with them in advance and as part of the health and social care influenza pandemic plan.

- **People** – Health and social care organisations should determine and maximise the pool of skills they have at their disposal from their employed, reserve, trainee and volunteer staff, so that redeployment is managed to best effect.

10.33 Further guidance on framework planning for surge and escalation of NHS services is contained in a Department of Health Guidance 2009 document[34]. The content of this document is still essentially relevant for planning purposes.

34 http://webarchive.nationalarchives.gov.uk/20130124045951/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098750.pdf

Taking action

10.34 Increased demand and reduced capacity will result in health and social care organisations being unable to maintain business as usual[35]. Acute hospital surge plans[36] are likely to reach a point of exhaustion very quickly. Therefore working collaboratively, they will be required to take a series of flexible and escalating actions to create capacity which will include:

- reducing non-essential activity;
- enhancing arrangements for discharge from hospital;
- re-prioritising access to some services in an ethical way;
- identifying options for alternative care.

10.35 In these circumstances Scottish Government, along with regulatory and key national bodies, will consider what flexibility can be introduced through current arrangements and through any other means e.g. legislative measures, to support health and social care organisations. For example, this may include measures to support the supply of staff or to temporarily suspend the Treatment Time Guarantee. In these circumstances, Scottish Government will fulfil a national coordination role with the support of expert advice.

[35] Paragraph 6.33 & 6.34, https://www.gov.uk/guidance/pandemic-flu#uk-influenza-pandemic-preparedness-strategy-2011

[36] 'Surge' is a term used within healthcare to mean 'the ability of the health service to expand beyond normal capacity to meet an increased demand for clinical care".

Public communication

10.36 During an influenza (flu) pandemic, the UK and Scottish Governments, via COBR and SGoRR respectively, will collaborate and lead on national public communication. The aim will be to inform, inspire confidence and provide reassurance. The specific focus of Government communications will be to let the public know:

- what is happening at a UK level and in Scotland;
- where they can find reliable information; and
- how to take care of themselves and get medical support if required.

10.37 Through existing Scottish Government (SG) communications channels, including SGoRR, there will be a proactive approach aimed at reassuring the public and encouraging health promoting behaviours, while simultaneously ensuring that responder agencies have up-to-date information to enable them to respond to enquiries from the public and prepare and manage staff concerns.

10.38 Good liaison between national and local communications teams is essential so that there is awareness and consistency of message at all levels. Key messages developed at national (SG) levels and will be issued to Regional Resilience Partnerships' Public Communications Groups (PCG). The PCG will be expected to issue these timeously to pre-identified points of contact (these may be local Control and Coordination groups) within Health Boards, Local Authorities and HSCPs for onward transmission.

10.39 NHS Board and Local Authority communications leads should take immediate steps to reiterate and reinforce national messages. Local public communication plans should cover issues including:

- roles, responsibilities and methods for communicating with a range of audiences during a pandemic;
- identify how staff will be communicated with proactively;
- arrangements for communications with the public about any changes to services;
- how to access antiviral medicines;

10.40 It is important that communications to health and social care professionals are timely, consistent and contain up-to-date guidance on best clinical approaches.

10.41 In view of the importance of the third/voluntary sector in minimising potential pressure on statutory health and social care services, NHS Board and Local Authority communication leads should collaborate with their local HSCP(s) to put in place plans for keeping them informed of the pandemic situation and pressures on the health and social care sector, as well as any change in strategic direction.

Human Resources

10.42 In view of their responsibilities for health and safety and wellbeing of staff during an influenza pandemic, NHS Boards and Local authorities, and Health and Social Care Partnerships (HSCP) should ensure that these issues – health protection, welfare / support, staff in at-risk groups or who are pregnant – are appropriately addressed in their plans.

10.43 As HSCP staff are employees of either the NHS Board or the Local Authority, the three organisations work together to address pandemic-related workforce issues and clearly identify in the influenza pandemic plan how various issues, such as staff shortages, (re)deployment in exceptional circumstances and changes to normal working patterns, will be tackled. These plans should be discussed with the relevant staff representative bodies during the planning process so that there is an agreed, consistent approach to potential challenges.

10.44 As part of the process of workforce contingency planning, organisations should identify options for recruiting and accrediting a pool of volunteers, such as recent professional retirees or medical / allied health profession students from local universities, at short notice. In order to rapidly deploy volunteers and ensure safe practice, fast-track training and action cards (defining role and task) should be prepared for specific roles that might be required. The action cards and associated governance arrangements should be included in the plan.

10.45 NHS Boards, Local Authorities and HSCPs should identify the collaborative arrangements that will be implemented during a pandemic situation to monitor key workforce issues (e.g. sickness absence) and impacts, and ensure that relevant workforce policies are consistently interpreted and applied.

10.46 A good understanding of workforce profile (e.g. those with carer responsibilities; health conditions; disabilities) and capabilities (e.g. specific skills and experience) is an important aspect of scenario-based business continuity planning and ensuring organisational resilience. Such information should be kept up to date as it will be valuable during a pandemic in terms of making efficient use of human resources.

10.47 It is important that human resource aspects are incorporated into exercising and testing regimes or tested separately against the various pandemic phases.

10.48 Guidance on pandemic workforce issues in health was issued during the 2009 H1N1 pandemic and will still be useful for Health Boards: Pandemic Flu: Guidance on Health Workforce Issues for NHSScotland Boards[37].

[37] https://www.gov.scot/Publications/2009/08/11132555/0

ANNEX A

Influenza Pandemic

A Summary of Actions For Organisations

This annex sets out some of the key actions to be undertaken by different organisation types before and during a flu pandemic. The lists are not exhaustive and should be one basis for agencies/partnerships developing their own.

This annex covers the following organisation (types):

- Generic Actions for most organisations
- NHS Boards (and/or HSCP as agreed locally)
  - Scottish Ambulance Service
  - NHS 24
  - NSS Health Protection Scotland
- HSCPs
  - Primary care, community and social care services
  - Services commissioned from independent/third sector interface

Generic Pandemic Influenza Actions

Pandemic phase	Action
Preparing	▪ Ensure business continuity, surge, winter and pandemic flu plans are up to date and reflect latest guidance and evidence ▪ Develop joint and/or mutually agreed pandemic plans with relevant partners ▪ Agree roles & responsibilities of your agency & partner agencies in pandemic planning & response ▪ Use planning assumptions to set out potential demand on services over the course of a pandemic – using mild/ moderate and severe scenarios ▪ Consider which of your services are “essential” in a pandemic & discuss these with relevant partner agencies ▪ Participate in relevant local & regional planning fora with multi-agency partners ▪ Plan for potential mutual aid arrangements with relevant partner agencies ▪ Maintain lists of vulnerable patients/service users ▪ Maintain robust seasonal flu vaccination programmes for staff and patients/service users ▪ Plan for additional staff capacity e.g. retired, students, volunteers etc. ▪ Consider arrangements for potential redeployment of staff to support essential services ▪ Ensure that planning aligns with Civil Contingencies Act (2004) structures ▪ Maintain lists of staff contact details identifying those who may have caring responsibilities or needs

	▪ Undertake regular training and exercising, including local health, social care and resilience partners
Detect/ assess	▪ Review & activate pandemic plans and related plans/arrangements, as necessary ▪ Timely communication with staff, the public and other stakeholders ▪ Consider promoting alternative care pathways to patients if appropriate ▪ Review vulnerable persons list ▪ Consider reducing non-urgent services and inform users of reduced service
Treat/ Escalate	▪ Timely communication with staff and public, including the use of local media ▪ Implement business continuity arrangements and surge escalation arrangements, whilst maintaining essential services as far as possible ▪ Implement any agreed local escalation arrangements for faster hospital discharge or admission avoidance ▪ Enact mutual aid arrangements if required (where & when this may be feasible) ▪ Encourage staff uptake of Pandemic Specific Vaccine, when available ▪ Maintain support to community patients
Recovery	▪ Agree prioritisation of return of normal services ▪ Prepare for any possible future wave of influenza pandemic ▪ Continue pandemic specific vaccine vaccination campaign ▪ Review previously identified vulnerable groups ▪ Consider physical rest/emotional support for staff ▪ Identify lessons to be learned ▪ Maintain communications to partners, staff, patients and public

Actions for Specific Organisation Types

HSCP Primary Care

Pandemic phase	Action
Preparing	▪ Support maintenance of the HPS led seasonal influenza surveillance infrastructure to support escalation of the pandemic response.
Detect/ assess	▪ Swabbing and sampling of patients if necessary ▪ Support response to outbreaks in closed settings such as schools
Treat/ Escalate	▪ Recommend GP clusters consider working together & supporting each other ▪ Maintain support to community patients ▪ Increased support to care/nursing homes to maintain unwell/vulnerable people in the community ▪ Prescribe antiviral medicines to children in special schools if required ▪ Death declaration and certification
Recovery	▪ See generic actions

NHS Boards (and/or HSCP as agreed locally)

Pandemic phase	Activity
Preparing	▪ Agree roles and responsibilities of Board and respective partners in both planning and response phases i.e. HSCP, LRP/RRP, including governance arrangements ▪ Develop plan covering health and social care with HSCP, including relationships, roles and responsibilities of LRP/RRP ▪ Ensure plans to increase critical care provision by at least 100% are maintained ▪ Engage with Local Medical and Pharmaceutical Committee(s) ▪ Agree local arrangements for antiviral distribution, including locations, facilities etc. – until such time as community pharmacies may be used as primary distribution points, the assumption should be that sufficient Antiviral Collection Points (ACPs) would be established by Boards/HSCPs to meet the full demand ▪ Engage with other Boards/HSCPs & independent sector on mutual aid ▪ Maintain the HPS led seasonal influenza surveillance programme to support escalation of the pandemic response ▪ Ensure that communication routes are in place with all independent sector providers, which are capable of being a platform for daily communications
Detect/ Assess	▪ Lead communications to multiagency partners ▪ Isolate patients to slow spread where possible ▪ Set up alternative arrangements for the assessment and initial management of suspected flu patients (e.g. a Flu Emergency Department) if required ▪ Set up Antiviral Collection Points (ACPs) in hotspots if required ▪ Prepare to commence storage and distribution of antivirals and personal protective equipment if required ▪ Review fit testing programme for FFP3 respirators for staff performing aerosol generating procedures ▪ Prepare to commence storage and distribution of personal protective equipment to staff if required ▪ Collate and review list of retired staff who might be re-employed ▪ Monitor and collate incidence data ▪ Establish reporting arrangements to both local and national levels ▪ Commission vaccination programme ▪ Increased support to care/nursing homes to maintain unwell/vulnerable people in the community ▪ Increased need for packages of care in the community due to early hospital discharges ▪ In severe pandemics, need to work closely with primary care, EDs and NHS 24 to ensure no single service over-whelmed
Treat/ Escalate	▪ Involvement in PPE storage, stock and distribution for own staff ▪ Manufacture of oral oseltamivir solution (in designated licensed Hospital Pharmacy Manufacturing Units) ▪ Cohort patients if necessary

	▪ Consider if any non-urgent services can be reduced or postponed ▪ Discharge patients into the community where safe to do so ▪ Increase ICU capacity if required and safe to do so ▪ Enact surge and escalation plans as required ▪ Support vaccination for vulnerable people
Recovery	▪ See generic actions

Scottish Ambulance Service

Pandemic phase	Activity
Preparing	▪ Surveillance of ambulance call rates related to flu
Detect/ Assess	▪ Continue with items in 'Preparing' stage as appropriate ▪ Consider reducing non-urgent services and inform users of reduced service ▪ Consider promoting alternative care pathways to patients if appropriate ▪ Continued use of REAP, DMP and other escalation plans to prioritise calls ▪ Review need for additional staffing ▪ Review fit testing programme for FFP3 respirators for staff performing aerosol generating procedures
Treat/ Escalate	▪ Identification of additional staffing capacity - retired/ students ▪ If capacity, the field assessment and treatment skills of ambulance staff could be utilised to support the wider delivery of home care ▪ In severe pandemics, work with primary care, EDs and NHS 24 to ensure no single service over-whelmed
Recovery	▪ See generic actions

NHS 24

Pandemic phase	Activity
Preparing	▪ Surveillance of 111 calls related to flu ▪ Surveillance of NHS Inform web hits related to flu ▪ Maintain digital approach to managing surge demand ▪ Engage with Out of Hours Partners
Detect/ Assess	▪ Continue with items in 'Preparing' stage as appropriate ▪ Encourage use of digital resources for self-care advice ▪ Support the National Pandemic Flu Service (NPFS) as required ▪ Establish Scottish Flu Response Centre (SFREC) with HPS ▪ Review need for additional staffing ▪ Implement specific alternative pathways to respond to call types
Treat/ Escalate	▪ Consider enacting any agreements with independent sector providers to support local NHS providers ▪ Identification of additional staffing capacity - retired/ students ▪ In severe pandemics, work closely with primary care, EDs and ambulance services to ensure no single service over-whelmed
Recovery	▪ See generic actions

NSS Health Protection Scotland

Pandemic phase	Activity
Preparing	▪ Review and update information and guidance on pandemic issues ▪ Ensure appropriate surveillance systems are in place building on existing seasonal influenza infrastructure and capabilities ▪ Maintaining the lab capability to detect a new virus & develop appropriate diagnostic tests ▪ Provide relevant data to inform review of planning assumptions and models ▪ Contribute to research and development where relevant ▪ Ensure up to date generic guidance on the investigation and management of cases and outbreaks is available ▪ Ensure generic information on influenza is available to the general public and health professionals
Detect/ Assess	▪ Communications to local NHS and public ▪ Identify key clinical epidemiological and virological features of the new virus ▪ Collect and assess data on severe cases and identify the risk groups most affected ▪ Monitor and collate incidence data from GPs/hospitals ▪ Describe the evolving pandemic, in particular the spread and impact on the population and health services ▪ Prepare to measure the uptake and assess the safety and effectiveness of pharmaceutical countermeasures ▪ Lead the rapid assessment of the first cases and their contacts, and giving an insight into the impact and transmission of the infection ▪ Closely liaise with Public Health England to support the development and deployment of diagnostic tests. ▪ Implement enhanced pandemic influenza surveillance systems including systems to measure community transmission and severe disease ▪ Liaise and share data with the UK, WHO, the European Centre for Disease Prevention and Control, and other countries, as required ▪ Adapt and roll out guidance, when available, on the investigation of possible cases and their contacts, clusters and outbreaks ▪ Establish Scottish Flu Response Centre (SFREC) with NHS 24
Treat/ Escalate	▪ Maintain surveillance systems of Influenza-Like Illness (ILI) cases and outbreak investigation ▪ Undertake community surveillance, sero-incidence surveillance and severe disease (hospital-based) and mortality surveillance ▪ Measure and monitor the uptake, safety and effectiveness of any pandemic influenza vaccination programme ▪ Continue to characterise viral isolates in order to detect any changes that may affect virulence, antiviral resistance, transmission or any other characteristic ▪ Disseminate information on the progress of the pandemic ▪ Provide timely and accurate information for the public and health professionals on the pandemic and the clinical effects of the infection

	▪ Adapt guidance on the management of cases and their contacts in light of emerging information on the virus, the clinical illness and the impact on society and services ▪ Work with the Government to develop advice regarding travel to affected countries, port health arrangements to be deployed, information at parts of entry & general public comms ▪ Through the Scottish Health Protection Network, manage vaccine implementation plans ▪ Advise on the potential impact of restrictions on public gatherings and public transport ▪ Provide advice on when to cease measures to slow transmission of the virus, if they have been commenced
Recovery	▪ Identify lessons to be learned ▪ Review effectiveness of infection prevention and control measures ▪ Continue to monitor the virus and susceptibility in the population ▪ Update algorithms, pandemic preparedness plans, business continuity plans as required ▪ Continue to produce and/or contribute to status reports as needed

HSCP Social Care (including local authorities, HSCPs and providers as relevant)

Pandemic phase	Activity
Preparing	▪ Agree roles and responsibilities of Local Authority and respective partners in both planning and response phases i.e. HSCP, LRP/RRP, including governance arrangements ▪ Develop plan covering health and social care with HSCP, including relationships, roles and responsibilities of LRP/RRP ▪ Ensure agreement about what are “essential” services - & agree with local partners how priorities across HSCP and RP areas would be managed ▪ Develop system to identify persons at risk – such as the Persons at Risk Distribution (PARD) system ▪ Ensure that communication routes are in place with all independent/third/ voluntary sector providers, which are capable of being a platform for daily communications ▪ Planning with adult social care providers, early years services and private, independent and voluntary providers ▪ Ensure service providers have robust and up-to-date business continuity plans in place ▪ Advise independent/third sector social care providers to make arrangements for influenza vaccination of their staff ▪ Arrangements for storing and distribution of facemasks ▪ Alignment with overall winter and capacity planning with local NHS ▪ Ensure that planning aligns with Civil Contingencies Act (2004) structures
Detect/ Assess	▪ Continue with items in ‘Preparing’ stage as appropriate ▪ Review communication channels to providers ▪ Consider reducing non-urgent services and inform users of reduced service

	▪ Consider promoting alternative care pathways to service users if appropriate ▪ Review vulnerable persons list ▪ Increased support to care/nursing homes to maintain unwell/vulnerable people in the community ▪ Prepare to commence storage and distribution of personal protective equipment to staff if required ▪ Distribution of face masks to front line social care workers ▪ Use of informal care networks and voluntary or third sector organisations to cover staff absenteeism or sickness ▪ Confirm "mutual aid" arrangements between providers ▪ Check vulnerable persons list ▪ Communication with elected members ▪ Management of central government/local information channels ▪ Optimise capacity in independent sector for early years and adult social care, including mutual aid arrangements ▪ Use local media to provide information on services to community ▪ Assist with set up of 'flu friends' service if required
Treat/ Escalate	▪ Consider enacting any agreements with independent/third/voluntary sector providers ▪ Maintain ability to care for patients outside of acute NHS settings as much as possible ▪ Encourage staff uptake of Pandemic Specific Vaccine, when available ▪ Support vaccination for vulnerable people
Recovery	▪ See generic actions

Annex B

Surveillance during a pandemic influenza

1. PHE will lead on the UK surveillance activities and co-ordination of epidemic intelligence from the devolved administrations to inform and manage the UK pandemic response effectively.

2.. HPS will play a key role in providing a range of surveillance information outputs to inform the changing epidemiological picture during a pandemic. Pandemic influenza surveillance in Scotland will be based on established seasonal influenza surveillance activities and arrangements. However, as for any infectious disease outbreak, rapid and more intensive data collection and analysis will be necessary, and more frequent reporting of data will be required at the start of an influenza pandemic.

3. Surveillance activities are likely to be required from a mix of health organisations such as General Practitioners (GPs), community services and hospitals, and are likely to include:

- rapid assessment of the first cases and their close contacts to provide an early insight into the clinical, virological and epidemiological features of cases;
- field investigation of the first clusters of cases and outbreaks of pandemic influenza in closed settings such as schools;
- regular syndromic surveillance data on consultation behaviour for patients with acute respiratory illness through telephone help-lines, in primary and secondary care;
- establishment of virological sampling schemes ensuring links with the surveillance arrangements put in place;
- collection of detailed clinical information on cases of severe disease admitted to intensive care;
- clinical, epidemiological and virological investigation of early deaths caused by the pandemic virus;
- rapid monitoring of age-specific excess mortality using data from the General Registry Office on-line system;
- rapid assessment through community surveillance, e.g. telephone surveys, to determine the rate of illness and healthcare seeking behaviour in the general population;
- establishment of specific systems to monitor the uptake, effectiveness and safety of any pandemic vaccine programme in targeted groups, and
- cross-sectional population estimations of background immunity and age-specific rates of infection.

Annex C

Influenza Pandemic : Business Continuity Checklist for Health and Social Care Organisations

The following checklist is intended to assist you in developing and reviewing your organisation's influenza pandemic plans. It identifies important and specific activities which organisations should do to prepare for a pandemic. Further information can be found at http://www.ukresilience.info

This checklist is not exhaustive. It is a guide to help you start thinking about what you may need to plan for.

1. Plan for the impact of a pandemic on your business	Complete	In progress	Not started
Identify a pandemic coordinator and/or team with defined roles and responsibilities for preparedness and response planning. The planning process should include input from a wide range of stakeholders.			
Identify the critical activities undertaken by your organisation which would have to continue during a pandemic, as well as the staff and other inputs that support services, logistics, and security. Consider how internal resources could be re-allocated to ensure those activities are maintained.			
Discuss with your suppliers/sub-contractors whether they have robust Business Continuity plans in place – your organisation is only as good as those on whom it depends.			
Consider preparing an additional pool of staff to undertake key tasks and provide training where appropriate.			
Establish an emergency communications plan and revise periodically. This plan should identify key contacts (with back-ups), chain of communications (including suppliers, patients and staff).			
Test your plan, and revise periodically taking into account updated advice and guidance from Government/ NHS Board.			

2. Plan for the impact of a pandemic on your staff and patients	Complete	In progress	Not started
Using Government guidance, forecast and plan for staff absences during a pandemic. This could be the result of a number of factors including personal illness, family member illness, bereavement, possible disruption to other sectors e.g. closures of nurseries and schools or reduced public transport.			
As a general approach to reducing the spread of the infection across the country, assess your organisations need for continued face to face contact with your patients and plan to modify the frequency and/or type of face-to-face contact.			
Identify vulnerable patients with special requirements, and incorporate the requirements of such persons into your preparedness plan			
Consider your patients' needs during a pandemic and whether to review your mode of operation / service priorities to continue to meet those needs.			

3. Establish policies to be implemented during a pandemic	Complete	In Progress	Not Started
Guided by Government advice, establish policies for sick-leave absences unique to a pandemic, including policies on when a previously ill person is no longer infectious and can return to work after illness (i.e. when they are no longer showing symptoms and feel better) and agree them with staff/trade unions and other professional representative bodies.			
Establish policies for flexible worksite (e.g. working from home) and flexible work hours (e.g. staggered shifts).			
Guided by Government advice, establish policies for reducing spread of influenza at the worksite (e.g. promoting respiratory hygiene/cough etiquette, and asking those with influenza symptoms to stay at home).			
Guided by Government advice, establish the current policies for employees who are suspected to be ill, or become ill at the workplace (e.g. infection control response, sick leave policies).			
Set up authorities, triggers, and procedures for activating and terminating the organisation's response plan, altering business operations (e.g. reducing operations as necessary in affected areas).			

4. Allocate resources to protect staff and patients during a pandemic	Complete	In Progress	Not Started
Provide sufficient and accessible means for reducing spread of infection (e.g. provision of hand washing facilities or hand-hygiene products).			
Consider additional measures to reduce the risk of infection, such as more frequent cleaning on premises, and ensure the resources to achieve these will be available.			
Consider whether enhanced communications and information technology infrastructures are needed to support staff working from home, tele-conferencing instead of face to face meetings.			

5. Communicate to and educate your staff	Complete	In Progress	Not Started
Disseminate easily-accessible information about pandemic flu to your workforce which is appropriate to the stage of alert (e.g. signs and symptoms of influenza, modes of transmission when this information is available), personal and family protection and response strategies (e.g. hand hygiene, coughing/sneezing etiquette, contingency plans). This should be based on the information already available on the SG/NHS Board website.			
Ensure that communications are culturally and linguistically appropriate.			
Disseminate information to employees about your pandemic preparedness and response plan for your organisation, including their role in this plan.			
Identify platforms (e.g. hotlines, dedicated websites) that will be used for communicating pandemic status and actions to employees, and service users, and have lines/key messages that are ready to push out at various stages.			
Ensure that, SG and HPS websites are the sources for timely and accurate pandemic information.			

6. Co-ordinate with external organisations and help your community	Complete	In Progress	Not Started
Engage with Local/Regional Resilience Forums and local resilience (NHS/LA) teams, and engage with relevant agencies and local responders.			
Share best practice / what has worked for you with others in your area			

Annex D

Acronyms

ACP	Antiviral Collection Point
BC	Business Continuity
BCM	Business Continuity Management
CCA	Civil Contingencies Act 2004
COBR	Cabinet Office Briefing Room
ED	Emergency Department
FFP3	Filtering Facepiece Class 3 (respirator)
FRSM	Fluid Repellent Surgical Mask
GP	General Practitioner
HSCP	Health & Social Care Partnership
HPS	Health Protection Scotland
HSE	Health & Safety Executive
ICU	Intensive Care Unit
ILI	Influenza-like illness
JCVI	Joint Committee on Vaccination and Immunisation
LRP	Local Resilience Partnership
NIPCM	National Infection Prevention and Control Manual
NPFS	National Pandemic Flu Service
NSS	NHS National Services Scotland
PARD	Persons At Risk Database
PCC	Scottish Government Pandemic Co-ordination Centre
PCG	Public Communications Group (of the Resilience Partnership)
PHE	Public Health England
PPE	Personal Protective Equipment
PSV	Pandemic Specific Vaccine
REAP	Resourcing Escalatory Action Plan
RP	Resilience Partnership
RRP	Regional Resilience Partnership
SAGE	UK Scientific Advisory Group for Emergencies
SAS	Scottish Ambulance Service
SGORR	Scottish Government Resilience Room
WHO	World Health Organization

Annex E

Glossary

Aerosol	A gaseous suspension of fine solid or liquid particles which remain suspended in the air for prolonged periods of time.
Antibiotic	A type of drug that can prevent the growth of bacteria.
Antiviral medicines	Used to describe a chemical or drug that inhibits virus replication.
Antiviral Resistance	A virus having changed in such a way that antiviral drugs are less effective or not effective at all in treating or preventing illnesses with that virus.
Bronchoscopy	A procedure where a flexible tube is passed into a patient's lung to view the lung and airways, while under sedation.
Clinical	Relating to the observation and treatment of actual patients, rather than theoretical or laboratory studies
Community	The general population, outside of a hospital or clinical environment.
Co-morbidity	The presence of one or more additional diseases or disorders co-occurring with (that is, concomitant or concurrent with) a primary disease or disorder.
Countermeasures	Interventions that attempt to prevent, control or treat an illness or condition.
Critical Care	The care of a patient in a life-threatening situation by staff specially trained in recognising and responding to emergencies.
Diagnostic	Relating to the specific identification of the illness that is causing a disease or set of symptoms.
Epidemic	The widespread occurrence of significantly more cases of a disease in a community or population than expected over a period of time.
Epidemiological	Relating to the study of the patterns, causes and control of disease in groups of people.
Excess Mortality	The number of deaths that occur during an outbreak and above that expected for the time of year.
Extubation	The process of removing a tube from a hollow organ or passageway, often from the airway.

H1N1 (2009) influenza pandemic	The worldwide community spread of a new H1N1 influenza virus, originating in pigs and entering the human population in 2009.
Hand hygiene	Thorough, regular hand washing with soap and water, or the use of alcohol-based products containing an emollient that do not require the use of water to remove dirt and germs at critical times, eg after touching potentially infected people/objects and before touching others or eating.
Immunity	Inherited, acquired, or induced resistance to a specific type of infection.
Immuno-compromised	Having an impaired immune system.
Infection	The acquisition and active growth of a foreign microbial agent in a host, such as a human or animal, usually with a detrimental outcome.
Infectious	A disease caused by a micro-organism that can be transmitted from one person to another.
Intubation	The insertion of a tube into an external or internal orifice of the body for the purpose of adding or removing fluids or air.
Isolation	Separation of individuals infected with a communicable disease from those who are not for the period they are likely to be infectious in order to prevent further spread.
Mitigate	To delay the spread, or moderate the severity or extent, of a pandemic.
Modelling	Use of the mathematical theory of disease dynamics to make a quantitative assessment from available data of the range of possible behaviours of a pandemic and the impact of various responses, most importantly those that are likely to be both effective and robust over the range of uncertainty.
Novel virus	A virus that has never previously infected humans, or has not infected humans in a long time.
Osteltamivir	Antiviral drug, marketed by Roche Pharmaceuticals under the trade name Tamiflu®, that acts by inhibiting Neuraminidase activity and thus blocking viral spread.
Outbreak	Sudden appearance of, or increase in, cases of a disease in a specific geographical area or population, e.g. in a village, town or closed institution.
Pandemic	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.
Pandemic-Specific Vaccine	Vaccine developed against the antigens of the specific viral strain responsible for the pandemic.
Prophylaxis	Administration of a medicine to prevent disease or a process that can lead to disease – with respect to pandemic influenza, this usually refers to the administration of antiviral medicines to healthy individuals to prevent influenza.
Relenza®	See 'Zanamivir'.
Respirator	A face mask incorporating a filter. In this document, it implies a particulate respirator, usually of a disposable type, often used in hospital to protect against inhaling infectious agents. Particulate respirators are 'air-purifying' respirators because they filter particles out of the air as one breathes.
Respiratory	Relating to the respiratory system (e.g. the nose, throat, trachea and lungs).
Seasonal flu / influenza	Annual period of widespread respiratory illness, typically occurring during the autumn and winter months in the UK, caused by the circulation of a strain of influenza virus that is slightly altered from the previous season.
Sero-incidence	The incidence of a particular material in blood serum quotations, as measured by blood tests.
Subtype	Viral strain classified by the versions of Haemagglutinin and Neuraminidase that it possesses.
Surge	A transient increase in demand for care or services above usual capacity.
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.
Suspected cases	The cases of illness identified through symptoms but not confirmed by laboratory analysis.
Swine flu	H1N1 influenza arising in 2009 from pigs and the cause of the 2009 pandemic in humans.
Symptomatic	Showing symptoms of disease or illness.
Tamiflu®	See 'Oseltamivir'.
Transmission	Any mechanism by which an infectious agent is spread from a source or reservoir (including another person) to a person.

Vaccine	A substance that is administered in order to generate an immune response, thereby inducing acquired immunological memory that protects against a specific disease.
Virological	Pertaining to viruses.
Virulence	The capacity of an infectious agent to infect and cause illness.
Virus	A micro-organism containing genetic material (DNA or RNA) which reproduces by invading living cells and using their constituent parts to replicate itself.
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.
Zanamivir	Antiviral drug, marketed by GSK Pharmaceuticals under the trade name Relenza® that inhibits Neuraminidase activity, thus blocking viral spread.