

Pandemic influenza

Guidance for GP practices

Swine flu H1N1 preparedness

Produced by the Royal College of General Practitioners and the British Medical Association's General Practitioners Committee

Working in partnership with the Department of Health (England)

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Please note: The first edition issued in January 2009 referred to the preparations for a non-specific pandemic and is now in abeyance



Royal College of
General Practitioners



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How to use this document

This is the second issue of the pandemic flu guidance document, which has been updated to include information on swine flu (H1N1). The first issue, published in January 2009, was produced in response to the then expected emergence of avian influenza, and was a generic document on prospective planning for a possible pandemic. In April 2009, novel swine influenza variant H1N1 caused human influenza in Mexico. On 6th June 2009 the World Health Organization (WHO) declared a world H1N1 influenza pandemic as swine flu spread worldwide. There have been, and continue to be a significant number of H1N1 cases in the UK.

This edition of the document sets out the current planning for and response to the swine flu pandemic as of December 2009. It will continue to be regularly reviewed as experience of dealing with H1N1 influenza is accumulated. The guidance will be amended as changes are agreed. You can access swine flu specific information at

<http://www.dh.gov.uk/en/PublicHealth/Flu/Swineflu/index.htm>

The whole document has been updated and you will need to read through all the chapters.

However, the main areas of new information are:

- Chapter 2 on H1N1 clinical presentation;
- Chapter 6 on Caring for the general public (including the National Pandemic Flu Service);
- Chapter 7 on Infection control;
- Chapter 10 on Prescribing issues, including antibiotics;
- Chapter 12 on H1N1 Vaccines.

The term H1N1 is used throughout the document to refer to the swine flu virus named 'Pandemic (H1N1) 2009' by the World Health Organization.

This document is intended to be of practical help to your practice in coping with the H1N1 pandemic and includes up to date information on the clinical presentation of swine flu in the UK.

Where the response to issues has not yet been agreed, this will be clearly stated in the text.

This updated guidance has been prepared by the British Medical Association's General Practitioners Committee (GPC) and the Royal College of General Practitioners (RCGP), with the support of the Department of Health (DH), England.

While this guidance relates to England we believe it should also be appropriate for use in the Devolved Administrations. If there are issues that relate solely to one particular country, we expect further guidance to be produced by its national bodies.

Foreword

Since the first edition of this guidance for GPs and their practice staff was produced we have moved from planning for a hypothetical situation to the reality of dealing with pandemic influenza. This second edition contains updated information for GPs and practice managers. Since the outbreak started, we have had an opportunity to reflect on lessons learned from the first wave and consider how processes could be improved. The guidance takes this into account and explains how practices may continue to operate during further waves. It also includes updates on the pandemic influenza related contract changes which have progressed or been finalised since the first edition came out.

If, as expected, the pandemic continues, we may have to suspend some normal services in order to concentrate on responding to swine flu cases. How and when this will happen is still subject to negotiations, but your practice resources will be protected so that you will not be penalised when directed to concentrate your efforts on caring for your patients during the pandemic.

We are very aware that the swine flu outbreak has created significant additional work for GPs and their staff. The response of practices to this challenge has been admirable, epitomising all that is good about general practice. On behalf of the BMA's General Practitioners Committee and Royal College of General Practitioners, we would like to say thank you to GPs and practice staff. We are extremely proud of your professionalism and efforts to deal with the situation as effectively as possible.

It is likely that the outbreak will spread widely in the coming months and much of the work of diagnosing and treating those infected with the virus will fall to GPs. We are confident that you will continue to rise to this challenge and that patients can continue to look to their GP practice for the best possible care in extraordinarily difficult circumstances.

Dr Laurence Buckman

Chairman of the BMA General Practitioners Committee

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Chairman of the Royal College of General Practitioners

1 Introduction

1.1 General overview and background

- 1.1.1 A pandemic occurs when a new influenza virus to which people have no immunity emerges and starts spreading as easily as normal seasonal flu. Influenza pandemics have occurred three times in the last century, in 1918, 1957 and 1968. The novel swine flu virus H1N1, which emerged in Mexico in March 2009, has spread worldwide and in June 2009 was declared a pandemic by the World Health Organization (WHO). Other than some partial immunity in the over 60s, in the general population there is no immunity to this new virus.
- 1.1.2 Original modelling for a flu pandemic suggested that once established in the UK, it could spread to all major population centres within one to two weeks, with the peak incidence occurring within 50 days.
- 1.1.3 In the initial wave of this infection, which peaked in late July 2009, the spread was slower than predicted by the modelling, with a geographical patchwork of development. In the areas of the country which were identified as influenza 'hotspots', medical services were stretched, whereas other areas of the country had relatively few cases.
- 1.1.4 After the last week of July, the number of new cases of swine flu slowed considerably. However, new cases of H1N1 flu increased during the autumn period and is likely to continue over the winter. It is unclear whether the pandemic will unfold as a single extended 'wave' or as multiple 'waves' separated by periods of reduced case numbers.
- 1.1.5 While it may be possible to maintain normal general practice in the early stages of a pandemic wave, it may not be possible to carry on as normal at the peak of the pandemic, nor for some time afterwards during the recovery phase. Arrangements are in place to identify when non-essential services have to be curtailed or dropped, and Primary Care Organisations (PCOs) will tell practices when this point has been reached, based upon advice from the regional directors of public health and the DH. This information is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104487
- 1.1.6 These arrangements cover protection of General Medical Services (GMS) practice income so that practices are not penalised when they are directed to suspend normal operations (such as Quality and Outcomes Framework (QOF) work and enhanced services). More details can be found in Appendix 1. The agreement includes recommendations to apply the same principles to Primary Medical Services (PMS) contracts and other services.
- 1.1.7 To react to the pressures and impact of this pandemic, graded responses to the increasing threat will be used. Decisions will be made at PCO, Strategic Health Authority (SHA) or national level after consultation with Local Medical Committees (LMCs) or the GPC. Information will then be disseminated to GP practices. At the peak of a pandemic, all parts of the NHS will need to work together in partnership with social services, the third sector and other bodies. Local plans must be flexible to meet the needs of a changing situation, as there may be large variations in how the pandemic unfolds from one locality to another.

- 1.1.8 Seasonal flu planning and seasonal flu vaccination programme for those in the traditional seasonal flu at-risk groups because an estimated 5-7000 people – mainly older adults - die annually in England and Wales from seasonal flu.

2 H1N1

Summary: This chapter gives the history of pandemics, H1N1 flu, emerging clinical features, high-risk groups, epidemiology and the effect on pandemic flu strategy.

2.1 Introduction

- 2.1.1 In previous pandemics, the overall UK clinical attack rate has been in the order of 25% to 35% of the community, compared with the usual seasonal range of 5% to 15%. Current guidance for planners for this H1N1 pandemic (published on 22nd October 2009) assumes a clinical attack rate of 12% between 1 October 2009 and mid-May 2010.

Please note that this planning guidance is different from that published in the first version of this document. It will be subject to further review and possible change as further data on the current pandemic strain of influenza becomes available.

The guidance for planners can be found at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107413

- 2.1.2 For planning purposes, response arrangements must be flexible enough to deal with the whole range of possible scenarios as well as capable of being adjusted as they are implemented. This guidance should not be taken as a prediction of how the pandemic will develop - for example, the possible effect of vaccination against this pandemic strain has not been taken into account.

2.2 Clinical presentation

- 2.2.1 The common presenting symptoms are in **Table 1**:

Fever / high temperature and two or more of the following symptoms:

- unusual tiredness
- headache
- runny nose
- sore throat
- shortness of breath or cough
- loss of appetite
- aching muscles, diarrhoea or vomiting.

- 2.2.2 Although in many cases the impact of the symptoms on the patient is mild, nevertheless they need time off school or work and in a few cases severe respiratory complications have occurred in previously healthy patients with no identified underlying health problem. Other symptoms, such as diarrhoea and vomiting have also been identified, especially in children.
- 2.2.3 Pregnant women have been identified as a group at particular risk from suffering H1N1 complications and the Chief Medical Officer (CMO) for England has produced guidance for pregnant women available at **www.dh.gov.uk/en/Publichealth/Flu/Swineflu/DH_103068**

Further advice on the management of pregnant women in primary care is contained in the document *Pandemic H1N1 2009 influenza: clinical management guidelines for pregnancy* available at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107770

- 2.2.4 Complication rates appear to be higher in the very young, in the clinical at-risk groups and in older people (table 2). Although older people are less likely to become ill, they are more likely to suffer from complications if they do become ill with the H1N1 virus.

Table 2: High risk groups for swine flu-related complications

- people with chronic lung disease including people who use regular inhaled corticosteroids to control symptoms
- people with chronic heart disease
- people with chronic kidney disease
- people with chronic liver disease
- people with chronic neurological disease
- people with suppressed immune systems (whether caused by disease or treatment)
- people with diabetes
- pregnant women
- people aged 65 years and older
- children aged 5 and under.

- 2.2.5 The groups in Table 2 are very similar to those who are vaccinated against seasonal flu or who may receive antivirals in a normal seasonal flu epidemic, with the addition of pregnant women and children aged 5 and under. This clinical situation will continue to be monitored as the number of overall cases increases.

- 2.2.6 The second phase of H1N1 vaccinations will include healthy children aged from 6 months up to 5 years and carers will also be added to the group of front line health and social care workers to be prioritised for vaccination.

- 2.2.7 It is unknown as to how many people will have a very mild or asymptomatic infection.

The best current estimate of the length of illness is that:

- Half of the people who become ill recover within about seven calendar days
- A further 25% of people who become ill need up to ten calendar days to recover, and
- 25% of people who become ill will have symptoms for more than ten calendar days.

As an average (mean), the duration of illness is nine calendar days.

- 2.2.8 Current data from the H1N1 pandemic and analysis of previous pandemics suggests that individuals who contract H1N1 flu without suffering complications will have an average unavailability for work of approximately 10 calendar days; for those with complications, average unavailability for work will be 14 calendar days. In addition to the period with flu symptoms, these figures include some allowance for a short period of recuperation following recovery from the clinical illness. These estimates also include the time away from work taken by people remaining at home to care for ill children (although this does *not* cover any additional absence caused by looking after ill dependent relatives – other than children - or friends, nor time off due to fear of contracting swine flu).
- 2.2.9 Further advice on the management of adults and children in primary care is contained in *Pandemic H1N1 2009 influenza: clinical management guidelines for adults and children*, available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107769

2.3 Delayed and missed diagnoses in children and adults

- 2.3.1 The symptoms of a flu like illness can also be the initial symptoms of another, potentially life-threatening pathology. Illnesses with a tendency to present with non-specific or insidious flu-like symptoms include meningococcal infections, streptococcal bacteraemias, staphylococcal bacteraemias in young people, malaria, gram negative septicaemia, measles, croup (which can be caused by flu infection) and bronchiolitis. Even in non-pandemic circumstances, a non-flu diagnosis is often only suspected upon a second presentation because of a change in the patient's condition.
- 2.3.2 **GPs must emphasise to patients who have been assessed and diagnosed with swine flu that they should seek medical advice immediately if their condition suddenly worsens.** Similar advice to seek medical aid is given by the National Pandemic Flu Service (NDFS) when authorising antiviral treatment. Some individuals will develop significant flu complications and others potentially serious non-flu illnesses. All patients contacting their GP under these circumstances will require expert clinical assessment.

2.4 Swine flu epidemiology and management strategies

- 2.4.1 The original strategy underlying the response to the flu pandemic was based on the presumption that a pandemic would rapidly spread throughout the population due to a high infectivity rate, thus necessitating two phases of management, to be enacted as follows:
- An initial first response containment phase, which would slow the spread of the infection, and buy time before the infection became more widespread in the community
 - A decision would then be made to enter the second treatment phase.

- 2.4.2 In the initial areas where a flu outbreak occurred, **the Health Protection Agency (HPA) was responsible for the containment phase.** Measures taken to limit the spread include school closures, swabbing of index cases and close contacts, supply of antivirals for treatment, contact tracing and supply of prophylactic antivirals. The GP role, with support from the HPA, was to assess potential flu cases using the HPA algorithm, swab and prescribe antiviral treatment.
- 2.4.3 As the infection became more widespread a central decision was made to move to **the treatment phase, which was the responsibility of the NHS.** The infection became so prevalent that treatment could be given on clinical assessment without diagnostic swabs.
- 2.4.4 In the treatment phase, assistance is provided to reduce the clinical burden on GPs. The public can access an internet or phone based system provided by the NPFS, which can authorise antiviral drug treatment without the involvement of a GP. Antiviral medicines can then be collected from an Antiviral Collection Point (ACP), using the Unique Reference Number (URN) allocated by the NPFS and appropriate proof of identity.
- 2.4.5 Initially, swine flu did not spread as rapidly through the community as had been envisaged when the original flu pandemic strategy was formulated. In part, this may have been due the combination of a successful containment strategy and a summer outbreak. By the end of June 2009, it was clear that sustained person-to-person transmission was occurring in the community.
- 2.4.6 **On 2nd July 2009, a decision was made to move to the treatment phase across England.**
- 2.4.7 There is no intention to return to a containment phase.

3 Dealing with H1N1

Summary: This chapter explains the need to prepare for a H1N1 flu pandemic, where to find guidance and why a service continuity and co-ordination strategy is necessary. Many of the preparations made for a flu pandemic should also prove relevant and useful for other emergencies.

3.1 Overview of preparations

- 3.1.1 Most health and social care will continue to be delivered in the community setting, with acute hospital capacity reserved for those in most clinical need. Even so, at the peak of the pandemic it may be necessary to prioritise for treatment those who will benefit most from in-patient treatment. At this stage, the relevant Community Assessment Tool (see appendices 4 and 5) will be used as an aid in assessing suitability for hospital referral for those with flu related complications.
- 3.1.2 **Clear service continuity and co-ordination arrangements will be essential should the swine flu pandemic spread rapidly throughout the UK.** This guidance explains how these will work and why **practices must follow the guidance to provide a uniform response to the pandemic.** This will boost capacity and ensure fairness to patients and staff.
- 3.1.3 A swine flu pandemic will put primary care and the NHS in general under pressure. General Practice and Out of Hours (OOH) services have a critical role to play in treating people who are ill in the community. Practices and OOH services are asked to acknowledge that **unless everyone follows the principles of the 'five Cs' – Command, Control, Communicate, Coordinate and Co-operate – there could be chaos.** To minimise risk, guidance documents are being published so that everyone knows what is expected of them and can take part in the planning to ensure that we are as prepared as possible and have well-understood action plans in place.

The five Cs:

- Command
- Control
- Communicate
- Coordinate
- Cooperate

- 3.1.4 General Practice is one of the critical 'pinch points' in responding to a pandemic. At the peak of a pandemic, the NHS will be placed under pressure and new ways of working may be introduced which will create extra capacity in order to meet increased demand for services. With hospital beds at a premium, general practice and GPs in particular will be providing more community-based and domiciliary care than normal to non-flu as well as to flu patients who might under normal levels of illness be expected to be cared for in a hospital setting. Experience shows that the ability of general practice to care for these patients outside of hospital should make a real difference to safely managing the worst pressures of the pandemic.
- 3.1.5 Practices must work with their local PCO when planning for, and during, a flu pandemic. There is published guidance for PCOs on their duties and roles. LMCs are assisting PCOs in the execution of their statutory duties.

3.1.6 The following guidance documents are available:

General:

www.dh.gov.uk/en/Publichealth/Flu/Swineflu

Country-specific guidance:

Scotland

www.scotland.gov.uk/Topics/Health/health/AvianInfluenza/mexicanswiuneflu

Wales

www.wales.gov.uk/topics/health/protection/communicabledisease/swine/?lang=en

Northern Ireland

www.dhsspsni.gov.uk/

Professional bodies:

RCGP

www.rcgp.org.uk/clinical_and_research/pandemic_planning.aspx

BMA

www.bma.org.uk/health_promotion_ethics/influenza/panflugp/panfluguide.jsp

Managing Demand and Capacity in Healthcare guidance published by the DH. You can find this at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098769

3.1.7 The present swine flu infection has so far behaved differently from that originally anticipated in the pandemic planning model. This means that any plans must be flexible enough to respond to the evolving clinical situation caused by the behaviour of the virus. Therefore, at present, the original UK pandemic alert levels are not in use.

4 Business continuity for GP practices: The role of GPs and their teams

Summary: This chapter sets out the predicted workload for GP practices in terms of patient numbers, highlights the importance of staff contracts and explains what practices can do to manage. It provides a step-by-step guide to setting up buddying-up groups, suggests emergency boxes, describes how locum GPs will work and describes the potential impact on GP trainees.

4.1 Impact on general practice – overview

- 4.1.1 During this H1N1 pandemic, it may not be possible or necessary to provide rapid face-to-face consultations with everyone. A public information campaign is directing people with flu-like symptoms not to come to their GP surgery but to telephone/contact the National Pandemic Flu Service (NPFs).
- 4.1.2 Practices should have plans to minimise exposure of staff and patients to the virus. This will involve increasing the awareness of reception staff about this issue and, where possible, keeping flu and non-flu patients apart. GPs should plan now for how this could be done, for example by using both separate waiting rooms and consulting rooms for non-flu patients where practicable. Those people who are most vulnerable in society (e.g. those that live alone, and those who do not speak English) may continue to use primary care services as their first point of call when seeking help for flu.
- 4.1.3 People will continue to be encouraged to stay at home as far as possible to help reduce and limit the spread of infection. The Government's messages to the public are:
- Stay at home
 - Phone a 'Flu Friend'
 - Phone the NPFs.

The autumn 2009 campaign to reinforce the routine respiratory and hand hygiene messages including *Catch it bin it kill it* will continue until February 2010. Details of the campaign are available at

www.dh.gov.uk/en/Publichealth/Flu/Swineflu/Campaignresources/index.htm

The majority of people should be able to rely on self-care, contacting the NPFs (see chapter 6 for more details), taking antiviral medicine and treating their symptoms with over-the-counter (OTC) medicines.

- 4.1.4 Communications play a huge role in coping with a flu pandemic. The Government has a mass communication programme to let the public know what is involved in a pandemic and how they can help make the best use of services. You can read more about the communications planned in appendix 6.

4.2 Resource impact on GP practices

- 4.2.1 **In England, the NPFs became operational on July 23rd 2009 and has significantly reduced the workload on practices.**

- 4.2.2 However, even with NPFS being operational, modelling suggests that about one-third of symptomatic patients, including **all** children under 1 year old and all women who are pregnant will require assessment and treatment by a GP or other healthcare professional. Patients who may be at risk of complications due to their age, other medical conditions, or the severity of flu symptoms may, in addition to being authorised to receive antivirals by the NPFS, be advised to seek further medical support from primary care services. If indicated, the NPFS will continue to advise the members of the public to contact their GP. Please see appendix 3 for information on those patients who may be expected to contact GP services following an assessment by the NPFS.
- 4.2.3 On top of this, practice are having to respond to any second consultations, flu complications, patients contacting their practice because they have concerns or needs that the NPFS cannot address and any other urgent non-flu patients.
- 4.2.4 Clearly, with this overall level of demand, general practice may be stretched beyond its current limits. In addition, there are further complications arising from primary care staff themselves getting flu, or being away from work because they have to care for children or other dependants.

4.3 Staff support, working patterns and flexibility

- 4.3.1 GP practices and their staff will be key to the delivery of primary care services during this H1N1 pandemic. Flexible working, both in terms of time and location, may be needed from all practice staff and GPs alike to ensure a maximum level of service capacity and to maintain practice income under the GMS practice payments agreements made between the DH and NHS Employers (NHSE).
- 4.3.2 Practices must consider workforce issues that will arise during this pandemic. They need to develop guidance and policy through discussion with individuals and local staff-side organisations, where appropriate, on changes such as hours of work and potential redeployment outside of the practice due to travel disruption and to manage local staffing arrangements.
- 4.3.3 Employers should also acknowledge the level of anxiety that the H1N1 pandemic may generate, and work closely with their staff to address these anxieties within the context of early planning. It will be vital for practices to have provisions and agreements in place in advance, and consideration may need to be given to other issues that may arise following any school closures and transport disruption.
- 4.3.4 Funding for the costs of additional practice staff travel to and from an alternative place of work incurred as a consequence of a PCO request has been agreed with the DH in England. Additional overtime taken by staff during the pandemic must also be funded by the PCO.
- 4.3.5 Staff contract terms and conditions should be maintained as normal during a pandemic. However, practices should consider the potential benefits of gaining agreement from employees to insert a flexibility clause into their staff employment contracts to allow for service continuity in the event of a flu pandemic or other emergency, to cover possible redeployment and/or altered hours of work.

4.4 What GP practices can do to respond

- 4.4.1 All practices must have a service continuity plan. For advice on how to create this and what to include, read the joint guidance produced by the RCGP and the GPC of the BMA found at www.bma.org.uk/health_promotion_ethics/influenza/panflugp/flupanprep.jsp and www.rcgp.org.uk/clinical_and_research/h1n1_pandemic_flu/capacity_business_continuity.aspx

4.5 Staff absence levels

- 4.5.1 According to the current planning guidance, up to 5% of staff could be absent in the peak weeks of a pandemic, which could last for two weeks. Duration of absence is likely to be seven to 10 working days. A proportion of staff may be absent due to their caring responsibilities, bereavement and other psychosocial impacts; practical difficulties in getting to work; or problems with childcare. Single-handed practices may be hit harder and will need support from their 'buddy' practices.

4.6 Deploying practice staff safely

- 4.6.1 **Any GP or member of staff who shows flu symptoms must be sent home immediately.**
- 4.6.2 GPs will need to work with their buddying-up partner practices to ensure that they can function effectively together whilst minimising the risk of the spread of infection.
- 4.6.3 Guidance for health workers who are pregnant or in other at-risk groups is available at www.dh.gov.uk/en/Publichealth/Flu/Swineflu/DH_107655

4.7 Sickness certification

- 4.7.1 So far, no changes have been made to the existing arrangements for medical certificates and sickness self-certification. The situation is being kept under close review to enable action to be taken quickly should it be necessary.
- 4.7.2 During earlier preparations for a pandemic, consideration was given to legislative changes to extend the period of sickness self-certification. This would be part of a package of measures intended to help reduce the burden on GPs in the event of a substantial surge in activity.
- 4.7.3 At present, the level of activity relating to swine flu remains manageable. Normal arrangements for sickness certification therefore remain unchanged and GPs may be asked by patients to continue to provide medical certificates within existing Social Security legislation.
- 4.7.4 Employers have been reminded of the flexibilities that exist in what they can accept as evidence of employee sickness. It is up to the employers to determine what forms of evidence of sickness they deem to be sufficient.

- 4.7.5 Patients are no longer infectious when free of flu symptoms and can return to work when they feel well. **There is no role for certificates stating that a patient is fit to return to work (as requested by some employers) nor ones stating that a person is fit to travel (as requested by some airlines).**

Guidance is available at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106298

4.8 Buddying-up system

- 4.8.1 Practices **must** work together in a pandemic. A buddying-up system is proposed, in which clusters of practices will actively cooperate to carry out pandemic work by sharing resources and exchanging staff as necessary.

- 4.8.2 By now, practices should have drafted plans on how the buddying-up would work for them locally. You can see an example from Teesside via the web link below. This guidance uses the Teesside model as the basis for buddying-up information. The model involves 15–20 doctors working in a buddying-up group covering 25,000 patients. The Teesside documents are accessible on the RCGP's website.

The College's H1N1 Capacity and Business Continuity Planning page is available at

www.rcgp.org.uk/clinical_and_research/h1n1_pandemic_flu/capacity_business_continuity.aspx

This page includes a:

- real example of a continuity agreement that gives details of the Tees Primary Care Services – Primary Care Continuity Agreement
 - real example of a pandemic plan that relates to the Caduceus Medical Practice Influenza Plan.
- 4.8.3 Buddying-up groups can be based on naturally occurring groups such as those in a discrete locality. However, no practice must be left isolated. PCOs, together with LMCs will, if necessary, step in to ensure that all practices are members of a local buddying-up group.

4.8.4 LMCs have a role to play in helping with the formation of buddying-up groups. The process will generally follow the steps outlined in the box below:

- **Step one:** Identify neighbouring practice to form a buddying-up group and notify the PCO and LMCs.
- **Step two:** Form a working group within the cluster of buddy practices. All practices in the cluster should be represented. Agree how often the group will meet on a regular basis, both before the pandemic and during it.
- **Step three:** The working group should draw up a combined pandemic flu plan. This will build on individual practices' service continuity plans. It should identify the existing capacity, responsibilities and constraints that each practice has in providing services during a pandemic so that resources can be pooled.
- **Step four:** Buddy practices may have to combine temporarily during this swine flu pandemic. Because of this, it is necessary to identify which IT systems are used in the buddying-up group and discuss compatibility and how practice staff could work together and operate the different systems. Steps are in hand to determine what secure IT arrangements can be made to allow primary care staff to work from home when, for example, they are looking after sick family members.

4.8.5 Any gaps in service provision must be identified now, and if the cluster cannot fill them, outstanding issues should be shared with the local PCO.

4.8.6 PCOs will be able to add to practice resources by relocating other healthcare workers into practices as necessary. Practices should be aware that the number of extra staff available will be limited, as all health sectors will be affected by the pandemic. Health professionals from the private sector may also augment the NHS workforce, along with recently retired staff (see section 4.11.5) and senior trainees (see section 4.12).

4.8.7 Within each buddying-up cluster, practices retain contractual responsibility for their listed patients, but responsibility for clinical decision-making will belong to the treating clinician (and/or their employed staff seeing the patient), irrespective of which practice within the cluster the patient belongs to.

4.9 Photo ID, safety and security

4.9.1 Photographic ID of doctors and staff will be essential in a pandemic for ensuring security and safety. For example, locum clinicians arranged by the PCT may not be known to the practice to which they are directed. Each practice should develop an electronic library of staff photographs as part of a staff contact database so that no time is wasted should these be needed by PCOs producing photo ID in a pandemic.

4.9.2 When produced, the ID card will need to confirm identity and contain a photograph **and a job role** (please note that not all NHS CfH smart cards are of use, as they may not carry the job role).

4.9.3 Photographic evidence is essential for clinicians who will be seeing patients in the practice and visiting people in their homes, and they may not be known already to staff or patients. Normal arrangements for checking the documentation of locums may be disrupted. However, all practical steps should be taken to verify a person's identity.

4.10 Emergency box

- 4.10.1 Every practice should have an emergency box for use if main services, such as electricity, fail and all staff should know where this is kept. The contents should be decided by the practice, but would include things such as torches with spare batteries. It is possible that computers could be down so paper forms will be needed. All appropriate staff should know how to access this box and open it. See appendix 7 for more information on suggested contents. Prescription pads are regarded as restricted stationery and must be locked up with restricted access, but designated people should know how to access them quickly and easily. Spare antiviral authorisation vouchers should also be kept with the prescriptions.

4.11 Locum GPs

- 4.11.1 It is agreed that if at any point the severity of the situation requires it PCOs will act as the employer for all available freelance locum GPs. This will preserve their continuity of service at a time when they will be working at maximum flexibility, possibly moving frequently between practices.
- 4.11.2 Like all GPs, locum doctors need to be on a performers' list relevant to the country in which they plan to work. As part of the preparation for a flu pandemic, PCOs must have checked their databases, ensuring that they are robust and that data on them is correct, including contact details, email addresses, General Medical Council (GMC) number, GMC Licence to Practise status and Medical Defence Organisation (MDO) certification. It is important that all GPs are kept in the regular communication loops and PCOs must ensure that locums are incorporated in to any established information cascade systems.
- 4.11.3 Locum GPs must be included in any preparation and training programmes, including information cascades, and be issued with any necessary photo ID cards as provided to other frontline doctors. This is the responsibility of the host performer list PCO.
- 4.11.4 It is envisaged that once PCOs will contract to employ **all** available locum GPs this will continue for the duration of the pandemic so that they have indemnity protection and death-in-service benefits. The rate of pay and details of the employment arrangements have been agreed and are available in the 'Locum' section of the BMA's pandemic flu Q&A www.bma.org.uk/health_promotion_ethics/influenza/panflugp/panfluqa.jsp
- 4.11.5 The BMA has identified retired doctors willing to help in a flu pandemic based on each PCO area. The Pandemic Flu Database for retired doctors can be found at www.bma.org.uk/health_promotion_ethics/influenza/pandemicinfluenzadatabase.jsp

4.12 GP trainees

- 4.12.1 A flu pandemic may affect the training of GP trainees. Not least, their trainers and educators may be needed to deliver clinical care and will not also have the time to carry out their educational job. The knowledge and skills of GP trainees may be required to cope with the impact of the pandemic, and the length of their training period may well be affected. It is envisaged if appropriate that all training rotational post changes will be suspended during the pandemic both inside and outside hospital. Further guidance from the Committee of General Practice Education Directors (COGPED) and the RCGP has been developed and sent to the Deaneries and is available on the RCGP website www.rcgp-curriculum.org.uk/pdf/ptb_COGPED_RCGP_Paper_re_swine_flu_3sep09.pdf

4.13 Anxiety amongst the public, patients and staff

- 4.13.1 Due to the pandemic situation, anxiety levels may rise amongst the general public. Healthcare workers will not only have to cope with their own concerns but will also have to deal with an increased level of anxiety among their patients. Some people may behave in ways that may challenge staff (e.g. an increase in complaints about the service or increased verbal aggression).
- 4.13.2 GPs should ensure that they and their staff are confident and competent to deal with difficult situations. There is, and will continue to be, a large-scale public information campaign before and during a flu pandemic, explaining what services are available and why healthcare services will be run differently to normal. Adopting an open and planned approach should help to avert confrontation, but inevitably GPs and their staff may come face to face with a difficult situation and need to be prepared.

Up to date information will be available on the following web sites, and you are advised to consult them regularly so that you are reliably informed. For the most up to date information, please see www.dh.gov.uk/en/Publichealth/Flu/Swineflu/index.htm
www.rcgp.org.uk
www.bma.org.uk
www.hpa.org.uk

For guidance on psychosocial support for staff in a pandemic, please see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103168

4.14 Different ways of working in a pandemic

- 4.14.1 During the H1N1 pandemic, GP practices may have to work in different ways. The balance between proactive and reactive medicine will change significantly to cope with demand. Practice staff may be asked to take on different duties within their professional capability, and to work in different locations including the OOH service or another practice's surgery.

- 4.14.2 In a buddying-up cluster of practices, for example, a nurse or doctor from one practice may be asked to work at a nearby practice that is particularly short-staffed. Medical Defence and Employer Liability insurance are being clarified, and all practices and OOH services are asked to check their own insurance policies.
- 4.14.3 PCOs may assign additional staff to struggling practices including community nurses, locum GPs, or perhaps local dentists. Community clinicians may also have a role to play. Community hospitals and walk-in centres could take on a different role during a flu pandemic. The majority of flu patients will stay in their own homes, carrying out self-care.
- 4.14.4 When the PCO takes over, GPs available for sessional work will be employed by PCOs during a pandemic at a pay rate that has been agreed in national discussions. Practices will not directly agree or contract new arrangements with locum GPs.
- 4.14.5 Where staff are working under such pressure, perhaps in unfamiliar surroundings, errors may be more common. The GMC has indicated that provided a doctor acts in good faith within his/her skills and competence, it does not anticipate that a disciplinary issue would emerge.

The GMC good practice guidelines can be found at
www.gmc-uk.org/guidance/news_consultation/medical_pandemic.asp

Action points

GP practices must take action now to look at their staff contracts with a view to planning for the flu pandemic. Any change made to a contract must be voluntary and carried out with the agreement of the staff member.

Each practice must now:

- draw up a list of telephone numbers, including mobile numbers, for all staff.
- review staff contracts and list staff working hours and flexibility
- be aware of staff members' external commitments (e.g. caring for young children or elderly dependent relatives)
- prepare a simple guide to logging on and using the practice computers, so that if necessary, non-practice staff can access them in a pandemic (e.g. if a PCO allocates extra resources at peak times by bringing in other healthcare workers to help out)
- identify the person in the practice who will act as the practice lead on flu pandemic issues
- prepare to work in clusters with other practices (see buddying-up advice below)
- consider how the practice could operate on an emergency basis should utilities such as gas, water or electricity fail
- prepare an emergency box with face masks, gloves, aprons, torches and spare batteries and other consumables. See appendix 7 for a suggested list of contents.

Questions to ask:

- are there sufficient suitable hand hygiene facilities, waste bins and bin liners?
- are there sufficient stocks and supplies of hand cleaning agents and paper towels?
- are there sufficient supplies of alcohol hand rub for use on home visits?
- does everyone in your practice understand the importance of hand cleaning procedures and the effective use of cleansing?

Ensure that your practice has:

- displayed posters (in appropriate languages) about hygiene.
- displayed posters (in appropriate languages) showing which areas are for flu patients and non-flu patients.
- prepared a welcome pack for anyone new to your practice, which should include a simple guide to using the practice IT systems, how to log on, log off and so on. Such information must be securely kept within the practice, as it would give the user access to patients' details. The welcome pack should give the key information about the practice, including names of staff and whom to contact in an emergency.
- has identified (as far as practicable) any tasks that may need to be taken on by staff on a flexible basis, so that any appropriate training can be given. This is a role for employers.

5 Service continuity and co-ordination

Summary: This chapter sets out the service continuity and co-ordination arrangements for this H1N1 pandemic and the roles of key agencies. There will be some variance between the four UK countries to reflect structural differences. Further details for England can be found in appendix 8.

5.1 Arrangements

- 5.1.1 *Pandemic Flu: A national framework for responding to an influenza pandemic* was published in November 2007 and covers all sectors, including health. It sets out the crisis management mechanism and clearly defined hierarchy of 'command and control' structures. However, both the framework and the previous version of this joint guidance were written with a more prevalent, severe and aggressive pandemic in mind, i.e. avian flu, and we now require a strategy for maintaining 'service continuity and co-ordination', rather than 'command and control'.
- 5.1.2 GP practices which agree to place their resources at the disposal of their PCO will receive instructions via their PCO and will be expected to follow these instructions. Using the service continuity and co-ordination arrangements should ensure that there is clear communication between all participants.

5.2 Primary Care Organisations (PCOs)

- 5.2.1 Under the Civil Contingencies Act 2004 PCOs are responsible for ensuring that local health plans and arrangements are in place in advance of a pandemic and for managing the local health response during a pandemic.
- 5.2.2 In England, each PCT should have a named pandemic influenza coordinator who leads on arrangements for providing an effective and sustainable community-based response during a flu pandemic.
- 5.2.3 PCOs will coordinate plans with partner health organisations and neighbouring authorities and ensure that social care and other key partners – including private sector and support service providers – are fully involved.
- 5.2.4 Clear arrangements for service continuity and co-ordination will be critical in ensuring a robust response. PCOs will report on health issues to their host SHAs who, in turn, will be the main communication channel with the DH.
- 5.2.5 In a pandemic, PCOs will provide advice and public information, and collate and report operational information to the SHA. They will make contingency arrangements for the distribution and collection of antiviral medicines and for delivering population-wide vaccine if available.

5.3 Local Medical Committees (LMCs) or GP sub in Scotland

- 5.3.1 As the statutory representative body for all GPs at local level, LMCs (GP sub in Scotland) will be involved in planning for a flu pandemic and implementing those plans by working with local practices and the local PCOs. This may be especially important in adopting the idea of working in buddying-up groups of practices. LMCs should have the knowledge to ensure that no practices are left isolated and that all are included in a local buddying-up group.
- 5.3.2 LMCs need to implement a 'duty' LMC rota to provide 24/7 advice and assistance to the PCO during the pandemic period. The rota should be from amongst the officers or other senior LMC members. LMCs will need to ensure that there are appropriate mobile communications devices available. The duty LMC officer rota should be communicated to the PCO Flu lead, and updated as necessary. It should in addition to having the mobile phone numbers, have the home and surgery ex directory phone numbers for all those on the rota.
- 5.3.3 LMCs should implement a system to identify 'hotspots' in their areas and ensure that there are systems to help these areas in discussion with their PCOs.

5.4 General practices

- 5.4.1 In a pandemic, GP practices working in buddying-up groups, will liaise with their PCO and LMC, sending and receiving information on a daily basis. It is essential that all medical, nursing and management staff be involved.
- 5.4.2 Directions on when non-essential services, such as QOF work, will be suspended (in order to cope with the pandemic), will come from the relevant authority, following discussions between local LMCs and PCOs and where relevant, the SHA. **Practice income will be protected provided their resources are placed at the disposal of the PCO.** For more information on how this protection will operate, see appendix 2 and read the document *Pandemic Flu – Joint NHSE-GPC agreement on practice resource maintenance* at www.bma.org.uk/health_promotion_ethics/influenza/panflugp/flupandemic0508.jsp

5.5 Social care, community hospitals and other key players

- 5.5.1 There needs to be strong and sustained communication with social care and local community hospitals at every stage of planning and implementation.
- 5.5.2 *An operational and strategic framework: Planning for pandemic influenza in adult social care* was published by the DH in November 2007 and is supported by the *Pandemic influenza guidance for commissioners and providers of social care* at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093380
- 5.5.3 The pack advises local authorities of the need to have plans in place with their healthcare partners to allow for efficient and timely referral and response.

- 5.5.4 GPs and district nurses who assess patients as not requiring referral to hospital but as in need of additional support to remain at home will need to be able to refer on to social care with some confidence that appropriate provision of services can be quickly put in place. Mechanisms may therefore need to be developed, discussed and then agreed locally to ensure that primary care colleagues are kept aware of the operational capacity of social care services during the course of a pandemic.

5.6 Community pharmacies

- 5.6.1 Community pharmacies can make an important contribution to support self-care during a flu pandemic. They can assist with dispensing of routine medicines, signposting other NHS services and supplying regular medicines to vulnerable groups such as residents of care homes. They can maintain medicine supplies under contract with other bodies such as mental health trusts, hospices and prisons, as far as possible. They will of course sell OTC treatments for symptomatic management of the flu and other minor ailments and provide help and advice to the public. They have an important role to play in educating the public on how to make the best use of scarce health services, as well as promoting messages of hand and respiratory hygiene.

- 5.6.2 To ease pressure on GP surgeries and community services, legislation has been enabled for antivirals to be supplied from premises other than registered pharmacies by staff who may not be regulated healthcare professionals. The legislative changes also enable pharmacists and dispensing doctors to supply medicines and pharmaceutical services in a more flexible manner, for example, being able to supply an emergency supply of medicines for up to 30 days.

Authorisation of antiviral medicines - Guidance on the use of FP10SS forms and Antiviral Authorisation Vouchers during the H1N1 (swine flu) pandemic in England is available at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108873

- 5.6.3 Plans are in hand to change *Home Office Misuse of Drugs Regulations*, supported by changes to the *Prescription Only Medicines (Human Use) Order* in a number of areas (in the event of a need during the pandemic) e.g. extending emergency supply provisions to Controlled Drugs (CDs) and giving pharmacists discretion (in limited circumstance) to order CDs under instalment prescriptions.
- 5.6.4 Where there are shortages of some medicines, as may happen in a pandemic, pharmacists are well placed to advise on the use of alternative medicines that have similar effects.
- 5.6.5 As the pandemic escalates, some of the routine services that pharmacies provide may have to be reduced or stopped for short or long periods as demands increase elsewhere. Specialist clinical pharmacists from either hospital or primary care settings may be able to support doctors in all settings and they could be deployed by the PCO to support GPs in their practices.

5.7 Reporting the daily situation

- 5.7.1 During a pandemic, each PCO and locality area will be placed under pressure, and good communication between these groups will help to make best use of service delivery. The normal supply chain may well be disrupted, possibly leading to shortages.
- 5.7.2 Many frontline healthcare workers will become ill and be unable to work. There will be other issues, such as school closures, which will prevent some staff from getting to work. It is important to make the best use of available staff, and provide a current overview for the GP sites, locality and the PCO.
- 5.7.3 What follows is a suggestion as to how to make the best use of the frontline GP services under these difficult circumstances.
- 5.7.4 The information that your PCO requires to help manage the local primary care response will be decided upon with your local health partners (including pharmacies and ambulance services). However, as a guide, your PCO will find information on the following business continuity issues to be useful:
- any pharmacy closures or medicines shortages
 - staff absence rates
 - impact on ambulance services
 - capacity for antiviral distribution at collection points.

Every day, each GP practice/buddying-up group will submit information about the local situation ('sit reps' – situation reports) i.e. staff absence rates to the designated PCO data collection office. Other health partners should contribute information to the data collection office.

- 5.7.5 The PCO will create a local daily sit rep and send it to the LMCs and to GP practices in the area that will give information to inform the primary health care response. There is likely to be intense interest in this sort of information from the local media, and PCOs will need this information to liaise with them on a regular basis. Newspapers, radio, television and the internet will be used to inform the public of the current pandemic situation.
- 5.7.6 In addition to this, the information will be used to assist PCOs in providing mutual aid to GP practices and other local primary care health services e.g. redeploying staff to areas of most need.

Action point

Practices should draw up a list of 'key numbers' to contact during this flu pandemic when normal services may not be available. This must include the numbers for social services and all utilities such as gas, water, electricity, fuel and heating.

6 Caring for the general public

Summary: This chapter explains the National Pandemic Flu Service (NPFs) and access to antiviral medicines.

6.1 Access to antivirals

- 6.1.1 The Government has stockpiled sufficient antiviral medicines to allow all patients with symptoms of swine flu to be treated **if appropriate**.
- 6.1.2 Antiviral medicines will be authorised through the NPFs by a GP or another appropriate healthcare professional.
- 6.1.3 Access to antivirals in England will be by the following routes **(if working in one of the other countries of the UK please make yourself aware of the system for access locally, which may differ)**:

A Through NPFs, an online and call centre assessment and authorisation service (see 6.4).

- Patients who think they have swine flu will contact the NPFs using the web-based service for self-assessment or by phone for assessment by non-clinical staff, who have had specific training. An algorithm will be used during the assessment and, if clinically indicated, antiviral treatment will be authorised. The patient will then be given an authorisation number
- ACPs established in each PCT area will issue antivirals authorised through this route on production of the authorisation number and valid ID of both the patient and the Flu Friend.

B By a GP for:

1. Children under 1 year of age
 2. Pregnant women
 3. Those with a serious underlying illness
 4. Those who are unable to access the on line and call centre service
 5. Those seen at home e.g. elderly/frail.
- 6.1.4 In England, Antiviral Authorisation Vouchers must be used by GPs to authorise antiviral treatment for those under 13 years of age. There are specific Authorisation Vouchers for:
- children under 3 months of age
 - children 3 months and over and up to 1 year of age
 - children aged 1 year and over.

Guidance on the use of antiviral authorisation vouchers is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105998

- 6.1.5 For those aged 13 years and over (including all adults), the right hand side of an FP10SS must be used when authorising antivirals. This will be the same as if generating a private prescription and must be endorsed with the letters "ACP" so that the ACP is aware that it is not a private prescription and is for the antiviral treatment. In exceptional circumstances, when a GP is unable to use a GP computer system, a '1 year and over' Antiviral Authorisation Voucher can be used for people of 13 years of age and over.
- 6.1.6 It is not appropriate to issue private prescriptions for antivirals, as there are adequate NHS supplies for all the UK population.
- 6.1.7 If a non-UK nationality resident and/or visitor becomes unwell with swine flu, they can access antiviral medicines via a GP or NPFS. ACPs will issue antivirals to these individuals, who will need to show their passport or European ID card as proof of their identity. Antiviral medicines will be free of charge.
- 6.1.8 Antiviral Collection Points (ACPs)
- These have been established in local pharmacies, libraries etc. and supply antivirals to individuals on the production of an authorisation number, a completed antiviral authorisation voucher or a completed FP10SS, when presented with appropriate identification.
- 6.1.9 Via a nationwide publicity campaign, patients will be asked to nominate people who can collect their antiviral medicines for them. These nominated people are known as **Flu Friends**.

6.2 Antiviral medicines

- 6.2.1 Antivirals can be administered for up to seven days after the onset of symptoms but preferably should be started within 48 hours of the onset of illness to be effective and to limit the spread of infection.
- 6.2.2 Adult treatment courses of antiviral medicines will be provided in original packs. For children aged 1 year and over, the GP/health care practitioner (HCP) must authorise the required oseltamivir (Tamiflu) capsule strength based on the child's weight (or age band when the weight is not known). Weight of the child is preferable, if it is available. However, it is recognised that during a pandemic, it may not always be easy to weigh a child. For children who are obviously very over- or underweight, every effort should be made to weigh the child, and then base the dose on the weight of that child.
- 6.2.3 Adults and older children who cannot swallow capsules will need to be advised to pull apart the capsule and empty the contents of the capsule into a small amount of sugary solution, chocolate syrup or other sweet diluents.

Adults must not be prescribed oseltamivir solution as only limited quantities are being manufactured to meet the needs of children under 1 year of age.

6.3 Specific patient groups requiring GP authorisation of antiviral medicines

6.3.1 Children under 1

Children under 1 cannot be authorised an antiviral through the NPFS and must be assessed in person by a GP or other HCP.

Children under 1 year of age will receive oseltamivir solution prepared by designated hospital pharmacy manufacturing units which will be available through a collection point on production of the appropriate GP completed 'under 1' authorisation voucher

6.3.2 Pregnant women

Pregnant women with flu symptoms are advised to promptly contact their GP for assessment and authorisation of antivirals.

Pregnant women presenting with uncomplicated illness due to influenza and who have no evidence of systemic disease can be offered either zanamivir (Relenza) or oseltamivir (Tamiflu). In view of the lower systemic exposure, zanamivir is recommended as first choice, although either drug can be used. If the patient suffers with conditions such as asthma or chronic pulmonary disease, or may have difficulty with an inhaled preparation, oseltamivir should be used.

Pregnant women developing severe, systemic or complicated disease due to influenza will typically be treated as an inpatient and should be offered treatment with oseltamivir.

6.3.3 Underlying Health Conditions

Those with flu symptoms are advised to contact their GP promptly for assessment and if appropriate, authorisation of antivirals. If they contact the NPFS they will be assessed and, if required, will receive authorisation for antivirals. They will also be advised to contact their GP if their underlying condition suddenly deteriorates, or if their flu symptoms have not got better after seven days.

6.3.4 Dosage information for the routine use of antiviral medicines is given in Table 4 (**this includes the new dosage schedule for the under 1s which was implemented with the new authorisation vouchers and protocols at the end of November 2009**).

Table 4**Dose table****Oseltamivir (Tamiflu)**

Under 6 months	
Treatment	2mg per kg twice a day for 5 days
Prophylaxis	2mg per kg once a day for 10 days
6 months and over and under one year of age	
Treatment	3mg per kg twice a day for 5 days
Prophylaxis	3mg per kg once a day for 10 days
From 1 year to under 3 years (< 15kg)	
Treatment	ONE 30mg capsule twice a day for 5 days
Prophylaxis	ONE 30mg capsule once a day for 10 days
From 3 years to under 7 years (15 - 23kg)	
Treatment	ONE 45mg capsule twice a day for 5 days
Prophylaxis	ONE 45mg capsule once a day for 10 days
From 7 years to under 13 years (23 - 40kg)	
Treatment	TWO 30mg capsules twice a day for 5 days
Prophylaxis	TWO 30mg capsules once a day for 10 days
From 13 years and over (including adults)	
Treatment	ONE 75mg capsule twice a day for 5 days
Prophylaxis	ONE 75mg capsule once a day for 10 days

Zanamivir (Relenza)

From 5 years and over (including adults)	
Treatment	TWO 5mg blisters to be inhaled twice a day for 5 days
Prophylaxis	TWO 5mg blisters to be inhaled once a day for 10 days

- 6.3.5 **Prophylaxis:** In the treatment phase, only a limited number of patients will require prophylaxis. Guidance on prophylaxis is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107133
- 6.3.6 For those aged 13 years and over, with significant renal impairment (CKD 4, 5) or on dialysis, zanamivir (Relenza) is the antiviral of choice. If this is unavailable or if the inhaler cannot be used effectively, oseltamivir can be used. The dose of oseltamivir will need to be adjusted as below (see table 5 below).

Table 5

Creatinine clearance	Recommended oseltamivir treatment dose
>30 ml/min	75 mg twice daily.
11-30 ml/min	75 mg once daily or 30mgs twice daily
Haemodialysis patients	Discuss with renal team
Peritoneal dialysis patients	Discuss with renal team
≤ 10 ml/min (not on dialysis)	75mg as a single dose

Further details are available from The Renal Association at

www.renal.org/pages/pages/posts/renal-flu-plan-revised-july-200972.php

(See under *Renal flu plan revised July 2009*)

- 6.3.7 Wherever possible, practices should identify all those within their practice with CKD 4/5 and inform them of their most recent eGFR or creatinine clearance. The patient should be advised to inform any person considering them for antiviral treatment that they have impaired renal function and give the result of the most recent eGFR/creatinine clearance.
- 6.3.8 Children with significant renal impairment will be attending a specialist paediatric renal unit and advice will be given to both to their parent/carer and to their GP about any necessary antiviral treatment. Those under 5 years of age will require the appropriate dose of oseltamivir according to the severity of their renal impairment, as zanamivir is not licensed for use in this group of patients. For those over 5, oseltamivir may be needed if the child is unable to use an inhaler. For this small number of patients, GPs are advised to contact the patient's specialist renal team if there is any doubt about treatment.
- 6.3.9 The side effects of treatment with oseltamivir are:

Nausea and vomiting

The usual prevalence of nausea in flu is about 10%, of whom about 50% vomit and this number is doubled by treatment with oseltamivir i.e. about 20%.

Other adverse effects (the information below is reprinted from the manufacturer's summary of product characteristics).

- **Immune system disorders**

Frequency not known: hypersensitivity reactions, including anaphylactic/anaphylactoid reactions

- **Psychiatric disorders and nervous system disorders**

Frequency not known: influenza can be associated with a variety of neurological and behavioural symptoms, which can include events such as hallucinations, delirium, and abnormal behaviour, in some cases resulting in fatal outcomes. These events may occur in the setting of encephalitis or encephalopathy but can occur without obvious severe disease.

In patients with influenza who were receiving oseltamivir, there have been post marketing reports of convulsions and delirium (including symptoms such as altered level of consciousness, confusion, abnormal behaviour, delusions, hallucinations, agitation, anxiety, nightmares), in a very few cases resulting in accidental injury or fatal outcomes. These events were reported primarily among paediatric and adolescent patients and often had an abrupt onset and rapid resolution. The contribution of oseltamivir to those events is unknown. Such neuropsychiatric events have also been reported in patients with influenza who were not taking oseltamivir.

- **Eye disorders**

Frequency not known: visual disturbance

- **Cardiac disorders**

Frequency not known: cardiac arrhythmia

- **Gastrointestinal disorders**

Frequency not known: gastrointestinal bleedings and hemorrhagic colitis

- **Hepato-biliary disorders**

Frequency not known: hepato-biliary system disorders, including hepatitis and elevated liver enzymes in patients with influenza-like illness. These cases include fatal fulminant hepatitis/hepatic failure

- **Skin and subcutaneous tissue disorders**

Frequency not known: severe skin reactions, including Stevens-Johnson syndrome, toxic epidermal necrolysis, erythema multiforme and angioneurotic oedema.

6.3.10 It is important that all possible side effects of medicines are reported to the Medicines and Healthcare products Regulatory Agency (MHRA). There is a specific portal on the MHRA web site for reporting pandemic flu antiviral side effects, available here: swineflu.mhra.gov.uk/

6.3.11 Further information on antivirals is available from:

MHRA paper entitled *Safety information on oseltamivir (Tamiflu) and zanamivir (Relenza) for pandemic swine influenza A/H1N1*, available at:

www.mhra.gov.uk/swineflu

The *Patient Information Leaflets and Summaries of Product Characteristics* for the various forms of Tamiflu and Relenza, which can be found by searching 'Tamiflu' or 'Relenza' on the electronic Medicines Compendium, available at:

emc.medicines.org.uk/

A paper published by the DH entitled *Use of Antiviral Drugs in an Influenza Pandemic: Scientific Evidence Base*, available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077276

Patient Decision Aids (PDAs) on the use of oseltamivir in influenza from the National Prescribing Centre available on www.npc.co.uk

6.4 National Pandemic Flu Service (NPFS)

(For England only, for other countries/devolved administrations, use the local agreed procedure).

PHONE NUMBER 0800 1 513 100

WEB ADDRESS www.direct.gov.uk/pandemicflu

6.4.1 In England only on 23 July 2009 the clinical demand on Primary Care was such that the NPFS went live. It ensured that there was a system for distributing antivirals rapidly to all those that needed them, whilst reducing the pressure on primary care (GP) services when required. The other countries of the United Kingdom continued to use their local agreed procedures and antiviral treatment was prescribed via the GP service. In England, following the introduction of the NPFS, there has been a significant reduction in the demand for primary care services.

6.4.2 Objectives

The key objectives of the NPFS are to:

- Provide access to the right antiviral treatment to the right people at the right time
- Reduce the burden on front-line primary care services as far as possible by providing a separate route to access and collect antivirals.

6.4.3 Components of the NPFS

The National Flu Service comprises of the following elements for accessing antivirals:

- The use of web and phone services for the assessment of a patient's symptoms
- The authorisation of antivirals where this is considered to be appropriate
- Antiviral Collection Points (ACPs) for the issue of antivirals

6.4.4 Patient Pathway (as at September 2009)

- After using the website or the dedicated phone-line (see 6.4), the patient/carer will be given an authorisation number.
- The Flu Friend will take this number, together with appropriate identification for the symptomatic individual to an ACP. They also need to take proof of their own identity.
- At the ACP, the authorisation number and ID information is checked to ensure that it matches the information provided during the assessment through NPFS (assuming use of the web or phone service).
- The ACP staff will reconfirm certain details with the Flu Friend to ensure that the correct antiviral was provided (e.g. if it was for a child). The Flu Friend will also be given a leaflet on self-care for the symptomatic individual. This includes MHRA advice on what to do if there is an adverse reaction to the antiviral medicine.

6.4.5 GP Pathway

- The patient is authorised an antiviral after being assessed by a GP who will be prescribing in line with the criteria used by the NPFS.
- The Flu Friend collects the FP10SS or Authorisation voucher from the patient or the surgery and presents this at an ACP to receive an antiviral. GPs could also fax the completed voucher or FP10 to the ACP if this facility is available.
- The Flu Friend is required to take appropriate identification for the symptomatic individual to an ACP, as well as proof of their own identity.
- PCOs have been asked to ensure that local planning takes account of the fact that some people will not be able to use the NPFS as intended.

For example:

- Those who are unable to access or use the phone or web service.
- Those who do not have a Flu Friend to assist them.
- Some vulnerable patients might contact their GP, or Walk-in centres if they have regular contact with them already.
- Some might turn up at a collection point and need to be assessed.
- The needs of their local population as well as the availability and capacity of healthcare professionals will determine how a PCT supports their ACPs.
- It is important that organisations plan how people will be supported in accessing antivirals and that this is communicated to staff so that they are aware of the options available when issues arise.

6.4.6 **Patients will not be able to access antiviral medicines from GP surgeries. Patients can get antiviral medicines from ACPs if they are authorised to do so by the NPFS (with an authorisation number) or via a GP using a completed FP10SS or antiviral authorisation voucher.**

6.4.7 There is a National H1N1 Information Line available to give general advice and information to callers. The number for the service is **0800 1 513 513**.

6.4.8 The DH and the RCGP have produced a flowchart to assist GP receptionists to determine which symptomatic flu patients should be seen most urgently, in particular those referred by the NPFS.
www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_109452

Action point:

You are advised to put up notices at your surgery as per text below. The language used for the signs should take account of the needs of any non-English-speaking patients.

PANDEMIC FLU

If you have symptoms of swine flu and need access to antivirals, you should return home and contact the NPFS by calling **0800 1 513 100** or online at <https://www.pandemicflu.direct.gov.uk/>

If you are someone's 'Flu Friend' and need to find out how to access antivirals on their behalf, you should also contact the **NPFS** (see above).

For **general information** on what people can do to look after themselves when they have swine flu, contact the **swine flu Information Line** on **0800 1 513 513**.

There are no stocks of antivirals held on these premises.

Please note that the NPFS number above applies only to England.

6.5 Swine flu Clinical Package

PLEASE NOTE: THESE TOOLS AND PATHWAYS ARE FOR USE ONLY WHEN HIGH SURGE DEMAND LEADS TO THE NEED FOR STRICT HOSPITAL ADMISSION TRIAGE IN AFFECTED AREAS.

- 6.5.1 The swine flu clinical package is a set of tools for use in a pandemic situation by frontline healthcare professionals and designed to be used when the healthcare demand locally has led to the need for hospital admission triage. Full details of the package and when it is to be used are available on www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106495
- 6.5.2 The *Swine Flu Clinical Package* contains three Community Tools of relevance to general practice.
- Swine Flu Paediatric Community Assessment Tool (Paediatric CAT)
 - Swine Flu Adult Community Assessment Tool (Adult CAT)
 - Community to Hospital Referral Form
- 6.5.3 The community tools are designed to support and empower GPs, community nurses, midwives and health visitors. The package will assist these HCPs to assess patients, authorise antivirals and refer those with severe illness or complications to hospital.

- 6.5.4 The tools will help with the face-to-face application of the guidance *Pandemic flu: Managing Demand and Capacity in Health Care organisations (surge)*, available to download here www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098769. It is therefore recommended that both these documents are read together.
- 6.5.5 Guidelines on the clinical management of respiratory conditions are available on the DH website at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107769

7 Infection Control

7.1 Simple hygiene precautions

- 7.1.1 Flu viruses can survive for more than a day on hard non-porous surfaces such as stainless steel. Experiments have shown that flu viruses can be transferred from these contaminated surfaces onto hands up to 24 hours later. With soft materials such as nightclothes, magazines and tissues, the virus can be transmitted onto the hands for up to two hours, although only in small quantities after the first 15 minutes.
- 7.1.2 Because the virus survives for a long time - over 24 hours - on frequently touched hard surfaces (e.g. doorknobs), frequent cleaning is essential to control the spread of infection. Non-essential soft furnishings and toys, which are not easily cleanable, should be removed from patient areas during a pandemic.
- 7.1.3 Influenza viruses are easily killed by washing with soap and water or alcohol hand rub and by cleaning surfaces with normal household detergents and cleaners. Practices should ensure that they have an adequate supply of these basic cleaning materials.

7.1.4 Hand washing is the single most important practice needed to reduce the transmission of infection in a healthcare setting. Good hand hygiene among staff and patients is vital for the protection of everyone.

- 7.1.5 Paper towels should be used to dry the hands thoroughly and be disposed of in a waste bin. Lined waste bins with foot-operated lids should be used whenever possible and hand hygiene facilities need to be made available.
- 7.1.6 Doctors and staff doing home visits should carry personal packs of alcohol hand rub.

7.2 Direct contact with those patients who are symptomatic, and means of virus transmission

- 7.2.1 GPs will need to see some patients who fall outside the NPFS algorithm or present with complications.
- 7.2.2 Flu spreads easily by droplet from person to person via the respiratory route when an infected person talks, coughs or sneezes. It also spreads via direct and indirect contact.
- 7.2.3 The incubation period (time from exposure to first symptoms) is between one and four days. People are most infectious soon after they develop symptoms. The greatest amount of virus is shed in the first 2-3 days and appears to correlate with fever.
- 7.2.4 Children have been shown to transmit virus for longer and at higher levels than adults.
- 7.2.5 Adults with flu but without additional complications may be away from work for up to ten days.
- 7.2.6 Certain procedures may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk; this includes administration of medication via nebulisation. For such procedures, gloves, an apron, and surgical mask (plus eye protection if there is a risk of eye splashes) are recommended.

- 7.2.7 In nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne.

7.3 Keeping flu patients separate

- 7.3.1 Wherever possible, patients with flu should stay at home to minimise the spread of infection. This will be a key message in the public information campaign. Keeping flu patients separate from non-flu patients should be a principal aim in infection control. Despite giving advice and asking patients with flu to stay at home, inevitably some will arrive in the GP practice. Where possible, separate rooms and waiting areas should be used for patients who may have flu. Patients might be separated on an upstairs/downstairs basis, or kept to a section of the practice if, for example, there is a rear door for entrance and exit.
- 7.3.2 Separating patients by timing is another or additional possibility. If feasible, a surgery for non-flu patients could be held first thing in the morning or last thing in the day. Practices should apply the regular hygiene controls needed throughout a pandemic.

7.4 Personal Protective Equipment (PPE)

- 7.4.1 Fluid-repellent surgical face masks will be the main form of PPE needed in a pandemic. They will provide a physical barrier and should be worn by any healthcare worker who will have close contact (within one metre) of people with flu.
- 7.4.2 You will have received stocks of PPE from your local PCO in the first wave of the pandemic and further stocks will be sent out in accordance with demand for frontline health and social care staff.
- 7.4.3 Surgical masks should:
- cover both the nose and mouth
 - not be allowed to dangle round the neck after or between each use
 - not be touched once put on until removed for disposal
 - be changed when they become moist
 - be worn once only and then discarded to an appropriate bin as clinical waste; hands should then be washed/cleansed after disposing of the mask.

For more information regarding putting on and removing PPE, see section 7.4.12

- 7.4.4 In practice, if there is a surgery for flu patients, or a GP/nurse is visiting patients in a nursing home, it may be more pragmatic to wear a single mask for the whole time or until it becomes moist and needs replacing.
- 7.4.5 Even with UK stockpiling, face masks will be in limited supply and should be treated as a scarce resource.

- 7.4.6 Practices must carry out a risk assessment when using PPE. Detailed guidance on infection control in a flu pandemic is available on the DH website at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734
- 7.4.7 Gloves are not needed for the routine care of patients with flu, but standard infection control principles require that gloves are worn for:
- invasive procedures
 - contact with sterile sites, non-intact skin and mucous membranes
 - all activities that carry a risk of exposure to blood, body fluids, secretions (including respiratory secretions) and excretions handling sharp or contaminated instruments.
- 7.4.8 If glove supplies become limited during a flu pandemic, priorities for glove use may need to be established. Do not attempt to wash or disinfect gloves for reuse. Once worn, dispose of as clinical waste and wash hands.
- 7.4.9 Disposable plastic aprons should be worn if there is a risk of clothes or uniform becoming contaminated when examining the patient. They are single-use items and should be changed between patients and disposed of as clinical waste. Gowns are not required for the routine care of patients with influenza. Staff need to be aware that PPE will be a scarce resource in the event of a pandemic.
- 7.4.10 Staff must be trained to remove their PPE safely and in the correct order to reduce cross contamination.
- 7.4.11 The level of PPE used will vary according to the procedure being carried out, and not all items of PPE will always be required. Standard infection control principles apply at all times.

7.4.12 Putting on and removing PPE

Putting on PPE

Healthcare workers should put on PPE before they enter a single room or isolation area. The order given here for putting on PPE is practical, but the order for putting on is less critical than the order of removal.



1. Apron

- Fully cover the torso from the neck to knees and the arms to the end of the wrists, and wrap around the back.
- Fasten at back of neck and waist.



2. Surgical mask

- Secure ties or elastic bands at middle of head and neck.
- Fit flexible band to nose bridge.
- Fit snug to face and below chin.



3. Disposable gloves

Removing PPE

Healthcare workers should remove PPE upon leaving the room or isolation area in an order that minimises the potential for cross-contamination. Hand hygiene should be performed after all PPE has been removed. The order for removing PPE is important to reduce cross-contamination. The order outlined as follows always applies, even if not all items of PPE have been used.



1. Disposable gloves

- Assume that the outside of the glove is contaminated.
- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the ungloved hand under the remaining glove at the wrist.
- Peel off second glove over first glove.
- Discard appropriately.





2. Apron

- Assume that the front of the apron is contaminated.
- Unfasten or break the ties.
- Pull the apron away from the neck and shoulders, touching the inside of the apron only.
- Turn the apron inside out.
- Fold or roll it into a bundle and discard appropriately.



3. Surgical mask

- Assume that the front of surgical mask is contaminated.
- Untie or break the bottom ties, followed by the top ties or elastic, and remove the mask by handling the ties only.
- Discard appropriately.



4. Perform hand hygiene immediately after removing all PPE

Infection control guidance and training DVD available at
http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/DH_085433

Action Points

- Make sure all your practice staff understand how the flu virus spreads and that they are trained in and understand hand hygiene practices.
- Do you have adequate stocks of cleaning products? Does everyone know where they are stored? It would be a good idea to have an information manual for the practice so that everyone knows where to find things and to discuss whether your practice cleaning arrangements should change in a pandemic.
- Identify and plan ongoing training for staff in the use of face masks. At present, to minimise the spread of infection, you should remove unnecessary soft furnishings/toys etc. from your surgery. Plan now for what can be removed and where it can be stored until after the pandemic.

8 People who will be and could become vulnerable in a pandemic and where GP involvement is more likely

Summary: This chapter highlights the need to identify vulnerable patients who will be particularly at risk in this H1N1 pandemic and where GP involvement is more likely.

8.1 Identifying vulnerable patients

- 8.1.1 All people are vulnerable to H1N1, not just the usual known 'at risk' groups for seasonal flu. People who are vulnerable in ordinary situations will be even more likely to fall outside the system during an influenza pandemic. An example might be single people living alone with few contacts. These potentially vulnerable groups would be in addition to patients who could be clinically 'at risk' because of existing illnesses.
- 8.1.2 Vulnerable patients may not be able to comply with the self-care principles involved in a flu pandemic. They may not have a telephone to contact the NPFs, for example. PCOs will work with social services, the third sector and faith groups to plan to meet the needs of vulnerable individuals. As primary care will be under pressure, the advocacy role may have to be passed to others, e.g. third sector volunteers.
- 8.1.3 In general, where specialist services (such as those provided for substance misuse patients) are provided for vulnerable groups, efforts should be made to continue these services for as long as possible during a pandemic. Guidance for meeting the needs of those people who are or may become vulnerable in a pandemic is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103679

8.2 Non-registered patients

- 8.2.1 In a flu pandemic, general practices may experience a surge of demand from non-registered people seeking help. Practices should discuss with their PCO how any increase in demand for their services will be dealt with, including the possible greater number of temporary patients. People who are legally resident in the in the UK are entitled to be registered with a GP.
- 8.2.2 Guidance on working with or providing services for rough sleepers during the swine flu pandemic, including advice on how to support rough sleepers and signposts to guidance and other useful sources of information is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109108

8.3 Maternity services

- 8.3.1 Pregnant women form one of the groups of patients for whom it is important that essential clinical services be maintained. Guidance on providing maternity services is currently being updated and will be available on the DH website in the next few weeks.

There is also guidance available on the use of antiviral medicines for pregnant women, women who are breastfeeding and children under the age of one year available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100361

- 8.3.2 There are approximately 635,000 live births in the UK each year. Most pregnant women with flu would be cared for at home. There may have to be some adjustments to antenatal care because of the pandemic. All pregnant women will need to be seen, assessed and authorised for antiviral medicines by their GP or HCP. The CMO's advice for pregnant women is on the DH website at www.dh.gov.uk/en/Publichealth/Flu/Swineflu/DH_103068

Further advice on the management of pregnant women in primary care is contained in:

Pandemic H1N1 2009 influenza: clinical management guidelines for pregnancy available at

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_107840.pdf

Guidance on caring for women who are pregnant and vaccinations is available at www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_107824

8.4 Paediatric services

- 8.4.1 Caring for children will be a crucial part of the pandemic. Midwives, health visitors and school nurses may be able to help with the assessment of children. All children under 1 year old will have to be assessed by a GP or healthcare professional in order to get the oseltamivir solution available for this age group. There is a training module for staff on paediatric pathways in primary care available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104962

Further advice on the management of children in primary care is contained in *Pandemic H1N1 2009 influenza: clinical management guidelines for adults and children* available at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107769

8.5 Mental health services

- 8.5.1 Caring for mental health patients is a critical service which must be maintained as far as possible during a pandemic. With 95% of patients with mental health problems being cared for in the community the impact on general practice is high. A pandemic is also likely to precipitate new demands as people experience disorders such as anxiety or depression for the first time. Healthcare workers often act as patients' advocates but in a pandemic, they may be focused on their clinical obligations. All those involved in community mental healthcare teams should plan for alternative advocacy arrangements during a pandemic, such as using current volunteer or befriending systems. Guidance on mental health services and H1N1 has been updated and is available at www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_109172

Guidance for the continuation of Substance Misuse services is being developed by the National Treatment Agency in collaboration with the DH.

8.6 End-of-life care

- 8.6.1 Around half a million people die in England each year, of whom almost two thirds are aged over 75. The large majority of deaths at the start of the 21st century follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere.
- 8.6.2 Inevitably, there will be a greater demand for end-of-life care during a pandemic and it is imperative that health and social care staff at all levels have the necessary knowledge and skills to enable them to deliver end-of-life care at home where resources permit. Guidance on end-of-life care and H1N1 is currently being updated and will be available on the DH website in the near future.
- 8.6.3 There is a considerable risk that care resources will be directed to managing patients with flu. Patients who have palliative care needs and their family and carers, and those with other severe chronic conditions may receive reduced support from primary and secondary care services.
- 8.6.4 There are an increasing number of children with life-limiting illness who survive for longer, and their families and carers (with outreach support from community and hospice services) care for many of these children at home. Pressure on critical care beds and the invocation of any triage pathway arrangements may cause particular distress to patients, family and carers of these children, especially if critical care is no longer an available option for them.
- 8.6.5 A small steering group, representative of the palliative care community, has been established to identify how best to support end-of-life care services for palliative care patients and their families. It also examines how specialist and generalist clinicians can work together to manage the resources available for end-of-life care.

9 Managing increased demand and patient prioritisation in primary care

Summary: This chapter describes how additional capacity will be freed up in a pandemic by introducing prioritisation of services and patients in a systematic manner, and gives reference to the underpinning ethical framework for the surge demand work.

9.1 Working patterns

- 9.1.1 Effective communications will be the key to managing the increased demand for primary care in this swine flu pandemic. This means not only communications with the public, but also communications with all aspects of the health services, social services and the third sector. Improved collaborative working should result in improved care and transition to the recovery phase of the pandemic. Appendix 6 gives more information on national communication plans.
- 9.1.2 In order to manage increased demand, prioritisation of services may be needed at the peak time of the pandemic. Such pressure may not be the same in all areas and hospitals may be able to undertake mutual aid. If this is not possible, as hospital beds fill up, patients who in normal circumstances would have been sent to hospital will have to be managed in the community. GPs will be looking after patients in the community who are more seriously ill than under normal circumstances, as well as caring for their normal patients and those with flu.
- 9.1.3 It will be important to maintain normal services for as long as appropriate. However, at some point, the pandemic workload could be unsustainable if some of the normal workload is not removed. At a given signal from the local NHS body (SHAs in England), practices will be told to stop doing work which is not essential to current clinical demand. Appraisals, work relating to the QOF and non-essential clinics will be suspended, along with some other areas of work.
- 9.1.4 In making these decisions the SHA (or equivalent body in the devolved countries) will liaise with its PCOs who must liaise with their LMCs and Local Pharmaceutical Committees. Together they will determine when resources have been stretched to the point at which services should focus on delivering essential work only. These decisions will need to be confirmed with the DH in England or equivalent health body in devolved administrations. At all stages, the response needs to be proportionate to the threat of the H1N1 pandemic.
- 9.1.5 As a substantial part of practice resources comes from performance-related pay (QOF), agreement has been reached with the Government that during a flu pandemic, practice resources will be protected at the level of the preceding year, plus any intervening Doctors' and Dentists' Review Body awards. **The Government does not intend for any general practice which makes available its resources for use at the PCO direction to be disadvantaged financially by responding to a flu pandemic.**

9.1.6 The RCGP and the BMA have issued joint guidance on service continuity. Suggestions as to which functions could be reduced, stopped, or be delivered through alternative means include:

- cancellation of outside activities (meetings, teaching etc)
- defining minimum safe staffing levels
- suspension of some chronic disease management
- suspension of (some) new routine referrals
- suspension of minor surgery
- having emergency-only open surgeries
- team working with neighbouring practices.

9.1.7 The use of telephone triage will also be important throughout a pandemic.

9.1.8 OOH services are critical in a pandemic. PCOs will wish to bolster this resource wherever possible with additional staff. Normal surgery times may well differ during a pandemic and practices will want to discuss this with the buddying-up group, PCO and LMC. Buddying-up clusters may be asked to help bolster OOH services and this will impact on the ability to deliver 'normal' in-hours services. If this happens, it might be necessary to introduce an earlier suspension of normal activity. Practices will receive instructions from their PCO if this is the case.

9.2 Managing demand and capacity

9.2.1 There will be a local contingency plan so that when the demand reaches a certain level, those services which are not immediately essential to healthcare may be suspended. For example, non-urgent operations (electives) will not take place, so that extra capacity in the health care system can be created using hospital facilities.

Access to care will be based on assessment informed by a set of clinical outcome tools, thereby ensuring that the access to care and treatment is equal for all. If demand becomes too great for hospitals to cope with, patients will be prioritised based on criteria which can help with identifying who will benefit most from available treatment. As the pandemic wanes, there will be a gradual, organised return to normality and this may take several months.

9.2.2 The decisions on the point at which contingency plans are to be activated will be made at a regional level by SHAs in England (and the appropriate level in the devolved administrations), in consultation with the relevant PCOs, **who in turn MUST consult with LMCs**. These decisions will then be communicated to primary and secondary care. Doctors will have clear information about the prevailing local situation and instructions on which clinical referrals can be made. It is not possible to know in advance how severe a flu pandemic will be, but it is necessary to plan now for a worst-case scenario.

9.2.3 Objective admission criteria for adults with pandemic flu and possible complications have been developed for use when demand exceeds capacity in healthcare services. These criteria are scaleable so that the maximum number of patients needing admission can be catered for within the day to day variations in available resource. An admission criteria tool for use with children has also been developed (See Adult and Paediatric Community Assessment tools in Appendices 4 and 5). The use of pulse oximeters to

measure oxygen saturation is an accepted and validated measure of hypoxaemia as a surrogate for respiratory distress. DH clinical management guidelines for use during the H1N1 2009 influenza pandemic recommended that the measurement of peripheral oxygen saturation by pulse oximetry is essential when making decisions to refer patients from primary care to hospital. If purchase of pulse oximeters is considered, care should be taken to ensure that they actually comply with ISO standard 9919:2009 (replacing ISO standard 9919:2005) – and are not only described as being 'designed to comply' with ISO 9919:2009

The General Practice Airways Group (GPIAG) has published advice, Pulse Oximetry and Primary Care, providing information on selecting oximeters and using them effectively.

www.opiag.org/resources/pulseoximetry.final.pdf

9.3 Indemnity

9.3.1 The Medical Defence Union, Medical and Dental Defence Union of Scotland and the Medical Protection Society say that doctors who have indemnity related concerns will be able to look to their medical defence organisations in the usual way for advice and for assistance with any medico-legal matters arising from the professional services they provide during a flu pandemic.

9.3.2 Up-to-date guidance can be found on:

www.the-mdu.com	in <i>Latest advice</i>
www.medicalprotection.org/uk	in <i>News Centre</i>
www.mddus.com	in <i>News digest</i>

9.3.3. While most people may well accept the general need for prioritisation, it will be hard for families and friends to accept a situation in which their loved one is not being referred for hospital treatment. GPs will need support from their peers during the peak of the pandemic if the need to make difficult decisions about patient care is needed.

9.3.4 The GMC has produced a special edition of *Good Medical Practice* to cover what will be expected of doctors in a flu pandemic. This is available at **www.gmc-uk.org/guidance/news_consultation/medical_pandemic.asp**

9.3.5 Where a PCO asks a doctor to work in a secondary care setting - for example, asking a GP to work in an Emergency department or in a community hospital - then indemnity is provided by the NHS. At the earliest practicable moment, the PCO must issue a temporary contract confirming such cover. The GP should also inform their Medical Defence Organisation.

9.4 Ethical issues

- 9.4.1 To ensure fairness and equity, an ethical framework has been prepared to underpin all the flu pandemic planning. By agreeing this in advance, and applying it when a pandemic strikes, everyone can be assured that scarce health service resources are being used in as an even-handed manner and as effectively as possible.
- 9.4.2 You can read the ethical framework at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080751

9.5 Out of Hours (OOH) Services

Out-of-hours services are critical to treating people in the community. The boundaries between GP daytime surgeries and OOH services will become blurred, and GP practices' hours of opening will need to be flexible to support patient care services on a seven day, 24-hour basis.

Guidance on escalation (including the use of OOH services) can be found in *Planning and responding to primary care capacity challenges* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104487

The guidance for PCTs on how to deliver primary care services whilst potentially short staffed and how to cope with increased patient demand during the pandemic and the anticipated seasonal flu was published in August 2009 . There is a section on PCT responsibilities for OOH services and also an escalation plan looking at suspension of primary care services.

In discussions with their PCOs, primary care practices may also wish to discuss:

- OOH mobilisation of locums and salaried GPs
- Non-clinical support and infrastructure e.g. allowing breaks for staff and access to food and drinks
- Accessing ongoing leadership support in the PCO from senior clinicians and Directors of Operations/Chief Executive.

10 Prescribing issues

Summary: This chapter explains the need to avoid overloading the pharmacy supply chain and antibiotic policy.

10.1 Medicines management

- 10.1.1 Practices should continue to issue repeat prescriptions at the same interval as normal. Patients should not be encouraged to stockpile medicines. Further pressures should not be placed on the pharmaceutical supply chain by issuing longer than normal repeat prescriptions.
- 10.1.2 The issuing of post-dated prescriptions for normal length repeat medicines should be considered, so that the number of patient contacts with the practice for medicines is minimised, without significant impact on the pharmaceutical chain.
- 10.1.3 Alternatively, GPs may wish to consider repeat dispensing, where they are able to issue prescriptions for up to one year, with pharmacies being able to dispense medicines on an instalment basis. This option may be more practical than using post-dated prescriptions. Patients can take the prescription to a pharmacy and the pharmacist will dispense the prescription at the requested intervals. This means that patients can obtain their supplies of medicines every month without having to visit their GP. It also enables pharmacists to check with patients whether they are experiencing any problems with their medicines. If any changes are made to a patient's prescription, the GP should make every effort to inform the patient and relevant pharmacist.

10.2 Antibiotics

10.2.1 Introduction

Patients without severe pre-existing illness and who have uncomplicated influenza do not routinely require antibiotics.

The main and most severe complication of influenza is secondary bacterial infection, particularly pneumonia. For example, in the 1957 pandemic, of patients with pneumonia studied in London teaching hospitals, 28% of those with staphylococcal pneumonia and 12% of those with non-staphylococcal pneumonia died. Infections can be serious, particularly in the very young, older people and those with certain risk factors such as pre-existing chronic respiratory disease or cardiovascular disease. The incidence of pneumonia associated with seasonal influenza ranges from 2 to 38% of cases. Mortality associated with cases of secondary bacterial pneumonia ranges from 7% to 24%, although some studies report higher mortality rates.

In light of this, during an influenza pandemic it will be essential to limit both hospitalisations and deaths by ensuring that those with respiratory tract infections (e.g. secondary bronchitis or acute suppurative otitis media) receive antibiotics as quickly as possible. Therefore, it will be even more important than usual to follow guidance about clinical implications for prescription, to avoid the risk of overloading the supply chain.

Nevertheless, should there be difficulties in the pharmaceutical supply chain as a result of manufacturers not being able to meet demand during the swine flu period, the DH has stockpiled a limited selection of appropriate antibiotics for the treatment of secondary complications of influenza (see 10.2.4). These could be released into the supply chain if required.

10.2.2 Scientific Advice

Procurement of the selected antibiotics has been informed by the following sources: current British Thoracic Society (BTS) guidelines for the management of community- and hospital-acquired pneumonia in adults; a review of the literature on previous pandemics and the complications observed during them; current surveillance data on the bacteria causing pneumonia and antimicrobial susceptibilities; and expert opinion. Once there is enough evidence to do so, we will review this guidance with specific reference to the swine flu pandemic.

Further information on the use of antibiotics in swine flu is available in the recently produced *Pandemic H1N1 2009 influenza: clinical management guidelines for adults and children*, which is available at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107769

A DH review of the scientific evidence base for the use of antibiotics in a pandemic can be found at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077276?ssSourceSiteId=ab

The consensus from this advice is that:

- The selected antibiotics should be effective against *Haemophilus influenzae*, *Streptococcus pneumoniae* and *Staphylococcus aureus*, the bacteria that most commonly cause secondary bacterial infections following influenza.
- The preferred first choice of antibiotic for non-pneumonic bronchial infections in adults should include an effective oral-lactamase stable agent such as a tetracycline or co-amoxiclav.
- A macrolide is an alternative for those intolerant of the preferred first choices, whilst remembering the possibility of antimicrobial resistance. Clarithromycin has better activity against *Haemophilus influenzae* than azithromycin.
- For children under 12 years of age, co-amoxiclav is the drug of choice, and for those over 12 years, doxycycline is an alternative. Clarithromycin should be used in children allergic to penicillin.

10.2.3 Stocks of Antibiotics

The DH has secured supplies of doxycycline, co-amoxiclav and clarithromycin specifically for use in a pandemic. If the current supply chain comes under strain during a pandemic wave, the DH will release its stockpile and issue advice that these will be the antimicrobial agents of first choice for the empirical treatment of complications related to pandemic influenza. In the meantime, prescribers should treat complications according to clinical indications and in line with normal prescribing practice.

Co-amoxiclav is a combination product containing amoxicillin and clavulanic acid. This is an inhibitor of beta-lactamase, an enzyme that is present in many penicillin-resistant bacteria, and helps amoxicillin retain its efficacy. In particular, co-amoxiclav should be effective against amoxicillin-resistant strains of *Haemophilus influenzae*, *Moraxella catarrhalis*, and methicillin-sensitive penicillin-resistant *Staphylococcus aureus*. The amoxicillin component will be effective against the vast majority of *Streptococcus pneumoniae*.

Doxycycline is also effective against the targeted bacterial pathogens and has activity against nearly all methicillin-resistant *Staphylococcus aureus* in addition.

Macrolides such as clarithromycin are for use in those who are allergic to penicillin-based antibiotics. Clarithromycin has better activity against *Haemophilus influenzae* than Azithromycin.

10.2.4 Treatment of secondary bacterial infections due to pandemic influenza

Features of an acute bronchitis, with cough, retrosternal discomfort, wheeze and sputum production are an integral part of the influenzal illness. Antibiotics are not indicated in previously well individuals who do not have pneumonia or new focal chest signs. If the patient is seen later in the course of the illness and the illness is worsening - for instance, with recrudescence fever, or breathlessness (dyspnoea) - a worsening bacterial bronchitis or developing pneumonia is possible and the use of antibiotics should be considered. Antibiotics should be given to anyone with disease severe enough to normally merit hospital admission, but who may not be admitted due to resource limitations.

Assessment and treatment of individuals who develop secondary respiratory tract infections after initial infection with pandemic influenza should follow the clinical decision pathway given in Table **A** on page 53. The purpose of the pathway is to ensure consistency of approach to prescribing antibiotics for secondary bacterial infections following an influenza infection during a pandemic.

The pathway is not intended to replace clinical judgement, but to provide a framework for decision-making for all prescribers. It is underpinned by the BTS guidelines for assessment and treatment of secondary bacterial chest infections.

Most patients can be adequately treated with a week's course of oral antibiotics.

10.2.5 Treatment of secondary bacterial infections due to pandemic influenza in those with underlying health conditions

Those at high risk of influenza-related complications because of chronic obstructive pulmonary disease (COPD) or other severe co-morbid diseases should be strongly considered for antibiotics at first consultation.

If, having started antibiotics, patients do not begin to improve over the following 48 hours of antibiotic treatment (or if they get worse), they should be advised to re-contact their GP for an assessment of pneumonia (and its severity).

10.2.6 Treatment of secondary bacterial infections due to pandemic influenza in children

Secondary bacterial infections, particularly pneumonia and otitis media, are common in children with influenza. As with adults, *Streptococcus pneumoniae*, *Staph. aureus* and *H. influenzae* are likely to be the most common pathogens encountered during influenza outbreaks. Children in any one of the following groups should be promptly treated with a first line antibiotic that will provide cover against these pathogens, as well as group A streptococcal infection:

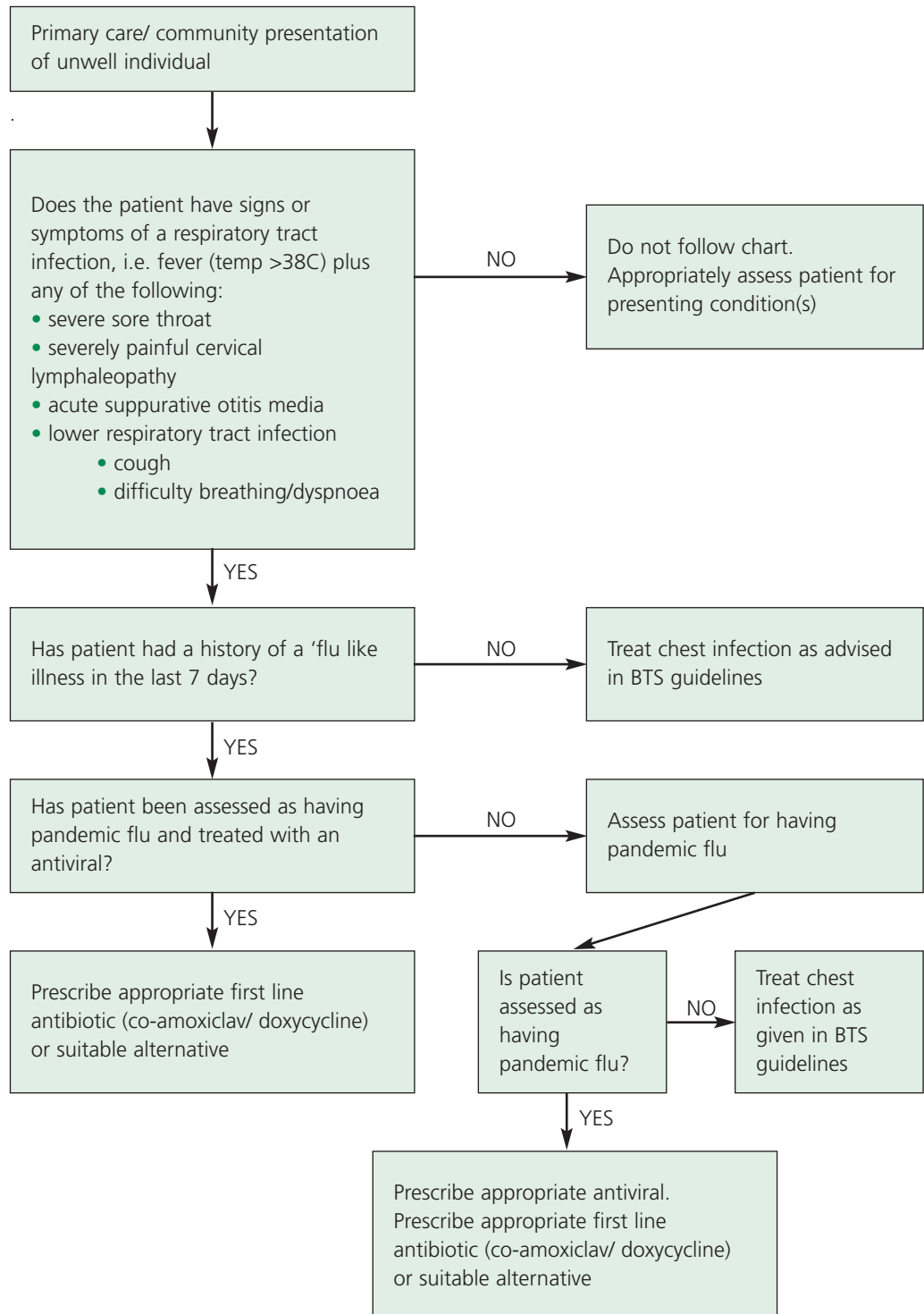
- those at higher risk of complications from influenza (see above)
- those with one or more of the following features of complications of influenza
 - a. evidence of respiratory distress such as increased respiratory rate, lower chest wall indrawing, intercostal recession or tracheal tug.
 - b. severe earache.
- those with disease severe enough to normally merit hospital admission, but who may not be admitted due to resource limitations.

Prescribers for children must consider other serious treatable diseases whose early features can mimic influenza-like illness. Prescribers should be aware that in children with signs of respiratory distress, hypoxia can only be excluded by measurement of peripheral oxygen saturation.

10.2.7 Prescriptions for antibiotics

Access to antibiotic treatment for secondary bacterial complications in primary care during the pandemic will be authorised by a prescriber in the normal way, using FP10 prescriptions to be redeemed at pharmacies. However, practices may wish to consider measures to reduce the number of people presenting with flu-related complications at GP practices. Such measures might include triaging patients over the phone, although a form of phone-based severity assessment and/or invitation to re-consult if symptoms worsen will be essential to ensure that those requiring hospital care are identified promptly. For telephone assessments, an FP10 form could be completed for collection from the surgery by a Flu Friend or forwarded to a pharmacy of the patient's choice.

Table A Clinical decision pathway for prescribing antibiotics to adults and children for bacterial respiratory tract infections during a pandemic



11 Death certification

Summary: This chapter explains mortality modelling and new arrangements for death certification in an influenza pandemic using retired doctors.

11.1 Mortality and death certification

- 11.1.1 According to the latest guidance for planners, the case fatality ratio in the present swine flu pandemic suggests that mortality due to H1N1 will be up to 1000 excess deaths.
- 11.1.2 At this level of expected mortality, it is expected that the usual processes for death and cremation certification will continue. In a pandemic, if necessary, a modified system of issuing cause of death certificates could be introduced and the cremation certification process could also be relaxed. Full details of the proposals on how this will be carried out in England and Wales can be found on the DH website. Find the document at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086832
- In Scotland, guidance for medical practitioners on death certification during an influenza pandemic can be accessed at www.scotland.gov.uk/pandemicflu
See under *Frameworks and Guidance*.
- 11.1.3 If required due to the level of pressure on local services, a decision will be made centrally to relax the legal requirement to refer a death to the coroner if the doctor issuing the Medical Certificate of Cause of Death (MCCD) has not seen the patient for 14 days (*Regulation 41 of the Registration of Births and Deaths Regulations 1987*) i.e.MCCD). The period will increase from 14 days to 28 days. This brings England and Wales in line with Northern Ireland, and will require legislation.
- 11.1.4 At a local level, the (non-statutory) practice of reporting to the coroner all deaths that occur within 24 hours of admission to hospital may be suspended where flu or its complications are involved. Practices will be told by their SHA when this takes place.
- 11.1.5 A change will be made to the law to allow doctors who have not attended a deceased patient to issue an MCCD where pandemic flu is believed to be the cause of death. The doctor can also complete Cremation Form B.
- 11.1.6 There will be a change to the Cremation Regulations to bring in a streamlined Cremation Form B. The requirement for Cremation Form C will be suspended, removing the need for a second doctor to confirm information.
- 11.1.7 Only registered medical practitioners may complete the MCCD. To increase the number of doctors for this work in a flu pandemic, retired doctors will be called on for this role. The BMA is working with the Government to provide a list of retired doctors who are willing to help, matched against PCO areas. You can read more at www.bma.org.uk/health_promotion_ethics/influenza/pandemicinfluenzadatabase.jsp

- 11.1.8 PCOs have been asked to develop and keep up-to-date a list of retired doctors willing to help with death and cremation certification in a pandemic.
- 11.1.9 Doctors carrying out this work will have to be temporarily registered with the GMC. Legislation is proposed which would permit the GMC, under new emergency powers, to grant a doctor registration subject to conditions. In England, PCTs would pay any costs of GMC registration for retired doctors.
- 11.1.10 The NHS indemnity insurance arrangements would cover temporary staff. However, NHS indemnity may not cover all temporary doctors' indemnity and medico-legal needs during a pandemic.
- 11.1.11 Doctors returning to medical work are advised to contact a medical defence organisation (MDO) to apply for temporary membership for the duration of the pandemic so that they will be able to seek medico-legal advice, assistance and indemnity.
- 11.1.12 In a flu pandemic, retired doctors will also be able to take on the role of medical referee at local crematoria.
- 11.1.13 Additional MCCD forms will be needed in a flu pandemic. PCOs will supply these to the retired doctors on their list.

12 H1N1 Vaccine

Summary: This chapter explains the H1N1 immunisation programme.

12.1 Current seasonal flu immunisation scheme

12.1.1 As described in the CMO's letter of 6 April 2009, the ordinary seasonal immunisation schemes for patients at risk of seasonal influenza should continue as normal.
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_097550

12.1.2 The seasonal swine vaccine can be given at the same time as the swine flu vaccine.

12.2 H1N1 pandemic specific vaccine

12.2.1 Two vaccines to A(H1N1) have been developed by GlaxoSmithKline (Pandemrix) and Baxter (Celvepan). Both vaccines have now been licensed by the European Commission following a recommendation from the Committee for Medicinal Products for Human Use (CHMP) at the European Medicines Agency (EMA).

12.2.2 Pandemrix, manufactured by GlaxoSmithKline (GSK), is an adjuvanted inactivated vaccine. There are separate vials of adjuvant and antigen that need to be mixed in order to reconstitute the vaccine. The vaccine comes in multidose vials (10 0.5 ml doses per vial) and contains a preservative, thiomersal. Once reconstituted, the vial can be used for up to 24 hours. Each box of Pandemrix contains 500 doses.

Celvapan, manufactured by Baxter, is an unadjuvanted inactivated vaccine. The vaccine comes in multidose vials (10 0.5ml doses per vial) and does not contain thiomersal. After first opening, the product should be used immediately. However, chemical and physical in use stability has been demonstrated for three hours at room temperature. Each box of Celvapan contains 200 doses.

12.2.4 Initially, the Pandemrix vaccine only will be delivered to PCOs and GPs.

12.3 Vaccine schedule

www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_107169

12.3.1 Following advice from the Joint Committee on Vaccination and Immunisation (JCVI), the following vaccination schedule is recommended in the UK:

Pandemrix (manufactured by GSK)

For all children aged from six months of age to less than 10 years of age:

- Two half doses (0.25ml each) of Pandemrix should be given with a minimum of three weeks between doses.

For individuals aged from 10 years to less than 60 years of age:

- One dose (0.5ml) of Pandemrix.

For individuals aged 60 years and over:

- One dose (0.5ml) of Pandemrix (this advice will be reviewed when more data become available).

For immunocompromised individuals aged 10 years and over:

- Two doses (0.5ml each) of Pandemrix should be given with a minimum of three weeks between doses.

Celvapan (manufactured by Baxter)

For children from 6 months of age and adults:

- Two doses (0.5ml each) of Celvapan should be given with a minimum of three weeks between doses.

12.3.2 Vaccines for children and young people

JCVI confirmed its earlier advice that Pandemrix should be the vaccine of choice for children and young people up to 18 years of age. This is because currently there are no paediatric data available for Celvapan.

People who have had laboratory-confirmed influenza H1N1 infection do not need to be vaccinated with swine flu vaccine. However, the vaccine can be given to these individuals with no ill effects. In the absence of a laboratory confirmed diagnosis of influenza H1N1 infection, individuals should be vaccinated.

This dosage schedule is based on advice given by JCVI, following consideration of clinical data available on the vaccines. The dosage and recommendations will be kept under review as more clinical data become available.

12.3.3 Vaccines in pregnancy

JCVI recommended that pregnant women should be given Pandemrix, since a one-dose schedule with this vaccine appears to provide adequate levels of antibodies and thereby confer more rapid protection than would be afforded by a two-dose schedule.

Expert scientific advice is clear that thiomersal-containing vaccines do not present a risk to pregnant women or their offspring. More detailed advice is available in the updated website edition of *Immunisation Against Infectious Diseases* (The Green Book), within the downloadable chapter on swine flu www.dh.gov.uk/greenbook

Further guidance is available at www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_107824

12.3.4 Contraindications

There are very few people who cannot receive swine flu vaccines. The vaccine should not be given to people who have had an anaphylactic reaction to the vaccine or a component of the vaccine.

Pandemrix should not be given to individuals (including children) with a history of severe anaphylactic reaction (shock or acute difficulty in breathing) to egg-containing products; they should receive Celvapan.

Pandemrix should be given to individuals (including children) with less severe allergic reactions to egg.

Pandemrix and Celvapan can be co-administered with all other vaccines, including seasonal influenza and childhood vaccines.

- 12.3.5 As with most vaccines, the most common adverse reactions are injection site reactions (such as redness and swelling), mild fever, general aches and pains, rash and fatigue. Vaccines may very rarely cause a serious allergic reaction.

For training materials, please see the HPA website:

www.hpa.org.uk/HPA/EventsProfessionalTraining/InfectionsTrainingAndEvents/InfectionsTrainingResources/1204012992964/

And the DH website

www.dh.gov.uk/en/PublicHealth/Flu/Swineflu/InformationandGuidance/index.htm
dated 08 October 2009.

- 12.3.6 As with any new vaccine, rare and very rare side effects cannot be identified until the vaccines have been used in large numbers of people in the general population. It is essential serious adverse reactions are reported to the MHRA.
www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Medicines/Reportingsuspectedadversedrugreactions/index.htm

12.4 Priority groups

- 12.4.1 Based on the advice from the JCVI, the following groups will be the first for vaccination with the AH1N1 swine flu vaccine, in the order below. Please see the letter from David Salisbury, Director of Immunisation, DH:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_106300

- Individuals aged between six months and up to 65 years of age in the current seasonal flu vaccine clinical at-risk groups.
- All pregnant women.
- Household contacts of immunocompromised patients.
- People aged 65 years or over in the current seasonal flu vaccine clinical at-risk groups.

- 12.4.2 Following successful negotiations between the DH, GPC and NHSE, vaccination of the 9.5 million people in these priority groups will be administered by GPs. The new deal will mean that general surgeries will receive £5.25 per dose of vaccine given. It will help surgeries to contact patients, administer the vaccine and, if necessary, take on extra staff.
- 12.4.3 The DH will transfer appropriate funding to SHA / PCT budgets for the GPs' administration costs of the swine flu vaccination programme to priority groups.
- 12.4.4 SHAs and PCTs are familiar with arrangements for paying GPs for the delivery of services, and appropriate arrangements for swine flu vaccination payments will be made locally under the national Directed enhanced service (DES).
- 12.4.5 In addition to this, front line health and social care workers will be offered the vaccine at the same time as the first clinical at-risk groups, as they are at increased risk of infection and of transmitting that infection to susceptible people. Practices will wish to ensure that their front line staff are made aware of this opportunity. Practice staff can access the vaccine from their own registered GP, or the employing practice may consider offering the vaccine in-house to its own staff. Further information is available from the BMA website: www.bma.org.uk/health_promotion_ethics/influenza/panflugp/index.jsp
- 12.4.6 The CMO also announced on 19 November 2009 that healthy children aged from 6 months up to 5 years will be included in the second phase of H1N1 vaccinations. This is due to an increase in GP consultation rates amongst school-aged children after half term, and a substantial increase in the number of under 5s in hospital, including in critical care. Carers will be added to the group of front line health and social care workers to be prioritised for vaccination.

Please see the letter from the CMO (England) about the second phase of vaccinations: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_108896.pdf

12.5 How will the vaccines be supplied to practices?

- 12.5.1 The first supplies of vaccines to general practices were delivered from 26 October 2009. It will take around 3-4 weeks to complete the distribution of first supplies to all practices. Initially practices will receive one box of Pandemrix vaccine containing 500 doses.
- 12.5.2 General practices already have standard security arrangements and it would be unrealistic to expect individual practices to implement high-level security over and above existing arrangements.
- 12.5.3 Practices should review their vaccine storage policy and temperature recording systems for their vaccine fridges. They should also consider whether they have sufficient vaccine fridge capacity. As with all vaccines, it is important that swine flu vaccines are distributed and stored between +2°C and +8°C. Under no circumstances should they be frozen. Vaccines should not be stored in direct sunlight.

Action points

- **Practices should review their current arrangements for vaccine storage.**
- **Practices should consider how the vaccination programme for the priority groups will be delivered.**

13 Recovery phase

Summary: This chapter describes the need for a gradual staged return to normal services. General Practice will still be under pressure with new patient demand and backlogs of work to contend with.

13.1 Rebuilding, restoring and rehabilitation

- 13.1.1 There will be a gradual movement towards resuming normal services, probably over many months. GPs and staff may be exhausted and other stresses and problems could emerge during the recovery phase. Healthcare workers who may not have had H1N1 may be surprised at feeling unwell at this point, but many are likely to do so and will need time off to recuperate. This absence will be on top of allowing staff to take any accrued leave and/or compensatory time.
- 13.1.2 General practice may therefore be short staffed in the recovery period, along with the rest of the health service.
- 13.1.3 Primary care services may experience persistent secondary effects for some time and there will be increased demand for continuing care from:
- patients whose existing illnesses have been made worse by flu
 - patients who may continue to suffer potential medium or long-term health complications from flu
 - the backlog of work from the postponement of treatment for less urgent conditions.
- Practices will need to:
- review their staffing levels and availability of staff for work
 - assess the need for psychological support for staff
 - ensure that premises are adequately cleaned and made ready for the resumption of normal service
 - check essential supplies and replenish them as soon as stocks become available
 - communicate with their patients to ensure they know when normal services are resumed.
- 13.1.4 Announcements from the SHA (or its equivalent in the devolved administrations) will be fed through to practices via the local PCOs on the return to 'normal' working practices.
- 13.1.5 As no one can predict the pattern of H1N1, there could be the scenario of moving into the recovery period only to find that a subsequent wave of the pandemic strikes. Should this occur the recovery arrangements will be postponed and, once again, GP practices will adopt the staged approach to managing services in order to cope with the needs of flu patients.
- 13.1.6 During the recovery phase, as at every stage of planning for and responding to a flu pandemic, healthcare workers will follow the ethical principles of fairness and equity, which underpin all treatment.

Appendix 1: List of acronyms

ACP	Antiviral Collection Point
BMA	British Medical Association
BTS	British Thoracic Society
CCC	Civil Contingencies Committee
DH	Department of Health
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GPC	General Practitioners Committee
HCP	Health Care Professional
HPA	Health Protection Agency
JCVI	Joint Committee for Vaccinations and Immunisations
LMC	Local Medical Committee
MCCD	Medical Certificate of Cause of Death
NHS	National Health Service
NHSE	NHS Employers
MHRA	Medicines and Healthcare products Regulatory Agency
NPFS	National Pandemic Flu Service
OOH	Out of Hours
OTC	Over-the-counter (medicines)
PCO	Primary Care Organisation
PCT	Primary Care Trust
PPE	Personal Protective Equipment
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SHA	Strategic Health Authority
WHO	World Health Organization

Appendix 2: General practice income

Ministers have endorsed an agreement reached between NHSE and GPC on the maintenance of GMS practice income where GP practices are involved in responding to an influenza pandemic.

This is in line with the principle set out in *Pandemic influenza: guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting*, that 'The Department of Health does not intend any general practice to be disadvantaged financially by its participation in responding to an influenza pandemic' (paragraph 10.3.3 of the guidance).

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080757

The financial agreement and the costing methodology can be found on the BMA's website at www.bma.org.uk/health_promotion_ethics/influenza/panflugp/flupandemic0508.jsp

This outlines the broad principles that have been agreed and some supporting guidance for PCOs and practices on the financial agreement.

In addition to agreeing GMS practice payments, NHSE is also working with the DH on guidance on the broader HR issues for all NHS organisations in responding to an influenza pandemic.

Appendix 3: Patients who may be expected to contact GPs following an initial assessment at a local ACP via the NPFS

Purpose of this document

The purpose of this document is to provide GPs and other healthcare providers with a summary of the types of flu patients that may be referred to them for assessment and advice during a flu pandemic, specifically from the NPFS.

This may help GPs decide how best to manage their patients, although it is important to note that GPs must continue to use their own clinical judgement on a case-by-case basis to determine how to provide care to their patients.

The document refers to the referral criteria used by the NPFS introduced in England on July 23rd 2009.

Introduction

During a pandemic, a symptomatic individual may be assessed and authorised antiviral treatment by the following means:

1. via a NPFS, accessed at home, by telephone or via the internet
2. by a GP or other qualified HCP.

The NPFS assessment is based on a clinical algorithm. The purpose of the assessment is to:

- assess flu symptoms
- determine if patient requires antiviral medicines
- identify if the patient requires additional healthcare services and refer the patient to the most appropriate service for them.

On completing this assessment, some patients will be advised to contact their GP for further support. If a patient also requires antiviral medicines, they will be authorised these and their Flu Friend will need to collect them from an ACP before contacting a GP (with the exception of children under 1 year – see section 1.2).

Anticipated GPs referrals

Patients who have been recognised as being at greater risk of developing complications, due to either their current flu symptoms or their medical history, will be advised to telephone their GP surgery. The support a patient needs from their GP (or practice nurse) will depend on their specific circumstances.

Broadly, patients will be referred to their GP surgery for one of the following:

1. an urgent clinical assessment
2. a further clinical assessment
3. a possible further clinical assessment.

1. Urgent clinical assessment (ideally within four hours)

This group of patients will be advised to contact their GP immediately.

- 1.1 Pregnant women are advised to contact their GP for a flu assessment and not use the NPFS. If they contact the NPFS, they will be again advised to contact their GP. However, it is possible for a pregnant woman to complete an assessment by the NPFS and, if appropriate, be authorised for antiviral treatment. If this occurs the woman will still be advised to inform their GP but not immediately.

1.2 Children under 1 year of age

Children less than 1 year will not be assessed and authorised antiviral at a local ACP or by the NPFs. Instead, they must be assessed and authorised antiviral treatment by a GP.

1.3 Patients with symptoms to suggest developing respiratory complications:

- tachypnoea
- pleurisy
- infected sputum/haemoptysis
- respiratory distress
- deterioration in conscious level.

1.4 Some patients who are pregnant or have significant renal impairment, who also have:

Either, a medical history of:

- chronic lung disease
- asthma on inhaled steroids
- heart disease
- diabetes or other metabolic condition
- chronic liver disease
- cystic Fibrosis
- neurological conditions such as cerebral palsy, stroke, multiple sclerosis or muscular dystrophy
- sickle cell

or, additional symptoms such as:

- watery diarrhoea
- profuse vomiting
- reduced urine output.

2. Clinical assessment (not urgent, ideally within the same day)

These patients will be advised to telephone their GP surgery, although no time frame will be given for when they should do this. These patients are likely to need further assessment, although the urgency for such assessment is for local decision.

2.1 All immunocompromised patients; that is, patients who are:

- having treatment for immune deficiency
- on immune suppressant drugs such as regular steroids, methotrexate, azathioprine or cyclophosphamide
- having, or recently completed, treatment for cancer, leukaemia or lymphoma
- a transplant recipient
- HIV positive.

2.2 Adults with flu symptoms that have continued to worsen for more than five days or children with flu symptoms that have continued to worsen for more than three days.

3. **Advice and possible clinical assessment**

Patients with a significant medical history which places them at risk will be advised to contact their GP if they experience worsening of their underlying condition specifically:

- chronic lung disease or
- asthma on inhaled steroids
- heart disease
- chronic liver disease
- cystic Fibrosis
- diabetes or another metabolic disease
- neurological conditions such as cerebral palsy, stroke, multiple sclerosis or muscular dystrophy
- sickle cell disease.

Referrals to other health care services

Some patients will be advised to seek further medical support for other health services. This includes:

- 999 ambulance service for patients in need of assessment for emergency care. For example, because they are:
 - unconscious
 - experiencing severe breathing problems
 - do they feel that their throat is closing off and they are unable to swallow saliva or drooling excessively?
 - have skin that feels icy cold or blue or grey
 - seizures
 - or because they are showing signs of meningitis
- NHS Direct for patients showing signs of serious dehydration or severe ear ache. It is expected that NHS Direct will be able to provide patients with further advice on how to manage these symptoms at home.

Appendix 4: Adult swine flu community assessment tool

ADULT

Swine flu adult community assessment tool

For use in all adults aged 16 years or older in the community

This assessment tool should be used during a pandemic situation to assist with the decision as to whether a sick febrile adult with flu-like illness needs referral to the nearest general hospital Emergency Department. The majority of adults are expected to be managed in the community.

Respiratory failure, shock, heart failure and encephalopathy are the most likely modes of presentation in adults suffering from severe infection.

Criteria label	REFER ADULTS TO THE NEAREST GENERAL HOSPITAL EMERGENCY DEPARTMENT IF THEY PRESENT WITH ANY OF THE FOLLOWING:
A	Severe respiratory distress. Severe breathlessness, e.g. unable to complete sentences in one breath. Use of accessory muscles, supra-clavicular recession, tracheal tug or feeling of suffocation.
B	Increased respiratory rate measured over at least 30 seconds. Over 30 breaths per minute.
C	Oxygen saturation $\leq 92\%$ on pulse oximetry, breathing air or on oxygen. Absence of cyanosis is a poor discriminator for severe illness.
D	Respiratory exhaustion. New abnormal breathing pattern, e.g. alternating fast and slow rate or long pauses between breaths.
E	Evidence of severe clinical dehydration or clinical shock. Systolic blood pressure $< 90\text{mmHg}$ and/or diastolic blood pressure $< 60\text{mmHg}$. Sternal capillary refill time > 2 seconds, reduced skin turgor.
F	Altered conscious level. New confusion, striking agitation or seizures.
G	Causing other clinical concern to their own GP or clinical team e.g. a rapidly progressive or an unusually prolonged illness.

Further information

- The tool is designed to support and empower all healthcare professionals working in difficult circumstances with limited resources but does not supersede a decision by an experienced clinician about whether, when or where to refer an adult.
- The assessment applies to all adults aged 16 years or over and is independent of any prior or existing medical condition.
- Fever alone is not used as a criterion for referral as it is a poor discriminator for severe illness.
- Difficulty in self care indicates a need for assessment but is not by itself a good measure of severe illness or need for hospital admission. Referral to a community-based support facility may be suitable.
- When referral is not indicated, a copy of the home care advice leaflet should be provided, with encouragement to seek medical advice again should the adult's condition deteriorate.
- Every assessment should include a record of the time of assessment and time of onset of illness. Referrals must include the criteria label(s) to assist with the treatment of adults on arrival at hospital.

The Swine Flu Adult Community Assessment Tool is endorsed by: The Royal College of General Practitioners, The Royal College of Physicians, The Royal College of Nursing, The College of Emergency Medicine, The Directors of Clinical Care of UK Ambulance Trusts and The British Medical Association

Appendix 5: Paediatric swine flu community assessment tool

PAEDIATRIC Swine flu paediatric community assessment tool

For use in all children under 16 years old in the community

This assessment tool should be used during a pandemic situation to assist with the decision as to whether a sick febrile child with flu-like illness needs referral to the nearest general hospital Emergency Department. The majority of children are expected to be managed in the community.

Respiratory failure, overwhelming gastroenteritis, shock, heart failure and encephalitis are the most likely modes of critical illness in children suffering from swine flu. Complications such as sepsis and meningitis may co-exist.

Criteria label	REFER CHILDREN TO THE NEAREST GENERAL HOSPITAL EMERGENCY DEPARTMENT IF THEY PRESENT WITH ANY OF THE FOLLOWING:
A	Severe respiratory distress. Lower chest wall indrawing, sternal recession, grunting, or noisy breathing when calm.
B	Increased respiratory rate measured over at least 30 seconds. ≥ 50 breaths per minute if under 1 year, or ≥ 40 breaths per minute if ≥ 1 year.
C	Oxygen saturation $\leq 92\%$ on pulse oximetry, breathing air or on oxygen. Absence of cyanosis is a poor discriminator for severe illness.
D	Respiratory exhaustion or apnoeic episode. Apnoea defined as a ≥ 20 second pause in breathing.
E	Evidence of severe clinical dehydration or clinical shock. Sternal capillary refill time > 2 seconds, reduced skin turgor, sunken eyes or fontanelle.
F	Altered conscious level. Strikingly agitated or irritable, seizures, or floppy infant.
G	Causing other clinical concern to their own GP or clinical team. e.g. a rapidly progressive or an unusually prolonged illness.

Further information

- This tool is designed to support and empower all healthcare professionals working in difficult circumstances with limited resources, but does not supersede a decision by an experienced clinician about whether, when or where to refer a child.
- The assessment applies to all children under 16 years old and is independent of any prior or existing medical condition.
- Infants less than 2 months old with increased respiratory rate and sternal recession should be referred promptly to the nearest hospital because they are at high risk of suffering severe illness or death.
- Fever alone is not used as a criterion for referral to hospital in children over 3 months of age, as it is a poor discriminator for severe illness.
- Difficulty in feeding indicates a need for assessment but is not by itself a good measure of severe illness.
- When referral is not indicated, a copy of the home care advice leaflet should be provided, with encouragement to call again should the child's condition deteriorate.
- Every assessment should include a record of the time of assessment and time of onset of illness. Referrals must include the criteria label(s) to assist with the treatment of children on arrival at hospital.

The Swine Flu Paediatric Community Assessment Tool is endorsed by: The Royal College of General Practitioners, The Royal College of Paediatrics and Child Health, The Royal College of Nursing, The Royal College of Midwives, The College of Emergency Medicine, The Directors of Clinical Care of UK Ambulance Trusts, The British Medical Association and Unite/The Community Practitioners' and Health Visitors' Association

Appendix 6: Communications

The national communications strategy has taken the approach of updating the public at the different stages of the pandemic. At the outbreak an advertising campaign, a door drop leaflet and an information line were launched to prepare the population for how the pandemic could develop and explained what the Government's plans were. The launch of the NPFS was also supported by advertising. Our communications plans are flexible allowing us to respond to further changes in treatment and service delivery through national campaigns and updating the phone information line and websites.

Embedding good respiratory and hand hygiene behaviours continues to be a key message underlying all of our campaigns as it is the first line of defence against the spread of swine flu.

Further national campaigns will promote the availability of the swine flu vaccine and will initially target those most at risk from complications if they catch swine flu.

Local healthcare communications are the responsibility of the PCO. Effective internal and external communications continue to be vital in responding to the swine flu pandemic. Local communications plans that reflect national activities should be developed in conjunction with local stakeholders. These include all aspects of the health service, pharmacies, social services and the third sector.

Appendix 7: Contents of the emergency box

This box is a minimum suggested kit list to start to manage failures in service continuity within an individual practice, and needs to be modified according to local need and circumstances. The protective clothing suggested is listed for use against a broad range of hazards, not specifically influenza, and it therefore offers a much higher level of protection than is required for pandemic influenza.

- torch
- spare batteries
- standard phone for use with emergency line
- re-charging adaptor for mobile phone
- space blanket
- up-to-date copy of this document
- copies of the service continuity plan and the practice's pandemic flu plan
- prepared signs for surgery
- photocopied patient encounter forms (in case computers are down)
- a ream of A4 paper and writing materials for logging decisions and recording clinical treatments
- antiviral authorisation vouchers
- hard copy list of up-to-date key contact numbers (practice staff and relevant PCO numbers).

Appendix 8: Service continuity and co-ordination arrangements for an influenza pandemic in England

Given the scale, complexity and international dimensions of a pandemic, central government coordination, advice and support are critical. A *national framework for responding to an influenza pandemic* in the UK has been published and is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734.

However, in the UK, the primary responsibility for planning and responding to any major emergency rests with local organisations, acting individually and collectively through Local Resilience Forums and Strategic Coordination Groups (SCGs). You can find a list of these bodies at www.cabinetoffice.gov.uk/ukresilience/regional_resilience.aspx

The Government has a dedicated crisis management mechanism – the Civil Contingencies Committee (CCC). In a time of increased threat of a flu pandemic, this would be activated. It supports the DH as the lead government department. The CCC has representation from other government departments and liaises closely with Regional CCCs and the devolved administrations.

The DH is the designated lead government department to respond to a flu pandemic. It also has overall responsibility for developing and maintaining the UK's contingency preparedness for the health and social care responses, establishing national stockpiles of clinical countermeasures and providing information and guidance. In a flu pandemic, in conjunction with the health departments of the devolved administrations, it will initiate and direct the Government's health response.

Each UK country's CMO will work collaboratively to ensure a comprehensive and coordinated UK-wide public health approach. The Pandemic Influenza Clinical and Operational group (PICO) allows experts to come together including the devolved administrations to ensure that there is a unified clinical approach during the pandemic.

Science advice to PICO and to CCC is brought together in the Science Advisory Group on Emergencies (SAGE) that is chaired by the Government chief scientist.

The devolved administrations are responsible for the major areas of pandemic flu devolved administration planning and response in their respective countries. More information on devolved administration structures can be found in the *National Framework*, paragraph 4.7 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734.

The HPA in England (working in conjunction with its equivalent public health organisations in the devolved administrations) is the lead agency responsible for providing public health advice to the DH and supporting all aspects of the public health response to a flu pandemic. It has a key role in national and international surveillance and intelligence gathering.

Some key players

Directors of Public Health for the English regions also act as Directors of Public Health for the local SHAs. In both roles, they will provide a strong public health input into planning and implementation.

In a flu pandemic, it is anticipated that some central decision making powers will be delegated to SHAs. These will include decisions on service priorities and suspension of targets. SHA decisions will need confirmation by the DH. SHAs have a key role in developing and coordinating strategic planning and response. They will act as an information channel and a reporting link to the DH.

