



Royal College of
General Practitioners



Preparing for pandemic influenza

Guidance for GP practices

What to do now and in a pandemic

*Working in partnership with
the Department of Health*



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How to use this document

This is the first issue of this guidance document. Some aspects of planning for and responding to an influenza pandemic have not yet been decided or agreed. This document will be regularly reviewed to include decisions as they are agreed plus any relevant changes, which relate to general practice. In future issues this section of the guidance will be used to highlight what changes have been made to the guidance so that practices can see at a glance what developments have occurred.

The document sets out guidelines for business continuity planning within your practice. It also introduces new systems and procedures, such as the National Pandemic Flu Line Service, which will operate in an influenza pandemic.

Many aspects of planning for a flu pandemic are agreed and reflected in this guidance. Where things are not yet agreed it has been clearly stated in the text. To help readers identify them, these areas will be marked by the following words:

To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

The guidance has been prepared by the British Medical Association's General Practitioners Committee and the Royal College of General Practitioners with the support of the Department of Health, England. Wherever possible it has been made applicable to the UK as a whole. It has used as a model a predicted flu attack rate of between 25% and 50% in line with *Pandemic flu: A national framework for responding to an influenza pandemic*. Response to a pandemic must be proportionate. Should the flu pandemic prove to be more or less severe than this attack rate, the response would have to be adjusted accordingly, consistent with the *National framework*. **It is expected that very similar guidance will be issued in Scotland, Wales and Northern Ireland.**

Foreword

This guidance is for GPs and their staff in general practice. Practice Managers in particular should find it helpful. It will also be of use to Primary Care Organisations (PCOs) and is relevant to patients. It tells practices what they need to do now and in the future in order to prepare for, and respond to, a pandemic influenza outbreak in the UK. It explains why there is a need to take action and how this will help minimise the spread of flu in a pandemic and make the best use of limited health resources.

We have worked with the Department of Health in England to produce this guidance, and where possible it should apply to the other countries of the UK. Not everything has been finalised, but we felt it was important to get information to GPs and their teams as soon as possible. It is a living document, which will be updated regularly as ideas emerge. It is therefore very important that you visit this website regularly: www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/index.htm.

In a flu pandemic general practice will be under enormous pressure. We will all be working differently and, at the pandemic's peak, we will have to suspend some normal services in order to get through. An example of such adaptation is the work practices under the Quality and Outcomes Framework (QOF). Your practice resources will be protected so that you will not be penalised for diverting your efforts to care for your patients during the pandemic. There will be clear command and control systems to make sure we act together in a fair and ethical way. A flu pandemic will stretch the NHS to the limit – general practice in particular – requiring us all to act together in a coordinated way.

GP practices will be asked to work together in groups – buddying-up – to make maximum use of all the staff available. This guidance is meant to be practical and show you how pandemic planning should be done. You will find action points, and checklists, which you can download and use to prepare your practice for a pandemic. Links are given to key information sources so that you can access them easily.

What is important is that no GP practice is left isolated and that we think about the potential problems in advance, training up as necessary and putting systems in place so that when a pandemic arrives we are as ready as we can be.

It will not be easy. There will be things such as prioritisation of services at the peak of the pandemic, which no one will like. However, by thinking things out now, before the pandemic, we can try to ensure that we limit the extent of sickness and death from flu, and will be able to care for non-flu patients as well.

If general practice is ready it could make the difference between 'getting through' and saving extra lives. Previous experience has shown us that there is a danger that non-flu patients with serious health problems could suffer in a pandemic unless general practices are on the alert to meet their needs.

A flu pandemic will place huge demands on general practice, but with the help of this guidance you will place yourselves – and therefore your patients – in the best possible position to cope.



Dr Laurence Buckman
Chairman of the British Medical Association's
General Practitioners Committee



Professor Steve Field
Chairman of the Royal College of
General Practitioners

1 Introduction

Summary: This introduction and chapter 2 give a general overview of what a pandemic entails. The following chapters provide detail of how general practice can respond.

1.1 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.
- 1.1.2 No one knows when a flu pandemic will occur, but modelling suggests that once in the UK, it could spread to all major population centres in one to two weeks, with the peak incidence occurring only 50 days from the initial entry to the UK.
- 1.1.3 It is likely that between a quarter and a half of the population will be affected. If half get symptoms, over the course of the pandemic 30 million people will be ill with flu. This might be over a number of waves or could be in a single wave. Most people will be asked to stay at home and self-care, ie look after themselves at home (if they are able to), but inevitably about a third – including children under 1 year old – may also need to be assessed and treated by a GP or other health professional. Some of these will require hospital admission if beds are available.
- 1.1.4 While it may be possible to maintain normal general practice in the early stages of a pandemic flu wave, it will 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 is reached, based upon advice from the regional directors of public health.
- 1.1.5 The arrangements cover protection of general medical services (GMS) practice income so that practices are not penalised when they have to suspend some 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 contracts and other services.
- 1.1.6 A graded response to increasing threat, with specific 'trigger points', will be used so that everyone understands at what stages of the pandemic certain functions will stop and/or start. The decisions on when specific milestones are reached will be made at regional or national level, and GP practices will be informed. At the peak of a pandemic, all parts of the NHS will need to work together in different ways in partnership with social services, the voluntary sector and other bodies.
- 1.1.7 A great deal of pre-pandemic planning is taking place across all sectors in addition to health, for example in the areas of power and food supplies. This document, however, is specifically for general practice guidance.

2 The timescale of an influenza pandemic

Summary: This chapter gives the history of pandemics, speed of development, predicted attack rates and effects of the virus.

2.1 History

- 2.1.1 Influenza pandemics have occurred three times in the last century, in 1918, 1957 and 1968. It is highly likely that another worldwide pandemic will occur at some time, but its timing cannot be predicted. It seems likely that a flu pandemic will start outside the UK, but within two to four weeks of the start of the outbreak in the host country it will affect the UK. It could then take just one or two more weeks to spread to all major population centres here.
- 2.1.2 General practice will be one of the critical 'pinch points' in responding to a pandemic. By planning now, a lot can be done to contain the impact of a pandemic. The NHS will clearly be placed under enormous pressures, and new ways of working will be introduced to create extra capacity (surge capacity) to meet demand. With hospital beds at a premium, general practice, and GPs in particular, will be providing more community-based critical care than normal to non-flu as well as flu patients. Experience shows that the ability of general practice to care for these critically ill patients outside hospital should make the difference between simply 'getting through' a pandemic and avoiding a significantly increased number of deaths among non-flu patients as well as those who are victims of the pandemic itself.
- 2.1.3 In previous pandemics, the overall clinical attack rate was of the order of 25% to 35%, compared to the normal seasonal flu rate of 5% to 15%. However, it is not possible to predict with any certainty the epidemiology of a new influenza pandemic virus and its clinical behaviour. This will only become apparent as person-to-person transmission develops, so plans have to be flexible enough to cope with a range of possible attack rates, with responses stepped up as appropriate. The *National framework* recognises the possibility of an attack rate of 50% in a single-wave pandemic. Plans should consider this, and will have to be adjusted as new information becomes available.

2.2 Effects of the seasonal flu virus

- 2.2.1 There are three broad types of influenza virus: 'A', 'B' and 'C'. 'A' viruses cause most winter epidemics (and pandemics) and can affect a wide range of animals as well as humans. 'B' flu viruses can only infect people, and circulate most winters. 'C' viruses are among the many causes of the common cold.

- 2.2.2 Around half of those who become infected with the seasonal flu virus have no symptoms and are not even aware of the infection.
- 2.2.3 For most of the others, while seasonal flu is unpleasant, it is self-limiting and not life threatening to the majority of people. All GPs will be aware of their patients who are in the high-risk group for whom, without intervention, flu would cause serious illness. An estimated 12,000 – mainly older – people die each year in England and Wales from seasonal flu.

2.3 Flu pandemic patterns

- 2.3.1 More recently, the A/H5N1 flu virus has caused concerns. While a number of people have contracted flu after contact with infected birds, worldwide there has been only limited evidence of person-to-person transmission so far, and this transmission has not been sustained. Whether derived from A/H5N1 or another virus, the fear is the emergence of an adapted or new virus capable of spreading easily between humans and causing a pandemic. A new strain is likely to transmit more easily to people if it contains genetic material from a human influenza virus – that is, if a strain of avian flu mixes with a human flu virus and evolves.
- 2.3.2 A pandemic can occur in one wave or a series of waves, weeks to months apart. Initially, a flu pandemic in the UK may last for three to five months depending on the time of year in which it starts. There may be subsequent waves, which may be more severe than the first wave.
- 2.3.3 The three pandemics in the last century were:

1918/19	'Spanish flu'	This pandemic caused 20–40 million deaths worldwide.
1957	'Asian flu'	The 1957 and 1968 pandemics were less severe than Spanish flu, but caused an estimated 1-4 million deaths between them.
1968	'Hong Kong flu'	

- 2.3.4 There are many uncertainties about a future flu pandemic. Response plans should allow for a clinical attack rate of up to half the population. Up to 4% of those with symptoms may require hospital admission.

3 Preparing for an influenza pandemic

Summary: This chapter explains the need to prepare for a flu pandemic, where to find guidance and why a command and control system must operate. Many of the preparations made for a flu pandemic should also prove relevant and useful for other emergencies and for general service continuity planning.

3.1 Overview of preparations

- 3.1.1 Most health and social care will be delivered in the community setting, with acute hospital capacity reserved for those most in clinical need. Even so, at the peak of the pandemic it may be necessary to prioritise who will benefit most from treatment. This will be done in an ethical and objective manner. Scoring systems for hospital admissions are being validated at present and further work is in progress to develop outcome tools.
- 3.1.2 Clear command and control arrangements are essential. 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 The General Practitioners Committee (GPC) of the British Medical Association (BMA) and the Royal College of General Practitioners (RCGP) have prepared this guidance jointly, supported by the Department of Health.
- 3.1.4 A flu pandemic will put primary care and the NHS in general under unprecedented pressure. General practice has a critical role to play. Practices are asked to acknowledge that **unless everyone follows the principles of the ‘five Cs’ – command, control, communicate, coordinate and cooperate – there will be chaos**. To minimise risk, guidance documents are being published so that everyone knows what is expected of them, can take part in the planning to ensure that we are as prepared as possible and has well-understood action plans in place.

The five Cs:

- Command
- Control
- Communicate
- Coordinate
- Cooperate

3.1.5 Practices must work with their local primary care organisation when planning for and during a flu pandemic. There is published guidance for primary care organisations on their duties and roles.

3.1.6 You can find guidance documents at.

General:

www.dh.gov.uk/pandemicflu.

Country-specific guidance:

Scotland – www.scotland.gov.uk/pandemicflu.

Wales – www.wales.gov.uk/topics/health/protection/communicabledisease/flu/?lang=en.

Northern Ireland – www.dhsspsni.gov.uk/index/phealth/pandemicflu/pandemic-contingency.htm.

Professional bodies:

RCGP – www.rcgp.org.uk/default.aspx?page=4302.

BMA – www.bma.org.uk/ap.nsf/Content/flupandemic0508?OpenDocument&Highlight=2,influenza,pandemic.

3.2 WHO international phases and UK alert levels

3.2.1 The World Health Organization (WHO) has defined phases in the evolution of a flu pandemic. These allow us to plan so that we can respond in steps according to the level of threat. WHO identifies six phases, where Phase 1 is the lowest level of risk and Phase 6 indicates a pandemic period, with pandemic alert phases in between.

3.2.2 WHO international phases.

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

As of December 2008, the WHO phase is Phase 3.

A version of the above table can also be found at appendix 2 for practices to print out and keep to hand.

3.2.3 If a pandemic is declared, action will depend on whether cases have been identified in the UK and on the extent of spread. Therefore, for UK purposes, four additional alert levels have been included within WHO Phase 6.

These UK alert levels are:

- 1. Virus/cases only outside the UK
- 2. Virus isolated in the UK
- 3. Outbreak(s) in the UK
- 4. Widespread activity across the UK

3.3 Clinical aims

3.3.1 The clinical aim is to limit the morbidity and mortality from influenza and minimise the spread of the flu virus by isolating flu patients wherever possible. This means asking patients to **stay at home and self-care**. Most patients will not need to see a GP or other healthcare professional. Only certain patients, such as those with the greatest clinical need, will be seen by a GP or other healthcare professional. Only the most seriously ill who have been assessed as likely to benefit from specialist treatment should be sent to hospital.

3.3.2 A more detailed explanation of how this will work can be found in chapter 8 and in the surge capacity guidance published by the Department of Health. You can find this at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734.

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, explains what practices can do to cope, predicts staff absence levels, provides a step-by-step guide to setting up buddying-up groups, suggests emergency boxes, describes how freelance GPs will work and describes the impact on GP trainees and infection control procedures.

4.1 Impact on general practice

- 4.1.1 Given the number of influenza patients in a pandemic, it will not be possible or necessary to provide rapid face to face consultations with everyone. Flu patients will be asked not to come to their GP surgery. If they do so, they should be advised to contact the National Pandemic Flu Line Service. This service will be made available in the event of a pandemic and will be the national system by which the general public will access antiviral medication. The National Pandemic Flu Line Service system is explained further in chapter 6. Inevitably, some patients who attend for other reasons may have flu and not realise it. Practices should have plans to minimise further exposure to staff and patients. This will involve increasing the awareness of reception staff of 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 separate waiting rooms and consulting rooms for non-flu patients where practicable.
- 4.1.2 Patients will need to access care in their homes as far as possible to help reduce and limit the spread of infection. **The majority of people will rely on self-care, contacting the National Pandemic Flu Line Service (please see chapter 6 for more details), taking antiviral medicine and treating symptoms with over-the-counter medicines.**
- 4.1.3 The Government's messages to the public will be:
- stay at home
 - don't spread it around
 - phone a 'flu friend'
 - phone the National Pandemic Flu Line Service.
- 4.1.4 Communications will play a huge role in coping with a flu pandemic. The Government has firm plans for a mass communication programme to let the public know what will be 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 4.

- 4.1.5 Modelling suggests that about one-third of symptomatic patients, including all children under 1 year old, will require assessment and treatment by a GP or other healthcare professional. Patients who may be at risk of complications due to their age, some other medical condition, or the severity of flu symptoms may, in addition to being authorised to receive antivirals by the National Pandemic Flu Line Service, be advised to seek further medical support from primary care services. The National Pandemic Flu Line Service will advise the public whether they would need to see a GP. GPs should be aware that they will then receive referrals from the National Pandemic Flu Line Service call centre.
- 4.1.6 This means that if we have a 50% attack rate and a complication rate of 25% (plus all children under 1) demand for pandemic-related GP consultations can be expected to increase to 14,250 per 100,000 population over the course of the pandemic.
- 4.1.7 For an average GP practice with three full-time doctors and a list of 6,000 patients, that equates to around 750 consultations over the course of the pandemic. The other practice patients who get flu will be asked to self-care.
- 4.1.8 The above figures are likely to be an underestimate of workload as they don't take account of any second consultations, complications of flu, or patients who contact their practice because they have concerns or needs that the National Pandemic Flu Line Service cannot address.
- 4.1.9 The duration of a pandemic will be unknown and it may be spread over several waves that are months apart. There will be times of peak activity and the peak is likely to occur within 50 days of the first cases of pandemic flu appearing in the UK.
- 4.1.10 Experience and modelling suggest that 22% of cases will occur in the peak week. This means that for every 100,000 people there will be an additional 3,100 GP consultations in the peak week. Again, these figures are likely to be an underestimate of the work involved for the reasons given above.
- 4.1.11 For a typical practice of three GPs with a list of 6,000 patients, that works out at 186 cases in the peak week of the pandemic. These are for pandemic-related consultations only and assume that older children and adults with symptoms without complications will get their antiviral medicines through the National Pandemic Flu Line Service.
- 4.1.12 For every 100 patients with flu symptoms up to four of them may require hospital admission, if there are beds available. Up to a quarter of these patients are expected to require critical care. The average length of stay in hospital is likely to be up to six days (ten for patients in intensive care). Modelling suggests that up to 2.5% of all flu victims may die. Special arrangements are being drawn

up for the issuing of death certificates during a pandemic, possibly using a workforce of retired doctors. The British Medical Association (BMA) is working with the Department of Health to help identify retired doctors willing to help in a flu pandemic.

- 4.1.13 Clearly, with this overall level of demand, general practice will be stretched beyond its current limits. Added to this are the complications arising from primary care staff themselves getting flu, or being away from work because they have to care for children or other dependants.

4.2 Staff contracts

- 4.2.1 GP practices and their staff will be key to the delivery of primary care services during an influenza pandemic. Flexible working, both in terms of time and location, will be needed from all practice staff and GPs alike to ensure the maximum level of service capacity, and to maintain practice income under the general medical services (GMS) practice payments agreements made with the Department of Health and NHS Employers.
- 4.2.2 Practices must consider workforce issues that will arise during a 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.
- 4.2.3 Employers should also acknowledge the level of anxiety that an influenza pandemic is likely to 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 school closures and transport disruption.
- 4.2.4 Funding for additional practice staff travel to and from an alternative place of work has been agreed with the Department of Health in England. Additional overtime taken by staff during the pandemic must also be funded by the primary care organisation (PCO).
- 4.2.5 Staff contract terms and conditions should be maintained as normal during a pandemic. However, practices should consider the potential benefits of inserting 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.

4.3 What GP practices can do to cope

- 4.3.1 All practices must have a service continuity plan. For advice on how to do this and what to include read the joint guidance produced by the Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) of the BMA found at www.bma.org.uk/ap.nsf/Content/flupanprep?OpenDocument&Highlight=2,business,continuity and www.rcgp.org.uk/default.aspx?page=3908.

4.4 Staff absence levels

- 4.4.1 Up to half the workforce may require time off at some stage over the pandemic period. People with flu are likely to be away from work for up to two weeks. At the peak of the pandemic up to a fifth of the workforce may be absent. However, many GP practices come into the category of small organisational units with five to 15 staff. Practices of this size should allow for a higher percentage of staff to be away from work – up to 35% at the height of the pandemic. Single-handed practices will be hit even harder and may become non-viable without support from 'buddy practices'.

4.5 Deploying practice staff safely

- 4.5.1 **Any GP or member of staff who shows flu symptoms must be sent home immediately.** Practice staff who have recovered from pandemic flu and feel well enough to work should have immunity and should be able to treat flu patients.
- 4.5.2 In a flu pandemic practices should assign GPs, nurses and other staff to see either flu patients or non-flu patients on a daily basis. GPs will need to work with their buddying-up partner practices to ensure that they can function effectively while minimising the risk of the spread of infection.

4.6 Sick certification

- 4.6.1 GPs would be overwhelmed if they were expected to continue with the normal process for issuing patients with sick notes during a pandemic. Plans are in hand to ease this workload. It is planned to change arrangements for self-certification so that in a pandemic self-certification will be extended from seven to 14 days.

4.7 Buddying-up system

- 4.7.1 Practices must work together in a pandemic. A buddying-up system is proposed in which clusters of practices will actively cooperate for pandemic work, sharing resources and exchanging staff as necessary.

4.7.2 Some practices have already drafted plans of how the buddying-up would work for them locally. You can see an example from Teesside at 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 can now be accessed on the RCGP's website. For the College's Pandemic and Flu Planning page go to www.rcgp.org.uk/clinical_and_research/pandemic_planning.aspx. Then within this page, under the title Further Examples of Pandemic Planning Documents, the following two documents can be accessed:

- Tees Primary Care Services – Primary Care Continuity Agreement: www.rcgp.org.uk/pdf/corp_Primary_Care_Pandemic_Continuity_Agreement_%20Tees%20_Primary_Care_Services.pdf.
- Caduceus Medical Practice Influenza Plan: www.rcgp.org.uk/pdf/corp_Caduceus_Medical_Practice_Pandemic_flu_Plan%20_April_08.pdf.

4.7.3 Buddying-up groups can be based on naturally occurring groups such as those in a discrete locality. However, no practice must be left isolated. Primary care organisations (PCOs) together with the Local Medical Committee (LMC) will, if necessary, step in to ensure that all practices are members of a local buddying-up group.

4.7.4 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 practices 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 the 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.

- 4.7.5 Any gaps in service provision will be identified and, if the cluster cannot fill them, outstanding issues should be shared with the local PCO.
- 4.7.6 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 sectors will be affected by the pandemic. Health professionals from the private sector may also augment the NHS workforce along with recently retired staff and senior trainees.
- 4.7.7 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.

4.8 Photo ID

- 4.8.1 Experience in the past fuel crisis shows that photographic ID of doctors and staff will be essential in a pandemic. For example, clinicians will need access to a fuel supply for their vehicles in order to do home visits. 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.
- 4.8.2 When produced the ID card will need to confirm identity and contain a photograph **and job role**.

4.9 Emergency box

- 4.9.1 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 5 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.

4.10 Locum GPs

- 4.10.1 It is envisaged that PCOS will act as the employer for all available freelance locum GPs during a flu pandemic. This will preserve their indemnity at a time when they will be working at maximum flexibility, possibly moving frequently between practices.

- 4.10.2 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 check their databases ensuring that they are robust and that data on them are correct, including contact details and email addresses.
- 4.10.3 Locums/freelance 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.
- 4.10.4 It is envisaged that PCOs will contract to employ ALL available locum GPs 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 are the subject of ongoing discussions at national level.

To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

4.11 GP trainees

- 4.11.1 A flu pandemic will affect the training of GP trainees. Not least, their trainers and educators will be needed to deliver clinical care and will not have the time to also do their educational job. The knowledge and skills of the GP trainees will be needed to cope with the pandemic and the length of their training period may well be affected. It is envisaged that all training rotational post changes will be suspended during a pandemic both inside and outside hospital.

4.12 Anxiety among public, patients and staff

- 4.12.1 Everyone will naturally be anxious during a pandemic. Healthcare workers will not only have to cope with their own concerns but will also have to deal with anxiety among their patients. This anxiety could take the form of aggression in some patients.
- 4.12.2 GPs should ensure that they and their staff are briefed to deal with difficult situations. There will be a large-scale public information campaign before and during a flu pandemic explaining what services are available and why healthcare services will be different from normal. Adopting an open and planned approach should help to avert confrontation, but inevitably GPs and their staff will come face to face with it and need to be prepared.

4.13 Infection control precautions

- 4.13.1 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 passed onto the hands for up to two hours, although only in low quantities after the first 15 minutes.
- 4.13.2 Because the virus survives for a long time on frequently touched hard surfaces (eg 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 surgeries during a pandemic.
- 4.13.3 The good news is that flu viruses are easily deactivated by washing with soap and water or alcohol handrub and by cleaning surfaces with normal household detergents and cleaners. Practices should ensure that they have an adequate supply of these basic cleaning materials.
- 4.13.4 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.
- 4.13.5 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.
- 4.13.6 Doctors and staff doing home visits should carry personal packs of alcohol hand rub.

4.14 Different ways of working in a pandemic

- 4.14.1 During a flu pandemic GP practices will 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.
- 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.
- 4.14.3 PCOs may assign additional staff to struggling practices including community nurses, locum GPs, or perhaps local dentists. Community clinicians too may 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 with self-care and antivirals.

- 4.14.4 It is envisaged that GPs available for sessional work will be employed by PCOs during a pandemic at a pay rate to be agreed in ongoing national discussions. Practices will not directly employ locum GPs.

To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

- 4.14.5 When staff are working under such pressure, perhaps in unfamiliar surroundings, mistakes may be more common. The General Medical Council (GMC) has indicated that provided doctors act in good faith within their skills and competence, it would not usually anticipate that a disciplinary issue will emerge.

Action points

- GP practices must take action now to look at their staff contracts with a view to planning for a flu pandemic. Any change made to a contract would be voluntary and with the agreement of the staff member.
- Each practice must:
 - draw up a list of key telephone numbers including mobile numbers for all staff
 - review staff contracts and list staff working hours and flexibility
 - note staff members' external commitments, eg young children, elderly dependent relatives
 - prepare a really simple guide to logging on and using the practice computers so that non-practice staff can access them in a pandemic if necessary (eg 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 if mains services such as gas, water or electricity should fail
 - prepare an emergency box with face masks, gloves, aprons, torches and spare batteries, and other consumables. See appendix 5 for a suggested list of contents.

Action points

- It would be good practice to identify buddying-up groups and have a pandemic flu contingency plan agreed between the group and the local PCO by 31 March 2009.
- Practices should prepare their emergency box now and keep the contents up to date. All staff must be told where to find it.
- Do you have sufficient suitable hand hygiene facilities and waste bins and liners?
- Are your stocks and supplies of hand cleaning agents and paper towels sufficient?
- Do you have supplies of alcohol handrub for use on home visits?
- Does everyone in your practice understand the importance of hand-cleaning procedures and the effective use of cleansing?
- Display posters (in appropriate languages) about hygiene.
- Display posters (in appropriate languages) showing which areas are for flu patients and which are for non-flu patients.
- Prepare posters/notices in advance of a pandemic.
- Prepare a welcome pack for anyone 'parachuted' into your practice. This 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.
- As far as practicable, employers should identify in advance of a pandemic any tasks that may need to be taken on by staff on a flexible basis, so that appropriate training can be given.

5 Command and control

Summary: This chapter sets out the command and control arrangements for an influenza 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 6.

5.1 Arrangements

5.1.1 *Pandemic Flu: A national framework for responding to an influenza pandemic* has been published (see appendix 6 for more details) and covers all sectors including health. There is a dedicated crisis management mechanism and a clearly defined hierarchy of command and control structures. GP practices will receive instructions via their primary care organisation (PCO) and will be expected to follow these.

5.2 Primary care organisations (PCOs)

5.2.1 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 primary care trust (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 Clear command and control arrangements will be critical in ensuring a robust response. A PCT coordination centre will monitor and coordinate the overall health response.

5.2.4 Through the pandemic flu coordinators, PCTs will coordinate plans with neighbouring authorities and ensure that social care and other key partners – including private sector and support service providers – are fully involved.

5.2.5 In a pandemic, PCTs will provide advice and public information, collate and report operational information to the strategic health authority (SHA), and 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)

5.3.1 As the representative body for all GPs at local level, LMCs 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 clusters 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 consider developing a 'duty' LMC officer rota to provide 24/7 advice and assistance to the PCO during the pandemic period.

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. All medical, nursing and management staff will be involved.
- 5.4.2 Directions on when non-essential services, such as Quality and Outcomes Framework work, will be suspended in order to cope with the pandemic will come from the relevant authority. Practice income will be protected. For more information on how this protection will operate, see appendix 1 and read the document *Pandemic Flu – Joint NHSE-GPC agreement on practice resource maintenance* at www.bma.org.uk/ap.nsf/Content/flupandemic0508.

5.5 Social care, community hospitals and other key players

- 5.5.1 There needs to be strong and sustained communications 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 Department of Health in November 2007 and is supported by the Social Care Tools and Implementation Pack at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080755.
- 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 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 Local pharmacies

- 5.6.1 Community pharmacies can make an important contribution in support of 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 over-the-counter (OTC) flu

treatments 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.

- 5.6.2 To ease pressure on GP surgeries and community services, new powers may be given to community pharmacists (subject to consultation and parliamentary approval) to supply medicines and pharmaceutical services in a more flexible manner. There will be a formal consultation before any proposed changes to the law are made.
- 5.6.3 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.
- 5.6.4 As the pandemic escalates, some of the routine services of pharmacies may have to be reduced or stopped for short, or longer, periods as demands increase elsewhere. Specialist clinical pharmacists may be able to support doctors in all settings including primary care. They could be deployed by the PCO to support GPs in their practices.
- 5.6.5 Guidance is being developed on the contribution pharmacists can make in responding to a flu pandemic. It will include responses to the legislative changes that might come into force to improve access to medicines and devices during a pandemic.

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 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 Every day each GP practice/buddying-up group would submit information about available staff in a situation report (sit rep) to the designated PCO data collection point (this could be also used to report numbers and demographics of consultations). Work is under way to determine the optimum timing for submitting these daily reports. The report will use a standard national template, which will be developed and agreed.

To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

- 5.7.5 The local data collection office would be able to assess staffing levels in each site, and if any sites were under-staffed/not staffed. This could allow staff to be transferred from one site to another.
- 5.7.6 If the staffing levels were significantly low, the data collection office could arrange for services to be provided by a reduced number of sites with 'signposting' for patients.
- 5.7.7 Using information from the daily sit rep, the PCO would send to GP practices in the area an overall sit rep report giving crucial local information. The exact format is yet to be developed but could take the form of the example at paragraph 5.8. There is likely to be intense interest in this sort of information from the local media. PCOs will liaise with them on a regular basis. Newspapers, radio and television, and websites will be used to inform the public of the current state of the flu pandemic. More information on communications at a national level can be found in appendix 4.

5.8 Example of a daily situation report to GP sites in a PCO area

WHO phase:		UK alert level:		PCO status:	
Flu Line					
National Pandemic Flu Line Service activity			Coping	Not coping	
GPs					
Average daily consultation rate:			? per 100,000		
The following GP surgeries are closed:			X,Y & Z		
Pharmacy					
The following pharmacy shortages are in:			(eg OTC flu remedies)		
The following community pharmacies are closed:			X,Y & Z		
Collection points					
Antiviral stocks are available at the following sites:			X,Y & Z		
Ambulance					
Current ambulance availability:			All services	Restricted to	Not available
Acute					
Hospital availability:			Normal	Restricted to	Only triage on the door
Hospital services cancelled:					
Current respiratory bacterial sensitivities:					
Specific notes:			(social care) and (capacity to benefit)		

Action point

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

6 Caring for the general public

Summary: This chapter explains the National Pandemic Flu Line Service; antiviral medicines; Flu Line Professional; keeping patients separate; direct contact with symptomatic patients; and the use of personal protection equipment.

6.1 National Pandemic Flu Line Service

- 6.1.1 In order to reduce the extra load on general practice, a UK-wide 24-hour telephone and web-based service will be set up for use by the general public.
- 6.1.2 At WHO phase 4, the Pandemic Flu Information Line will be activated to give general advice and information to callers.
- 6.1.3 At WHO phase 6, UK alert level 2 (virus isolated in the UK), the National Pandemic Flu Line Service will be authorised to give people who are symptomatic access to antiviral medicines (Tamiflu/oseltamivir) as appropriate. This will be the only route for patients to access antiviral flu drugs.
- 6.1.4 This means patients will not be able to access antiviral medicines from GP surgeries. Patients can get antiviral medicines only from official collection points and only if they are authorised to do so by the National Pandemic Flu Line Service.
- 6.1.5 It is possible that some dispensing practices will be an exception if they are chosen as an antiviral collection point.
- 6.1.6 **Action point:** You are advised to put up notices at your surgery saying:

PANDEMIC FLU

If you have symptoms of pandemic flu and need access to antivirals, you should return home and contact the **National Pandemic Flu Line Service** by calling [insert telephone number] or online at [insert URL].

If you are someone's 'flu friend' and need to find out how to access antivirals on their behalf, you should also contact the **National Pandemic Flu Line Service** (see above).

For general information on what people can do to look after themselves when they have pandemic flu, contact the **Pandemic Flu Information Line** on [insert telephone number] or go to [insert URL].

There are no stocks of antivirals held on these premises.

Practices should fill in the contact details when they are made known.

- 6.1.7 The language used for the signs should take account of the needs of any non-English-speaking patients.

6.2 Antiviral medicines

- 6.2.1 The Government is currently in financial discussions with the Treasury and is planning to stockpile sufficient antiviral medicines to allow all pandemic flu patients to be treated up to an attack rate of 50%. This is in line with the worst case planning in the *National framework*. This stockpile will be monitored to inform decisions relating to take-up.
- 6.2.2 Antiviral medicines will not be available on prescription (FP10). Patients who think they have pandemic flu will contact the National Pandemic Flu Line Service by phone and non-clinical staff, who have had specific training, will follow an algorithm to find out if the patients have flu symptoms. The National Pandemic Flu Line Service can also be accessed by the internet.
- 6.2.3 In order to use the National Pandemic Flu Line Service, patients must know their NHS number. They will also be asked questions to see if they fall into specified groups (eg children under 1 year old or patients who are immunosuppressed) who **may** need to consult a GP or other health professional. If flu patients have had their symptoms for less than 48 hours (the maximum time-scale for effective use of antiviral medicine), they will be given a **unique reference number (URN)**, which will entitle them to collect antivirals from a local centre called a 'collection point'.

To be agreed. How people will find out their NHS number is currently under discussion at national level.

- 6.2.4 The antiviral medicines should be started preferably within 12 hours, and not more than 48 hours from the onset of symptoms, to be effective and to limit the spread of infection by taking them early on in the illness. The local primary care organisation (PCO) will decide the location of the collection point centres. These will not be located at GP surgeries and only very exceptionally at selected dispensing GP surgeries.
- 6.2.5 Via a nationwide publicity campaign, patients will be asked to nominate people who can collect their antiviral drugs for them. These helpers will be known as **flu friends**.
- 6.2.6 Security measures will be in place to make sure there is no unauthorised or duplicate access to antivirals.

- 6.2.7 Adult treatment courses of antiviral drugs will be in pre-packed capsules. Separate paediatric flu guidance is being produced. Children aged 13 and under will get an age-related dose of oseltamivir in the form of lower-dose capsules. Information relating to children's doses can be found at appendix 3.
- 6.2.8 Where children are not able to swallow the capsule whole, parents/children will need to be advised to empty the contents of the capsule into a small amount of sugary solution, to mask the taste of oseltamivir. Children under 1 year of age will receive oseltamivir solution prepared by designated hospital pharmacy manufacturing units. Discussions are taking place to decide how this solution will be made available for infant patients.

To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

- 6.2.9 Dosing schedules for children are available in appendix 3 and in the Department of Health guidance for primary care trusts (PCTs). The document can be found at the following link www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080757.
- 6.2.10 Within 24 hours of UK alert level 2 being announced, PCO antiviral collection points will receive initial supplies of antivirals for adults and children.
- 6.2.11 After this, further allocations of antiviral drugs will be made to the PCO on an ordering and re-supply basis. A national coordination centre will be set up to take orders for further supplies, oversee transportation and manage the national stockpile of antiviral medicines.
- 6.2.12 The National Pandemic Flu Line Service will be capable of activation from spring 2009. Should a pandemic arrive in the meantime, PCOs have been asked to agree local alternative arrangements for managing and responding to demand. This must involve discussions with Local Medical Committees, local GPs and the out-of-hours service.
- 6.2.13 At the same time as the National Pandemic Flu Line Service is activated, a web-based **Flu Line Professional** service will be introduced. This will not be available to the public but will give doctors and healthcare professionals access to a patient's National Pandemic Flu Line Service record and allow them to check for previous antiviral authorisations. Flu Line Professional will allow doctors and healthcare professionals to authorise an antiviral without going through the standard National Pandemic Flu Line Service process (including the clinical algorithm). They will be able to generate a URN that can be presented at a local antiviral collection point in return for an antiviral.

6.3 Keeping flu patients separate

- 6.3.1 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 advice 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.
- 6.3.2 Separating patients by timing is another or additional possibility. 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.

6.4 Direct contact with those patients who are symptomatic – means of transmission

- 6.4.1 GPs will need to see some patients who fall outside the National Pandemic Flu Line Service algorithm or present with complications.
- 6.4.2 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 hand-to-face contact if hands are contaminated.
- 6.4.3 The incubation period (time from exposure to first symptoms) is between one and four days. People are most infectious soon after they develop symptoms.
- 6.4.4 Children have been shown to transmit virus for longer and at higher levels than adults.
- 6.4.5 Adults with flu but without additional complications may be away from work for up to ten days.
- 6.4.6 More detailed information on flu viruses is available at www.dh.gov.uk/pandemicflu.

6.5 Personal protective equipment (PPE)

- 6.5.1 Fluid-repellent 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.
- 6.5.2 The Government is planning to place orders to stockpile face masks on a UK-wide basis. These will be held centrally until a change in WHO flu phase

status triggers despatch to PCOs. The point at which the face mask supplies are distributed to GP practices has not yet been decided and will be for PCOs to determine. However, each practice should be prepared to store several large boxes of face masks. The masks will be supplied to practices free of charge.

6.5.3 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.

6.5.4 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.

6.5.5 Even with UK stockpiling, face masks will be in limited supply and should be treated as a scarce resource.

6.5.6 The Government will not provide renewable supplies. All stocks will be distributed and may not be refreshed, simply because of sourcing difficulties. This may prove particularly difficult if there is a second or third wave of a flu pandemic.

6.5.7 Practices must use a risk assessment in using PPE. Detailed guidance on infection control in a flu pandemic is available on the Department of Health website at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734.

6.5.8 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.

- 6.5.9 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.
- 6.5.10 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.
- 6.5.11 With all PPE, users should carry out a risk assessment when deciding whether to use it or not. Further advice on PPE will be provided.

Action points

- Display notices in surgery advising patients with flu symptoms to stay at home and contact the National Pandemic Flu Line Service.
- Make sure all your practice staff understand how flu spreads and that they are trained in 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.
- See paragraph 6.5 on personal protective equipment for information on face masks/gloves etc
- There will be centrally produced information sheets for patients telling them the facts and what to do to limit the spread of the virus in their homes.
- Discuss whether your practice cleaning arrangements should change in a pandemic.
- In a pandemic, 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.
- Identify and plan ongoing training for staff in the use of face masks.

7 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 a pandemic and where GP involvement is more likely.

7.1 Identifying vulnerable patients

- 7.1.1 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 and with few contacts. These potentially vulnerable groups would be in addition to patients who could be clinically 'at risk' because of existing illnesses.
- 7.1.2 Vulnerable patients, such as those with learning difficulties, 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 National Pandemic Flu Line Service, for example. Primary care organisations (PCOs) will work with social services and voluntary and faith groups to plan to meet the needs of vulnerable individuals. As primary care will be under pressure the advocacy role staff play may have to be passed to others, eg voluntary sector volunteers.
- 7.1.3 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.

To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

7.2 Non-registered patients

- 7.2.1 In a flu pandemic, general practices may experience a surge of demand from non-registered people seeking help. PCOs will seek discussions with practices regarding how this demand might be coped with, including the possible greater number of temporary patients.

7.3 Maternity services

- 7.3.1 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 during a flu pandemic is available on the Department of Health website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091737.

- 7.3.2 There are approximately 635,000 live births in the UK each year. A 50% attack rate in a flu pandemic would lead to around 80,000 pregnant women getting flu during the 15 week course of a pandemic wave. Most pregnant women with flu would be cared for at home. There may have to be some adjustments in antenatal care because of the pandemic. Current thinking is that all pregnant women will be referred to primary care and not be assessed by the National Pandemic Flu Line Service.

7.4 Paediatric care

- 7.4.1 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. Hospital facilities will be a scarce resource. With this in mind, work is being done to produce a tool kit* for GPs to use when deciding whether to refer a child to hospital. The principles should be accepted by both primary and secondary care.

*To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

7.5 Mental health services

- 7.5.1 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 entirely taken up with 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 pandemic flu are available on the Department of Health website.

- 7.5.2 The Department of Health, England, is preparing guidance for health and social care services for their contribution to psycho-social responses required by people who are involved in major incidents and events of all kinds including a flu pandemic.

To be agreed. This topic is currently under discussion at national levels. Further guidance will follow.

7.6 End-of-life care

- 7.6.1 Inevitably, there will be a greater demand for end-of-life care during a flu pandemic. Every effort must be made to draw on the expertise of specialists both within and outside the NHS such as hospices. This may be particularly important when coping with the increased call for bereavement counselling.

8 Managing surge capacity and patient prioritisation

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.

8.1 Working patterns

8.1.1 Effective communications will be key to managing surge demand in an influenza pandemic. This means not only communications with the public, but also communications with all aspects of the health services, social services and the voluntary sector. Improved collaborative working should result in improved care and transition to the recovery phase of the pandemic. Appendix 4 gives more information on national communication plans.

8.1.2 In order to manage demand surge, prioritisation of services will be needed. 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.

8.1.3 It will be important to maintain normal services for as long as possible, but at some point, the pandemic workload will be unsustainable without removing some of the normal workload. At a given signal from the local NHS body (strategic health authorities (SHAs) in England), practices will be told to stop doing work which is not essential to current clinical demand. Appraisals, work relating to the Quality and Outcomes Framework (QOF) and non-essential clinics will be suspended along with other areas of work.

8.1.4 In making these decisions the SHA (or equivalent body in the devolved countries) will liaise with its primary care organisations (PCOs) who must liaise with their Local Medical Committees (LMCs) and Local Pharmaceutical Committees. Together they will determine when resources are stretched to the point at which services should focus on delivering essential work only. These decisions will need to be confirmed with the Department of Health in England or equivalent Health body in devolved administrations. At all stages, the response needs to be proportionate to the threat of the flu pandemic. LMC officers should discuss with their PCOs any issues and training needs that arise and how best the LMCs might be deployed.

8.1.5 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 any general practice to be disadvantaged financially by responding to a flu pandemic.

- 8.1.6 The Royal College of General Practitioners (RCGP) and the British Medical Association (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.
- 8.1.7 The use of telephone triage will also be important throughout a pandemic.
- 8.1.8 Out-of-hours services will be critical in a pandemic. PCOs will want 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 out-of-hours services and this would have an impact on the ability to deliver 'normal' in-hours services. If this happened, it might be necessary to introduce an earlier suspension of normal activity. Practices will receive instructions if this is the case.
- 8.1.9 There is specific guidance for managing demand surge across the whole of the health and social care system. This includes national admission criteria to help the management of demand across the primary and secondary care interface. This guidance, *Pandemic influenza: Surge capacity and prioritisation in health services*, can be found on the Department of Health website at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080744.

8.2 Managing surge demand

- 8.2.1 A staged approach will be used. When demand reaches a certain level, services which are not immediately essential to pandemic healthcare will be suspended. Non-urgent operations (electives), for example, will not take place so that hospital facilities can be cleared to create extra capacity. At the next level, only emergencies will be referred.

After that, only patients with life-threatening problems will be referred. If even this demand is too large for hospitals to cope with, patients will be prioritised based on who will benefit most from available treatment. As the pandemic wanes, the stages will be reversed towards a gradual return to normality.

- 8.2.2 The decisions on when stages are activated will be made at a regional level – by SHAs in England and the appropriate level in the devolved administrations – and communicated to primary and secondary care. Doctors will have clear instructions about which stage we are at and 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.
- 8.2.3 The Medical Defence Union and the Medical Protection Society say that doctors who have concerns will be able to look to their medical defence organisations for advice in the usual way and for assistance with any medico-legal matters arising from the professional services they provide during a flu pandemic.
- 8.2.4 No one will like this kind of healthcare. While most people may well accept the general need for prioritisation, it will be hard for families and friends to accept a situation when their loved one is not being referred for hospital treatment. It will be difficult for doctors too.
- 8.2.5 The General Medical Council (GMC) is producing a special edition of *Good Medical Practice* to cover what will be expected of doctors in a flu pandemic.
- 8.2.6 Work is under way developing objective admission criteria for adults with pandemic flu and complications. An admission criteria tool for use with children is also being developed. The use of pulse oximeters to measure oxygen saturation is an accepted and validated measure of hypoxaemia as a surrogate for respiratory distress. If purchase of pulse oximeters is contemplated, specialist guidance should be sought as to the suitability of different models. The RCGP is in discussions to develop criteria for the purchase and use of pulse oximeters, including their use and suitability for very young children.

To be agreed. This topic is currently under discussion at national level between the RCGP and health professionals. Further guidance will follow.

8.3 Ethical issues

- 8.3.1 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 an even-handed manner and as effectively as possible.
- 8.3.2 You can read the ethical framework at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080751.

8.4 Prioritising patients and services

- 8.4.1 Clinical prioritisation of some sort will occur at all stages of a pandemic. Work is under way to produce tool kits, which use a scoring system for use by GPs to help in making referral decisions. With any such system, both primary and secondary care must apply the same principles if it is to work equitably.

9 Prescribing issues

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

9.1 Medicines management

- 9.1.1 Practices should continue to issue repeat prescriptions with the same interval as normal. Patients will not be encouraged to stockpile medicines. Further pressures should not be placed on the pharmaceutical supply chain by issuing longer than normal repeat prescriptions.
- 9.1.2 The issuing of post-dated prescriptions for normal length repeat medications should be considered so that the number of contacts with the practice for medication is minimised without significant impact on the pharmaceutical chain. 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.
- 9.1.3 Antibiotic therapy is not generally required by influenza patients, unless they have complications. It may be needed where there is a pre-existing infection, where the diagnosis is unclear or where there is a marked deterioration in the patient's respiratory system.
- 9.1.4 The Government is taking steps to ensure there are stocks of appropriate antibiotics available. In a flu pandemic local community pharmacies may have an enhanced role to play.

10 Death certification

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

10.1 Mortality

- 10.1.1 Deaths from any new pandemic may be up to 2.5% of symptomatic patients. In previous pandemics, the fatality rate was between 0.2% and 2%.
- 10.1.2 To help with planning, the Government has done some modelling (see table below) based on various clinical attack rates and fatality rates. It shows the number of deaths in the UK possibly being between 55,500 (the least bad scenario modelled) and 750,000 (the worst scenario modelled).
- 10.1.3 Range of possible excess deaths for various permutations of case fatality and clinical attack rates based on UK population.

Overall case fatality rate (%)	Range of possible excess deaths in the UK		
	25% clinical attack rate	35% clinical attack rate	50% clinical attack rate
0.4	55,500	77,700	111,000
1.0	15,000	210,000	300,000
1.5	225,000	315,000	450,000
2.5	375,000	525,000	750,000

Source: *Pandemic flu: A national framework for responding to an influenza pandemic*, Cabinet Office/Department of Health

- 10.1.4 Even with a low attack rate, it is likely a modified system of issuing cause of death certificates will have to be introduced in a pandemic. The cremation certification process will also be relaxed. Full details of the proposals on how this will be carried out in England and Wales can be found on the Department of Health website. Find the document at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734.

In Scotland, guidance has been produced for doctors. You can find guidance to medical practitioners for death certification during an influenza pandemic at www.scotland.gov.uk/pandemicflu. See under **Frameworks and Guidance**.

- 10.1.5 If the level of pressure on local services requires it, there will be a centrally made decision to relax the legal requirement (Regulation 41 of the Registration of Births and Deaths Regulations 1987) 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. The period will increase from 14 days to 28 days. This brings England and Wales in line with Northern Ireland and will require legislation.
- 10.1.6 At 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 primary care organisation (PCO) when this takes place.
- 10.1.7 A change will be made to the law to allow doctors who have not attended the 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.
- 10.1.8 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.
- 10.1.9 As at present, only registered medical practitioners will be allowed to complete the MCCD cause of death form in a flu pandemic.
- To increase the number of doctors for this work, retired doctors will be called on for this role. The British Medical Association (BMA) is working with the Government to provide a list of retired doctors willing to help. You can read more about it at www.bma.org.uk/ap.nsf/Content/pandemicinfluenzadatabase.
- 10.1.10 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. At WHO Phase 5, doctors on the PCO list will be contacted, and others encouraged to come forward.
- 10.1.11 Doctors carrying out this work will have to be registered with the General Medical Council (GMC). Legislation is proposed which would permit the GMC, under new emergency powers, to grant a doctor registration subject to conditions. In England, primary care trusts (PCTs) would pay the costs of GMC registration for this purpose.
- 10.1.12 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.

- 10.1.13 Returning doctors are advised to contact a medical defence organisation 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 for work that NHS indemnity does not cover.
- 10.1.14 In a flu pandemic, doctors will also be able to take on the role of medical referee at local crematoria.
- 10.1.15 Other arrangements will be put in place during a pandemic for nurses and other healthcare workers to confirm the fact of death. Regulatory requirements will be available on the appropriate websites.
- 10.1.16 Additional MCCD forms will be needed in a flu pandemic. PCOs will supply these to the retired doctors on their list.

Action points

- Retired doctors are asked to contact the BMA or their local PCO if they are willing to help, even if they stopped work some time ago. At the same time they are advised to contact a medical defence organisation to apply for membership.
- GP practices can prepare for a pandemic by checking they will have sufficient MCCD forms and making plans to increase their supply as necessary.
- At WHO phase 5:
 - check with your PCO for the plan for deployment of additional medical practitioners and of the actions that should be taken if a bereaved person contacts the practice seeking a death certificate
 - ensure that any staff receiving such requests (eg reception staff) know what to say and do.

11 Immunisation

Summary: This chapter explains how a mass immunisation programme might operate when vaccine becomes available and the impact it would have on GP workload.

11.1 Current immunisation scheme

11.1.1 Ordinary annual immunisation schemes for patients at risk of seasonal influenza should continue as normal (up to WHO Phase 5) in the absence of a pandemic.

11.2 Flu pandemic specific vaccine

11.2.1 Until a pandemic arrives, and the strain of virus can be identified, it will not be possible to produce a specific vaccine to protect people. Even when the virus is known, it will take some time to prepare a vaccine and longer still to produce it in quantities sufficient for mass immunisation. In practice a pandemic specific vaccine will not be available for some months after the start of a pandemic and therefore not in the first wave of a pandemic.

11.2.2 The Government has sleeping contracts with vaccine manufacturers for a pandemic specific vaccine. This allows for the provision of up to 132 million doses for the UK population.

11.3 How will the vaccine be supplied to practices?

11.3.1 The vaccine will be in multi-dose vials not pre-filled syringes. These can be manufactured more quickly and take up less cold storage space. Needles and syringes will be needed in considerable quantities. The supply of these forms part of the national purchasing and distribution arrangements for which a framework agreement is in place.

11.3.2 Delivery arrangements are currently being reviewed with key stakeholders. In a pandemic, primary care organisations (PCOs) will be asked to identify a named person and a deputy from local pharmacy services to take the lead role in coordinating the storage distribution and stock control arrangements. This will include the storage of the necessary needles, syringes and any other consumables.

11.3.3 General practices already have standard security arrangements and it would be unrealistic to expect individual practices to have high-level security over and above this.

11.4 Will healthcare workers receive pre-pandemic immunisation?

- 11.4.1 The UK has limited stocks of A/H5N1 vaccine bought specifically for the protection of healthcare workers. It is not possible to say whether this will be effective against a pandemic flu strain. It has not been finally decided how these stocks will be used.*

*To be agreed. This topic is currently under discussion at national level. Further guidance will follow.

- 11.4.2 PCOs will provide the necessary vaccine if it becomes available and will oversee local arrangements, but the occupational immunisation is an employer responsibility. GP principals would be responsible for ensuring that their staff members were vaccinated if indicated. They would also have to provide data on vaccine uptake among staff.

Practice staff also have access to the local NHS occupational health service. It is likely the immunisation would be delivered through the occupational health service.

- 11.4.3 Healthcare workers will be notified if this pre-pandemic immunisation is triggered.

Action point

- Practices should review their current security arrangements. PCOs will need to support this process, seeking advice as a flu pandemic is likely to cause high levels of anxiety, which could lead to unusual public behaviour and unrest.

12 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.

12.1 Rebuilding, restoring and rehabilitation

- 12.1.1 There will be a gradual movement towards resuming normal services, probably over many months. GPs and staff will be exhausted and experience has shown that it is during the recovery phase that stresses and problems can emerge. Healthcare workers who thought they had survived the influenza pandemic 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 off.
- 12.1.2 The recovery phase may well involve the administration of a specific pandemic flu vaccine, putting added pressure on primary care if there is a mass immunisation programme.
- 12.1.3 General practice will therefore be short staffed in the recovery period, along with the rest of the health service. The recovery period will necessarily link into the resumption of hospital services.
- 12.1.4 Primary care services are likely to experience persistent secondary effects for a long time. 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 for work
- assess the need for psychological support for staff
- ensure that premises are adequately cleaned and made ready for 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.

12.1.5 Just as there was a staged reduction in normal services in the build-up to the peak of the pandemic, so there will be a staged re-introduction of normal services in the recovery period. At some point, for example, elective treatments in hospitals will be resumed and GPs will again be allowed to refer patients for these non-emergency procedures. The local strategic health authority (SHA) (or its equivalent in the devolved nations) will announce when this stage has been reached.

12.1.6 Similarly, the local SHA (or its equivalent in the devolved nations) will announce when GP practices will resume Quality and Outcomes Framework activities and any other targets used before the pandemic.

Resumption of performance targets will have to take into account the loss of skilled staff and their experience, problems in recruiting at a potentially difficult time, and the need for staff to have rest and recuperation.

12.1.7 Announcements from the SHA (or its equivalent in the devolved nations) will be fed through to practices via the local primary care organisations.

12.1.8 As no one can predict the pattern of a pandemic, there could be the scenario of moving into the recovery period only to find that a second or third wave of the pandemic strikes. A second wave could be even more serious than the first wave. 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. A pandemic flu specific vaccine could be available at this stage, depending on the timing of the pandemic waves. If so, general practice will be called upon to play its part in administering the mass immunisation programme as described earlier in this report. Healthcare workers who have not been ill may be among the first to receive such immunisation as appropriate.

12.1.9 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.

List of acronyms

BMA	British Medical Association
CCC	Civil Contingencies Committee
DH	Department of Health
GMC	General Medical Council
GMS	general medical services
GP	General Practitioner
GPC	General Practitioners Committee
LMC	Local Medical Committee
MCCD	Medical Certificate of Cause of Death
NHS	National Health Service
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
URN	unique reference number
WHO	World Health Organization

Appendix 1: GPs' pay

'Ministers have endorsed an agreement reached between NHS Employers and the BMA's General Practitioners Committee (GPC) on the maintenance of General Medical Services (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 9.3.3 of the guidance).

The Financial Agreement and the costing methodology can be found on the NHS Employers' website at www.nhsemployers.org/pay-conditions/pay-conditions-3721.cfm.

This contains a guidance note for PCTs on the Financial Agreement. It outlines the broad principles that have been agreed and some supporting guidance for PCTs.

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

Appendix 2: WHO international phases and UK alert levels

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

Appendix 3: Children's dosage

Children within the normal weight range for their age who have high fever and cough or influenza-like symptoms should:

- if aged under 1 year, or of any age if at high risk of complications (due to co-morbid disease), be seen and assessed by a GP or suitably qualified practitioner
- if aged 1 year or over, be assessed by the National Pandemic Flu Line Service staff using a clinically based paediatric algorithm and referred for antivirals and/or to a suitably qualified practitioner if indicated (eg those at risk of suffering complications of influenza).

Oseltamivir (Tamiflu) is licensed for use in children over 1 year old. The Government has procured appropriate dose capsules from the manufacturer for use in children over 1 year old and under 13 years old. In the algorithm, dose is determined by age as a proxy and is set out below:

- age 1 year or over but under 3 years (body weight under 15kg) – 30mg twice daily for five days
- age 3 years or over but under 7 years (body weight between 15kg and 23kg) – 45mg twice daily for five days
- age 7 years or over but under 13 years (body weight 24kg and above) – 60mg twice daily for five days
- age 13 years and over – 75mg twice daily for five days.

NB: If children aged 1 year and older, seen by a suitably qualified practitioner, are **obviously under- or over-weight**, Oseltamivir should be given as directed in the BNFC (British National Formulary for Children).

GP prescribing for children less than 1 year old

Children under 1 year of age should be given Oseltamivir at a dose of **2mg per kg twice daily for five days**. Oseltamivir is not licensed for use in the UK in children under 1 year old. There is, however, published evidence from Japan that it has been used safely at a dose of 2mg per kg twice daily in children under 1 year of age. The dose for this age group will be weight-dependent. The Royal College of Paediatrics and Child Health has developed a consensus statement that will help clinicians to make a decision about whether to treat and the dose to be prescribed.

The Government has purchased the active ingredient powder for the reconstitution into a solution for use during a pandemic. There are sufficient drums to make up antiviral solution to treat the UK population of under-1s at a clinical attack rate of 23% but this will be increased to cover 50% in line with

plans for the rest of the population. A number of licensed hospital pharmacy manufacturing units will manufacture oral Oseltamivir solution for use by children. The shelf life of oral Oseltamivir has been extended following further validation and it now has a shelf life of 12 weeks and can be stored at ambient temperatures.

Once the solution has been manufactured, it will be bottled and labelled at the manufacturing units. Further consideration of how the solution will be distributed is taking place at national level. Guidance on dosage and the most effective way of administering the oral solution should also be provided by a healthcare professional.

Appendix 4: Communications

The national communications strategy takes the form of measured engagement with the public in the different WHO phases.

In WHO phase 3, the focus is on embedding good respiratory and hand hygiene behaviours with the public. This will be the first line of defence against the spread of a pandemic.

In WHO phase 4, the emphasis moves to prepare the population for the emergence of an influenza pandemic and its potential impacts. Activities will include the first of two national door drop leaflets together with the launch of an information line and website. These information sources will explain the role of vaccines and antivirals and how they will be accessed via the National Pandemic Flu Line Service and the need for identifying flu friends.

In WHO phase 5, the messages focus on developing the public's understanding of pandemic influenza and how to prepare for it if it reaches the UK. National TV advertising will begin and a second national door drop leaflet will be distributed. The information line and website will be regularly updated and there will be formal media briefings. Self-care videos educating people on what to do if they contract the virus will be available online and on digital screens in, for example, town centres and stations.

In WHO phase 6, all channels will update on the status of the pandemic and continue to give self-care advice including how to use the National Pandemic Flu Line Service.

Local healthcare communications are the responsibility of the primary care trust. Effective internal and external communications will be vital in responding to an influenza pandemic. Local communications plans that reflect national activities should be developed in conjunction with local stakeholders. These will include all aspects of the health service, pharmacies, social services and the voluntary sector.

Appendix 5: 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.

Appendix 6: Command and control arrangements in 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.ukresilience.info.

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 would support the Department of Health as the lead government department. The CCC would be guided by input from central departments and agencies, from Regional Civil Contingencies Committees and from the devolved administrations.

The Department of Health 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 Chief Medical Officer will work collaboratively to ensure a comprehensive and coordinated UK-wide public health approach.

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 Health Protection Agency 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 Department of Health 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 strategic health authorities (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 Department of Health. 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 Department of Health.

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