

PANDEMIC FLU

Guidance on the provision of healthcare
in a community setting in Scotland

October 2007

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Executive Summary

The purpose of this guidance is to assist NHS Boards and community health providers in developing their plans for responding to an influenza pandemic by setting out a framework for the provision of healthcare in a community setting.

The twentieth century saw three influenza pandemics, and a repeat of such occurrences is highly likely. Since the timing of an outbreak cannot be predicted a high level of general preparedness is the best protection for the Scottish population.

An influenza pandemic will place considerable pressure upon health services in the community. They will need to provide care both to those suffering influenza and to those who routinely depend upon community healthcare services for a variety of non influenza treatments at a time when there will be high levels of staff absence. This guidance, which should be read in conjunction with other planning documents, sets out a framework and identifies issues for local operational planning across Scotland.

The main features of the document are:

- Context setting: it makes explicit the legal obligation to develop plans along with the planning assumptions and principles upon which plans are to be founded.
- Organisation: patient pathways are set out, the scope and purpose of national telephone support described and local coordination arrangements made explicit.
- Roles: the specific roles that General Practice, Community Pharmacy, NHS24, Scottish Ambulance Service and Community Care Services are to play in the response to a pandemic are set out.
- Medicines and vaccines: factors to be considered in local planning concerning the distribution of antivirals and vaccines are described.

The document provides advice throughout on specific actions that NHS Boards and other organisations can take to develop their operational preparedness for an influenza pandemic.

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1 INTRODUCTION

1.1 Purpose

The purpose of this guidance is to assist NHS Boards and community health providers in developing their plans for responding to an influenza pandemic by providing a framework for the provision of healthcare in a community setting. Local contingency plans should fit within the broad framework articulated in this guidance. The intention is to ensure a degree of consistency and equity in response to a pandemic, while allowing local flexibility in order to cope with variations in both the progression of the pandemic, and in local resources and health service configuration.

The approach taken here seeks to build upon existing plans and arrangements where possible and to augment normal delivery mechanisms in order to cope with increased demand. Working jointly across agencies and sectors will produce the best possible result from the capacity and skills available. The main part of this document sets out the operational planning elements that NHS Boards and community health providers should be considering. It sets out a model for access to care within which the delivery of healthcare services in Scotland should be framed.

1.2 Development

This guidance has been informed by a report and recommendations produced by a RCGP Scotland led group at the invitation of the Minister for Health and Community Care. The report drew on the expertise of an advisory group which included representation from the British Medical Association, Scottish General Practitioners Council, Association of Directors of Social Work, NHS24, Scottish Ambulance Service, Scottish Pharmacists General Council and Health Protection Scotland. A draft report was also shared with and commented upon by wider stakeholder organisations.

1.3 Related guidance

This guidance is related to a number of other pieces of work. It is supplementary to the revised *Scottish framework for responding to an influenza pandemic*, which can be found at <http://www.scotland.gov.uk/Pandemicflu>

1.4 Audience

This guidance is intended for NHS Boards, Community Health Partnerships and front line health care providers including general practice, community pharmacy and ambulance services. While there will be separate guidance for other

components of the health sector, elements of this framework are likely to be widely relevant to organisations involved in health and community care.

1.5 Aim

The overall aim of this guidance is to support those involved in the organisation and delivery of community based healthcare in the development of their operational plans for the provision of care in a community setting during a pandemic. The provision of care involves both the direct response to patients who suffer from influenza, and the maintenance of services for people who require care for non influenza related conditions.

The aims of the health and community care response to an influenza pandemic are to reduce mortality and morbidity by:

- maintaining surveillance to detect the emergence of a novel virus strain or any illness attributable to it
- providing prompt access to rapid and reliable diagnostic tests
- reducing the severity of illness and incidence of complications in infected individuals
- reducing disease transmission and rates of illness by applying individual and community infection control measures
- adjusting responses to reflect emerging epidemiological data
- developing surge capacity to meet expected demand, recognising that this will require the reactive redefinition of boundaries between primary and secondary care
- making targeted and effective use of potentially scarce healthcare skills, facilities and resources
- reducing/ceasing non-essential activity as demand increases but maintaining essential care for emergencies or patients with chronic or other illness
- assessing all symptomatic patients rapidly and treating them promptly with antiviral and other medicines if indicated
- providing effective treatment for those suffering complications
- educating the community and providing public advice and information
- providing vaccination, if and when suitable vaccines are available

- providing data to monitor the impact and effectiveness of interventions.

1.6 How this guidance is intended to be used

This guidance is intended to cover healthcare in a community setting, which includes primary care provision in the context of the community or home.

This guidance seeks to provide framework for planning, rather than to be a detailed and prescriptive operational plan itself. Good reason may exist in local circumstances for divergence from the framework (for example, remote and rural areas may choose to configure services differently, or a particular local authority may have different emergency mechanisms in place which have implications for local health services). It is essential that NHS Boards work with local stakeholders to develop robust plans in their area which take account of local needs and local resources.

The timing and impact of an influenza pandemic is uncertain. Planners and health care providers should acknowledge the possibility that a pandemic may occur before further guidance is developed. Regular assessment, updating and testing of response plans and business continuity arrangements are therefore necessary in order to prepare for a pandemic at any time.

1.7 Relationship to other administrations

This guidance has been developed for the community healthcare sector in Scotland and reflects the structure, organisation and delivery of services in Scotland. Where appropriate, this guidance is also compatible with planning guidance across the rest of the UK.

2 THE CONTEXT OF INFLUENZA PLANNING IN PRIMARY CARE

2.1 Civil Contingencies Act 2004

NHS Boards are identified as Category 1 responders in the Civil Contingencies Act 2004. Boards therefore have a responsibility to prepare for emergencies, which include infectious disease emergencies such as an influenza pandemic.

An emergency as defined by the Civil Contingencies Act is: 'An event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.'

To constitute an emergency, this event or situation must require the implementation of special arrangements by one or more Category 1 responder. An NHS Board therefore has responsibility for developing and maintaining a major incident plan that is built on the principles of risk assessment, cooperation with partners, emergency planning, communicating with the public and information sharing.

2.2 The operational challenge

An influenza pandemic will present unique international, national and local challenges to the delivery of health and community care, producing case numbers likely to be far in excess of the capacity and capability of both systems to cope in conventional ways. Although curtailing non-urgent activity will release some hospital capacity it is likely that it will become quickly oversubscribed. This means that, in the majority of cases, influenza sufferers' initial assessments and subsequent care and support will have to be provided outside of hospital. This will therefore create particular pressures on primary and community care.

Even when there are small numbers of people infected or potentially infected, it is likely that public concern and demand for information (and potentially treatment and/or medication) from primary care services will be high.

As a pandemic spreads, primary health care organisations will find that, because of the parallel pressures on hospital services, there are more people with acute care needs that need to be treated and cared for within the community setting. This will occur at a time when community healthcare resources in terms of staff, consumables and utilities are likely to be compromised.

Primary Care services are likely to be faced with:

- the increased workload of patients with influenza and its direct complications

- the particular needs for infection control facilities and equipment
- additional pressure on health services caused by anxiety and bereavement
- depletion of the workforce and of numbers of informal carers, due to the direct or indirect effects of influenza on themselves and their families
- logistical problems due to possible disruption of supplies, utilities and transport as part of the general disruption caused by an influenza pandemic
- delays or difficulties in dealing with other medical conditions
- longer-term shortages in supplies due to the macroeconomic effects of an influenza pandemic on the national (and global) economy
- an increase in deaths and pressure on mortuary facilities (possibly exacerbated by delays in death registrations and funerals)
- pressure on social services, which will impact upon the health–community care interface, and on integrated health and community care teams.

It is crucial that NHS Boards plan with other local and regional stakeholders so that they can respond in a coherent, effective, coordinated and ethically appropriate way to an influenza pandemic.

2.3 Key planning assumptions

Planning should be based on the national set of assumptions and the ranges of possible impacts that are outlined in *A Scottish framework for responding to an influenza pandemic*. These are reproduced below for reference.

Planners should be aware, however, that the epidemiology of an emergent influenza pandemic virus and its clinical behaviour cannot be predicted with certainty. The actual behaviour of the virus, extent of illness and excess deaths will only become evident as a pandemic develops. Response arrangements must be flexible enough to deal with the range of possibilities and be capable of adjustment as necessary.

A graded response to an increasing threat, with certain ‘trigger points’, would also be appropriate so that all partners understand at what stages of a pandemic certain functions will start/cease. Providing the origin of a pandemic is outside the UK, emerging surveillance data may also allow the use of real-time modelling to confirm and/or refine these assumptions.

2.3.1 Severity and extent

- Up to 50% of the population may show clinical symptoms of influenza over the entire period of a pandemic (planning range 25-50%), and up to 25% of these may develop complications (planning range 10-25%).
- Up to 2.5% of those who become symptomatic may die (planning range 0.4-2.5%).
- Up to 22% of influenza cases can be expected during the 'peak week' of a pandemic wave.
- Up to 27.5% of symptomatic patients (including all symptomatic children under three years of age) will require assessment and treatment by a GP or suitably experienced nurse (planning range 13% – 27.5% of cases).
- Up to 4% of those who are symptomatic may require hospital admission if sufficient capacity is available (planning range 0.55% to 4.0% of cases with 25% of hospital admissions expected to require critical care). The average length of stay for those with complications may be six days (ten days if in intensive care).

2.3.2 Health and community care demand

- Most health and community care will need to be delivered in the community setting, with hospital capacity protected and preserved for those in most clinical need.
- Hospitalisations and deaths are likely to be greatest if the highest attack rates are in the elderly. The lowest burden on health care may be associated with higher attack rates in adults aged 15-64.
- Most patients will be treated at home with antiviral medicines initially.
- Children of three years and under will need to be assessed by a GP or suitably experienced nurse, because weight-related doses of antiviral solution must be specifically prescribed. Alternative formulations are being investigated.
- Assuming a complication rate of 25%, an attack rate of 50% and those under three years needing to see a health professional, general practices can expect to see 3,025 influenza patients per 100,000 population per week at the peak.
- Demand for hospital admission can be expected to increase to 440 new cases per 100,000 per week at the peak and is unlikely to be met from current available acute hospital capacity.

- An increase in the numbers suffering with influenza and its direct complications may be accompanied by other demand, caused by anxiety and bereavement, and service provision challenges exacerbated by depletion of the workforce and logistical difficulties.

2.3.3 Impact on the workforce

- Up to 50% of the workforce may require time off at some stage over the entire period of the pandemic, with individuals absent for a period of seven to ten working days. Absence patterns should follow the pandemic profile, with an expectation that it will build to a peak lasting for two to three weeks, when between 15% and 20% of staff may be absent, and then decline.
- Modelling suggests that small organisational units (5 to 15 staff) or small teams within larger organisational units should allow for higher percentages of absenteeism – up to 30% to 35% over a two to three-week peak period. Even higher rates are possible in very small organisations.
- Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, family bereavement, other psychosocial impacts, fear of infection and/or practical difficulties in getting to work.
- The Scottish Government may advise schools, nurseries and childcare settings in an area to close in order to reduce the spread of infection among children. Any such advice would probably be to close for a few – probably 2-3 – weeks, but closures may be extended if the pandemic remains in the area.
- National guidance is currently being prepared on human resource issues for health services in a flu pandemic, to support local planning and will be made available at: <http://www.scotland.gov.uk/Pandemicflu>.

2.4 Key planning principles

Effective contingency arrangements developed jointly by health and community care agencies will be critical to the relief of suffering and to achieving the wider public health aims of keeping symptomatic patients at home, caring for them in a community setting and reducing the demand on healthcare facilities. Plans should encourage multi-agency working and seek to mobilise the capacity and skills of all public, voluntary and private sector healthcare staff (including retired GPs, nurses, pharmacists, contractors and volunteers).

Response arrangements should be based on expanding normal delivery models to retain the advantages of familiarity, maintainability, reliability and local flexibility for as long as is possible. Plans must also recognise that peak demand

– compounded by peak sickness absence means that normal delivery models will need significant augmentation as the pandemic wave(s) develops.

Advising symptomatic patients to remain at home is agreed to be the most practical and effective way of slowing or limiting the general spread of infection. It facilitates the delivery of standard and simple public messages, allows for the fact that many patients may not be well enough to travel, and avoids creating infection ‘hot spots’. For these reasons, response plans should aim to provide initial assessment and most treatment without requiring symptomatic patients to attend a surgery or community pharmacy facility.

In order to limit the spread of infection and maximise individual health benefits, patients should take an antiviral medicine as soon as possible after the onset of symptoms – ideally within 12 hours but, if that is not possible, within 12 to 48 hours. During the initial stages of a pandemic, any patient who has been symptomatic for less than two days should be offered treatment with antiviral medicines unless contraindicated. This policy will be reviewed as information on the attack rate, clinical impact, optimum dosage regime, stock consumption, any resistance and the timeframe within which treatment remains useful emerges.

To sustain the availability of essential care for emergencies and patients with chronic or other illness, reducing or ceasing non-essential care will be required. Pre-planned measures to both maintain core service/business continuity and to adjust activity levels to cope with additional demand should feature in local planning.

Local plans should be based on:

- strengthening and supplementing normal delivery mechanisms as far as is practicable
- applying interventions where they achieve maximum health benefit, but may also be required to help maintain essential services
- developing an integrated multi-agency approach with risk sharing and cross-cover between all organisations
- encouraging pan-organisational working, seeking to mobilise the capacity and skills of all public and private sector healthcare staff (including students and those who are retired), contractors and volunteers
- influenza patients avoiding leaving home as far as possible
- initial telephone-based assessment being necessary to meet demand
- primary care response strategies focussing the available clinical capacity and skills primarily on treating those suffering with the complications of

influenza or requiring other essential clinical care and assessing young children or patients in groups identified as being at particular risk

- antiviral medicines initially being available to all patients who have been symptomatic for less than 48 hours and ideally within 12–24 hours of reporting symptoms
- developing response measures that maintain public confidence and feel fair
- treatment and admission criteria remaining clinically based and hospital admission criteria being applied in a transparent, consistent and equitable way that utilises the capacity available for the seriously ill and most likely to benefit
- recognising the need to respond to psychosocial issues and concerns such as anxiety, grief and distress and for sympathetic arrangements to manage additional fatalities.

National arrangements are based on having in place national telephone and web based services for influenza patients and worried-well. These services are described in more detail in chapter 3.

3 ORGANISATION OF CARE IN A COMMUNITY SETTING

Core primary care services, most particularly general practice and community pharmacy, will bear a considerable burden of expectation from the community in the event of a pandemic. Configuring front line primary care services is therefore at the heart of healthcare preparations for a pandemic.

3.1 Patient pathway

Key Points

- The line of first contact in the patient pathway will be an influenza telephone service, which will provide information, assess patients, and prescribe antiviral medication where appropriate.
- Patients who require face-to-face care or assessment from a health professional will be referred to front line primary care or secondary care services.
- The telephone service should be used as widely as possible in order to ensure consistent public access to assessment and antiviral medication, and to manage demand for primary care services.

This document presents a model of care which is based upon primary care augmented with telephone and web services. From this starting point, a pathway of care for an individual patient can be defined, and in light of this a number of issues in the organisation of care can be identified. The patient pathway is therefore the starting point for the operational guidance provided in this document.

The patient pathway begins with the national telephone service which provides general advice, and prescribes antivirals for non complex cases. The patient will be directed to ask a friend, relation, carer or neighbour to collect an antiviral from a local antiviral collection point. Home delivery of medication will be restricted to the seriously ill who are housebound without access to help from other people. In some cases the pathway may begin with a healthcare professional's assessment of a patient for a condition unrelated to pandemic influenza, but in which influenza like illness emerges as the issue for the patient or a member of the household.

If the case cannot be dealt with by the automated telephone system or assessed by non clinicians working to the telephone algorithm, the call will be transferred to a clinician who will conduct triage over the telephone. The triage will result in either direct prescription of an antiviral, or a recommendation for face-to-face assessment through either general practice or via the Out Of Hours (OOH)

service, whichever is appropriate for the time of day. In some cases the triage service may identify a need for an ambulance and hospital admission.

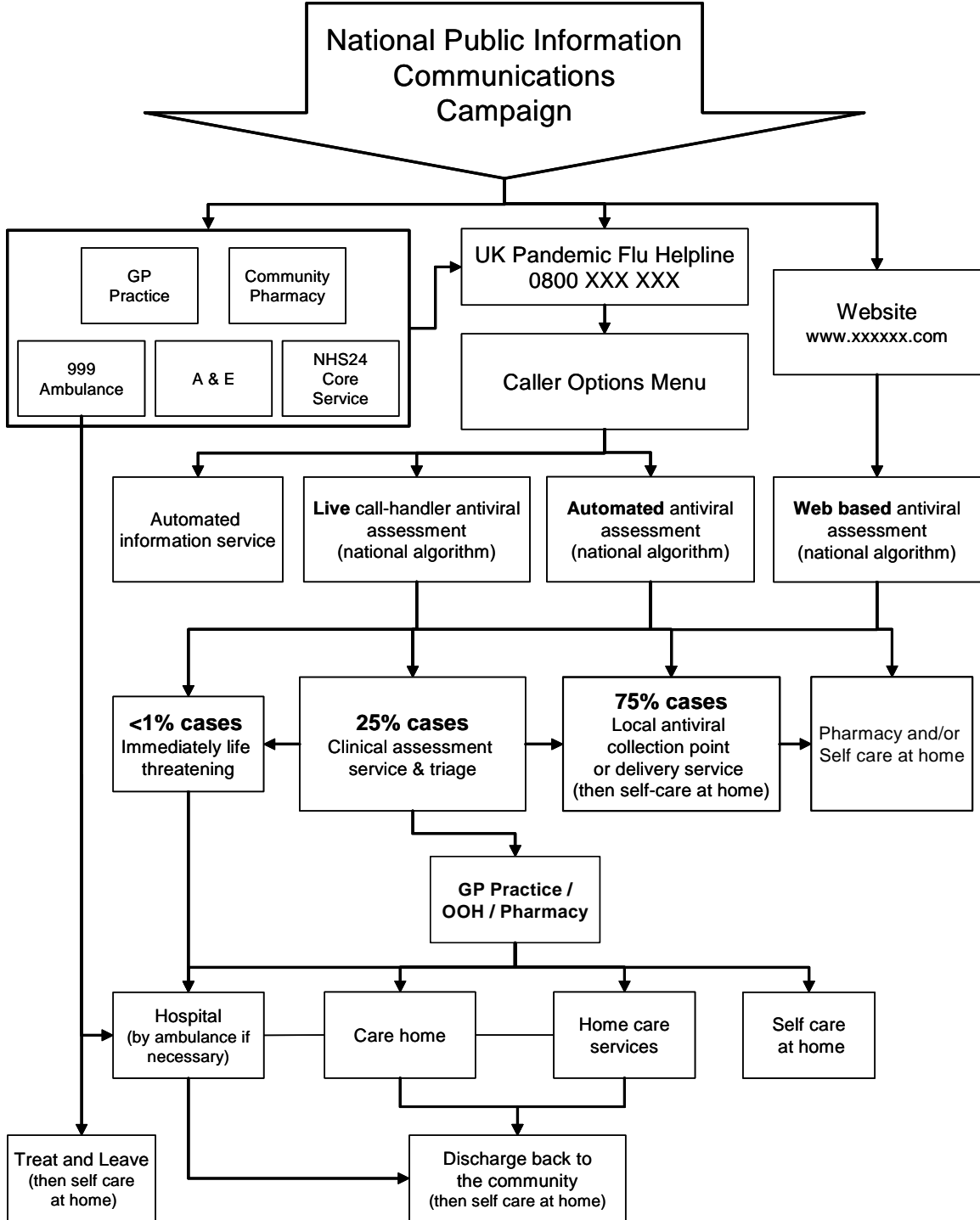
If referred by the national flu line for a face-to-face consultation, GPs, practice nurses and other community based nurses, whether in usual practice or operating from an OOH service, will assess patients and may advise, dispense or refer patients to pharmacy or antiviral collection points to receive antivirals, antibiotics, or other symptomatic treatment e.g. analgesics or refer the patient to a number of levels of care including home care services, care homes or hospital.

Usual emergency services must not represent an easier route or short-cut into medication or referral services for influenza patients. The main principle for emergency services must be to conduct their usual assessments with criteria which are consistent with the criteria for accessing influenza services through other parts of the pathway. They should also make use of the national telephone service for influenza patients wherever possible.

For example, influenza patients calling 999 would be diverted back to the national telephone service for assessment and possible prescription. If the ambulance service attends a patient, their clinical protocol must allow a decision to be made about either taking the patient to hospital, as would be usual practice, or treating the patient and leaving them at home, possibly with supplies of an antiviral. Similarly, Accident and Emergency services will need to refer uncomplicated influenza patients to the telephone assessment service and may wish to consider telephone access arrangements on site to accommodate.

Overall, apart from the telephony service which acts as a point of first contact and directs patients with lower level of need from pandemic influenza directly to the local antiviral collection point, the main clinical pathway is focussed around usual and familiar primary care services with the usual range of treatment and referral options.

Figure One: Overview of Patient Pathway



3.2 National influenza telephone line services

Key Points

- A national influenza information line will be provided at WHO international phase 5.
- The information service will expand to provide initial patient assessment and antiviral authorisation from UK alert level 2 (WHO phase 6).

Telephony and internet technology represent one of the central techniques for deploying health care resources quickly and safely in the event of a pandemic. The use of telephone and web services will allow timely triage, access to information (such as infection control advice for the public or self care advice for people with uncomplicated influenza) and will allow health professionals to provide clinical advice without risking infection themselves.

Face-to-face clinical assessment for every patient will not be feasible at the peak of a pandemic. Department of Health analysis suggests that general medical practices will not be able to expand their collective telephone call-taking capacity sufficiently to meet the level of additional demand that is anticipated. Whilst patients may still choose to make contact via their GP surgery, call centres using trained call takers operating to a clinically-based algorithm offer a viable and acceptable alternative.

To provide public information and advice before and during a pandemic, the Government - in conjunction with the Central Office of Information, NHS Direct and NHS24 - will establish a national influenza information line service at WHO international phase 5¹

From UK alert level 2 (WHO phase 6) the service will expand to provide initial patient assessment and antiviral authorisation and both functions will then remain operational until the impact of the pandemic and the threat of further waves subside.

The key objectives for the national influenza line services are to:

- provide pandemic influenza related advice and information
- provide access to pandemic related literature
- provide situation reports and daily updates

¹ Details of WHO Phases and UK Alert Levels can be found in *A Scottish framework for responding to an influenza pandemic*.

- provide access to a mechanism for rapidly assessing those suffering influenza-like symptoms
- authorise access to antiviral treatment (if that is indicated)
- give information on the nearest antiviral medicine collection point
- refer to some other part of the health and social care system if that is a more appropriate disposition
- facilitate the capture of critical surveillance information (number of people calling who are symptomatic, demographics of those accessing treatment, take-up of treatment etc.) to inform the local and national pandemic response.

Initial assessment will focus on confirming that the patient has signs and symptoms of influenza, no indicators of complications, is aged three or over, has been symptomatic for less than 48 hours and antiviral treatment is not otherwise contraindicated. Suitably trained staff using a clinically based decision tree algorithm will perform these tasks and authorise the collection of antiviral medicines for the patient.

Analysis suggests that, at a 50% clinical attack rate, such a service might need the capacity to handle a minimum of 11,000 influenza-related telephone calls per 100,000 of the population. This would require 28 staff per 100,000 of the population per day to provide 24-hour cover during the peak week.

The Department of Health is developing a suitable national algorithm and producing model protocols/guidelines to allow the supply of oseltamivir following a telephone assessment. It also proposes to make the necessary amendments to medicines legislation to enable alternative prescription and supply arrangements in a pandemic and a consultation will take place on the proposals.

Studies into the technical feasibility of providing helpline services have been carried out by Department of Health and the Central Office of Information. These have demonstrated that a national flu line service is technically feasible.

The Scottish Government and NHS24 will work with territorial NHS Boards to develop local delivery arrangements for national influenza helpline services. This will involve identifying, assessing and selecting operational delivery options, sourcing and resourcing the required call handling capacity, training and systems testing.

3.3 Local response management

Key Points

- NHS Boards have specific roles in coordinating local services.
- Community Health Partnerships will be an important mechanism for coordinating local services, collecting information and feeding local information back
- Tested arrangements will need to be in place by the time WHO Phase 5 is declared.

A critical factor in delivering a successful local response will be the effective coordination and cooperation of community based services. Each NHS Board's Pandemic Influenza Coordinating Committee has the role of maintaining oversight of health services, making strategic decisions, and liaising with local authorities, police and other emergency services.

In addition to these strategic arrangements, each territorial board will need to establish and resource an effective mechanism for directing and coordinating the local operational response. Unless other local arrangements are in place, Community Health Partnerships, under the direction of their NHS Board, should convene a Local Response Management Team to carry out the local coordination of community services. The general functions they will need to be capable of delivering are outlined below.

Functions of local response management

- Act as a focal point, providing a link to and oversight of the local health response.
- Monitor and coordinate the overall health response on a pan organisational, whole systems basis.
- Maintain the continuing provision of general practice and primary care services both in and out of hours;
 - monitor business continuity among practices and pharmacies, and act as a conduit for information to the Health Board and higher level planners
 - communicate to practices and pharmacies when non essential services may be suspended (and when they are re-commissioned)

- coordinate any consolidation that may be required among general practices and pharmacies if business continuity fails, including the redeployment of both staff and stock resources
 - coordinate cooperative arrangements, such as staff redeployment or changed opening hours specified in business continuity plans
 - coordinate regional implementation of measures such as Patient Group Directions.
- Collect, collate and report information on the local health situation.
 - Ensure that national messages are cascaded, reinforced and that the public are well informed and advised of local response arrangements.
 - Link with local authority services, particularly community care services but potentially also including transport, housing and others.

In many NHS Boards, Community Health Partnerships are in a strong position to conduct these roles within the broader scope of NHS Board strategic plans. While alternative mechanisms might be appropriate in some Board areas, the coordination roles which are identified here must be explicitly assigned to Local Response Management Teams at some level within each territorial Board.

Local response management arrangements should be included in NHS Boards' routine exercising and testing of pandemic response plans; should be placed on stand-by upon the declaration of WHO Phase 5 and be ready to "go-live" at the declaration of WHO Phase 6 - UK Alert Level 1.

Pandemic Influenza Coordinating Committees will need to consider what local conditions would need to be evident to support their decisions to relax consolidation arrangements and return to normal activities.

4 CORE PRIMARY CARE SERVICES

Core primary care services, particularly general practice and community pharmacy, will bear a considerable burden of expectation from the community in the event of a pandemic. Configuring front line primary care services is therefore at the heart of the problem of designing community health services for a pandemic situation. Identifying an appropriate configuration of general practice and pharmacy as a starting point will determine what roles are usefully played by other health providers, and what the needs for support and coordination will be.

In the event of a pandemic, cooperation among professionals will be essential at every level. Planners and practitioners must work together to produce primary care structures which will respond to increased demand as effectively as possible.

4.1 General Practice roles

The issues for general practice to address in a pandemic include:

- Consolidation of practices
- Business continuity
- Ceasing non-essential activities
- Personal protective equipment (PPE)
- Hours of operation and out of hours services (OOH)
- Guidelines for clinical practice
- Home visiting
- Staff roles
- Workforce monitoring
- Pandemic activity monitoring
- Death certification
- Vaccination

These issues should be considered by general practices both at the individual level and in collaboration with other primary care providers and NHS Boards.

General practice will be subject to a very high level of demand, at a time when the practice workforce will be under considerable stress. However, the principle of building upon existing services dictates that general practice will play a central role in providing community based health services in a pandemic and that general practice will also be essential in governing the flow of patients into and out of secondary care services and care homes. Such roles will have to be carefully coordinated with other health and non health services such as Local Authorities, the voluntary sector and others.

4.1.1 Consolidation

Where general practices are not able to maintain their usual services in the face of extreme demand, consolidation across practices will be required, particularly where small practices are involved. In those circumstances Local Response Management Teams will coordinate services across practices at a local level to ensure continuity of service. To facilitate this, practices will need to ensure Local Response Management Teams routinely have timely access to information about practice and workforce status and supplies.

NHS Boards should work with general practices to establish local consolidation plans and protocols. These should be capable of rapid activation and implementation in order to cope with worst-case planning assumptions. These arrangements should, where practical, build on existing networks for covering practice services. Plans and protocols should address de-escalation and recovery arrangements in the post and inter-pandemic phases.

4.1.2 Business continuity

Practices will wish to have in place arrangements to make their service as robust as possible in a pandemic situation. The RCGP/BMA have produced guidelines for this purpose and these are available from the RCGP website (<http://www.rcgp.org.uk/default.aspx?page=3908>).

Specific consideration should be given to the telephony resources of practices and pharmacies. It will be important that mechanisms for professional-to-professional communication remain open. In an emergency situation it may be appropriate for professionals to use personal mobile telephones for such communication. Ensuring that practices have an adequate number of telephone lines, and the staff to operate them, will require attention at an early stage of pandemic planning. Key service areas, including those services which are time sensitive, which will need to be maintained to some level include the following:

- Acute clinical disease management
- Screening
- Procedures

- Monitoring (i.e. of certain therapies such as anti coagulation therapy)
- Childhood immunisations
- Child protection

4.1.3 Ceasing non-essential activities

Practices will not have the resources to conduct all of their usual activities during a pandemic and will need to cease services which are not immediately relevant to patient care. In some cases patients who do not have immediately life threatening conditions may have to have their care postponed which otherwise would have been provided in normal circumstances. People will be encouraged, supported and enabled to self care wherever possible, by the Scottish Government, NHS Boards and healthcare professionals.

The Royal College of General Practitioners (RCGP) and the British Medical Association (BMA) have issued service continuity guidance, which those working in primary care will wish to refer to. The guidance suggests that the following functions and activities could be ceased, reduced, or delivered by alternative means to enable practices to focus on delivering essential work:

- 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 (some) minor surgery
- providing mainly emergency-only open surgeries
- team working with neighbouring practices
- identifying recently retired or non-practising colleagues who might be utilised.

It is important that practices have clear guidelines to support their decision in providing or denying care to individual patients. It must be clear to patients that such decisions are made consistently and equitably, and are not a whim of the individual practitioner, who may otherwise find themselves in an invidious position. To assist NHS Boards and front line providers with these issues, UK guidance is being developed for issue in mid-2008. Provisional guidance will be published in Autumn 2007.

In the context of social distancing and to reduce routine workload, repeat prescriptions for people with some long term conditions could be written in advance of a pending pandemic, for an increased prescribing interval (up to three months) provided this was supported by endorsements on the prescription to allow instalment dispensing. Any changes to routine prescribing intervals must not place avoidable pressures upon the pharmaceutical supply chain.

The local response management function will need to determine when resources are stretched to the point at which activities should be scaled back or suspended among local practice. Equally, a decision will need to be made about when to reinstate suspended activities as a pandemic wave declines.

4.1.4 Personal protective equipment (PPE)

Although national discussions are continuing about stockpiling of PPE, it is the responsibility of employers to source adequate types of PPE for their staff. Infection control is covered in more detail in section 7.2.

4.1.5 Hours of operation and out of hours services (OOH)

Decisions about modifying hours of operation, including temporary extension of general practice hours at the point of greatest demand and arrangements for resourcing Out of Hours services will be for Pandemic Influenza Coordinating Committees to make as the pandemic progresses and on the advice of Local Response Management Teams.

Decisions about hours of operation of usual daytime services must acknowledge that many GPs and other professionals are also likely to be involved in providing OOH services or contributing to influenza phone line response.

Good communication between practices and Local Response Management Teams will be crucial to maintaining and sustaining core services in the face of rapidly evolving circumstances as the pandemic progresses.

4.1.6 Guidelines for clinical practice

The British Thoracic Society and The British Infection Society have worked with the Health Protection Agency and Department of Health to develop clinical guidelines. These are available at: <http://www.scotland.gov.uk/Pandemicflu>

4.1.7 Home visiting

While planning is based upon the principle of taking care to patients rather than vice versa, the need for home visits will have to be carefully prioritised to avoid placing excessive pressure upon health professionals. Mobilising and utilising the skills of the whole healthcare team, using telephone assessment and triage and linking practices to specific care homes and residential settings may all help to spread the additional home visiting work load.

4.1.8 Staff roles

Nursing and clerical staff may be required to work outside their usual roles, whether by working directly with influenza patients or by taking on aspects of care for non influenza patients in order to relieve other primary care staff. NHS Boards may wish to give thought to training, contractual and indemnity requirements for the primary care workforce. Training initiatives could appropriately be delivered from WHO Phase 5.

4.1.9 Workforce monitoring

The local response management function will be required to monitor the primary care workforce in order to collect information about how practices are coping on a daily basis. This information will be required for Health Board situation reports, and ultimately for national assessment of how capacity and resources are being used across Scotland. NHS Boards should liaise with General Practices to establish pandemic reporting arrangements.

4.1.10 Pandemic activity monitoring

Local information will need to be collated and communicated to central planning agencies to allow Health Protection Scotland (HPS) to describe the pattern of clinical presentations with pandemic influenza and allow estimation of the impact of pandemic influenza and any control measures (including the clinical effectiveness of antivirals and antibiotics and the effectiveness of any pandemic influenza vaccine if it becomes available) implemented across Scotland.

NHS Boards will also need to monitor the distribution and stockpiling of antiviral and antibiotic medication so that measures such as the number of people responding or not responding to medication can be known.

4.1.11 Death certification procedures

National advice has been prepared to provide assistance and support to medical practitioners with their clinical responsibility for the appropriate certification of death during a flu pandemic. Medical practitioners and other relevant people e.g. registrars of births and deaths, have been informed of these procedures via a Chief Medical Officer's letter a copy of which is reproduced at: <http://www.scotland.gov.uk/Pandemicflu>

4.1.12 Vaccination (see also 5.3)

NHS Boards should work with general practices to develop operational delivery arrangements for targeted vaccination when/if a suitable pre-pandemic or specific vaccine becomes available. Further guidance on pandemic vaccination will be made available at: <http://www.scotland.gov.uk/Pandemicflu>

4.2 Community Pharmacy roles

Key Points

Community Pharmacy will be a key front line provider of primary care in the event of a flu pandemic. Plans for the local organisation of pharmacy services in the event of a pandemic should reflect local needs and service configurations.

Major issues for community pharmacy will include:

- Maintaining medicine supplies
- Local coordination of services
- Business continuity
- Providing augmented services and managing Patient Group Directions
- Pandemic activity monitoring

Community Pharmacy plays a central role in front line primary healthcare, and as such will be an integral part of services which respond to an influenza pandemic. Demands upon pharmacies are likely to arise in a number of different ways including; patients seeking information or over the counter symptomatic relief; patients exhibiting influenza symptoms and seeking assessment and patients seeking prescription medicines and antivirals. As well as these influenza related demands, there will be a need to manage existing patients who have a regular need for pharmacy services. As with the rest of the health sector, these pressures will have to be managed in circumstances of limited resources, as pharmacy staff themselves may experience illness and be unavailable for work. Dispensing Doctors may also find this section helpful to their planning.

A particular issue for pharmacists will be the maintenance of medicine supplies. Pressure upon supplies is likely to arise both from increased public demand as well as from potential interruptions to the supply chain at international, national and regional levels. Supply chain resilience and public information messaging are being considered on a UK basis. Further advice on these topics will be provided in due course.

Plans for community pharmacy in the event of a pandemic must reflect local configurations of services. The geographic distributions of population and the location and size of individual pharmacies may dictate that different approaches to business continuity and emergency planning are needed in different locales.

NHS Boards, working with local pharmacy groups, will wish to carefully consider the role that community pharmacy should play in the local distribution of antiviral medicines. Antiviral distribution options are discussed further in chapter 5.

4.2.1 Coordination

As pandemic progresses through local populations the impacts of additional demand and staff absence may mean that some pharmacies are not able to maintain their usual services. In those circumstances Local Response Management Teams will coordinate services across pharmacies at a local level to ensure continuity of service e.g. to vary/stagger opening hours or make arrangements for emergency redeployment of stocks and manpower. To facilitate this, pharmacists will need to ensure that Local Response Management Teams routinely have timely access to information about service availability and supplies.

NHS Boards should work with local pharmacists' groups to establish local coordination arrangements. These should be capable of rapid activation and implementation in order to cope with worst-case planning assumptions. These arrangements should, where practical, build on any existing local arrangements.

4.2.2 Business continuity

As is the case with general practice, community pharmacies will wish to have in place arrangements to make their service as robust as possible in a pandemic situation. The Royal Pharmaceutical Society of Great Britain has produced guidance documents on Service Continuity for Community Pharmacists and these are available from the RPSGB website:

<http://www.rpsgb.org/informationresources/downloadsocietypublications/#g>

Specific consideration should be given to the telephony resources of pharmacies. It will be important that mechanisms for professional-to-professional communication remain open. In an emergency situation it may be appropriate for professionals to use personal mobile telephones for such communication.

There will be great pressure upon pharmacies to provide a range of services, and prioritisation may be required. In the event of a pandemic, the services that will need to be given priority may include:

- support for self care including advising on the use of over-the-counter medicines for symptoms of flu and other conditions, including managing shortages by for example, limiting the number of packs sold
- dispensing and repeat dispensing
- sign-posting to other available NHS and local authority services
- acceptance of unwanted medicines
- supply of regular medicines to vulnerable people such as residents of care homes or those with long-term conditions

- maintenance of medicines supplies under contracts with other bodies, e.g. hospices, prisons etc.
- support and promotion of national public health campaigns on basic hygiene measures such as hand hygiene and other positive health messages.
- access to medicines out of hours
- subject to further consideration nationally, pharmacists may additionally be required to help maintain public confidence in supplies of medicines by managing short-term supply problems or substitutions of products in accordance with nationally agreed algorithm or cascade protocols.

4.2.3 Augmented services

NHS Boards already have the benefit of pan-Scotland Patient Group Directions (PGD) to deal with the urgent supply of repeat prescription medicines to patients in emergency situations. Further PGDs may be deemed necessary or desirable at either national or local level to more rapidly deal with pandemic situations. Advice and guidance on the preparation and use of PGDs can be found at the Medicines and Healthcare products Regulatory Agency's web site at <http://www.mhra.gov.uk>. Boards' plans should also recognise the role of the Minor Ailment Service in reducing pressure upon other parts of primary care and ways in which that might be affected / extended during a pandemic.

NHS Board and Community Pharmacists' plans should recognise that there may be a need for increased prescribing intervals with repeat dispensing for a period of three months or more to patients with chronic diseases such as asthma, diabetes, COPD, CHD, or for other circumstances such as oral contraception. However, any such changes to routine prescribing intervals must not place avoidable pressures on the pharmaceutical supply chain.

4.2.4 Pandemic activity monitoring

As with a range of other health professionals, community pharmacists should ensure that they have arrangements in place to contribute to centrally collated information about care provided for individual patients, and to the monitoring of supplies and patient outcomes.

5 MEDICINE AND VACCINE DISTRIBUTION

Key Points

- NHS Board plans for the distribution of antivirals should be flexible, responsive and capable of ensuring timely access.
- NHS Boards will need to set aside resources for home delivery of antiviral medication.
- Strain-specific pandemic flu vaccine is unlikely to be available in the first wave of a pandemic, but may be ready for use in subsequent waves.

5.1 Antiviral medication

NHS Boards plans should specify local distribution arrangements for the national antiviral stockpile. The following discussion outlines the main considerations in developing local arrangements.

5.1.1 The time factor

A key parameter which will determine the best means for distributing antiviral medication is the recommended minimum duration of time from identification of symptoms to receiving the medication. Current advice is that antivirals should preferably be taken within 12 hours of the onset of influenza symptoms.

5.1.2 The risks to core community pharmacy services

Distributing antivirals via community pharmacies may increase the exposure of pharmacy staff to flu infection and will bring an associated additional workload. The relative risks to and consequences of disruption to core pharmacy services will need to be carefully considered in a local context and local arrangements made explicit in operational plans.

5.1.3 Centralised or decentralised distribution

In developing plans for the local distribution of antivirals a key consideration for territorial Boards will be whether to adopt centralised distribution, with some combination of pick up and home delivery services for individual patients, or to have a decentralised distribution mechanism which is integrated with existing community pharmacy services.

Centralised distribution would probably be managed directly by the Board and would involve a number of specifically planned distribution points per Board area. These would manage antiviral stocks, and have the necessary resources in place to make deliveries to individuals. As the pandemic develops, this model might

cease to be sustainable and home delivery might have to be restricted to a minimal number of patients with no other means of acquiring antiviral treatment. To compensate, the number of centres through which antivirals are distributed would need to increase correspondingly.

Advantages of centralised distribution include:

- ensuring strong centralised control over the stock of antivirals, particularly if stocks run low
- reducing the potential for transmission of influenza by home delivery
- avoiding adding to the existing workload of community pharmacies
- reducing the impact which failures in business continuity at pharmacy level will have upon antiviral distribution
- avoiding public order issues if patients try to demand antiviral medicines from community pharmacies.

However, centralised distribution with home delivery is clearly dependent upon the Board being able to provide a workforce and fleet of vehicles which can undertake such a task. This may not be feasible under the pressures of a pandemic, when many staff will themselves be affected by influenza or other factors such as shortage of fuel.

Decentralised distribution would involve providing supplies of antiviral medication to community pharmacies and relying upon patients to pick up medicines from pharmacies via friends and relatives who are well enough to visit the pharmacy. Boards would need to provide, exceptionally, some level of home delivery to support those who have nobody to collect their antivirals on their behalf e.g. those who live alone with no immediate family in the locale and no social care support.

An important advantage of decentralised distribution is that while it may be affected at a small scale by the closure of individual pharmacies, the business continuity and local coordination functions which will occur at local level will work to ensure that at least some degree of function is maintained. A further advantage of decentralised distribution is that it builds upon a routine process for distributing medications, so that patients will not be expected to make any change from their usual behaviour.

Between the extremes of centralisation or decentralisation there will be specific arrangements that are appropriate to each locale. These should reflect the prevailing clinical consensus about the best use of antivirals, the specific circumstances of the local population and geography and include arrangements to reduce or mitigate the potential for adverse impact on infection control and core community pharmacy services.

5.1.4 Antiviral record keeping

A record will have to be kept of who has been authorised to receive and who has actually received antiviral medication via a central database and identified through their unique CHI number. This will ensure that distribution is taking place equitably, will make sure that stocks can be controlled by central planners and will make sure that records of antiviral use are available to GP's and all workers who may be involved in patient care. Antiviral collection points will need to have access to appropriate IT for accessing and updating the planned national antiviral database.

5.2 Medicine supply

Demand for antibiotics, other medicines and over-the-counter remedies is likely to be high in a pandemic and the supply chain may be disrupted. The Department of Health and the Scottish Government are reviewing available stock levels and working with the pharmaceutical sector and others to improve supply chain resilience and consider options for meeting demand and maintaining supply.

Further guidance will be issued on the prescribing and use of medicines during a pandemic outbreak and there will be consultation on proposed changes to medicines legislation and related regulations, with a view to implementing those changes in the event of a pandemic.

5.3 Vaccinations

A specific vaccine for the strain of pandemic influenza is unlikely to be generally available early in the first wave of a pandemic. However, there is a possibility of vaccine becoming available in the recovery period between waves or in subsequent waves, and the UK has secured manufacturing capacity for the production of the vaccine if required. Once production starts it will take an estimated 44 weeks for the total volume of vaccine to be manufactured.

A small amount of H5N1 vaccine has also been purchased for healthcare workers. Immunisation with this vaccine before the first wave may offer some limited, but useful protection. Decisions on the use of this vaccine will need to be made following assessments of the likely degree of cross-protection afforded (if any) and balance of risks against benefits as the pandemic phases change.

Guidance is being prepared for health planners about the model for delivery of these vaccines and issues to be considered in the development of local vaccination plans. While there will be flexibility in the approach taken to reflect local circumstances, the proposed models will be for H5N1 vaccine to be delivered through local occupational health services and for the pandemic specific vaccine to be delivered through Primary Care.

6 RELATED SERVICES

6.1 Ambulance services

Key Points

The main issues for the Scottish Ambulance Service to address are:

- Supporting Acute capacity management by developing an algorithm for treating and leaving pandemic flu patients.
- Working with NHS24 to establish an interface with the National Flu Line.
- Working with territorial Boards and NHS24 to develop pandemic information recording and sharing protocols.

Demand on the Scottish Ambulance Service (SAS) is likely to increase significantly in a pandemic. The primary focus of service continuity plans is the maintenance of capacity to answer all emergency and urgent calls, although some prioritisation and changes in normal performance standards may become unavoidable. NHS Boards plans should provide for all non-emergency patient transport services becoming progressively restricted or temporarily suspended.

Patients will contact SAS through one of several avenues: the 999 emergency telephone service, the NHS24 core service, local out of hours telephone services, or on request of a doctor after either a house call or telephone consultation (known as "doctor's urgents"). Where patients are referred in this way, a clinical assessment and triage will have been carried out and the service can operate in its usual mode.

Where patients contact the service directly without prior assessment and triage, the ambulance service will need the ability to make judgments about whether a patient should enter their normal clinical algorithm (being stabilised and transported to hospital), should be transferred to the national telephony system for pandemic flu, or should receive assessment for influenza and appropriate treatment if already present on site, without being transferred to hospital. The service does not currently perform "treat and leave" procedures, except under a very few specified circumstances. The Scottish Ambulance Service should work with NHS Boards to develop algorithms which facilitate paramedics to conduct assessment of influenza patients, and to provide appropriate treatment or referral to the relevant part of the influenza pandemic patient pathway.

The ambulance service must not be seen by the public as an easy route to hospital admission, bypassing the kind of admission criteria which will be applied in other parts of community health services. This would undermine the ability to manage hospital resources and would risk a flood of direct calls which would

have the potential to swamp both the ambulance service and secondary care resources. In addition to developing “treat and leave” protocols, the Scottish Ambulance Service and NHS24 should work together to establish an interface with the National Flu Line.

Information about contact between the ambulance service and influenza patients should feed into any centralised mechanisms for surveillance and for recording care given to influenza patients. The Scottish Ambulance Service will also need to establish access to the planned antiviral database. Working with territorial Boards, NHS24 and others, the Scottish Ambulance Service should ensure that effective pandemic information recording and sharing protocols are in place.

6.2 NHS24 core services

Demand for non-flu health advice and information is likely to increase significantly during a pandemic. NHS24 will continue to play their important role in providing health advice and information through their normal telephone number, and via the NHS24 website (www.nhs24.com). Demand on NHS24 core services is likely to increase and the primary focus of service continuity plans is the maintenance of core services in the face of high levels of staff absence.

6.3 Community Care

Local Authorities have responsibility for ensuring that Community Care services have pandemic influenza contingency arrangements in place. To support Local Authorities guidance has been developed and a pandemic flu framework for Community Care can be found at: <http://www.scotland.gov.uk/Pandemicflu>

Business continuity difficulties arising in the Community Care sector during an outbreak would have a profound impact on NHS resilience. For this reason NHS Boards will wish to liaise closely with their Local Authorities to understand the arrangements for service continuity, prioritisation and consolidation in the community care sector and how these arrangements will work alongside NHS plans.

NHS Board plans should describe how the local NHS response will integrate with Local Authority services. Plans should also describe what operational arrangements will be in place to aid business continuity in the Community Care sector. For example:

- providing emergency redeployment of Board employees to nursing and care home settings
- coordinating the pairing up of GP practices and care facilities
- making pragmatic antiviral distribution arrangements and supporting the maintenance of medication supplies.

7 OTHER PLANNING ELEMENTS

7.1 Vulnerable or hard-to-reach groups

The impact of a pandemic may mean that there are more individuals and groups who become temporarily vulnerable or hard to reach, for example, those within closed communities whose location puts them at risk.

NHS Boards should work with other agencies, including community care services and voluntary organisations, to identify those known to be at risk, and to identify those groups at risk who may be unknown to health and community care providers. These may be groups who are at risk due to underlying health or social conditions, or because of their hard-to-reach status (those with difficulties in understanding English, those who are not registered with a GP, etc).

These groups should be identified so that their needs can be taken into account when developing local arrangements for the provision of healthcare in the community setting, in particular the assessment and treatment (and management) of influenza patients and, if applicable, distribution of antivirals.

The following list identifies a number of individuals and groups who could be classified as vulnerable or hard to reach (permanently or temporarily). This list is not exhaustive, and some individuals may fit into more than one category:

- those with a mobility impairment
- those with a sensory impairment
- those with a mental/cognitive impairment
- non-English speakers
- children
- those living alone
- older people
- those who are clinically at risk
- those with ill health and taking regular medicines
- those with ill health and using medical support equipment (oxygen, etc)
- the homeless
- travellers

- those in residential institutions (residential homes, prisons, nursing homes, sheltered accommodation, half-way houses, boarding schools, colleges, etc).

7.2 Infection control

Guidance on infection control for hospital, primary care and some other settings is available. The advice and principles within this guidance should be applied across all local plans to assist in limiting and preventing the spread of infection.

The guidance is available from the Scottish Government website at: <http://www.scotland.gov.uk/Pandemicflu>

Some professional bodies have also developed infection control guidance. Guidance from RCGP/BMA for general practice can be found at: <http://www.rcgp.org.uk/default.aspx?page=3908>

Primary care organisations such as GP practices and pharmacies will wish to think about the potential of their staff to act as role models for good practice in infection control, and to take action to minimise the potential for their premises to spread the virus. They may also wish to consider the following:

- how they will reduce the risks of droplet spread in seated areas, such as waiting areas in GP practices, and in collection areas, such as pharmacies
- the availability and adequacy of hand washing facilities. Adequate hand washing practice and facilities are fundamental to good infection control. As part of their general response to infection control, primary care organisations should review the availability of hand washing facilities and hand washing procedures/practices. They should also be providing guidance to patients and relatives on hand washing (using national guidance where possible)
- the availability and adequacy of other facilities that help minimise virus spread, eg tissues and tissue disposal facilities for those people coughing and sneezing in areas of close human-to-human contact
- the most appropriate management of areas of close human-to-human contact in all areas of the site. Primary care organisations will wish to plan for how they will minimise mixing in areas of high contact, such as reception areas, waiting rooms and triage stations
- the standards set for cleaning premises and facilities before and after use. Infection control standards are important at all times regardless of the presence of an influenza pandemic. However, primary care organisations will need to ensure that high-quality cleaning standards are maintained

during a pandemic, with particular attention given to places affected by droplet spread

- Primary care organisations will wish to consider and plan for their own duty of care to their staff so that they can continue to provide their services whilst minimising exposure to the infection where possible, for example by using screens between reception staff and patients, or making use of telephone interaction systems.

7.3 Promotion of self-care

Promotion of self-care will be crucial in encouraging the community at large to look after its health. Encouraging those who are symptomatic with influenza to care for themselves at home if they are able to do so will enable healthcare professionals to concentrate on helping those with greater clinical needs.

Messages on self-care with regards to influenza will be included in the national public communications campaign, but benefits can also be realised through local targeting of specific groups, such as those with long-term chronic diseases. NHS Board plans should specify how self care will be encouraged locally.

7.4 Communications

Any emergency of this scale needs strong national direction from the outset. Timely, accurate and consistent advice will help prepare the population for the potential impact of a pandemic and will be critical to its subsequent management.

The Scottish Government's communication plan supports the UK Framework and recognises that the Department of Health has the overall UK lead and will be the primary source of health information. However, all four health departments/directorates, the Cabinet Office, other government departments/directorates, the Health Protection Agency and Health Protection Scotland are working together to deliver a nationally co-ordinated communications strategy. (Please refer to section 11 of *A Scottish framework for responding to an influenza pandemic* for full details of the strategy.)

Health Boards and primary health care providers should work with the Scottish Government and other national bodies to both, support the national communications plan and to communicate to the public on local operational issues.

Where possible, all material should use nationally available resources contextually applied to local circumstances and should be available in suitable languages for the local population.

7.5 Surveillance, reporting and data collection

A common theme across all local planning is the need to gather information. This will be used to monitor the behaviour of the virus, response to the pandemic and the availability of resources (beds and staffing levels). It will help to evaluate the efficacy of antivirals and other interventions such as vaccinations, antibiotics, social distancing etc.

Health Protection Scotland will work with NHS Boards and primary health care providers to ensure that systems for epidemiological monitoring are in place. NHS Boards will have requirements to provide regular situation reports for decision making at Scottish and UK levels.