



Swine Flu H1N1

*Updated Guidance for mental health services in
England*

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Swine Flu H1N1
Updated Guidance for mental health services in England

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Introduction

Context

- 1.1 The first cases of the new H1N1 flu virus were diagnosed in the UK in April 2009. The World Health Organization declared a H1N1 pandemic on 11th June 2009.
- 1.2 There was increased pressure on NHS services during July and August with some health communities coming under particular pressure. From the experience of previous pandemics, a second higher wave of illness could occur in the coming months. Although the timing and the severity of this cannot be predicted with certainty, NHS services need to ensure that they are ready to care safely for people during the pandemic.
- 1.3 H1N1 will affect all parts of society and will have consequences for mental health services as well as other parts of the NHS.

Purpose

- 1.4 The purpose of this guidance is to support mental health trusts and other specialist mental health service providers in implementing their plans for responding to this flu pandemic. Please note swine flu will be referred to as H1N1 throughout this document. There are actions for organisations listed throughout the document and these are compiled together in appendix 1.
- 1.5 The emphasis throughout this document is on business continuity and ensuring access to services and treatments for service users throughout the pandemic phase.
- 1.6 H1N1 specific guidance is found at:

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

General pandemic guidance is found at www.dh.gov.uk/pandemicflu

Aims

- 1.7 The two main aims of this guidance are to:
 1. To give support, advice and up to date information in order to minimise the negative impact of H1N1 on mental health services and people in contact with those services.
 2. To support mental health services to prepare for a greater role in meeting the physical health needs of their service users during the pandemic.

Audience

This guidance is for all mental health trusts and partners. It is also for use by all services within mental health trusts including all tertiary, specialist, forensic, child and adolescent mental health services (CAMHS) and older peoples' mental health services (OPMHS).

The current context of H1N1 Planning

- 2.1 The effects of this H1N1 pandemic will depend on a number of factors, including the characteristics of the virus, the severity of the illness it causes and its clinical attack rate. The current guidance for planners is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107413

Services may experience, and may have already experienced, increased pressure for some or all of the following reasons:

- the increased workload caused by service users with H1N1 and the physical complications arising from this
- the additional burden on people's health caused by distress, anxiety and bereavement
- the need for infection control facilities and equipment
- depletion of the workforce and pool of informal carers due to the direct or indirect effects of H1N1 on themselves and/or their families
- pressure on social services and primary care services impacting on the interface between these and mental health services
- delays or difficulties in dealing with medical conditions other than H1N1, and strain on acute care in hospitals
- logistical problems caused by the possible disruption to supplies, utilities and transport.

- 2.2 Mental health and other relevant trusts will have to find innovative approaches to delivering many aspects of care if they are to respond effectively to the demand for services during this H1N1 pandemic. It is crucial that mental health and other relevant Trusts have planned with their local and regional stakeholders so that they can respond in a coordinated, effective and ethically appropriate way to this H1N1 pandemic.

- 2.3 Many of the issues that are relevant to a H1N1 pandemic are common to other emergencies and will already have been addressed as part of usual contingency planning. However, most emergency plans are based on the short-term escalation of needs for services, but the H1N1 pandemic could have a sustained impact on demand that affects areas simultaneously. This will require different planning responses. Alternatively, some areas ("hot spots") may be more severely affected than others, as was seen in July 2009. Additionally, mental health trusts and other mental health services providers should be aware that this pandemic may occur over more than one wave, and response plans must cover this possibility. In England, case numbers initially peaked in July and case numbers have been rising again since mid-September. The recovery period after a wave should be used to restock, prepare and review plans for possible subsequent waves.

- 2.4 In previous pandemics, the overall UK clinical attack rate has been in the order of 25% to 35% of the community, compared with the usual seasonal range of 5% to 15. Current guidance for planners for the H1N1 pandemic, published on 22nd October 2009

assumes a clinical attack rate of 12% between 1 October and mid-May 2010. This is an average figure for the UK and could be higher in local hotspots.

- 2.5 A single wave can last for 15 weeks and as noted above there may be more than one wave over the course of the pandemic. Local plans will need to be flexible to meet the changing nature of the pandemic. The guidance for planners remains under continuous review by independent scientific advisers and may be subject to change.

Key Response principles

- 2.6 There are generic principles that have been developed to inform planning for the pandemic and it is important that all mental health service implementation plans are in line with these principles, which are:
- joint working and integrated planning between all key agencies
 - flexible planning to deal with a range of possible scenarios and clinical attack rates
 - flexible thinking in maximising local staff capacity
 - building on normal delivery models (as far as possible)
 - advising and enabling symptomatic H1N1 service users to remain at home
 - facilitating rapid access to antiviral medicines
 - reducing (some) routine activity but continuing to make essential care available.
 - operational plans informed by national planning assumptions
- 2.7 Local response plans for mental health services will also need to consider the following three principles:
- People with mental health problems should receive the same degree of protection and support with managing H1N1 as other members of the population.
 - In preparing for and responding to an H1N1 pandemic, staff within mental health and other relevant trusts will face difficult choices and decisions that may affect the care provided for service users.
 - Timely and consistent advice and information is provided which is sensitive to the needs of people with mental health problems and ensures people are not discriminated against or socially excluded during a pandemic.
- 2.8 These will be true during this pandemic, when capacity limitations, staff and supply shortages and possible increased demand may result in different levels of care. Response plans and arrangements should adopt measures that maintain public confidence and balance individual care with the priority to reduce illness. To help staff with considering the ethical aspects of care, please read the guidance on *Responding to pandemic influenza: The ethical framework for policy and planning*. Furthermore, people are more likely to accept the need for, and the consequences of, difficult decisions, if these decisions are made in an open, transparent and inclusive manner.
- 2.9. Services should read the Managing Demand and Capacity in Healthcare Organisations as a guide to service prioritisation on http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098769

- 2.10 The response to this H1N1 pandemic must reflect the needs of local populations and this is particularly important in the communication and access to services and treatment response.

The impact of H1N1 on Mental Health services

- 3.1 In this H1N1 pandemic, the key role of mental health and other relevant trusts is to ensure that core mental health services continue to be provided and maintained at an acceptable level. A reduction in the number of staff will affect the continuity of services, and local plans should have considered the minimum numbers of staff required to run each individual service. There should have also been consideration given to which staff may be redeployed in order to maintain essential services. Plans should aim to minimise disruption to mental health services as far as possible. However, it is possible that some routine outpatient appointments and inpatient admissions will be delayed, suspended or delivered by alternative means during a pandemic.
- 3.2 Mental health and other relevant trusts will face specific challenges during a pandemic. The health and well-being of service users who are cared for in the community depends significantly on their ability to access care and treatment and if necessary the continuing supply of prescribed medicines.
- 3.3 The need to provide speedy diagnosis and care for service users who present at accident and emergency (A&E) or primary care with mental health-related symptoms will continue despite an H1N1 pandemic.
- 3.4 Contingency plans should include infection control measures to minimise the spread of H1N1 in residential establishments. This is because it may not be possible to move people who may have significantly challenging behaviours, present risks to themselves or others to other inpatient settings.

Trust Responsibilities

- 3.5 Ensuring that services can continue to operate safely during a flu pandemic will be an important governance issues for all NHS Boards.
- 3.6 Within each trust, the board should take overall control of the preparations for responding to an H1N1 pandemic.
- 3.7 Every mental health trust should appoint an executive director for flu resilience. This lead director will need to ensure that robust response plans are in place, based upon the information and approach outlined in this guidance. They will also be required to ensure that planning is an integrated activity and that all plans are regularly reviewed, updated and tested. Any gaps, areas of concern and actions identified through the planning process should be raised and taken forward, with regular updates provided to the Board.

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- 3.8 Each trust should have a clinically led internal management steering and planning group to ensure that robust plans and preparations are implemented.
- 3.9 The membership of this group should include the following representatives:
- director for flu resilience
 - emergency planning lead
 - infection control lead
 - clinical lead, with representation from inpatient care and community care as appropriate,
 - AHP Lead
 - Nursing lead
 - Pharmacy lead
 - Locality/borough services lead
 - Estates and facilities lead
 - HR lead
 - Occupational health lead
 - Representation from the PCT or links to the PCT from trust representatives.
 - Staffside/ union representation.
- 3.10 In an H1N1 pandemic, it is vital to have robust reporting pathways within an organisation so that decision-makers have the information they require to take any necessary action. It is also important that decisions and information are cascaded effectively to all staff.
- 3.11 Command and control plans should allow for the possibility that the people who are in positions of authority could become ill. Organisations are advised to develop action cards, which describe the actions to be taken by staff at different stages of the flu pandemic and can be used by staff during a flu pandemic, thus facilitating effective delegation.

Actions for all Boards
1. Appoint a full time director level lead dedicated to flu preparedness and resilience with immediate effect. This can be a single individual or shared between directors but must provide visible, full-time, senior leadership and ensure a well-resourced team on this issue through the months ahead.
2. Stress-test your pandemic preparedness plans to ensure that the provision of high quality care to flu and non-flu patients now and during a second, sustained wave of up to five months can be sustained (i.e. tested through exercises).
3. Understand and test capacity constraints that may be caused through increased demand and workforce sickness absence. This includes but is not limited to those clinical areas that are likely to face most flu-related pressures. Recent ' <i>Pandemic Flu: Managing Demand and Capacity in Health Care Organisations (surge)</i> ' guidance and the NHS Employers/

Department of Health document ' <i>Pandemic Influenza Human Resources Guidance for the NHS</i> ' will help with this work.
4. Engage in discussion with trade unions about a staff vaccination programme and wider communications to, and support for, staff.
5. Build on existing relationships with local partner agencies to ensure that their role, channels of communication and ways of working during any second, sustained wave are clear.

Partnership working

- 3.12 Partnership working between mental health trusts, PCTs, local authorities and acute trusts is essential to ensure that people with mental health problems have their needs met as effectively as possible during a pandemic. Users of mental health services may receive care from a variety of providers. Decisions about service provision should not have been made unilaterally as decisions in one area will have knock-on effects on other services and sectors.
- 3.13 The overall responsibility for the health aspects of H1N1 pandemic preparedness within the community rests with PCTs. Each PCT has a named pandemic influenza coordinator who leads on the arrangements for providing an effective and sustainable community-based health response during this H1N1 pandemic.

Communications

- 3.14 Good communication with the public, during and after a H1N1 pandemic is vital. A national public awareness campaign was initiated to inform the public on key pandemic-related issues, including advice on how to protect themselves and others from contracting H1N1 and what to do if they develop symptoms. PCTs have key responsibility for cascading and supporting national messages and adding any local advice and information, as necessary. Communications material found at <http://www.dh.gov.uk/en/PublicHealth/Flu/Swineflu/Campaignresources/index.htm>
- 3.15 Trusts and other mental health service providers should ensure that their communication systems are developed in conjunction with PCTs and that the channels and mechanisms for cascading routine and urgent information have been tested. During the pandemic, it is essential to inform people who use mental health services that contingency care arrangements are in place. This information should be as clear and concise as possible to avoid misinterpretation and panic. Vague timelines such as 'closed until further notice' should be avoided where possible. Consideration needs to be given to the communication media most appropriate to the needs of service users, e.g. the provision of easy to read material. Again, it is important to provide timely, consistent advice and information, which is sensitive to the needs of people with mental health problems and ensures that people are not discriminated against or socially excluded during this H1N1 pandemic.

Actions

Ensure that there is H1N1 information available for service users,
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carers and staff on the signs and symptoms of the flu and access to treatment.
Ensure that the information is available in all inpatient and community services in formats and languages that meet the needs of the local community

Promotion of self-care

- 3.16 For health services to remain as functional as possible, the public will need to follow advice on protecting themselves and their families, complying with public health measures, and knowing when and how to seek medical advice or care. Mental health trusts and other relevant organisations have a role to play in encouraging and supporting staff, service users and the local population to self-care where they are able.
- 3.17 It is important that all types of communications, including those which do not rely solely on written information, should be used to engage with service users, carers and staff including face-to-face communication or use of interactive websites to communicate information. In medium and high secure units, one-to-one education with a staff member that service users know well would be of benefit. Messages on self-care should be simple and clear, and should include basic infection control advice such as on the use and disposal of tissues. The ‘Catch it, Bin it, Kill it’ campaign can be used as part of the general promotion of good infection control practice measures.

Actions

Ensure all areas have “catch it, bin it, kill it” posters
Ensure that all areas have tissues and hand hygiene gel and each member of staff has an individual hand hygiene gel
Ensure each inpatient services patient education programme includes a session on respiratory hand hygiene and H1N1 symptoms and treatment.

Symptoms of H1N1

- 3.17 The symptoms of H1N1 in people are similar to the symptoms of regular human seasonal influenza. Gastro-intestinal symptoms (eg diarrhoea) appear slightly more common than in seasonal flu.
- 3.18 So far, most H1N1 cases have been mild, with symptoms similar to those of seasonal flu. However, a small number of people have had more serious symptoms and some have died.
- 3.19 H1N1 has been affecting all age groups including young people, adults and the middle aged as well as the very young and older people who have traditionally been most affected by seasonal flu.

3.20 Patients with H1N1 typically have a fever or a high temperature (over 38°C / 100.4°F) and two or more of the following symptoms:

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

Identified “at risk” groups for H1N1

3.21 Some people are more at risk than others of developing a serious illness if they contact swine flu. The current at risk groups are identified as those people who have:

- Chronic respiratory disease
 - Chronic heart disease
 - Chronic kidney disease
 - Chronic liver disease
 - Chronic neurological disease
 - Immunosuppression (whether caused by disease or treatment)
 - Diabetes mellitus, and
-
- Patients who have had medical treatment for asthma within the past three years
 - Pregnant women
 - People aged 65 years and older
 - Young children aged five years and under.

3.22 Although mental illness is not a risk factor for H1N1, people with mental health problems may of course fall into one of the identified at risk groups.

Access to Antiviral medicines

3.23 Individuals with the symptoms of H1N1 can access antiviral medicine via the National Pandemic Flu Service (NPFS).

3.24 This is a telephone and web-based service where, if a person thinks that they have H1N1, they should initially contact the National Pandemic Flu Service. The contact details for the NPFS are

WEB ADDRESS www.direct.gov.uk/pandemicflu

PHONE NUMBER 0800 1 513 100

3.25 After being assessed via a national clinical algorithm, if a service user is assessed to be eligible for antiviral treatment, they will be authorised to receive antiviral medicines and

given an authorisation number. A 'flu friend' e.g. family member, friend or carer, will then take their authorisation number to collect their antiviral medicines from a local antiviral collection point. If the service user has higher-level needs (i.e. in the identified at risk groups), they will be referred to primary care for further advice and care.

- 3.26 It is anticipated that some people with mental health problems may have difficulty in using the National Pandemic Flu Service. It will therefore be necessary to provide assistance on a local level to support service users with this process. Community Mental Health Teams (CMHTs) should have identified individuals who will need help in gaining access to the NPFS service. Service users should be encouraged to build a network of 'flu friends' from amongst their family, friends, neighbours and health and social care staff that may be willing to support them should they become ill. Health and social care staff can pick up antivirals for service users after the person has been assessed via the NPFS and received an authorisation number. The member of staff will need to take proof of their identity to the antiviral collection point as well as proof of the service user's identity.

Medicines interactions and side effects

- 3.27 Tamiflu and Relenza can be taken in conjunction with medicines prescribed for mental health problems. Where there are concerns about the possible contraindications of antiviral drugs with drugs already prescribed for a particular condition, clinicians can consult the *British National Formulary* (BNF). Both Relenza and Tamiflu are licensed products, which mean that they have been through the regulatory process to establish safety and efficacy before getting their marketing authorisation.
- 3.28 As is the case with all medicines, there are known side effects, such as nausea, in a small number of cases. Symptoms may lessen over the course of the treatment, and it may help to take Tamiflu either with or immediately after food.
- 3.29 The EU regulatory position remains that no causal association between Tamiflu (or Relenza) and an increase in neuropsychiatric events has been established. Purely as a precaution, the Summary of Product Characteristics (SPCs) were amended to include reference to this possible risk to ensure both service users and prescribers remain vigilant.
- 3.30 There is an established process for reporting the side effects of medicines through the Yellow Card system operated by the UK regulator, the Medicines and Healthcare products Regulatory Agency (MHRA). Information on how to report adverse reactions is included in the leaflet that is provided when antivirals are collected from the antiviral collection point.

Actions

Ensure all staff understand the process for accessing antivirals for their service users and service users know how to access antivirals for themselves via the NPFS.
Ensure all service users have an identified flu friend if they are unable to identify one for themselves. This flu friend may need to be a member of staff and their details need to be in the service users care plan.
Ensure there is a system in place for service users to report to their community or inpatient team if they have accessed antivirals from the NPFS

Seasonal and H1N1 vaccinations

3.31 At the height of a pandemic, frontline NHS staff will need to be at work in order to treat service users, with or without H1N1. Whilst the majority of cases of H1N1 have been relatively mild, some people will suffer from complications and therefore need caring for.

3.32 Leaders across the NHS also have a critical role to play in supporting their workforce throughout the pandemic in every respect. Details of the H1N1 vaccine delivery programme are available at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_106300

The following groups will be the first to be vaccinated with the H1N1 vaccine:

- Individuals aged between six months and up to 65 years in the current seasonal flu vaccine clinical at-risk groups
- All pregnant women
- Household contacts of immuno-compromised individuals
- People aged 65 years and over in the current seasonal flu vaccine clinical at-risk groups

3.33 In addition to this front line health and social care workers will be offered the vaccine at the same time as the first clinical at risk groups as they are at increased risk of infection and of transmitting that infection to susceptible service users. Further details are found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_104267 and the 2009/2010

The vaccination programme details are available at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_107169

<http://www.dh.gov.uk/en/Publichealth/Flu/Swineflu/InformationandGuidance/Vaccinationprogramme/index.htm>

- 3.34 For the H1N1 vaccine, frontline staff include staff who have regular clinical contact with patients and who are directly involved in patient care. This includes doctors, dentists, midwives and nurses, paramedics and ambulance drivers, occupational therapists, physiotherapists and radiographers. Students and trainees in these disciplines and volunteers who are working with patients must also be included.
- 3.35 Seasonal influenza immunisation helps to prevent influenza in staff and may also reduce the transmission of influenza to vulnerable patients. Influenza vaccination is therefore recommended for healthcare workers directly involved in patient care, who should be offered influenza immunisation on an annual basis.
- 3.36 Training for staff in delivering vaccinations is available at <http://www.dh.gov.uk/en/Publichealth/Flu/Swineflu/InformationandGuidance/index.htm>

Actions

Encourage the uptake of seasonal and H1N1 flu jabs for all frontline staff.
Identify and encourage the uptake of seasonal and H1N1 flu jabs for all service users in the “at risk” groups.
Ensure that identified staff are trained in the delivery of vaccinations to service users.

Access to clinical skills and clinical support relating to physical health care

- 3.37 Although the H1N1 virus appears to be relatively mild, it could still place significant strain on healthcare services. At the peak of the pandemic, it is possible that mental health inpatient and residential care services will be unable to immediately transfer service users who have increased physical health needs to acute trusts. This would occur because of increased demand for local acute medical services. This does not mean that mental health service users will not be able to access acute care. However, organisations need to be aware of the pressures on their local acute services, which may affect the normal access routes to acute care for their service users.
- 3.38 Furthermore, access to primary care could also be limited, and mental health services may be required to care for service users who are suffering from H1N1 and its possible complications. They may also be required to deal with service users in the community or in hospital with other physical health needs that arise during this H1N1 pandemic, which would ordinarily have required referral or transfer to another healthcare facility.
- 3.39 Psychiatrists, trainee psychiatrists, registered mental health nurses (RMNs) and other staff may need to work outside or extend their normal roles, although they will need to continue to work within their scope of competence and receive adequate training and supervision. Mental health and other relevant trusts should consult the guidelines *Pandemic H1N1 2009 influenza: clinical management guidelines for adults and children*

available at

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

Staff should regularly check the Swine Flu website on

<http://www.dh.gov.uk/en/Publichealth/Flu/Swineflu/index.htm> as the website provides the most up to date H1N1 information.

- 3.40 Training should consist of both basic and enhanced skills training. For training at a basic level, trusts should be training staff in recognising and managing common healthcare emergencies. In particular, staff should have had training in diagnosing and managing H1N1 and the methods for limiting its spread. All professional staff in mental health services are likely to require update and refresher courses in basic physical healthcare, including assessment and examination techniques, common complications of H1N1, hand washing and infection control skills.
- 3.41 Trusts will need to ensure that they have identified the risks associated with increasing the numbers of people nursed within their facilities and have addressed these. For example, there may be greater potential for ligature points to be available or scope for self-harm due to facilities, equipment or consumables. It is recognised that influenza could provoke depression, which can complicate the risk assessment and treatment of some service users. All service users will need to continue to have thorough risk assessments based on their clinical presentation.
- 3.42 here are guidance, tools and exercises available to support organisations and some of these are listed below:

Managing Demand and Capacity in healthcare organisations available at

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

Guidance on managing an influenza-like illness in care homes is available

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105362

Actions

Identify staff that have the skills needed to carry out enhanced physical health care e.g. venepuncture, management of IVs including administration of antibiotics and any associated training issues.
Ensure that there is a competency based skills assessment for all staff who will be carrying out physical health care interventions with service users.
Ensure there are clinical on call systems in place 24/7 in order that staff can access a senior clinician for advice on care and treatment of a service user with H1N1.
Ensure there are robust and flexible plans in place to respond to the potential increase in service users who may need interventions for their physical health

due to H1N1 e.g. how to use staff resources, use of facilities and management of equipment.
Ensure there are systems in place to access equipment needed to provide health care to an increased number of service users e.g. IV cannulas, IV fluids and giving sets, oxygen cylinders and masks, nebulisers and medicines, gloves and aprons.
Ensure there are systems in place to manage the increase need for linen, increase in clinical and non-clinical waste and increase in the consumption of food and beverages.
Establish links with acute trusts to support training and decision making on the physical assessment of service users.
Ensure there are robust and flexible systems in place for managing bed capacity and admissions in inpatient care for those service users with and without H1N1.
Address risks associated with caring for more people in facilities.

Infection control

- 3.43 Infection control measures are of the utmost importance. This is especially so when it is not possible to move those people whose behaviour is seriously challenging to other settings. In many units, service users have their own rooms, and decisions to instigate further isolation may need to be taken. The separation of service users with the symptoms of H1N1 from service users who are non-symptomatic should be carried out as far as possible.
- 3.42 Admissions during a pandemic may also have to be restricted to essential admissions (i.e. those on Mental Health Act section or considered to be at high risk). With regard to visitors, there should be visiting policies that help to contain the spread of the virus. Visiting should be reduced as much as possible, other than for those people for whom a visit is essential or required by law. It is advisable to avoid transportation as far as possible once people have contracted the virus. Infection control guidance is available at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080771

Actions

- | |
|---|
| <ul style="list-style-type: none"> Staff will require access to personal protective equipment (PPE) and additional training in infection control and hygiene matters. Collaboration with PCTs, acute trusts and local authorities may be necessary to determine access to stockpiles of PPE. |
| <ul style="list-style-type: none"> As previously stated, general nursing and physical health skills |

will be required of staff.
<ul style="list-style-type: none">• Review visiting policies and ensure service users and carers are aware of any changes to visiting times.

Workforce Management and support

- 3.45 The NHS has a long history of responding effectively to emergencies and major incidents and staff are renowned for their resilience and resourcefulness under pressure. The expectation is that the NHS, including its mental health services and their staff, will respond in this way during the pandemic. However, there may be a number of staff who find the experience overwhelming. They will need support.
- 3.46 A workforce that is well-informed and trained is more likely to be able to respond to the additional pressures and challenges arising during a pandemic. Infection control and occupational health should work together to ensure that staff education about H1N1, including information about PPE, vaccines and antiviral drugs, is available.
- 3.47 *Pandemic Influenza: Psychosocial care for NHS staff during an influenza pandemic* provides best practice guidance about: (a) sustaining the psychosocial resilience of the staff; and (b) providing more substantial support and interventions for those staff members who need them. It presents an evidence-informed and values-based approach that takes the psychosocial resilience of persons and the collective psychosocial resilience of teams as the anticipated responses, but not as inevitable. It provides:
- background information on the strain that some staff may experience;
 - guidance on developing people's personal resilience and the collective resilience of teams before events occur, and for supporting their resilience during the course of a pandemic and afterwards;
 - a six level stepped model for the preparing, supporting and caring for staff.

This guidance is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103168

- 3.48 The attention of chief executives, medical directors and organisational development and workforce directors of mental health trusts is drawn to Figure 2 on page 7 of that guidance: it provides actions for senior managers to support and monitor implementation of the guidance.
- 3.49 Training is necessary for all staff in relation to the recognition of H1N1 symptoms and infection control measures. Early detection and treatment of staff and service users presenting with H1N1 symptoms will be essential to prevent the spread of infection to other members of the team. *Guidance for pandemic influenza: infection control in hospitals and primary care settings* is helpful regarding the use of PPE, the deployment of staff who have been exposed to H1N1 and the staffing of units where service users are particularly vulnerable to the effects and complications of H1N1.
- 3.50 Appropriate training for working in settings or roles that are different from usual will be required. Plans should be in place to ensure that staff that are redeployed to work in areas beyond their normal field of expertise have appropriate supervision. The wider

health and safety needs of all staff are to be considered, especially where they are redeployed and working in unfamiliar roles/areas. See the *Pandemic influenza: Human resources guidance for the NHS* for further advice on redeployment issues. Updated workforce guidance is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106389

Information for staff who are pregnant or in other at-risk groups is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107646

Staffing and staff capacity

- 3.51 According to the current guidance for planners, up to 5% of staff could be absent in the peak weeks of a pandemic which could last for 2 weeks. Absence is likely to be seven to ten working days. A proportion of staff may be absent due to their caring responsibilities, bereavement and other psychosocial impacts; practical difficulties in getting to work; or problems with childcare. However, there will still need to be sufficient staff available to run essential mental health services and having plans to maximise the use of available staffing levels should be a key focus for the H1N1 flu response.
- 3.52 Staff will fall into the following groups:
- those performing tasks that will be essential during a pandemic (clinical and non-clinical)
 - those performing tasks that will be non-essential during a pandemic (clinical and non-clinical)
 - managerial
 - voluntary
 - external contractors
 - other reserve staff pools (retired, etc).

Key elements to consider in relation to managing and deployment of these staff groups are:

- normal operational staffing levels
- the minimum staffing levels required to maintain a satisfactory level of care
- the current management of sick leave and other staff absences from work
- the ethical and professional obligations of staff during a H1N1 pandemic, contracted hours and the European Working Time Directive (EWTD)
- occupational health
- health and safety
- restriction of deployment of potentially infected staff, reserve staff and volunteers
- regulatory issues
- indemnity
- certification
- Criminal Records Bureau (CRB) assessment of all staff, including volunteers.

- 3.53 Employers may need to draw on a range of sources to supplement existing staff in the case of absence. Extra staff could come from workers who have recently retired, local students or trainees in the sector, local voluntary or faith groups and staff working in non-essential services.
- 3.54 When using temporary staff or deploying currently employed staff to help keep core services running, consideration will need to be given to the roles in which they can be employed, the training and supervision requirements associated with this and how these requirements would be delivered in an emergency situation. Arrangements for travel to work and childcare will also need to be considered if local schools close and transport links are affected.
- 3.55 All staff may need to review the way they work during a pandemic, with a view to them becoming more flexible, as regular duties may be altered to take account of service priorities. Administrative staff may have to work from home or may be transferred to other duties. Clinical staff with desk or administrative duties may be moved to other care environments. Risks to staff and service users should be mitigated where possible. For example, staff at high risk of H1N1 complications (eg pregnant women or those who have pre-existing respiratory disease) may need to be redeployed to roles in which they are not directly exposed to people with the symptoms of H1N1.
- 3.56 In order to reduce the impact of an H1N1 pandemic on staffing levels, mental health and other relevant trusts should consider the steps needed to ensure that employees who are ill or think they are ill with H1N1 are positively encouraged not to come into work. There should be information available for staff on the signs and symptoms of H1N1 infection. If a staff member becomes unwell at work, they must be sent home immediately. Staff can access information on swine flu at NHS Choices. Once staff have recovered from the symptoms of H1N1, it may be appropriate to use these staff to look after service users with the symptoms of H1N1, provided the health and safety needs of such staff are taken into account. It is important that all staff continue to use appropriate PPE when dealing with service users with flu symptoms.

Actions

Ensure your organisation has implemented the recommendations from the Psychosocial Resilience guidance published in July 2009.
Have robust and flexible systems to continue with individual and group staff supervision and appraisal.
Staff capacity may be reduced due to staff sickness and absence for other reasons, and staff may have to be redeployed. Flexible rotas and changes to staff shifts may need to be introduced and workload prioritised. When required, non-emergency activities could be suspended in order to free up capacity and staff.
Disruption to transport links may affect staff members' journeys to work, and could prevent them from returning home. It may be necessary to provide areas of rest and refreshment facilities and the

means for staff to maintain contact with their families. When planning, the geographical areas where staff live should be identified and, if possible, accommodation for staff identified where they are unable to travel to and from home.

Implications for the Mental Health Act 1983

3.57 It is important that steps are taken to enable mental health services to deal with potential increased staff shortages at the peak of a pandemic whilst maintaining the safeguards for patients in the Mental Health Act 1983 (the 1983 Act). In particular, there is a need to ensure that the 1983 Act can continue to be used to detain and treat people, where it is necessary. There has recently been a consultation on potential temporary changes to the Act, which might be introduced, if necessary, in a pandemic. It is however, now looking increasingly unlikely that there will be a need to introduce any of the consultation proposals in order to cope with the current swine flu pandemic. However, the situation will continued to be kept under review.

The main proposals were:

- A temporary change so that, where an application has been made by an approved mental health professional (AMHP), a person may be detained under section 2 or 3 on the recommendation of one section 12 approved doctor without need for a second doctor's agreement.
- Suspending the requirement for a second opinion appointed doctor (SOAD) to approve the medication given without consent to someone detained in hospital after a period of three months.
- Suspending the requirement for a SOAD to approve medication given to someone on supervised community treatment (SCT) after one month.
- That Strategic Health Authorities (SHA's) should be able to approve certain former responsible medical officers to undertake the role of the approved clinician without following the full normal approval process.
- That SHA's should also be able to approve current section 12 approved doctors to be approved clinicians.
- That local social services should be able to approve certain former approved social workers (ASWs) who have maintained their registration as social workers with the General Social Care Council to undertake the role of the approved mental health professional (AMHP) without following the full the normal approval process.

3.58 The consultation ran from September to October 2009. We are considering the comments and aim to publish a response to the consultation later this year.

3.59 Were they to be adopted, successful implementation of some of the consultation proposals would require some pre-planning. For example, suitable people would need to

be “sounded out” about the possibility of acting as temporary approved clinicians and AMHPs. Those identified would probably need refresher briefing or training that they may find helpful. It would be prudent to be prepared to implement any such temporary changes in the law to cope with any sustained future emergencies.

Mental Capacity Act

3. 60 It is essential that the usual consent procedures be followed when service users, who may not have capacity to consent to treatment, need H1N1-related medicines. All practitioners should follow the law on consent in the Mental Capacity Act 2005 and its Code of Practice, including the use of common law. This can be found at http://www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/YourRightsInHealth/DG_10016888

3.61 The Mental Capacity Act 2005 gives the right to make lasting powers of attorney (LPA) which enable other identified persons to make decisions on the service user’s behalf if they are unable to do so (unless the treatment is covered by mental health legislation). Should a service user have made an LPA, the attorney would need to be consulted about the person’s treatment. This consultation may be affected if the LPA is affected by H1N1 and contingency plans will need to be in place to meet this potential need.

Safeguarding adults and children processes and procedures

3.62 All organisations have a legal duty to provide services that protect the rights, and support the needs, of vulnerable adults and children. It is essential that these services are identified as “core business” and systems are in place to protect the continuity of these services in a pandemic.

Action

Ensure Safeguarding services are identified as “core business” and discussions with relevant PCTs have taken place to identify and implement service continuity plans

Maintenance of access to medicines

3.63 Similar to people suffering from other conditions such as diabetes, users of mental health services who rely on medicines as part of their care and treatment will need to continue to take these medicines throughout the H1N1 pandemic.

3.64 Continuing access to medicines requires a local response. PCTs should coordinate access to pharmacy provision and include the requirements of people who use mental health medicines in their planning. These plans should incorporate the possibility that some community pharmacies will close due to staff absences and the fact that the

global distribution chain may be interrupted. In areas where there is one mental health trust but a number of PCTs, the mental health trust should have liaised with each individual PCT to ensure standardisation of policies across the area with regard to maintaining supplies of a selected range of medicines during a pandemic.

- 3.65 There are certain drugs that may require additional contingency planning. For example, there may be problems regarding **Clozapine**, which is used to treat schizophrenia. This treatment may reduce white blood cell count, and regular monitoring is required. The MHRA have stated that the Clozapine licences will not change and therefore it will be for individual trusts to decide on whether or not they will safely reduce monitoring requirements based on their own resources.
- 3.66 Access to phlebotomy and laboratories could be affected by staff absences. Mental health and other relevant trusts should identify in their plans those commonly prescribed drugs that require additional contingency planning with a view to putting in place arrangements to ensure their safe continuing availability and usage during this pandemic.

Continuity of Care

- 3.67 During a pandemic, people with mental health problems will continue to rely on mental health services, including existing service users and those who become ill during the pandemic, irrespective of whether or not they have H1N1 infection. There will be a group of people whose care will have to be delivered differently due to staff absences or other impacts of this H1N1 pandemic. It may be difficult to sustain certain people on intensive care packages in the community during some periods of the pandemic. Eligibility criteria for care during a pandemic should be transparent and applied in a consistent and equitable way that reserves capacity for those in greatest need.
- 3.68 In primary care, essential primary mental healthcare must continue to be provided. Many vulnerable people are treated within the community, and it is imperative that they receive support throughout the duration of the pandemic. Community mental health practitioners have an important role as service users' advocates to primary care services. Since primary care could be severely depleted, roles as advocates may need to be balanced against the needs of essential mental health services. Alternative arrangements for advocacy, such as using current volunteers or befriending systems, should be made.
- 3.69 People with severe mental illness and/or learning disabilities have high rates of physical morbidity and are at risk of social exclusion and discrimination. Crises need to be anticipated and prevented and, if a crisis does occur, the service users involved require prompt and effective help. This includes timely access to appropriate and safe mental health placements or hospital beds that are as close to home as possible and it is important that these needs are documented in a person's care plan.
- 3.70 A large number of service users rely on family members or friends for daily support and care. These informal carers or caregivers are a vitally important group within mental healthcare. Mental health and other relevant trusts should identify the carers within their areas who are looking after service users who are most at risk or dependent on

continuing care and make contingency plans now to ensure continuity of care. Caregivers will be trying to cope during the pandemic and will require support. Provision of information to informal carers on how they can both protect themselves from contracting H1N1 and support/care for a service user with H1N1 infection is critical. This includes advice on what to expect and what to do in this outbreak, how certain services should be accessed, and hygiene and infection control measures.

- 3.71 It is likely that there will be an increase in demand for emergency short-term care for service users if informal carers fall ill. This will be a difficult challenge during a time when bed capacity and staffing are limited. Mental health and other relevant trusts should liaise with local authorities to plan and prioritise how they may meet this increased demand, with a view to people remaining in their own homes with support if possible. Crisis and contingency care plans will need to be updated with key information (eg what particular service users like to eat, medicines, allergies, etc). This will help enable straightforward passing of care from carer to health professional, or between health professionals, should the need arise.

Community and crisis services

- 3.72 When implementing plans for this pandemic, it is necessary to identify those individuals who are at risk of their care being disrupted and those who may increase their demand or use of the services at a time when the services are already strained. Robust risk assessments will need to be undertaken as part of the assessment process.
- 3.73 During this pandemic, each aspect of the service will have an enhanced role in ensuring that essential health and support services are provided and are in place for service users. Examples of these include:
- work resulting from the earlier discharge of service users from inpatient and residential settings, and the corresponding additional support needs of those service users
 - supporting emergency departments in assessing service users who present there and who require mental health services
 - working closely with GP practices, community pharmacists, social services departments and other services as appropriate, to identify the long-term support requirements of those caught up in the pandemic and their family and friends, and arranging for onward referral into mainstream services, if needed.
- 3.74 Community Mental Health and Crisis (CMHT) teams will need to prioritise their work according to volume of demand, urgency of need and staff availability. Flexibility in work and practices will be required. The capability of systems to share information on caseloads and priorities between the staff of different CMHTs and other services and the robustness of these systems should have been tested.
- 3.75 As far as possible, teams should try to ensure that care packages continue during the pandemic, despite potential staff sickness in the different agencies involved. Teams should work with social care teams in identifying any vulnerable service user groups who may be at risk of not receiving a service during the pandemic. Using the Care Programme Approach (CPA) process, information on the different services and

agencies involved in meeting each person's needs should be communicated between the organisations. This can help to identify those service users who are vulnerable to services being reduced or to staff absences. Carers are as likely as the rest of the population to contract H1N1 or develop other illnesses. Sickness amongst carers will leave some service users without their normal level of care at home.

- 3.76 Individual CMHTs may be at risk of not maintaining their current frequency of contacts with service users, particularly because of staff absences, and teams should have considered how they would deliver services in different ways, including merging teams and prioritising which service users receive home visits. For example, it may be possible to carry out assessments over the phone for non-priority cases or if a service user is known to have symptoms of H1N1. In addition, an assessment of the frequency with which support and interventions need to be offered to individual service users and how these can be altered, depending on available staff, could be considered and a management plan prepared.
- 3.77 Planning should have also explored the possibility of social care services and third sector organisations supporting the delivery of care. CMHTs must aid their service users in taking appropriate precautions against infection and provide advice on self-care should they develop the symptoms of H1N1 infection.
- 3.78 Intensive home treatment services have been developed to enable more people to be cared for in the community and to avoid admission to hospital. The risks to these services need to be considered given that a reduction in their activity could result in increased pressure to admit people to hospital.
- 3.79 Other Organisational and Service User issues
- Where inpatient beds are located in acute hospitals, mental health trusts should link with acute trusts to address the particular needs of the service users of the mental health service. For example, there may be an issue around providing secure accommodation, or acute trusts may be under pressure to close wards in order to use the beds for other service users.
 - Discharging service users from general inpatient wards to the community may be difficult during an H1N1 pandemic. It will be necessary to evaluate the risk of discharge to the service user and to others compared with the risks of catching H1N1 if remaining as inpatients and any loss of liberty that might be involved. This would include assessing the level of support at home for those who are ready to be discharged, and the capacity of community services to provide care when their workloads may have already been increased by the H1N1 pandemic.
 - Forensic services (low, medium and high security) pose an additional management challenge in that some service users are on restriction orders imposed under mental health legislation (administered by the Ministry of Justice). Court appearances and procedures may be affected. Services should have guidelines and protocols in place for the transfer for service users to acute medical care and the impact that will have on staffing numbers.
 - During a pandemic, prison inmates may develop mental illness and be moved to a high-security unit for a period. There could be a problem with discharging the

prisoners back to prison if H1N1 has broken out in the prison or if the prisoner has developed H1N1-like symptoms. Mental health trusts should liaise with prisons when deciding a course of action if this situation arises.

The role of third sector organisations

- 3.80 The third sector may be able to help support the response to the H1N1 pandemic at a local level. Mental health trusts, along with local authorities and PCTs, will need to consider how to involve voluntary organisations in their area with whom they do not usually have business arrangements.
- 3.81 Mental health and other relevant trusts should have identified local third sector groups in advance. Some third sector groups provide helplines, and it is important that the messages these groups put out are consistent with the National Pandemic Flu Service. Closer ways of working and the enhanced role of the third in providing services alongside mental health trusts during a pandemic should have been agreed. Additionally, there should be agreement on what roles any volunteers could undertake. CRB checks on volunteer and temporary staff will need to be carried out and these staff will need to be aware of the organisation's policies on confidentiality and information sharing.

Tertiary/Specialist Services

- 3.82 Mental Health organisations can offer services to people across the UK and internationally. In this H1N1 pandemic, services will need to have robust continuity plans in place that consider the impact of the pandemic in their region so that they can manage the access to services for services users from other parts of the country or abroad. If services sit in a "hot spot" for H1N1, there will need to be a discussion of the risk in bringing new service users into this environment. The same discussions will need to occur if sending service users to another part of the country, which is also a "hot spot" for the H1N1 virus.
- 3.83 It is important that referrers have access to expert clinical and management advice if admissions to tertiary services are delayed and this can be done by the use of teleconference, telemedicine and videoconference facilities if available.
- 3.84 The following services will need to have plans in place to meet the individual needs of their service users and carers:
- Mental health services for mothers and their babies
 - Mental health and learning disability services
 - Substance misuse services
 - Eating disorder services
 - Specialist outpatient teams

- CAMHS services
- Psychological medicine and anxiety disorders services
- Forensic services
- Any other tertiary or specialist service

CAMHS and Mother and Baby inpatient services may find the attached link to a training module for staff working with children useful.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104962

Recovery

- 3.85 Whilst the first priority at the end of the first wave would have been to develop recovery plans and restore mental health services to their original capacities; plans must assume that some regrouping may be necessary in anticipation of future waves. Ongoing constraints on supplies and services may also continue to place pressure on mental health services. Second or subsequent waves may be more or less severe than the first wave.
- 3.86 Although the objective is to return to pre-pandemic levels of functioning as soon as possible, the pace of recovery will depend on a number of factors, including demand for services, backlogs, staff and organisational fatigue and supply difficulties. Therefore, a gradual return to normality should be anticipated and expectations shaped accordingly. Trust plans should recognise the potential need to prioritise the restoration of services and to phase the return to normality in a managed and sustainable way.
- 3.87 Mental health services may experience persistent secondary effects for some time. There may be increased demand for continuing care from people such as:
- service users whose existing illnesses have been exacerbated by H1N1 (eg people with severe learning disabilities may be particularly vulnerable to the secondary effects of H1N1)
 - Those people who suffer from underlying medium- or long-term health complications.
- 3.88 In addition, there may be a backlog of work resulting from the postponement of treatment for less urgent conditions.
- 3.89 Most staff will have been working under pressure for prolonged periods and are likely to require rest and continuing support. Facilities and essential supplies may also be depleted and resupply difficulties might persist. Impact assessments will therefore be required.

Appendix 1- Overview of Actions

1. Appoint a full time director level lead dedicated to flu preparedness and resilience with immediate effect. This can be a single individual or shared between directors but must provide visible, full-time, senior leadership and ensure a well-resourced team on this issue through the months ahead.
2. Stress-test your pandemic preparedness plans to ensure that the provision of high quality care to flu and non-flu patients now and during a second, sustained wave of up to five months can be sustained. (i.e. tested through exercises)
3. Understand and test capacity constraints that may be caused through increased demand and workforce sickness absence. This includes but is not limited to those clinical areas that are likely to face most flu-related pressures. Recent ' <i>Pandemic Flu: Managing Demand and Capacity in Health Care Organisations (surge)</i> ' guidance and the NHS Employers/ Department of Health document ' <i>Pandemic Influenza Human Resources Guidance for the NHS</i> ' will help with this work.
4. Engage in discussion with Trade Unions about a staff vaccination programme and wider communications to and support for staff.
5. Build on existing relationships with local partner agencies to ensure that their role, channels of communication and ways of working during any second, sustained wave are clear.
6. Ensure that there is H1N1 information available for Service users, carers and staff on the signs and symptoms of the flu and access to treatment.
7. Ensure that the information is available in all inpatient and community services in formats and languages that meet the needs of the local community
8. Ensure all areas have "Catch it, Bin it, Kill it" posters
9. Ensure that all areas have tissues and hand hygiene gel and each member of staff has an individual hand hygiene gel
10. Ensure each inpatient services patient education programme includes a session on respiratory hand hygiene and H1N1 symptoms and treatment.
11. Ensure all staff understand the process for accessing antivirals for their service users and service users know how to access antivirals for themselves via the NPFS.
12. Ensure all service users have an identified Flu Friend if they are unable to identify one for themselves. This flu friend may need to be a member of staff and their details need to be in the service users care plan.
13. Ensure there is a system in place for service users to report to their community or inpatient team if they have accessed antivirals from the NPFS

14. Encourage the uptake of seasonal and H1N1 flu jabs for all frontline staff.
15. Identify and encourage the uptake of seasonal and H1N1 flu jabs for all service users in the “at risk “groups.
16. Ensure that identified staff are trained in the delivery of vaccinations to service users.
17. Identify the staff that have the skills needed to carry out enhance physical health care e.g. venepuncture, management of IV's, administration of antivirals and antibiotics and any associated training issues.
18. Ensure that there is a competency based skills assessment for all staff who will be carrying out physical health care interventions with service users.
19. Ensure there are clinical on call systems in place 24/7 in order that staff can access a senior clinician for advice on care and treatment of a service user with H1N1.
20. Ensure there are robust and flexible plans in place to respond to the potential increase in service users who may need interventions for their physical health due to H1N1 e.g. how to use staff resources, use of facilities and management of equipment.
21. Ensure there are systems in place to access equipment needed to provide health care to an increased number of service users e.g. IV cannulas, IV fluids and giving sets, Oxygen cylinders and masks, nebulisers and medicines, gloves and aprons
22. Ensure there are systems in place to manage the increase need for linen, increase in clinical and non-clinical waste and increase in the consumption of food and beverages.
23. Establish links with Acute trusts to support training and decision making on the physical assessment of service users
24. Ensure there are robust and flexible systems in place for managing bed capacity and admissions in inpatient care for those service users with and without H1N1.
25. Address risks associated with nursing more people in facilities
26. Staff will require access to personal protective equipment (PPE) and additional training in infection control and hygiene matters. Collaboration with PCTs, acute trusts and local authorities may be necessary to determine access to stockpiles of PPE.
27. As previously stated, general nursing and physical health skills will be required of staff.
28. Review visiting policies and ensure service users and carers are aware of any changes to visiting times and infection control regimes.
29. Ensure your organisation has implemented the recommendations from the Psychosocial Resilience guidance published in July 2009.

30. Have robust and flexible systems to continue with individual and group staff supervision and appraisal.
31. Staff capacity will be reduced due to staff sickness and absence for other reasons, and staff may have to be redeployed. Flexible rotas and changes to staff shifts may need to be introduced and workload prioritised. When required, non-emergency activities could be suspended in order to free up capacity and staff.
32. Disruption to transport links may affect staff members' journeys to work, and could prevent them from returning home. It may be necessary to provide areas of rest and refreshment facilities and the means for staff to maintain contact with their families. When planning, the geographical areas where staff live should be identified and, if possible, accommodation for staff identified where they are unable to travel to and from home.
33. Ensure Safeguarding services are identified as "core business" and discussions with relevant PCTs have taken place to identify and implement service continuity plans