Department of Health

Pandemic influenza

Guidance on planning for vulnerable groups

DRAFT FOR COMMENT

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/ Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
Document Purpose	Draft for Comment
Gateway Reference	10283
Title	Pandemic influenza: Guidance for Planning for Vulnerable Groups
Author	DH
Publication Date	06 Aug 2008
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads
Circulation List	Voluntary Organisations/NDPBs
Description	This guidance is to aid organisations in their planning for vulnerable groups in the event of a Pandemic Flu. This is a draft document and there is a list of questions that need to be considered. The document will be out for consultation until 30th September 2008.
Cross Ref	Pandemic Flu: A national framework for responding to an influenza pandemic
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
Contact Details	The Pandemic Influenza Preparedness Team Department of Health 452C Skipton House 80 London Road London SE1 6LH Email: pandemicflu@dh.gsi.gov.uk
For Recipient's Use	

Invitation to comment

The UK's plans for responding to an influenza pandemic are set out in *Pandemic Flu: A national framework for responding to an influenza pandemic*.

To assist responders in developing their local plans further this draft guidance has been produced with the participation and advice of subject experts and representatives from key stakeholder groups.

We are seeking wider comments on this draft and would particularly welcome views and contributions from those individuals and organisations involved in pandemic influenza planning and preparedness. These will be collated and analysed in depth and used to inform final guidance on this issue, which will be available on the DH website in due course.

We would be grateful for your comments by **30th September 2008**.

Please send your comments and feedback to our dedicated email address: **pandemicfluguidance@dh.gsi.gov.uk**

Or in writing to: The Pandemic Influenza Preparedness Team

Department of Health
452C Skipton House
80 London Road
London SE1 6LH

More information on pandemic influenza is available at: www.dh.gov.uk/pandemicflu

Pandemic influenza

Guidance on planning for vulnerable groups

Contents

1 Introduction

Context

1.1 Influenza pandemics are natural phenomena, which occurred three times in the last century. Pandemics arise when a new influenza virus emerges and spreads rapidly across the world with widespread epidemics in countries. Severity of a pandemic varies but in the last century, there were three pandemics: the 'Spanish flu' of 1918–19, in which 20–40 million people worldwide died (with peak mortality rates in people aged 20–45), the 'Asian flu' of 1957–58 and the 'Hong Kong flu' of 1968–69. While the later pandemics were much less severe, they also caused significant illness levels (mainly in the young and old) and an estimated 1–4 million deaths each.

1.2 Another pandemic is highly likely to occur. However, there is uncertainty about the timing and the impact. This uncertainty poses a challenge to planners and providers but by having premptive, coordinated and robust plans in place, the impact of a pandemic can be reduced and recovery of services hastened.

1.3 Planning for pandemic influenza for health services, local authorities and their partners entails business contingency and changes to the provision of services. This will have an impact upon the population they serve. In particular, there is a range of people susceptible to changes within these services and it is likely that they will be even more vulnerable during a pandemic. These groups should be identified early in the planning stages so that their needs can be taken into account when developing local arrangements for the provision of health and social care in the community setting.

1.4 For the purpose of this guidance, 'vulnerable groups' is being used as a collective term for a wide range of individuals who face particular disadvantage in accessing mainstream public services, including NHS and social care. The Government's Social Exclusion Unit identified six groups in society that are vulnerable:

- disabled people and those with long term health conditions
- people belonging to some ethnic minority groups
- excluded older people
- younger people with complex needs
- people with low levels of literacy
- disadvantaged people who move frequently.

However, in relation to pandemic flu, the term 'vulnerable' can be extended to mean anyone who is at a particularly high risk of suffering severe consequences from a flu pandemic. Examples include people who are socially or geographically isolated or who cannot afford to stay home from work for even a short period of time. Some vulnerable groups are permanently vulnerable whilst others will be temporarily vulnerable either due to pandemic flu or during the period in which it takes place.

Purpose

1.5 The purpose of this guidance is to emphasise the inclusion of vulnerable groups in the pandemic flu plans by primary care organisations and their partners such as local authorities and the voluntary sector.

1.6 All plans for an influenza pandemic should be sensitive to the needs of local populations, including population demographics, ethnic and cultural backgrounds and geographic dispersion of residents. This is important for communications and access to services and treatment. The consideration of the presence of vulnerable groups and individuals in the population is essential to good pandemic flu plans.

1.7 In advance of a flu pandemic, PCT Pandemic Influenza Planning Committees and Local Resilience Forums should:

- identify the individuals and groups who are potentially 'at risk'
- establish their needs
- develop systems to ensure continuity of care.

Please refer to Cabinet Office guidance *Identifying people who are vulnerable in a crisis* available at www.ukresilience.gov.uk

1.8 This planning for vulnerable groups guidance consists of general contingency advice for planners. It is not intended to prescribe detailed operational guidance for responding to an influenza pandemic. Instead, this document provides a national approach, setting out the key planning assumptions, roles and responsibilities that can inform the development of local plans.

1.9 The arrangements described do not cover planning for or the response to seasonal influenza outbreaks, avian influenza (eg A/H5N1) or any other animal influenza infection. Planners should be aware that the information available on pandemic influenza can change rapidly. Guidance is therefore continually being revised. Planners should ensure that their plans reflect the principles underpinning the latest information.

1.10 General planning principles should apply across the spectrum of groups that are classified as vulnerable. There are groups who are already receiving specialist services, eg individuals with substance misuse problems, disabled people, children and older people. Where specialist services are provided for such groups, efforts should be made to continue the services for as long as possible during a pandemic. Given the uncertainty about the effects of a pandemic, some flexibility in planning and responding is expected.

1.11 The emphasis throughout the document is on the identification of local vulnerable groups and their needs and on maintaining their access to services throughout the pandemic phase. For any one group of service users, there may be a number of providers and these partners must work together. Furthermore, *Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England* focuses on the provision of healthcare within the community setting. In particular, the guidance advocates supporting the public to self care and enabling symptomatic patients to access care from their own home as far as possible.

1.12 This guidance on planning for vulnerable groups is supplementary to *Pandemic flu: A national framework for responding to an influenza pandemic*, and should be read in conjunction with it and other national guidance on pandemic influenza planning. These can be found at www.dh.gov.uk/pandemicflu and include the following:

- *Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England*
- *An operational and strategic framework: Planning for pandemic influenza in adult social care*
- *Pandemic influenza: Guidance on preparing mental health services in England*
- *Pandemic influenza: Guidance on preparing acute hospitals in England*
- *Pandemic influenza: Guidance for ambulance services and their staff in England*
- *Pandemic influenza: Human resources guidance for the NHS* (forthcoming)
- *Responding to pandemic influenza: The ethical framework for policy and planning*
- *Pandemic influenza: Guidance for infection control in hospitals and primary care settings.*

Objectives

1.13 The main objectives of this framework are as follows:

- to prevent vulnerable groups from being discriminated against or socially excluded during a pandemic
- to encourage the inclusion of vulnerable groups in the development of effective and resilient local response plans to an influenza pandemic
- to minimise the impact of pandemic flu on vulnerable groups known to health and social services
- to minimise the impact of pandemic flu on individuals who become vulnerable due to a flu pandemic
- to minimise the impact of health and social services' business contingency plans on vulnerable groups
- to ensure access to health and social care during a flu pandemic for vulnerable groups
- to promote partnership working and integrated local response plans, eg with social and primary care services.

Audience

1.14 This guidance is primarily intended for those preparing primary care trusts, local authorities, mental health services and voluntary organisations for a flu pandemic. It is also of relevance to staff and providers of ambulance trusts and acute trusts. Additionally, it will be of interest to other stakeholders, including community pharmacies, NHS Direct, carers associations, faith and community groups and providers of out-of-hours and unscheduled care.

1.15 This guidance is for England only. Parallel guidance will be issued by the Scottish Government, the Welsh Assembly Government and the Department of Health, Social Services and Public Safety, Northern Ireland. While there may be some differences in operational approach and organisational responsibilities, all four health departments work closely to ensure a consistent approach wherever possible.

2 Planning assumptions

Definition of vulnerable groups

2.1 In the context of pandemic flu planning, the term 'vulnerable groups' refers to groups or individuals who either become vulnerable due to a flu pandemic or have a condition or mitigating circumstances that would make them more vulnerable during a flu pandemic. The definition of 'vulnerable' is taken from the Civil Contingencies Act 2004, which states that vulnerable people are those 'who are less able to help themselves in the circumstances of an emergency' and should 'be given special consideration in plans'. Taking this definition of vulnerability, vulnerable groups for pandemic flu planning can fall into four main categories:

- pre-identified vulnerable groups
- 'known' vulnerable individuals
- 'unknown' vulnerable individuals
- those vulnerable due to pandemic flu.

2.2 **Pre-identified vulnerable groups**

- people with a mobility impairment
- people with a sensory impairment
- people with a mental/cognitive impairment
- non-English speakers, including refugees, asylum seekers and migrant workers
- children
- older people
- people who are homeless, including rough sleepers and people in hostels, night shelters or insecure accommodation such as squats, sleeping in cars, sofa-surfing etc
- gypsy and travelling communities
- people in residential institutions (residential homes, prisons, nursing homes, sheltered accommodation, half-way houses, boarding schools, colleges etc) or who live in other forms of supported accommodation with either residential or floating support

- people whose physical and/or mental health is dependent on taking regular medicines
- people whose good health is dependent on using medical support equipment (oxygen etc)
- people who are clinically at risk
- people with substance misuse problems including those receiving prescribed opiate substitutes for the treatment of addiction.

2.3 'Known' vulnerable individuals

As well as the known vulnerable groups, there may be individuals who are known to the health, local authority or voluntary sector services as being vulnerable, eg:

- people with mobility difficulties, including those with physical disabilities or a medical condition
- people with a sensory impairment (eg visual or hearing difficulties)
- people with mental health disorders or problems
- people who are dependants, eg children
- individuals who live alone and may be isolated from family or other social networks
- people and small communities in isolated or remote areas.

2.4 'Unknown' vulnerable individuals

This category comprises those individuals who are not known to the health services or services of local authorities. These individuals may be reliant on care from friends or relatives or may choose not to be documented, eg visitors to the area or rough sleepers who are hard to reach or unwilling to engage with support. It will also include those who are not registered with a GP.

2.5 Those vulnerable due to pandemic flu

Everybody can become vulnerable due to circumstances or incidents and it is likely that this may happen during a flu pandemic, eg:

- people who are hourly paid or on low income such as migrant or temporary workers, who are more likely not to be paid sick pay than salaried staff
- low paid workers concentrated in jobs where it is harder to work from home

- those on a low income who will be least able to cope with a short period of income loss
- single working parents who may be unable to work due to reduced public transport or having to remain at home to care for children if schools close
- self employed workers or farmers
- university/any students living on campus or in residences in the local community.

The challenge to planners is to determine who these people are and a risk assessment of the impact of pandemic flu on the local population may help guide planners.

Barriers to access

2.6 There is a body of evidence demonstrating that vulnerable groups face barriers in accessing health and social services. This experience varies between groups and individuals. For example, some studies suggest that those of black and minority ethnicity may feel alienated from organisations that seem to stereotype them or treat them insensitively. People from minority ethnic backgrounds have been found to be more likely to have difficulties in physically accessing GPs compared with white people. Another example is that older people who are residents of a nursing or residential home are dependent upon the care in the home and can face barriers to accessing mainstream and specialist NHS services.

2.7 A person's ability to attend health services can depend on several factors, such as language, access to telephones, personal mobility, available transport and childcare. Those living in low socio-economic or deprived areas can have limited support in accessing health and social services. People tend to think of health and social services in terms of accessibility and whether or not they are user-friendly. If someone has to navigate the system by gathering information about what services are available and then find practical resources to help them before they can access care, they are unlikely to do so. There is evidence that homeless people, the gypsy and travelling communities and young people are especially likely to have difficulties in finding help. This can be due to the characteristics of the service or of the client or both.

2.8 In addition, people's access to services can be affected by lack of capacity within local health services. There is also a need to distinguish between provision of health services and use of health services. Some vulnerable groups make high use of emergency departments but make little use of primary care or preventive services. In relation to influenza, there are low uptake rates of influenza vaccine in deprived areas, with the most deprived fifth of PCTs having the lowest uptake among the over 65s.

Impact of pandemic flu on vulnerable groups

2.9 It is difficult to predict the precise impact that an influenza pandemic would have on the UK population. The effect of a pandemic would depend on a number of factors, including the characteristics of the virus, the severity of the illness it causes and its clinical attack rate. However, the impact of an influenza pandemic is likely to be sustained and intense, affecting the whole country. Health and social services will be under tremendous pressure. There will be an increased workload caused by patients with influenza and complications arising from influenza. At the same time, there will be a depletion of the workforce and pool of informal carers. Primary care services will need to deal with large numbers of individuals infected with influenza and because of the parallel pressures on hospital services, there will be more people with acute care needs who will have to be cared for within the community setting. See the *National framework* for further information on the possible severity and extent of an influenza pandemic.

2.10 Although the scale of disruption is unknown, vulnerable groups and individuals are likely to be affected. Where access is already limited, vulnerable individuals may find themselves increasingly isolated, unable to reach medical help for flu or other illnesses. It is likely that there will be a surge in demand for services as previously unregistered individuals seek out primary care or A&E departments in hospitals. This may cause problems for primary care, which will be under tremendous strain. People affected by homelessness, ethnic minority groups and the gypsy and travelling communities may be stigmatised further by associations with influenza. They may be viewed as being 'carriers' and may be scapegoated. Individuals who are already known to the services (eg those with disabilities) may find themselves in situations where their care package is disrupted and may be at further risk if their informal carer falls ill or dies.

Impact of the *National framework* on vulnerable groups

2.11 The *National framework* response to an influenza pandemic relies upon providing care in the community setting. Most health and social care services will need to be delivered outside of hospital settings, which will be reserved for those who are most seriously ill and most likely to benefit. Influenza patients who are unable to access secondary care will need to be cared for in their own home or in a residential setting as far as possible, and where required and appropriate, care will need to be taken to them. Those influenza patients who do not have access to any accommodation may need to have emergency intermediate care arrangements made for them.

2.12 Members of the public will be encouraged to self care and symptomatic patients will be advised to remain in their own homes as far as possible. Advising those who are ill to self care and/or access care from their own home is agreed to be the most practical and effective way of slowing or limiting the spread of infection. Access to antivirals

and treatment will be done via a web based and telephone National Flu Line service. See *Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England* for further information on how the Flu Line will operate. There will be an updated version of the primary care guidance (due out in early autumn 2008) to include best practice examples on ensuring that vulnerable groups have access to antiviral medication in a pandemic.

2.13 Communicating the messages of self care, remaining at home if ill and how to access treatment will be pertinent for vulnerable groups. This will form part of the Department of Health's overall communications strategy for pandemic influenza. Such communication will be difficult, particularly since the vulnerable groups encompass a whole range of individuals. Ensuring access to the Flu Line is another issue in relation to vulnerable groups, as many will not have access to a telephone, may be unable to use a telephone or the web, may not understand the process or may not have a friend to collect the antivirals on their behalf. The emphasis should be on building and developing support networks at a local level in advance of an influenza pandemic. Types of support networks may include:

- informal networks, friends, family and informal carers
- voluntary organisation networks
- community networks, faith and religious groups, community groups and local schemes such as Neighbourhood Watch.

These networks can be tested prior to an influenza pandemic as part of the overall development and regular testing of local resilience plans.

3 Business continuity arrangements for vulnerable groups

Business continuity plans

3.1 A phased approach of immediate and recovery plans is recommended when developing business continuity plans. The aim should be to try to maintain normal services for as long as possible and then activate a proportionate response to the pandemic. Primary care organisations, mental health trusts, social services and voluntary groups should decide early on in the planning process which of their services are considered 'core' or 'essential' and which services could be scaled down or delivered differently during a pandemic. Such decisions should be made using services' business continuity plans and bearing in mind the projected staff absence of up to 50% at some stage during the period of the influenza pandemic. All services should consider the implications of staff absence at a time when workload and pressure on services may be at their highest. Modified models of care should be developed to incorporate staff absences, patient prioritisation and surge management. Business continuity plans should be reviewed, updated and tested regularly. PCTs, social services and their partners should have consistent local policies regarding ways of working.

Please see current guidance from the Cabinet Office on business continuity available at www.ukresilience.gov.uk

3.2 With regard to vulnerable groups, business continuity issues fall into two main categories:

- continuity of existing services for 'known' vulnerable groups
- advance planning for 'unknown' vulnerable groups including provision for possible surge in demand for services.

Both categories will require integrated planning and partnership work and plans should be mindful of staff shortages due to staff sickness or absences. Working practices should be flexible during a pandemic in order to minimise the spread of disease and to continue to provide essential care despite staff shortages.

Identifying and assessing needs of vulnerable groups

3.3 Vulnerable groups experience difficulties in accessing and using health and social services in general. Therefore, pandemic influenza planning for vulnerable groups will require particular considerations so that a safe and appropriate response can be made. This involves:

- identification of vulnerable individuals and groups in the area
- identification of people who are not registered with a GP and developing a means to address this
- identification of sources of good quality reliable information about vulnerable groups/individuals and a means to maintain this
- identification of the barriers to accessing health services in the area and how these can be reduced in the event of a flu pandemic
- identification of the barriers to accessing the Flu Line and a means to address these
- identification of self care issues for some of the groups without secure accommodation or who are isolated within the community for varying reasons and the means to address these
- assessment of the needs of vulnerable groups/individuals
- identification of contacts with vulnerable groups/individuals and a means to build networks and partnerships.

3.4 Identification and assessment of needs should be done prior to an influenza pandemic, ideally in the pre-pandemic stages. This should prevent a reactionist, reductionist approach occurring during the crisis. It may be useful to establish a sub-group of the PCT Pandemic Influenza Planning Committee or Local Resilience Forum for the purposes of identifying people who will be vulnerable during an influenza pandemic. This sub-group would have the responsibility for the process but the overall command and control would fall to the PCT Pandemic Influenza Planning Committee.

3.5 The process of identifying and assessing needs of vulnerable groups entails obtaining and sharing information about these groups. Agreed data sharing procedures should be put into place in the pre-pandemic stage. For the purpose of pandemic flu planning having 'lists of lists' will help. These lists will not be of personal information about individuals but a list of partners and contact numbers that can be used to gather relevant material in the event of a pandemic.

Identifying vulnerable groups

3.6 The first step in including vulnerable groups in pandemic flu plans is to identify those who are at risk of being vulnerable during an influenza pandemic. Since vulnerable groups vary geographically, identification of vulnerable groups should occur at a local level. This should be part of wider emergency planning. Furthermore, good planning for an influenza pandemic should already reflect the needs of the local population.

3.7 When identifying vulnerable groups, it is worth noting that many groups are not homogeneous. An example is those with hearing impairments. The term 'deaf' can refer to people who have dual sensory loss, deafened adults, older people with hearing loss, deaf children, deaf adults who use British Sign Language and multiple disabled deaf people.

3.8 Ascertaining information about vulnerable groups can start with answering the following questions:

- Who do you define as being vulnerable?
- Where are they?
- How many are in this group?
- Who holds the data on these people (eg PCTs, GPs, police, local authorities) and how can we get hold of it?
- What do members of the group have in common?
- Do they meet regularly? If so, where?
- Who do they trust?
- Which organisations could we work with to develop an information network?
- Are there individuals or voluntary groups that we could work with?
- What do vulnerable people need in their daily lives (eg knowledge, communication, assistance, resources)?
- What do vulnerable people need to cope in an emergency, such as pandemic flu (eg information, communication, understanding, mobility, medication, reassurance)?

Assessing needs of vulnerable groups for a flu pandemic

3.9 The most effective way to assess the needs of vulnerable groups during a flu pandemic is to work with those who are in the position to have up-to-date records of individuals and who will be aware of their needs. It is likely that PCTs already hold information on vulnerable groups in their locality. Such information should be reviewed and regularly updated in relation to pandemic influenza.

3.10 Health and social care professionals who are in contact with vulnerable groups (eg community matrons, social workers) are good sources of information. Where possible, members of vulnerable groups should be involved when carrying out an assessment of their needs during a flu pandemic. Some vulnerable groups (eg ethnic minorities) can be readily contacted to assess their needs directly.

3.11 Utilities companies, such as electricity suppliers and water companies, are often useful sources of information about vulnerable groups. For instance, water companies may have details of vulnerable individuals who would be made more vulnerable if their water was turned off. Information of this nature can be elicited in producing the risk register of vulnerable people for pandemic flu planning as long as the information is being utilised only for that purpose.

3.12 A health needs assessment of a sub-population or population group is a common method used by public health specialists and there is plenty of material published on how to conduct a health needs assessment. A good example is the National Institute for Health and Clinical Excellence's (NICE) *Health needs assessment: A practical guide* (www.nice.org.uk). Health Needs Mapping (HNM) is a form of health needs assessment that has been used to design/improve services for hard-to-reach populations, eg the South Asian population. Information can be ascertained from routinely collected data, and for vulnerable groups can be supplemented by other sources such as the Health Poverty Index (www.hpi.org.uk), neighbourhood renewal programmes, Sure Start programmes and community projects.

3.13 Once needs have been identified, ways of addressing these needs should be explored (eg pre-pandemic training for all support and care workers and organisations). A risk register can be set up for vulnerable people. This would provide guidance for named vulnerable groups' needs with identified organisational responsibility for each vulnerable group. It may be helpful to place the defined vulnerable groups against pandemic flu scenarios where they could become more vulnerable. Once risks are considered, the outcomes should be decided upon, in particular how such outcomes can be obtained. Provision to prevent further marginalisation and stigmatisation of vulnerable groups and individuals should also be included.

3.14 Where maintaining an up-to-date risk register is difficult, an up-to-date list of organisations and links to vulnerable groups can be made. In this instance, information sharing and training regarding pandemic flu will need to be an ongoing process in the pre-pandemic stage to ensure appropriate response and partnership working in the event of an influenza pandemic.

Continuity of care and facilitation of access

'Known' vulnerable groups and individuals

3.15 Vulnerable individuals known to health and social services (eg an older person with mobility problems) will continue to rely on these services during an influenza pandemic and it may be difficult to sustain their normal care. There will be a group of people whose care will be compromised due to staff absences or other effects of a pandemic. Once the needs of 'known' vulnerable groups and individuals are identified, PCT Pandemic Influenza Planning Committees or Local Resilience Forums should consider how vulnerable people's access to and reliance on services can be maintained during a flu pandemic. This may involve the use of different methods to deliver care. Plans to deliver care in the 'known' vulnerable groups should be decided in advance of a flu pandemic. It is also important to note the relevant networks and contacts and what they need to do in order to cascade information and care (eg care plans for older people, community matrons, Help the Aged, local carers groups, Meals on Wheels, mental health services for older people and volunteers will need to be consulted).

3.16 Since primary care will be severely depleted, roles as advocates may need to be balanced against what health and social services can actually provide. Alternative arrangements for advocacy, such as using volunteers or befriending systems, could be made. Some networks that vulnerable groups have will continue during a pandemic (eg support workers for homeless people) and their links and provision of service could be adapted to help protect vulnerable groups from becoming more vulnerable during a crisis.

3.17 Partner agencies will need to plan for the discharge of vulnerable individuals from secondary care following influenza. This would involve identifying a patient at risk of vulnerability on admission to hospital and planning for discharge from that time. Liaison between key health professionals and sharing of information is vital to ensuring that the person is supported and accommodated in the community upon discharge.

'Unknown' vulnerable individuals

3.18 Efforts will have to be made prior to a flu pandemic to identify unknown vulnerable individuals (ie those not registered with a GP). Advanced planning to encourage registration with a GP would be of benefit. This would help ease unknown vulnerable individuals' access to health and social services and to antivirals and other medicines during a flu pandemic. In addition, it could help offset a surge in demand on primary care and hospitals. It is likely that information already exists on the numbers of people registered with GP practices versus size of population in the practice catchment areas. Mapping of GP practices and their accessibility by public transport, foot etc would be useful. This could involve use of Geographical Information Systems (GIS) to map primary care practices in relation to vulnerable groups. Community pharmacists, community nurses, health visitors, social workers, voluntary groups and volunteers could help facilitate GP registration for specific vulnerable groups, eg the gypsy and travelling communities.

3.19 In advance of a flu pandemic, PCT Pandemic Influenza Planning Committees or Local Resilience Forums may need to discuss with primary care providers whether there is the capacity to accommodate an increase in numbers of registered GP patients. Such discussions should also consider whether temporary registration can be facilitated during a flu pandemic.

3.20 Finding the unknown vulnerable groups will require innovative communication methods. However, some vulnerable groups who are unknown to public health and social services are known to voluntary organisations or outreach services, such as asylum and refugee services, drug and alcohol misuse services or Sure Start. Hence the importance of identifying contacts and establishing networks and partnerships in advance of a flu pandemic.

Integrated planning and partnership working

3.21 The inclusion of vulnerable groups in local pandemic flu plans involves the collection and sharing of data and the continuance of integrated provision of care and facilitation of access during a pandemic. Therefore, strong partnership working with all stakeholders utilising their expertise and knowledge of vulnerable groups is essential from early on in the planning process.

3.22 PCT Pandemic Influenza Planning Committees or Local Resilience Forums are responsible for developing the list/register of vulnerable groups, which includes the identification of known and unknown vulnerable people, an assessment of their needs during a pandemic and the ways in which care will continue to be provided. This information should be held by PCTs and should be tested and updated regularly. It is

the responsibility of other partner organisations to inform PCTs who their vulnerable people are. This should be accompanied by estimates and geographical information of where these people might be found, eg a particular housing area or hospital.

3.23 The voluntary sector should be involved in the planning and coordination of roles via local PCT Pandemic Influenza Planning Committees or Local Resilience Forums. These should identify local voluntary groups in advance of a flu pandemic. They will also need to consider how to involve voluntary organisations in their area with which they do not usually have business arrangements, eg the Red Cross, the Salvation Army and local self help groups.

3.24 Voluntary groups and volunteers (eg those who help operate Meals on Wheels) may be able to support the response to pandemic influenza at a local level by:

- communicating key messages, information and advice, both before and during a pandemic
- making links with vulnerable or isolated individuals
- supporting vulnerable or isolated individuals by facilitating the collection of antivirals on their behalf
- putting in place initiatives for 'good neighbour' schemes.

Some voluntary groups provide helplines, and it is important that the messages they put out are consistent with national messages.

Principles of staffing and training for health, social care and voluntary organisations

3.25 Up to 50% of the workforce could be absent at some stage over the course of a pandemic. As a minimum, organisations should ensure that they plan for handling staff absence rates of 15% to 20% over the two- to three-week peak of a pandemic (and up to 30% for smaller organisations). Absence due to influenza is likely to be seven to ten working days. A proportion of staff will be absent due to their caring responsibilities, bereavement and other psychosocial impacts; practical difficulties in getting to work; or problems with childcare. However, there needs to be sufficient human resources available to run essential social and health services to vulnerable groups. Therefore, planning to maximise the use of available staffing levels should be a key focus for influenza pandemic preparedness. A register can be developed to establish the skill mix of staff and to identify staff with skills and experience in physical healthcare. Furthermore, PCT Pandemic Influenza Planning Committees or Local Resilience Forums should develop a risk assessment grid or framework that

shows the likelihood of particular events occurring against the degree of impact they would have. This could include scenarios with different levels of staff absence, timings for closing areas and deploying staff. These scenarios should be tested in advance of a pandemic.

3.26 In order to reduce the impact of an influenza pandemic on staffing levels, all organisations should consider the steps needed to ensure that employees who are ill or think they are ill with influenza are positively encouraged not to come into work. This may involve reviewing current personnel policies. They will also need to have arrangements in place for handling staff who become ill with influenza-like symptoms while at work and for identifying staff who have influenza-like symptoms before they arrive at work. Once staff have recovered from pandemic influenza, it may be appropriate to use these staff to look after patients with pandemic influenza, provided that the health and safety needs of such staff are taken into account.

3.27 A workforce that is well informed and trained is likely to be able to manage the additional pressures and challenges arising during a pandemic. Primary care organisations, mental health trusts and social services should consult the following guidance for further information on training of staff:

- *Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England*
- *An operational and strategic framework: Planning for pandemic influenza in adult social care*
- *Pandemic influenza: Guidance on preparing mental health services in England*
- *Pandemic influenza: Guidance for infection control in hospitals and primary care settings*
- *Pandemic influenza: Human resources guidance for the NHS* (forthcoming).

3.28 Volunteers and staff in the voluntary sector will also need to be trained. Local Resilience Forums or PCT Pandemic Influenza Planning Committees should ensure that training in infection control and information regarding pandemic flu is cascaded and updated regularly to voluntary groups and faith communities. This could involve the provision of flu preparedness workshops in community centres or other convenient locations for members of faith based or community based services.

Recovery phase

3.29 A single wave pandemic profile with a sharp peak provides the most prudent basis for planning. However, second or subsequent waves have occurred in some previous pandemics, often weeks or months after the first wave. While the first priority at the end of the first wave will be to develop recovery plans and restore health and social 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. The Department of Health will issue guidance to inform health plans following its review of the first wave and the availability of countermeasures.

3.30 As the threat of further waves subsides, the UK will move into the recovery phase. 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, supply difficulties, and staff and organisational fatigue. A gradual return to normality should be anticipated and expectations shaped accordingly. However, local resilience plans should have provisions for pre-pandemic identified vulnerable individuals and groups in order to prevent their needs from being forgotten as services are being rebuilt.

4 Partnership working

Role of public sector

4.1 The public sector comprises health and social services provided by primary care trusts, local authorities, mental health services, hospitals, primary care, and foundation and other specialist health trusts.

4.2 PCTs are responsible for assessing local risk and for commissioning, supporting and monitoring the development of integrated health response plans. They are also responsible for developing arrangements to maintain and support patients in a community setting and for ensuring that health plans take account of the needs of different sub-populations who may require specific planning. This includes vulnerable groups.

4.3 PCTs should seek to engage the voluntary sector and other stakeholders in pandemic influenza planning for vulnerable groups and have a joint approach to self care and supporting vulnerable individuals to remain in their own homes (or other community/residential setting) during a pandemic.

4.4 Local partnership working is central to the inclusion of vulnerable groups in pandemic influenza planning. This should involve the sharing of information and contacts ('gatekeepers') for accessing vulnerable individuals. Social services are aware of, and are in regular contact with, many vulnerable individuals in the community. These clients may be either more vulnerable to or more affected by pandemic influenza. Environmental officers in local authorities often have liaison officers or links to the gypsy and travelling communities. Community pharmacies also have an important role to play in supporting and educating informal carers, promoting self care, and providing advice and information to vulnerable groups. They can be a first point of contact for vulnerable individuals who do not use primary care.

4.5 Pandemic flu partnership working should build upon existing local partnerships where possible. If such partnerships do not exist, PCTs, local authorities and the voluntary sector should work together in seeking out and building network ties to vulnerable and isolated communities (eg ethnic minorities, the gypsy and travelling communities, rough sleepers and people in insecure accommodation). Using established ways of reaching some vulnerable groups (eg hepatitis outreach services, local carers groups, charities such as the Motor Neurone Disease Association, refugee and asylum seekers support services, street outreach services, resettlement services, substance misuse teams) should be considered.

4.6 Provision for vulnerable groups should be planned and publicised well in advance and pre-pandemic relationships and procedures tested. It should be part of the flexible, integrated planning process for pandemic influenza and developed jointly by health and social care agencies.

Role of voluntary organisations

4.7 Many voluntary organisations are involved in the provision of services to vulnerable sections of the community. They also act as a support network to their members. The voluntary sector can support a number of 'known' vulnerable groups such as older people, children with additional support needs, mental health groups, people with long term conditions or chronic illness, ethnic minority groups and gypsy and travelling communities.

4.8 Voluntary organisations have a range of services that can be tailored to meet the needs of vulnerable groups during a flu pandemic. Such services include telephone helplines, assisting those experiencing stress, providing social support to maintain sufferers in a community setting, helping sufferers to find appropriate emergency accommodation if homeless or supplementing healthcare resources. In addition, they are well placed to provide information and advice to vulnerable individuals. The voluntary sector should be represented on PCT Pandemic Influenza Committees or Local Resilience Forums.

4.9 Voluntary organisations will already be in contact with many of their known vulnerable groups. Planning arrangements, particularly with the specialist voluntary organisations (eg those working with deaf and blind people or charities working with people with neurological disorders), will be critical to ensuring that the different groups are reached and supported. The arrangements should take into account that some smaller specialist voluntary organisations are insufficiently staffed and funded to be able to provide alternative support to their service users for a prolonged period.

4.10 Voluntary organisations will need to develop business continuity plans in order to continue providing their services during a pandemic. These plans should seek to mobilise the capacity and skills of all staff and there should be business contingency plans to cover staff absences. Staff should also be provided with training in infection control measures for pandemic influenza. Developing and testing of business continuity plans are essential as it is likely that disruption to the provision of services by voluntary organisations may impact negatively on the service users.

Role of volunteers and faith communities

4.11 Volunteers (from faith groups, community networks or small voluntary organisations) provide a proportion of health and social care to vulnerable groups. Volunteers are regularly involved in delivering food, undertaking domestic chores and other tasks, and providing companionship to older people, disabled people and other vulnerable individuals in their neighbourhood. These individuals will be crucial during a flu pandemic. They could help with access to the Flu Line, collect antivirals and deliver essential supplies to people. Local pandemic flu plans should make provisions to ensure that volunteers have adequate briefing, training, skills and personal protection for those who will be continuing to support others in their local communities. Faith based and community based organisations should be encouraged to develop plans for the provision of services and supplies during a pandemic.

The Department for Communities and Local Government has produced helpful guidance. *Faith communities and pandemic flu* is available at www.communities.gov.uk

Role of informal carers

4.12 A large number of known vulnerable individuals, such as those who have a mobility disability, older people and/or people who have mental/cognitive impairment, rely on a number of family members or friends for their day-to-day care. These informal carers or caregivers are a vitally important group within mental healthcare because they carry such a large burden of responsibility. Partners in Local Resilience Forums (eg community nursing, social services and mental health services) should identify the carers within their areas who are looking after patients who are most at risk or dependent upon continuing care and make contingency plans where possible.

4.13 Caregivers will be trying to cope during the pandemic and will require support. There may also be a requirement for new carers. Provision of information to informal carers on how they can both protect themselves from contracting influenza and support/care for a patient with influenza will be critical. This includes advice on what to expect and what to do in the event of an outbreak, how certain services should be accessed and hygiene and infection control measures. It is likely that there will be a marked increase in demand for emergency short term care for patients when their informal carers fall ill. Local influenza pandemic plans need to include specific provisions for how to support informal carers both before and during an influenza pandemic.

5 Key challenges

Access to antivirals and the National Flu Line service

5.1 In order to limit the spread of the influenza virus, people with influenza will need either to access care or self care from their own homes as far as possible. A National Flu Line service will be activated to provide people with access to information and antiviral medicine where they require it. The Flu Line is intended to supplement and protect existing primary care arrangements by taking much of the burden of initial assessment, triage and antiviral authorisation away from frontline healthcare services. It also encourages the message of staying at home if ill as patients can contact the Flu Line over the internet or by telephone from their own home. The public will also be encouraged to identify a 'flu friend' who can collect their antivirals (and other medicines) from a local antiviral collection point. See *Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England* for more details.

5.2 While the Flu Line is intended to meet the majority of demand for antivirals, some antivirals will still need to be issued through existing local healthcare arrangements. This is due to a number of symptomatic people being unable to access the Flu Line for various reasons. Vulnerable individuals and groups may have problems in accessing the Flu Line. They may face barriers in accessing the Flu Line, eg they may not have a phone, they may be uncomfortable using a phone or the internet, they may be unable to use a phone (perhaps due to hearing difficulties or physical disabilities), English may not be their first language or they may not understand what the process entails. They may also not know someone who can access the collection point for the antiviral on their behalf or may be socially isolated. Some vulnerable groups and individuals will rely on a third party organisation to access antivirals on their behalf, eg people living in closed communities or in secure units. Others may be reliant upon their carer.

5.3 It is important that, when the PCT Pandemic Influenza Planning Committee or Local Resilience Forum is identifying and assessing the needs of defined vulnerable groups in the locality, scenarios regarding using the Flu Line are considered. There are a number of options that are useful in reducing barriers to accessing the Flu Line:

- targeted educational material that incorporates the information needs of identified vulnerable groups is needed. This should include key messages on what the Flu Line is, how it works and how and when people should contact it.

Carers and health and social care staff who are likely to act as a third party to access antivirals for people in their care should receive information about the Flu Line so that they are clear about their role in supporting people to access it

- a 'flu friend' is the term given to a family member, friend, neighbour or carer who will provide support to a symptomatic person during a pandemic. Some vulnerable individuals and groups will not have a contact who can act as a flu friend. Health and social care staff, community groups, voluntary organisations and volunteers will need to be engaged in order to act as a flu friend and help vulnerable people access the Flu Line
- PCT Pandemic Influenza Planning Committees or Local Resilience Forums should also consider increasing access to technology and support through existing public facilities (eg libraries, walk-in centres etc) to help vulnerable people and their flu friends to access the technology to call the Flu Line.

The Department of Health is giving further consideration to the implications of the operation of the National Flu Line service on vulnerable groups.

Access to vaccines and other medicines

5.4 Vulnerable groups face barriers in accessing health services. During an influenza pandemic, this may be acutely so. Working with the voluntary sector and volunteers from faith and community groups will be important as these groups are good at reaching those who either view health and social services negatively or who are unable to access them.

5.5 Uptake of vaccines is low among many vulnerable groups. Specific arrangements may have to be put in place for reaching vulnerable groups. See Annex D of *Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England* for suggestions for vaccine provision for vulnerable groups.

Promotion of self care

5.6 The promotion of self care will be crucial in encouraging the community to look after its health and to take the necessary steps to avoid contracting and spreading the influenza virus. A second component of promoting self care involves supporting those who are symptomatic with influenza to care for themselves at home or within residential settings. Promotion of self care will enable primary care services to focus on those with more urgent or critical healthcare needs. There is a national communication strategy that encourages the public to support and engage in self care prior to and during a pandemic. Further information on health communication in a pandemic is available at www.dh.gov.uk/pandemicflu

5.7 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 when and how to seek medical advice or care. There will be difficulties in communicating to vulnerable groups. Some homeless people are vulnerable to flu and may have addictions that complicate prevention and communication regarding flu and self care. It cannot be assumed that these vulnerable groups are able to comprehend or comply with the advice on self care. Alternative forms of communication to written information will need to be utilised. These could include face-to-face communication, with an interpreter if necessary, or with a support/key worker from a statutory or voluntary care organisation, or by use of an interactive website to give information.

5.8 In the pre-pandemic stages, informal carers should be informed about self care and they can then give the information to the vulnerable individuals in their care. Informal carers can be reached through health services, social services, mental health services, charities such as the Motor Neurone Disease Association or through engagement with carers organisations.

5.9 Information about self care will be provided nationally and locally to the public. However, vulnerable individuals will vary geographically and there is a need for communication strategies to be developed dependent on the needs of the local community. Alternative methods to distributing written communication by health professionals should be explored, eg use of face-to-face communication, community meetings, street theatre, local radio, parish or charity newsletters.

Communication about pandemic flu

5.10 The provision of information regarding pandemic influenza and use of the National Flu Line service will be done both nationally and locally. At a national level, informing and educating the public is likely to consist of media campaigns and distribution of written materials (eg leaflets and information packs) to GP practices, pharmacies, NHS Direct etc. The national communication campaign will be available in various formats and languages according to normal central Government guidelines. This will cover accessibility issues such as braille, tape and large print. It is intended that information will also be available for use by national voluntary organisations (eg Carers UK, Age Concern, WRVS, Red Cross etc) which they can cascade through their networks.

5.11 At a local level, it will be the responsibility of the PCT Pandemic Influenza Planning Committee or Local Resilience Forum to agree what local information will be made available and how this will be communicated. This information will be specific to the local population and will include communicating about the location of the antiviral

collection point(s) and the current status of local services, transport etc. Such information will need to be sensitive to the needs, languages and vulnerabilities of the local population.

5.12 While vulnerable groups may have limited access to health and social services, they can receive information through a variety of media, the principle being that everyone is reached somehow. Some people listen to community radio, others use cafes and hairdressers to exchange information or communicate about issues, and informal carers may talk to each other regarding care. It is possible to reach vulnerable groups if the message is relayed in a form that they wish to receive. This reverts to identifying who the vulnerable people are in the locality, and finding out what they read, see and hear and how to grab their attention. Information about pandemic flu should be available in forms that people find easy to use. This can include using supermarket loyalty cards, DVD shops, community radio, parish newsletters and 'community flu champions'. Agencies other than the NHS can be engaged to communicate about pandemic influenza.

5.13 Timely advice and information for all groups will help the management of a pandemic. Advice will be disseminated using a range of channels including national broadcast, door drop leaflets and news announcements. The national communications strategy will ensure that the needs of all groups, including vulnerable people, will be addressed.

Appendix

Questions to promote discussion

Would the guidance be enhanced if examples of scenarios were added? If yes, can you provide any examples?

Would a template be useful in supporting planners with developing an understanding of groups within their local health economy? If yes, can you provide any examples?

Should there be more emphasis on organisations being accountable to their strategic health authority for the development and maintenance of vulnerable lists? If yes, what would this look like?

How do organisations safely share information about vulnerable groups without breaking data protection rules and stigmatising sections of the community?

Are you confident you have thought creatively about how to engage with voluntary groups?

What training and preparation could be delivered centrally for national voluntary organisations?

Are you confident that local voluntary organisations are engaged with statutory organisations and involved in pandemic flu planning and local exercises?

Have you developed a strategy to encourage engagement with all partners in pandemic flu planning?

Produced by COI for the Department of Health
289376 1p Aug 2008