Proposals to support Directors of Adult Social Care and local areas to prepare now for a future flu pandemic

The most up to date source of Government guidance documentation is the Gov.UK Pandemic Flu Webpage.

https://www.gov.uk/guidance/pandemic-flu

The Government flu pandemic website was updated in November 2017. Although links are provided in this report to national guidance documents for ease of reference, readers should use the website to check they are reading the most up-to-date version.

April 2018

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1. Introduction

The Department of Health and Social Care asked ADASS to provide expertise in relation to the Director of Adult Social Services' (DASS's) role in multi-agency planning for a flu pandemic, and what they require to fulfil that role. The Department wishes to ensure that local areas have the required support and flexibilities to increase capacity and manage increased demand in the event of such a Pandemic.

ADASS issued a survey about local area preparedness for a flu pandemic to DASSs in England in December 2017. Its purpose was to provide greater insight on local multi-agency planning for a flu pandemic, with specific reference to the role of the DASS in that multi-agency planning, and *what a DASS requires to carry out the role.*

ADASS also commissioned a set of reports written between December 2017 and February 2018 that reviewed different aspects of planning for a flu pandemic from the Adult Social Care perspective. Each report included recommendations to the Department of Health and Social Care (DHSC). The reports are based on a literature review of national legislation, regulations and guidance relevant to a flu pandemic and on telephone interviews with ADASS Policy Leads, some individual DASSs, the Local Government Association Director of Social Care the Department of Health and Social Care Head of Adult Social Care Performance and Insight Team and Care Provider representatives at the Care Provider Alliance (CPA) and the UK Home Care Association (UKHCA).

This report is for two audiences - DASSs and DHSC. The recommendations are listed in Annex A along with the recommendations in the other related reports.

The overarching message in this report is that DASSs should refresh and rehearse their strategic and operational flu pandemic plans now, well ahead of a true flu pandemic. To do so effectively they should engage with their Local Resilience Forum, their Health and Social Care Resilience Partnership and with social care providers and the voluntary sector in their area.

Recommendation 1: DASSs and their emergency planning teams should refresh and rehearse strategic and operational plans now, well ahead of a flu pandemic. To do so effectively they should engage with their Local Resilience Forum, the local health and social care resilience partnership and with social care providers and the voluntary sector in their local area.

There is a considerable amount of government legislative, regulatory and guidance documents on flu pandemic. The national documents date from 2009 to 2013.

The key documents for DASSs are referred to in this report, referenced with links to the versions of the documents used during the literature research in December 2017 and January 2018. The reader should assure themselves they are reading the most up to date version. The most relevant planning documents for DASSs will be found through the Gov.UK Flu Pandemic website. Some Local Authority and other organisations flu pandemic and emergency plans published on the internet are referenced. The internet version referenced may not be the most up to date draft,

the reader should anticipate that Local Authorities and other organisations may publish updated plans in 2018.

2. Why DASSs and their local areas should plan and prepare well ahead of a flu pandemic

The various national guidance documents on flu pandemic express the risks and potential impacts slightly differently in each. The Gov.UK/Pandemic Flu Guidance Web Page Overview [1]document is the most up to date. The section 'Impacts of a Pandemic' (within the section Pandemic flu: description of the risk) includes the following:

> *"In the UK, up to one half of the population may become infected and between 20,000 and 750,000 additional deaths (that is deaths that would not have happened over the same period of time had a pandemic not taken place) may have occurred by the end of a pandemic in the UK…society is also likely to face social and economic disruption, significant threats to continuity of essential services, lower production levels, shortages and distribution difficulties…large numbers of staff are likely to be absent from work at any one time. It is impossible to forecast the precise characteristics, spread and impact of a new influenza virus strain[2]".*
>
> *(UK Government Pandemic Flu Guidance)*

The UK and Europe functions on a 'just in time' supply system. The Overview to the Pandemic Flu Strategy states that social infrastructure can be expected to be damaged, for example fuel supplies, wholesale prescription supplies, community call line services, ambulance services, public transport, energy suppliers, maintenance engineers. Workers in obscure jobs often find that their essential skills are only noticed when they are not there to provide them.

An influenza pandemic can occur either in one wave or in a series of waves. Each wave can last 12 – 15 weeks and occur weeks or months apart. Second or subsequent waves could be more serious than the first. A local epidemic may be more highly peaked and over faster than the national average [3].

It is not known which age groups will be most affected by the pandemic. For instance, the strain of flu might have its most serious impact on working age people and/or young people and children. Modelling in the DH plans anticipates 25 – 30% general workforce absence due to influenza like illness, not including absenteeism to care for sick children and relatives or withdrawing labour due to fear of becoming ill themselves. The high vacancy level in care worker and nursing posts, together with a high workforce sickness rate will have a major impact on care provision.

In this report references to vulnerability are mainly about elderly people because of the current high level of demand on health and social care within that age group already, but the guidance makes it very clear that there are many types of vulnerability and responses appropriate for each type. A further reason to not think just about elderly people is that until the pandemic numbers start to rise nationally it will not be clear which age groups are most affected. Clearly people with compromising health conditions may be at greater risk of infection and complications, but age

[1] www.gov.uk/guidance/pandemic-flu
[2] www.gov.uk/guidance/pandemic-flu
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

groups not previously exposed to this pandemic strain of the virus and therefore with no built-up immunity may be at greater risk.

A flu pandemic with a strain of flu causing a severe impact in the population (high rates of morbidity and mortality) will require heavily prioritised or critical level health and social care and general societal and environmental infrastructure services will be at prioritised or critical level for a period of several months. This will require a very different level of planning for prioritised services compared to the critical incidents that Local Authorities and care providers have experienced, although the learning from any major incident is valuable and should be reviewed for its relevance to aspects of responding to a flu pandemic.

> *'In preparing for and responding to an influenza pandemic, people working at all levels, from Government to those on the front line, will face difficult decisions and choices. These will impact on the freedom, health and, in some cases, survival prospects of individuals. Many people are also likely to face individual dilemmas and tensions between their personal, professional and work obligations. Given expected levels of additional demand, capacity limitations, staffing constraints and potential shortages of medical supplies, hard choices and compromises are likely to be necessary in the fields of health and community care.'* Executive Summary,
>
> (*Pandemic Flu – Managing Demand and Capacity in Health Care Organisations, DH 2009)*[4]

In 2009 there was a flu pandemic of the H1N1 strain, but that flu pandemic had a low impact in terms of its severity:

> "*The H1NI (Swine Flu 2009) pandemic does not lessen the probability of a further pandemic in the near future and should not be seen as representative of future pandemics".*[5]
>
> *(Section: Description of the risk)*

There is concern in government that the 2009 Pandemic and its mild to moderate impact caused some disbelief in the likelihood of a future pandemic with a severe impact in terms of morbidity and mortality in the population and the associated impact on national infrastructure and public confidence. (Section 5 of the UK-Pandemic-Influenza-Communications-Strategy)[6]:

Public sector reorganisations and staff turnover in recent years will have resulted in some lack of organisational memory of flu pandemic planning nationally and locally that took place between 2008 and 2013.

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[4] http://webarchive.nationalarchives.gov.uk/20130124045951/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098750.pdf

[5] https://www.gov.uk/guidance/pandemic-flu

[6] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213268/UK-Pandemic-Influenza-Communications-Strategy-2012.pdf

Troubles never come alone, for example:

- If a pandemic flu has peaks in November and December, care staff supply is further depleted by staff who are on low contract hours taking retail jobs to boost their income. If it occurs during school holidays care workers cannot be compelled to cancel their holidays.
- The impact of extreme weather for example floods, storms, snow or a heat wave on an already fragile social infrastructure cannot be overly stressed.
- Emergencies such as a major fire, chemical leak, motorway accident or terrorist incident.

Provider representatives were interviewed. They identify risks to routine maintenance in care homes for example "lift and hoist maintenance", continence and clean linen supplies and IT support delays.

Engagement with providers and the local voluntary sector and service user advocacy groups for a wide range of age groups is a positive means of communicating the implications of a flu pandemic in a context of working together to plan to minimise harm and maximise mutual support. This should begin in the pre-planning stage and continue throughout the pandemic to learning the lessons reviews during recovery phases.

The forms of flexible working and easements of normal standards and practices listed in this report are aimed at the peaks in the waves of a flu pandemic with a severe impact. To be applied safely and effectively they will need to be consulted on, planned for and aspects rehearsed in advance. If local areas prepare for a flu pandemic with a severe impact, they can choose to implement some of the strategies and flexibilities to ease capacity pressures at other times of severe NHS and social care pressure.

3. Why the recommendations attached to this report are most applicable to a severe impact of a flu pandemic

The literature review and interviews with Directors and Provider representatives undertaken for these ADASS reports demonstrated that health and social care winter escalation plans, including current forms of highly flexible working, appear to be largely sufficient for a mild to moderate rate of flu like illness with complications mainly in the elderly population. However, current winter escalation plans are inadequate for a severe impact flu pandemic lasting several months.

The DH Flu Pandemic Strategy 2011 refers to the learning from the 2009 pandemic, and the need to plan for different degrees of impact of a pandemic. In other words, planning and prioritisation of services should not be solely aimed at the severe impact end of the spectrum.

The preparation and planning, forms of flexible working, easements of normal practices and standards listed in this report are aimed at the peaks in the waves of a flu pandemic with a severe impact. To be applied safely and effectively they will need to be, planned for with partners and stakeholders and practiced in advance of a pandemic.

4. Statutory Responsibilities of the NHS, Social Services and the Health Protection Agency

These are set out in Annexes A, B and C pages 66 – 68 of the Health and Social Care Influenza Pandemic Preparedness and Response Best Practice Guidance 2012[7].

Government is in the process of updating its statutory requirements and Best Practice Guidance across a number of flu pandemic planning documents. The most recent overarching Guidance is the **UK Influenza Pandemic Preparedness Strategy 2011[8]**.

Sourcing government guidance via the Gov.UK Pandemic Flu website should ensure that the most up-to-date version of any document is relied on[9].

Several Local Authority strategic plans are referred to in this report:

- Derbyshire Local Resilience Forum (LRF)[10]
- Southampton Public Health Pandemic Influenza Plan[11]
- Hampshire County Council Pandemic Influenza Planning & Response Plan 2017[12]

The Derbyshire and Southampton plans were sourced from the web and Hampshire from the Council. They are included because they demonstrate a strong planning approach for emergencies in general and flu pandemic at strategic level. LRF plans published and referred to in this report as examples set out the roles and responsibilities of different functions in the Council.

5. The role of the Local Resilience Forum

Section 4 of the Guidance for Local Planners/LRFs[13] lists Government expectations of operational response arrangements:

> *"In England and Wales, the primary responsibility for planning for and responding to any major emergency rests with local organisations, acting individually and collectively through Local Resilience Fora (LRF) and Strategic Coordinating Groups (SCGs). The purpose of the SCG is to take overall responsibility for the multi-agency management of an outbreak at local level".*
>
> *"Local Health Resilience Partnerships (LHRPs) are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations, in line with their respective statutory duties. Local authorities will also contribute more widely…given their range of responsibilities…and their community leadership role[14]".*
>
> (Section 4 of *Preparing for Pandemic Influenza, Guidance for Local Planners)*

[7] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf

[8] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213717/dh_131040.pdf

[9] https://www.gov.uk/guidance/pandemic-flu

[10] www.derbyshireprepared.org.uk/files/uploads/Derbyshire_Strategic_Plan_for_Pandemic_Influenza.pdf

[11] www.publichealth.southampton.gov.uk/images/scc-pandemic-influenza-plan-v3.2-january-2016.pdf

[12] Hampshire County Council Pandemic Influenza Planning & Response Plan 2017, (not available online)

[13] www.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

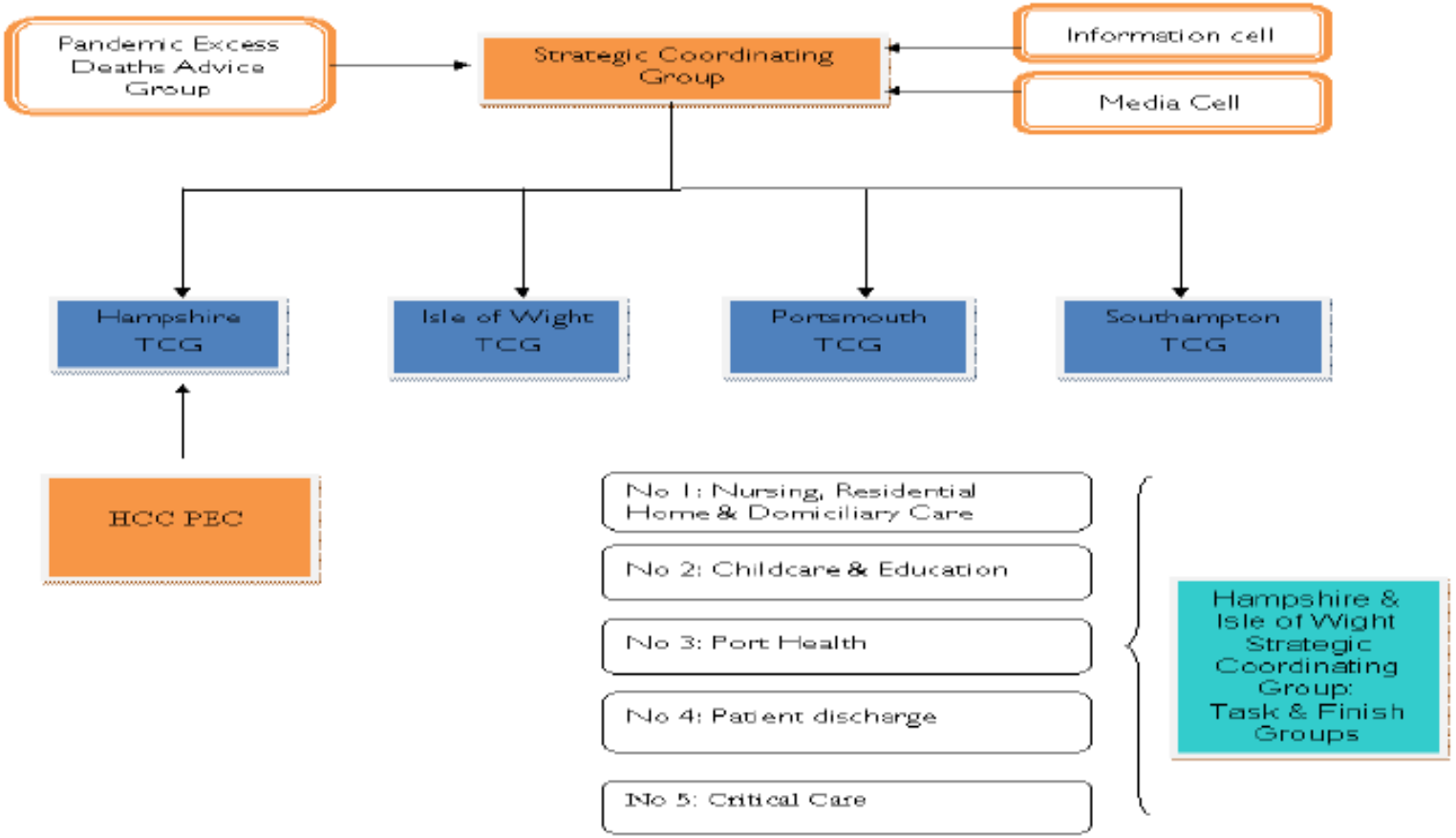
[14] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf

It is vital that DASSs, their Local Authorities and partners make strategic decisions on prioritisation of services within the formal decision-making arrangements of the LRF. DASSs may benefit from requesting their LRF to convene to review and test its flu pandemic plans.

At the most local organising level the NHS, Local Authorities, and, in particular, the DASS, DCS and Directors of Public Health carry the statutory responsibility for preparedness, implementation and recovery in local areas.

The diagram below is extracted from "Hampshire County Council Pandemic Influenza Planning & Response Plan 2017" and provides an example to illustrate an LRF Planning Structure.

The Hampshire and Isle of Wight multi-agency response structure is likely to work as set out in the diagram below:



DASSs may be required to represent social care and each other across Local Authorities in the LRF area. They may also find themselves representing other directorates from their own council, such as housing and children's services. The DASS should be well briefed about the flu pandemic impact on a wide range of services, able to represent their Council in the LRF as representation could be impacted by illness.

LRFs and Local Health and Social Care Resilience Partnerships should consider how to need a very high demand for communication channels by professionals and the public wishing to notify them of vulnerable people becoming ill with flu. These should include ample telephone call handling capacity; live web chats; email messages and smart phone apps may be another route. All require prompt triaging and appropriately prioritised response.

DASSs have a further support and mutual aid group through their ADASS Regional Branches.

6. The role of ADASS Branches in providing mutual aid

ADASS branches will be an ideal place for DASSs to work together on cross-boundary issues and manage fluctuating demand and supply across local authority boundaries. The benefits of mutual support and regional/sub regional activity should not be underestimated.

ADASS Executive recently adopted an internal report *'Provider Failure – A check list for Regional Response. ADASS 2017* [15]. It gives guidance to DASSs on managing the consequences when for whatever reason care quality is compromised to the point that it is not appropriate to refer or place service users with that provider. Part of the management of the care capacity pressures caused by provider failure is ADASS branches or sub regions identifying appropriate vacancies very quickly, facilitated by a lead officer working for the branch.

Some ADASS branches have experience of managing care capacity crises and have developed mechanisms to do so, especially in respect of specialist settings, staff skill sets and commissioners' current knowledge about care quality within individual providers or registered units.

ADASS branches may wish to appoint a regional lead on flu pandemic planning with the experience and knowledge to assist them in managing a live pandemic situation, able to have discussions on their behalf with providers about available and appropriate care capacity. This is particularly useful in terms of specialist services.

[15] https://www.adass.org.uk/provider-failure-and-emergency-incidents-a-checklist-for-regional-response

7. The phases of a flu pandemic

The UK categorises a pandemic into:

a.) Preparation and Planning

b.) Detect and Assessment

c.) Treatment

d.) Escalation

e.) Recovery

National criteria determine when the country reaches each phase of a pandemic. Under the UK Influenza Pandemic Preparedness Strategy 2011, Local Resilience Fora (LRFs) will determine the status of the population within the LRF area according to the national criteria. The changing status in LRF area populations throughout a pandemic is not expected to be linear, so communications activities at LRF level and below will be tailored to meet the current situation in that area – bearing in mind there may be other national or regional problems arising at the same time, such as extreme weather or utility supply failures.

Government expectations of social care planning for different phases of the pandemic can be found in *Health and Social Care Influenza Pandemic Preparedness and Response DH 2012*[16]*.* The table in Annex B of that document is set out below. It sets out the responsibilities of social care during the different phases of the pandemic.

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf

Annex B – Summary of social care roles and responsibilities during a pandemic

Stage	Local Authorities
Planning	• Governance of local planning • Ensure that planning aligns with Civil Contingencies Act structures, e.g. Local Resilience Fora • Ensure that there are communications in place with all independent sector providers, which are capable of being a platform for daily communications • Local schools closure policy • Planning with early years service and private, independent and voluntary providers • Planning with adult social care providers • Advise independent sector social care providers to make arrangements for vaccination of their staff • Arrangements for storing and distribution of face masks • Agreement within local authority about what are "essential" services which take priority over everything else • Arrangements for redeploying staff into essential services • Alignment with overall winter and capacity planning with local NHS • Arrangements for identifying and supporting "vulnerable people"
Detect/ Assess	• Set up local communications for public, councillors and staff, and align to NHS communications • Re-test communication channels to providers • Test responses to SOCCON if this is put in place centrally • Confirm "mutual aid" arrangements between providers • Check vulnerable persons list • Confirm arrangements for vaccination of social care staff • Response to school outbreaks and decisions on school closures
Treat/	• Distribution of face masks to front line • Management of SOCCON and other central/local information channels • Communication with public/councillors/staff • Optimise capacity in independent sector for early years and adult social care, including mutual aid arrangements • Implement any agreed local escalation arrangements for faster hospital discharge or admission avoidance • Encourage social care staff to access vaccination programme • Support vaccination for vulnerable people including flu friends arrangements • Continued response to school outbreaks and decisions on school closures • Use local media to provide information on services to community

8. Identifying People who are vulnerable in a crisis

The methodologies to identify people who are likely to be vulnerable in a flu pandemic should be agreed with partners, recorded and tested during the **Preparation and Planning phase** for a flu pandemic that is well in advance.

Whilst ADASS does not refer to people with care and support needs as "vulnerable people", the *Cabinet Office Guidance on Identifying People who are vulnerable in a crisis*[17] defines vulnerable people in the context of an emergency as:

> *"(those who) are less able to help themselves in the circumstances of an emergency"*

In the event of a pandemic, these may include: children, older people, mobility impaired, mental/cognitive function impaired, sensory impaired, individuals supported within the community, immune-compromised children and adults, those with underlying health conditions, individuals cared for by relatives, homeless people, pregnant women, and those in need of bereavement support.

Early estimation of numbers, types and locations of people with vulnerabilities will enable planners to estimate required resources and care capacity. Local planners should ensure they include **planning for additional supplies of community equipment** such as Personal Protective Equipment (PPE) for care staff and volunteers. Other examples of community equipment include commodes, continence supplies, walking frames, slide sheets, disposable bed linen and laundry services. The NHS will plan for additional supplies of medicines, clinical waste and anti-viral medication to meet demand, but this is likely to focus on hospitals.

9. People who may become vulnerable because of the pandemic and need additional care and support may not themselves have flu

They may become acutely ill with another condition and highly vulnerable because the level of treatment and care they would normally receive is not available. Decisions need to be made about who receives what level of response to any health or care need, dependent on the local situation.

The Cabinet Office Guidance is one of the older published guidance documents and its detailed checklists and analyses of different types of vulnerability are of assistance to emergency planners for any emergency. It should be read alongside Annex D – Social Measures – Vulnerable People (page 27) of the Pandemic Influenza Guidance for local planners/LRFs, which refers to lists of lists (Page 24-29 at the attached link)[18].

The Guidance is still relevant to flu pandemic and other emergencies and recommends specific detailed lists and analyses of vulnerability to assist planners. It should be read alongside *Annex*

[17] www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders

[18] www.gov.uk/government/uploads/system/uploads/attachment_data/file/61228/vulnerable_guidance.pdf

D. - Social Measures – Vulnerable People (page 27) of the Pandemic Influenza Guidance for local planners/LRFs)[19].

It is comprehensive, but due to its age does not take account of the development of GP registers and lists of high risk patients as a comprehensive source of information about vulnerable people. This information is shared now in the form of statistics and geographical locations of different groups, but sharing it as identifiable personal data, beyond normal recipients, raises issues of information governance. This needs clarification at national level, including the agreements and protocols necessary for GPs to release patient data during a pandemic.

The preparation and planning phase includes early agreement about who will provide the DASS and and/or local health and social care emergency coordination team with information about the numbers of people who will be potentially vulnerable under the definition, the types of vulnerability and their geographical clustering.

This can then be modelled through expertise in the LRF group during the **detect and assess phase** into a dataset that can be updated dynamically during the phases of a pandemic over several weeks or months, with potentially daily situation reporting to the LRF and from the LRF up to government.

Based on existing guidance, to be updated by government: when national and LRF trigger points occur, specific local plans will be activated. This will include identification of potentially vulnerable people and their locations. This will be followed by the identification of individual people, their needs, their relative priority and the care required. Once a phase of pandemic flu activity has passed, it will be necessary to consolidate information during what could be a short period of recovery before preparation for a further wave.

10. Prioritisation and reprioritisation plans for care and support

Once a flu pandemic begins, the communications on reprioritisation become essential to enable the available staff to support those who most need care and support and service users, carers and the public to understand why their services are temporarily restricted or stopped, potentially for many weeks or months. Managers and staff should have been briefed on the necessity for this in earlier phases, at this stage it is a reminder of 'why' and clear information about 'what, how and when' to prioritise.

Prioritisation becomes operational during the **treatment phase** with further, reprioritisation to possibly critical level during the **escalation phase.** This should be a dynamic process, reviewed frequently, potentially daily, based on the gap between demand and supply of health and care services. Planners should not focus solely on a 'reasonable worst case' response – this is learning from the 2009 pandemic in UK.

Most of the above section of the Guidance is about prioritising and minimising assessments and admission to beds. There are no clear criteria for deciding on who should receive and therefore who might well not receive care at home, unlike in the hospital orientated *Pandemic Flu Managing*

[19] www.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

Demand and Capacity in Health Care Organisations (Surge) DH April 2009 v1. Appendix 5[20]*.* This guidance is for medical staff and hospital managers and is very clear about priorities for treatment at different stages of surge, as it was then described.

Many domiciliary care providers have contracts with several local authorities. If each of these local authorities has their own prioritisation criteria, banding and forms there will be a significant burden on providers and the risk of confusion. If providers are to be asked to share work between companies, this is a further reason for consistent prioritisation systems. Providers hope a national set of criteria, banding and templates will be developed.

Once a flu pandemic begins, the communications on reprioritisation become essential to enable the available staff to support those who most need care and support and service users, carers and the public to understand why their services are temporarily restricted or stopped, potentially for many weeks or months. Managers and staff should have been briefed on the necessity for this in earlier phases, at this stage it is a reminder of 'why' and clear information about 'what, how and when' to prioritise.

- *Lancashire County Council Pandemic Planning in Different Independent Social Care Settings July 2009* is helpful guidance for commissioners and providers. It is the only detailed social care prioritisation framework identified in the literature search for this report[21].

- *Southampton City Council Pandemic Influenza Plan 2016 v3.2 Annex B* differentiates between the response required for Low, Moderate and High Impact Pandemics[22].

- *Derbyshire Strategic Plan for Pandemic Influenza 2009 Appendices A B and C* sets out situation reporting templates for essential services, communications etc[23].

Managing fluctuating demand and supply at local area level will be supported through mutual aid within ADASS branches. The benefits of this means of mutual support and regional/sub regional activity should not be underestimated.

Recommendation 2: DHSC should consider developing a national system of prioritisation of care and support at home during the escalation phase of a flu pandemic.

Recommendation 3: DASSs should, through their regional ADASS branches consider collaborating on a single regional system of prioritisation suitable for care at home to reduce the risk of confusion amongst providers serving more than one local authority area.

[20] http://webarchive.nationalarchives.gov.uk/20130124045951/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098750.pdf

[21] http://www3.lancashire.gov.uk/corporate/enewsviewer/frmDcDnLd.asp?id=8489

[22] www.publichealth.southampton.gov.uk/.../scc-pandemic-influenza-plan-v3.2-january- ...

[23] http://www.derbyshireprepared.org.uk/files/uploads/Strategic_Plan_for_Pandemic_Influenza.pdf

11. Recovery phase and return to business as usual:

Health and Social Care Influenza Pandemic Preparedness and Response[24] (pages 50 – 53). Readers will note the emphasis on restoring data and personal confidential information in this section.

DASSs should remember that there are likely to be recovery periods announced by LRFs between waves of the pandemic, before a final recovery phase is announced nationally. Recovery periods between waves should be used to restore control of and review plans, ahead of a second or third wave which may have a worse impact than the first.

Adult Social Care is likely to have a long period of recovery (a long tail). This is because it will take long term responsibility for people who have long term care and support needs arising from the complications of flu. It is probable that dependency levels will be significantly proportionately higher. This probability would benefit from modelling by Public Health England.

12. Ethical Framework for decision making about treatment and care priorities

The Ethical Framework, to be found in the Gov.UK Pandemic Flu Overview web sets out the importance of minimising harm, recognising that some harm is likely to be unavoidable.

> *"Decision makers will need to use the best information that is available to them at the time (for example the likely effects of a particular decision). Whether or not a decision was ethically appropriate has to be judged in relation to the situation that existed at the time it was made, rather than by reference to facts that only became apparent at a later stage."*
> *"Harm is a broad concept and is intended to cover the physical, psychological, social and economic harm that a pandemic might cause [25]".*
>
> *(Health and Social Care Influenza Pandemic Preparedness and Response)*

The Ethical Framework is intended to guide strategic policy makers and local planners consider the ethical aspects of their decisions in an emergency.

It will help professionals and decision makers, guided by their own professional codes, to develop policies on clinical prioritisation for use during a pandemic. It is not intended as a practical guide for front-line care staff. Without further detailed guidance, staff may be unable to decide between priorities in difficult situations.

The ethical framework and any local prioritisation framework must be understandable and usable by care workers and health and social care professionals making decisions about relative priorities within their workload. Without this, decision making will be slow and cumbersome and a greater harm to individuals may result than if an informed decision was made (and recorded and reported) by the worker on the spot.

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[24] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf
[25] www.gov.uk/guidance/pandemic-flu#ethical-framework

The Ethical Framework guidance states that records should be kept of decision taken and the justification for them. This matters for accountability and to review decisions at the end of short, specified periods. Such records can also help people learn from experience in order to respond to further pandemic waves, or to a different pandemic in the future.

Interviews with DASSs have included reference to care service prioritisation strategies and solutions used during extreme weather and during the Tour de France Yorkshire leg. At the time of writing however, only one written record has been identified in the literature review. Other than this one example the view expressed in interviews is that prioritisation is incident specific, intuitive, common sense and that mutual aid between providers plays a major part.

> Lancashire County Council developed and published comprehensive social care prioritisation guidance for its area: *Pandemic Planning in Different Independent Sector Social Care Settings, July 2009* [26] (not available online). The importance of up to date, even daily, local capacity and demand information becomes evident when applying the ethical framework and local prioritisation criteria to decision making.
>
> *Derbyshire Strategic Plan for Pandemic Influenza Appendix C* [27] includes a daily situation report to Gold for the Local Authority with a significant emphasis on adult and children's social care capacity on page C2.

13. Linking Ethical Decision Making to securing additional care and support capacity

Decisions about how to use volunteers should be made at local level in the context of avoiding a greater harm in an escalation period/a peak. For example:

- Volunteers provide a second pair of care hands or act as driver to a paid and trained worker but do not enter the house
- Volunteers undertake visits alone within specific parameters.
- Volunteers may include adults with learning disabilities or physical disabilities or children who become carers of their relatives and will require support.

14. Volunteering

Local decision makers will need to consider whether it is a greater harm to have no carers go into a 'too sick to get out of bed' person (perhaps in a very rural location) because the only available person, perhaps their nearest neighbour who has phoned the contact line is not given permission. For example, a neighbour phones expressing concern that she can't get an answer to the door or phone. But she is not known to the decision maker, does not hold her neighbour's key or key box code and is not known to be DBS checked for another volunteering or paid role.

> **Flu Friends:** a designated friend or relative who collects medicine on behalf of a person with flu who has been advised to remain at home. The definition does not mention volunteers acting as flu friends, volunteers will be necessary for socially isolated people with flu.

[26] *Pandemic Planning in Different Independent Sector Social Care Settings, July 2009* [26] (not available online)
[27] http://www.derbyshireprepared.org.uk/files/uploads/Strategic_Plan_for_Pandemic_Influenza.pdf

Actual care giving, and social support is not currently in the definition of a Flu Friend. Whilst adding it in may cause people to step back from being a flu friend, some flu friends may, without already being a relative or friend, start to add support or physical care to isolated individuals with flu if they see that no care has been provided when they visit to deliver the prescription. This eventuality needs to be anticipated and planned for – either to support and guide them or to ensure they do not step beyond the Flu Friend role.

Facilitating resilience in villages and neighbourhoods is a vital step to reduce the risks of socially isolated people being left uncared for in an emergency, but needs time to be planned for and bedded in. In Derbyshire the Emergency Planning Teams are working with local communities on building local resilience and recruiting flu friend. Some communities that experienced prolonged flooding have formed resilience networks.

National voluntary organisations, for example:

- British Red Cross
- St Johns Ambulance
- Khalsa Aid
- Age UK
- Street Pastors

All these volunteers are DBS checked and well trained to a standard set by their national organisation. The volunteers are well supervised at local level, generally accustomed to assessing risks and reporting up appropriately and used to dealing with distress and challenging behaviour.

The Red Cross, Age UK and St Johns Ambulance have training capabilities and capacity that can train other volunteers in basic care giving. Khalsa Aid and Street Pastors could train in social support, keeping safe whilst volunteering etc. Neither of these faith organisations do not allow their volunteers to proselytise. There will be other organisations with capabilities, the above is given as well-known examples.

Local voluntary organisations, that already apply Safeguarding policies and procedures. Examples of these include local faith organisation pastoral care teams - their volunteers are accustomed to visiting frail/needy people at home. Local councillors and school governors are also vetted. Local volunteers know their neighbourhoods well, can call on the resources with them, and have a local infrastructure to work within.

The capacity of national and voluntary organisations will vary from one area to another, and arrangements to involve them in care and social support may best be made at local operational level.

Whilst all respondents to the Survey of Directors in December 2017 said they had arrangements to monitor availability of care services, fewer than 45% had arrangements to monitor availability of volunteers or family carers.

Even if the availability is known, the utilisation of available resources is likely to need coordination so that it can be used where it is needed. A further question asked if there is a process for

coordinating the capacity of carers, volunteers and care providers to enable the availability of real time information on capacity:

> "Thinking about real time information flows on capacity - Is there a process for coordinating capacity of carers, volunteers and Care Providers?"

ANSWER CHOICES	RESPONSES	
Yes	46.05%	35
No	53.95%	41
TOTAL		76

Fewer than half (46%) of the respondents believed they had a process for coordinating available capacity. 40 respondents provided comments on this. These included weekly or twice weekly calls, regular email correspondence, and arrangements in contracts for information updates on capacity. Some recognised that information on volunteers was less developed than for paid services.

15. Human Resources

Forward planning for the gap between health and care service capacity and demand – the available care capacity will be greater than the safe, useable beds and safe/competent staffing capacity. Local health and care resilience partnerships and their equivalents will already be monitoring care capacity in hospital, in care homes and in the community at least weekly to manage care capacity pressures during winter, and at variable frequency during calmer months. Section 13 of this report is about the powers, flexibilities and easements requested by DASSs and Care Provider representatives to be able to respond to a flu pandemic. There are brief references in Section 13 to flexibilities to support human resource capacity.

15.1 Paid Staff: Forward assessment of workforce capacity and dynamic monitoring of health and care staff supply in the community should include:

- NHS staff
- Staff in registered care providers in whom there is confidence about care quality
- Specialist skill sets
- Family/informal carers
- Paid/contracted staff in different roles but whose
    - DBS certificates and safeguarding training are in date
    - Remit in their normal roles mean they have useful transferable skills, for example:
        - School staff of all types
        - Foster Carers

The following flu pandemic plans published on the internet by Local Authorities and Public Health England are good examples of Human Resource planning for a pandemic:

- **Hampshire County Council Pandemic Influenza Planning and Response Plan 2017 v3**[28]

[28] Hampshire County Council Pandemic Influenza Planning and Response Plan 2017 v3 (Not yet available online)

- **Southampton City Council**[29]
- **Dudley Metropolitan Borough Council Pandemic Influenza HR Policy 2009**[30]
- **Public Health England - Pandemic Influenza Response Plan**[31]

The Hampshire and Public Health England plans particularly refer to the risks of staff not attending work for various reasons and some of the elements of their Human Resources plans are clearly targeted at supporting staff who have other caring responsibilities, health conditions, fears of contagion etc, the aim being to encourage staff to return to work, close monitoring, but minimising or setting aside of HR procedures such as the Bradford Score triggers, disciplinaries, less frequent sickness certification if any etc.

15.2 Monitoring of care staff sickness levels: Interviews with DHSC, DASSs and Care Provider representatives included discussion about the methodologies to do this, the barriers to gathering accurate information, and the benefits of collecting and monitoring it beyond local commissioner/operations level. Our conclusion is:

> Where social care commissioners already have these arrangements in place, contracted for and working well, they should continue and there may be a useful sample for national collection to monitor trends of sickness in care staff for example length of illness, whether they return from sick leave in a pandemic etc.
>
> Where such collection and analysis are not already well established it could be considered that the barriers to accurate and timely collection are large and the benefits too few. It is considered that the real indicator of supply pressures is care service supply and local population flu sickness levels in the workforce and child age groups which may lead to care staff taking sick leave or carers leave.

There would be value in adult social care and health tracking sickness levels in social work and community health staff who have assessment roles. Beyond that, the organisational change in health and local authorities means that the essential support functions for social care and community health care are often dispersed and no longer managed in one directorate, such as council contact centres. Some essential functions may be contracted out. So beyond monitoring of assessors, it is recommended whole council staff sickness rates are monitored using normal reporting systems and forwarded to LRFs and beyond.

16. Communication during the phases of a pandemic

The Flu Pandemic Communications Strategy 2012 [32] is the source of government guidance in this section.

> The Cabinet Office, the Home Office, Department of Communities and Local Government (DCLG) and DHSC will agree briefings and cascade alerts down through health and social

[29] https://www.gov.uk/government/collections/pandemic-flu-public-health-response
[30] Recommend access through search engine. Search for: Dudley Pandemic Influenza HR Policy – (no link available)
[31] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/344695/PI_Response_Plan_13_Aug.pdf
[32] www.gov.uk/government/publications/communications-strategy-for-uk-flu-pandemics

care organisations. National media will also put out regular bulletins and will be a useful source of information for staff as well as the public.
The key challenge of communicating about the flu pandemic as clearly as possible without underplaying or exaggerating the risk.

The Code of Practice for Official Statistics requires publishing of weekly epidemiological reports on an appropriately accessible website for example they list the Health Protection Agency (HPA) – to update professionals and the public and *'allow complex issues to be debated*' [33].

National and local communications will need to be honest, clear and timely so that media – including social media – views on what is happening don't become the dominant source of information. The current National Communications Strategy is over five years old, which means that the impact of personal social media and 'fake news' was not fully addressed. This will need to be rectified in any redraft.

National and local guidance needs to be clear about the role of social care as well as health at every phase.

- Preparation and Planning
- Detect and Assessment
- Treatment
- Escalation
- Recovery

At each stage, in addition to general communications, DASSs will need to be clear on what needs to be communicated about local care and support services and about reprioritisation. This will change on a day to day basis during a wave as it rises to a peak and then starts to fall and 'lists of lists' will be necessary to keep track of exactly what is planned.
Communication audiences for targeted information about local prioritisation levels should include:

- Practitioners
- Managers across local public sector
- People who need care and support and their families.
- Councillors
- Local MPs
- Local businesses
- Local news media

During telephone interviews two DASSs referred to the need for there to be a very clear national message, amplified locally, about the importance of what individuals, families and communities do for themselves and for each other during a flu pandemic.

16.1. National and Local Communications Channels: The National Communications Strategy (Dec 2012) states that DH will be the primary source of health-related messages and ensure that direct communications to the public include Braille, audio, Easy Read and language translations. Specific channels will be targeted to reach all sections of the population, for example asylum seekers, refugees and foreign nationals.

NHS Choices, the Public Heath England (PHE) website and other key health and social care channels, third party/stakeholder websites will need to ensure wide dissemination. There is a risk that NHS/health information will dominate so DASSs should ensure that social care communications have a strong presence locally, although integrated/alongside NHS and Public Health communications.

It is expected that LRFs will plan communications delivery in their local areas, for instance a scenario where the outbreak is more severe locally than the national picture.

Council and NHS websites will need to provide links to consistent local information and advice. Local broadcast media, local TV and radio will be essential to get up to date messages to all sectors of the community. News channels will use traditional broadcast, Twitter and other online media.

Reprioritisation of services at local level: Local contact channels for health and care providers, service users, carers and the wider public must be well staffed so that phone calls and electronic messages are responded to quickly and decisions and actions communicated promptly. Electronic channels will be used, but in times of stress the telephone continues to prove to be the key route used by the public to get help from public services.

16.2. Communications during the Preparation and Planning phase: This is the time for DASSs to be engaging with local providers, voluntary sector and other stakeholders. The reader is referred to the National Communications Strategy**.** and the Health and Social Care Influenza Pandemic Preparedness and Response – the Role and Responsibilities of Social Care sections and charts in Annex B for more guidance, taking account of the age of the document and its lack of focus on Social Care throughout.

Recommendation 4: DASSs should work with local partners to compile a local health and social care communications plan suitable for the phases of a pandemic in the current national and local contexts of health and social care.

Recommendation 5: DASSs should ensure that there are local agreements on communication channels and the matters listed below are completed well ahead of a pandemic and refreshed bi-annually.

Preparation and Planning communication actions:
a) Establish communication links with partners

b) Brief staff, providers and other stakeholders on the phases of a pandemic and what the key communication themes will be at each phase
c) Emphasise the personal protection and hygiene messages
d) Listen to what partners need from health and social care commissioners and others to be confident about working to maximum effectiveness throughout a pandemic.
e) Plan local communications to take those matters into account
f) Plan to negotiate any contractual changes and flexibilities to apply in a pandemic with providers at this stage.
g) Recruit volunteer support via selected voluntary organisations
h) Ensure national information sharing protocols (confidential patient information) are understood and adopted at local level
i) Test plans/scenarios.

(Extract from DHSC Communications Strategy 2012)

16.3. Communications regarding Anti-Viral Treatment and The National Pandemic Flu Service: The 2012 Communications Strategy states that there will be a system of call centres that provide an authorisation number for people to pick up anti-viral treatment on behalf of patients. This phone number will be disseminated on a range of government health websites.

Once anti-viral medications are available, local authority public health departments will be responsible for establishing anti-viral distribution centres where the medication will be administered to those directed there by health professionals.

It is anticipated in the guidance that DASSs would support local public health teams to source appropriate, accessible Anti-Viral Distribution Centres and consider what social care support may be needed at the Centre to ensure that patients, relatives, "Flu Friends" are able to be properly informed about the anti-viral treatment. for example, translators and sign language experts might be required. Communications channels may be required to seek spare capacity for Anti-Viral Distribution Centres among care provider staff and volunteers.

16.4. Managing public demand for contact with health and social care during escalation: There will be formal arrangements between NHS111 and any other contact centres which have been set up to manage the flu pandemic demand in the community. It is expected that national decisions will be made about call numbers and handling capacity but responding to request for social care will be at local level.

Alongside messaging there should be toolkits of pre-prepared information and advice, access to equipment such as commodes and mobility aids and the ability to get one to one advice and support on the telephone or in live web chats etc.

People will take more steps and actions in support of their neighbours, whom they may not know beyond saying 'hello' in the street, if they are able to tell someone in authority what they are doing or have just done.

DASSs should not underestimate the demand for contact with adult social care from other services and the public and should plan for ample capacity, much easier to

stand down than stand up rapidly. Learning from flooding[34] and other major disasters in England has repeatedly demonstrated the problems arising from insufficient visibility of public sector responders, difficulty contacting them and slow responses. Anger, frustration and alternative, conflicting routes of decision making develop quickly. This results in confusion, 'fake news' and loss of trust in public services.

17. Sharing confidential client/patient information:

The *NHS Governance Toolkit - The Caldicott Principles 1997(Revised 2013)*[35] is about sharing of information in health and social care in line with the Data Protection Act 1998.

Information: To Share or Not to Share: Government Response to the Caldicott Review September 2013[36]. This document endorsed the revision of the Caldicott principals to include the 7th principal on the duty to share information, as follows:

- *Justify the purposes*
- *Don't share confidential data unless it is necessary*
- *Use the minimum information necessary for the purpose*
- *Access to personal confidential data should be on a strict need-to-know basis*
- *Everyone with access to personal confidential data should be aware of their responsibilities*
- *Comply with the law*
- ***The duty to share information can be as important as the duty to protect patient confidentiality***

Retention periods and deletion of personal data are crucial activities during recovery periods between pandemic waves and at the end of the pandemic. Personal confidential information may have been shared with or by voluntary organisations or, in emergency situations, with or by informal volunteers such as neighbours, local parish councillors and faith based pastoral care teams. Attention to these issues will be essential.

The EU General Data Protection Regulation (GDPR) will apply from 25 May 2018 and is expected to continue to apply, post Brexit. A guidance document has been published by the Information Governance Alliance *CEO Briefing Note – Changes to Data Protection legislation: why this matters TO YOU' 2016[37].* States:

> *"Although in general the principles of data protection remain similar, there is greater focus on evidence-based compliance… and considerably harsher penalties for non-compliance"*

Caldicott Guardians and Data Protection Officers in organisations are necessarily expert and powerful officers. They will require clear government guidance on information sharing during a pandemic to enable them to be of real expert assistance, rather than being perceived as a block to

[34] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292924/geho1107bnmi-e-e.pdf

[35] https://digital.nhs.uk/information-governance-alliance/resources/information-sharing-resources

[36] www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

[37] https://digital.nhs.uk/media/31435/Changes-to-Data-Protection-legislation-why-this-matters-to-you/pdf/GDPR_CEO_Briefing_3-7-17

managing such information flows. Their importance means Councils should ensure there are deputising arrangements to cover sickness.

Whilst sharing confidential personal information does not require easements of Data Protection law, it does require data sharing protocols to be in place. In addition to managerial level protocols between partners, health and care operational services and voluntary organisations need clear, straight forward advice about how to apply the law and guidance in a severe impact flu pandemic phase.

Flexible working by care staff in the community could involve the use of telephone apps. For instance, reporting on client visits via a phone app, or sending their employer a photograph of, for instance, a pressure area or unhealthy skin on a leg, so that the office can request a health assessment. These actions would normally be completely unacceptable by a health or care worker, although a friend or relative might readily do this in a situation where they can't get a GP or community nurse visit in the normal way due to overwhelming demand.

Smart Phones offer the potential for a GP or nurse to consult a patient face to face on camera through the smart phone of a care worker, relative or volunteer – this is a form of mobile telemedicine but using insecure channels and without protocols. This potentially valuable technology has major data protection issues to be understood and addressed.

Recommendation 6: DHSC should consult the UK Caldicott Guardian Council about what guidance it can give to facilitate information sharing during a pandemic and proper retrieval/deletion of information with reference to a severe impact in the community, when needs outstrip healthcare supply.

17.1 Doctors' duty of confidentiality: *The General Medical Council Guidance 2009: Pandemic Influenza, Good Medical Practice – the Responsibilities of doctors in a national pandemic*[38] sets out the regulators expectations of Doctors. Included in the 'musts' about the doctor-patient relationship on page 12, the doctor:

> *"Must as far as possible respect patients' privacy and right to confidentiality."*

In part of Section 37 on Confidentiality, the guidance says:

> *"During a pandemic, staff working in health protection agencies will be part of the healthcare team and you should share information with them freely. In addition, you should provide the minimum necessary data for any additional public health monitoring or surveillance introduced during a pandemic."*

Section 50 and 51 refers to the importance of sharing information when referring a patient to other healthcare professionals for safe and effective care, and that all relevant information should be shared.

It appears from the literature that sharing confidential personal information does not require easements of Data Protection law but does require data sharing protocols. In addition to managerial level protocols between partners, health and care operational services need clear, straight forward advice both about how to apply the law and guidance in a severe impact flu pandemic phase.

[38] www.gmc-uk.org/guidance/news_consultation/medical_pandemic.asp

18. School Closures, Educational and Child Care establishment closures:

Closures are included here only because some DASSs and Care Provider representatives interviewed mentioned the health and care workforce implications if schools and nurseries close during periods of a pandemic.

Annex C of the LRF/Local Planners Flu Pandemic Guidance refers to Education and the implications of schools closing or remaining open on infection spread and on the workforce. There may be LRF or national decisions to close, taken by Public Health England. However, decisions to close a school due to concerns about the safety of children and staff due to staff shortages appear to lie entirely with the Head Teacher and school governors.

The Gov.UK pandemic flu guidance overview states that Education and Childcare guidance is currently under review. The literature research only found the following relevant national guidance, which was published in 2006, and does not advise on the role of Ofsted:

> *Planning for a Human Influenza Pandemic Guidance to schools and children's services, Department for Education (DfE) 2006*[39]*.*

This report does not address the complexities of closing education and child care establishments. The DfE guidance indicates there are significant implications for the wellbeing and safety of particular types of establishment and children, requiring careful planning and management.

There would be similar and different issues with nurseries, many of which are run as small or medium sized businesses or franchises. The impact of staff shortages and closure on cash flow will influence their decisions.

The degree of control that Local Education Authorities (LEAs) have over schools, colleges and nurseries since the last pandemic is considerably reduced, with the emergence of academies. They have influence and expertise to provide support and advice to Head Teachers, Governing Bodies and nursery managers about how to adapt their school day and week, curriculum, staffing and use of trusted volunteers during a pandemic.

Recommendation 7: DHSC should, in consultation with DfE and Ofsted, encourage educational and child care establishments to work with the LRF to plan for both options of remaining open and closing, well ahead of a flu pandemic taking into account the impact of closures on the wider workforce, that is, parents of children who cannot attend due to closure.

a) Relevant government departments should update advice to education and child care establishments about flu pandemic and the role of public health advice. Where closures are threatened due to staff shortages there should be recommendations about cooperation between schools and adapting provision rather than closure if possible, in the interest of the local community.

b.) Pandemic guidance to Directors of Children's Services and local planners should consider how school closures might be minimised.

[39] http://dera.ioe.ac.uk/6536/1/STERL-0706-WEB.pdf

19. Powers and Flexibilities required to increase capacity and manage demand during escalation periods of a flu pandemic:

Appropriate easements, agreed by all relevant parties, will support social care services to maintain essential services and protect the health and wellbeing of service users and the wider population. Their use, accompanied by effective, recorded decision making, will maximise capacity and flexibility of response in a managed way as the pandemic progresses. Good record keeping of ethical decision making will support commissioners and providers in the face of complaints from clients who did not receive their usual standard and pattern of service.

The *Gov.UK Pandemic Flu Strategy 2011 Overview* [40]makes clear that local planners should plan for a mild, moderate and severe impact of flu on the population. Current health and social care escalation plans, and local adaptation of processes being used in the winter of 2017/18 will probably be sufficient for a mild to moderate impact, depending on the age groups most affected.

The easements described in this report will be of value and therefore justifiable in a pandemic with a severe impact. Potential easements and flexibilities are discussed in detail in one of the associated reports, the recommendations arising are included in the Annex to this report.

Most of the suggested easements below are achievable at local level, so recommendations are to DHSC and DCLG to ensure Local Authority Chief Executives and Leaders are aware of the duties of the Local Authority in a flu pandemic and provide the necessary resources and permissions to implement them.

Planned vs Ad Hoc local easements in processes: DASSs report that in an emergency or when Acute Trusts go in to 'Black'/OPEL 4 status, or when there are sudden, short-term emergencies such as a fire or flood and Care Home residents need help to move immediately, DASSs describe how everyone pulls together both across the NHS and the council, for example, staff working round the clock, and also in the voluntary and private sector, with care providers providing care first and talking about costs later. In such short-term emergency situations, ad hoc responses are often used, and the focus during the emergency is on results with less scrutiny on the process or longer-term outcomes for the people concerned.

During a flu pandemic, however, the local health and care system may be working at this level for weeks or months at a time, and it will not be possible for short-term ad hoc solutions to be used. In a pandemic, there may be one or more waves, with possibly 30% (or more) staff shortages due to flu and staff staying away from work to care for family who are ill, or because they are afraid of being infected themselves. Cooperation and heroic efforts that might be used on an ad hoc basis suitable during short-term emergencies are unreasonable to expect and less likely to work well during the lengthy period of a pandemic. Planned and rehearsed responses will be necessary. It is therefore essential to plan for any easements that would be used.

It should also be noted that ad hoc arrangements also increase financial risks to both commissioners and providers. At local level, normal spending control measures will need to be adapted and a different set of financial monitoring and control put in place.

20. Easements suggested by DASSs

In the ADASS Survey of Directors DASSs were asked what powers and flexibilities they required

[40] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213717/dh_131040.pdf

to increase capacity and manage demand. In addition to responding to some suggested flexibilities and powers, there was the option to make other suggestions.

ANSWER CHOICES	RESPONSES	
Rapid recruitment processes	65.75%	48
Rapid processing of security checks and references	73.97%	54
Priority access to fuel	68.49%	50
Emergency transport arrangements	69.86%	51
Permission to commandeer premises, should the need arise	47.95%	35
Emergency paid carers' leave	53.42%	39
Emergency access to rotas and records	67.12%	49
GP availability for responding to flu instead of other non-priority work	80.82%	59
Other (please state what else you would need and/or make comments or suggestions on what else would help)	19.18%	14
Total Respondents: 73		

The answers reflect the priorities of the Directors, for instance 65.75% (48) replied that they wanted rapid recruitment processes with 73.97% asking for rapid processing of security checks and references. 14 made suggestions about other flexibilities that would be useful.

CQC: Interestingly, easements in respect of CQC were not mentioned by DASSs. This may be because DASSs are confident that CQC will work positively with them during an emergency to temporarily relax standards and processes during a pandemic, to secure capacity and avoid greater harm. Providers, however, are concerned about this. Several of the flexibilities below, raised by DASSs both in the survey and in telephone interviews are expanded on in the Human Resources Section of this report Section 15**.**

20.1. Staffing Capacity:

a.) Staff who are sick: clear public health and HR advice about when to stay away from work and when to return to adapted or normal duties.

b.) Emergency Paid Carers leave (staff who are family carers of people with flu): clear HR advice about emergency carers leave in the context of a flu pandemic.

c.) Working Time Directive: Staff must be properly rested, but flexibility beyond the Directive limits may be required.

d.) Rapid Recruitment Processes that enable new staff to start work pending full clearance, based on risk assessments.

e.) Use of volunteers well beyond usual forms of volunteering.

f.) Cross organisation staff supervision arrangements: One DASS interviewed described potential process and 'norms' easements concerning Community Nurses – a nurse supervising a group of domiciliary care workers, so they can reach more people under a nurse's supervision. Selected, experienced care workers could each coordinate 10 volunteers who are making visits and undertaking tasks within the care workers client list such as preparing food and drink, checking heating, buying food.

g.) Trusted Assessors and simple assessments: Training a much wider group of

health and care staff to act as assessors, able to authorise initial care for a short period of up to five days using a simple assessment. This would be followed by a skilled assessment.

Retired Nurses and Allied Professionals no longer registered but have local professionals/last employer willing to provide references would be invaluable.

Simple assessments undertaken by a much wider range of people designated as assessors to provide access to short term care, create a record of immediate needs and care, equipment or supplies required immediately.

Paper-based short assessments will be of value to trained volunteers and to micro-providers taking on new clients without access to electronic record/reporting software. Smart phone/App based assessments and reporting are discussed in the Information Sharing Section 22.

There is some concern expressed by DASSs about short-term simple assessments undertaken by people authorised to assess during the pandemic but who may have less accountability or knowledge of Adult Social Care processes. In this situation, there may be an increased need for early reviews to confirm that the allocated resources are justified. This may in turn create a backlog of short-term reviews (occurring perhaps within 5 days), although it could be argued that the majority of frail/elderly/disabled people with flu requiring social care support in their home for a few days will not require reviews, as they will recover sufficiently for family and friends to give the support required.

It could be argued that the frailest elderly people with flu, requiring personal care and possibly a commode at home for a few days, will not require reviews as they will recover sufficiently for family and friends to give the support required. Perhaps reassessment by Adult Social Care in five days is too short a period, and care providers should be trusted to step down or end care and to report if care is required for a further period due to the impact of flu on the client. It is a balance between resources spent on care provision and the limited resources of Adult Social Care to monitor and control demand and costs of care.

Recommendation 8: DHSC should support the use of shortened, electronic (tablet or smart phone app) or paper-based assessments: **People authorised to assess during the pandemic would need briefing on the requirements and Care Act eligibility for services and full needs assessments may need to be set aside in favour of brief assessments followed by reviews, as necessary.**

Recommendation:9: DASSs, the NHS and Social Care Providers should consider a potential extension of the training and role of Trusted Assessors in a flu pandemic before a pandemic arises. Consideration should also be given to training an additional workforce of competent volunteers in formal organisations such as Age UK, the Red Cross, who could be authorised as assessors during the pandemic.

20.2. Commandeering Premises and access to staffing rotas and client records:

The Survey of Directors in December 2017 identified that 47.95% of respondents wanted the permission to commandeer premises**,** should the need arise. The use of this power could be crucial in a pandemic wave approaching 40%, or if it is combined with further emergency situations rendering sick and highly vulnerable people at risk of homelessness and an emergency move.

National Guidance states that councils are responsible for securing premises for the administration of flu treatment (vaccination) if it is available.

This flexibility could encompass commandeering a closed or failing Care Home and the Council running it with staff from another provider. Or commandeering other buildings such as hotels, with the added possibility of associated hospitality services, such as housekeeping and meal preparation.

Some Councils may already have experience of doing this to secure care in a failing provider and avoid moving residents in haste and could offer experience and protocols used. The easement lies in the departure from CQC standards such as the environmental standard and the use of housekeeping and reception staff not DBS cleared.

Commandeering premises such as a failing care provider – Care Home or Domiciliary Care – would require access to staffing rotas and client records.

Recommendation 10: **DASSs should work with local LRF partners to develop plans about how to commandeer a Care Home or hotel well in advance of a pandemic.**

20.3. Priority access to vehicle fuel: This should already be well rehearsed as a separate contingency plan, but Adult Social Care and providers should check their plans and processes are still appropriate for a situation with a high level of sickness amongst social care staff (who may have just filled their tank) and other essential services such as tanker drivers due to the competencies required for fuel tanker drivers, that is, there may not be a ready supply of substitute drivers. In rural areas relying on small garages, sickness may result in periods of closure with no one competent being at premises to receive fuel delivery or sell fuel.

Derbyshire Strategic Plan for Pandemic Influenza 2009 Appendix B B3[41] is a template to report on the local/regional impact of shortages, power and telecommunication outages, panic buying, broadcasting, waste management.

20.4. Emergency Transport arrangements: DASSs should assume that private Ambulance contractors are already fully booked by the NHS so should, through their emergency planning team, plan for alternative transport arrangements appropriate for their local areas.

20.5. General Practitioners: Availability to respond to flu instead of other non-priority work: Various DH, NHS and GMC guidance documents between 2009 and 2013 indicate that GPs will be required to prioritise their work, but DASSs should plan in the knowledge of greatly changed landscape in primary care services in England.

There is a serious shortage of GPs in England and a growing proportion of GP locums and part time salaried GPs who work part time in general practice and part time in hospital. They may be commandeered by their hospital full time. Given they are not partners in the GP practice their loyalty to the practice and practice population will not be the same as GP partners.

When flu patients cannot be admitted to hospital due to over demand, the NHS system relies on GPs to attempt to meet their medical needs in the community. There are clinical

[41] https://www.derbyshireprepared.org.uk/files/uploads/Derbyshire_Strategic_Plan_for_Pandemic_Influenza.pdf

prioritisation algorithms and protocols for GPs to follow but they still rely on GPs being able to make home visits to medically assess people who are becoming severely ill due to complications of flu and to have access to the medicines, oxygen, nursing and physiotherapy as well as social care to maintain a patient in the community who would ordinarily be treated in a Medical Assessment Unit.

20.6. Mortuary Capacity: Other DASSs raised the issue of mortuary capacity and body storage together with coroner arrangements and increased cremation capacity. Whilst this is not in the purview of adult social care, it is a local authority responsibility during a pandemic and at periods of very high death rates it will be essential in bed-based services to move the bodies of deceased people promptly, so that care facilities can be brought back into use.

20.7. Contracts and Procurement rules: Could be loosened or set aside at local level for letting contracts/arranging care and other essential work to provide timely goods and services.

Two DASSs interviewed described contracts with Care at Home providers that maintain a steady flow of income in that funding is not removed immediately a client is admitted to hospital, or moves into a Home, or dies. One example: the funding continues for up to two weeks with the expectation that the provider will take on more clients very quickly, for example, patients awaiting discharge with care at home packages not waiting longer than 24 hours after being fit for discharge. This is a contractual arrangement for normal conditions.

a.) In a flu pandemic the time between fit for discharge and discharge will need to be no more than a few hours – as would a new care at home package to avoid a hospital admission. This will be extremely challenging in the cases of people with dementia, and yet these are the patients who will be placing a heavy demand on nursing resources in hospital.

b.) During a pandemic, residential homes may find that several of their residents who are normally relatively mobile and self-caring, become highly dependent at the same time. High dependency from flu may last two weeks or longer given their frailty and risk of acquiring complications. This will have a real staffing and equipment/disposable supplies cost to providers.

c.) There may be a need for emergency/commandeered placements for fluctuating periods over several months which may skew provider finances. To maximise cooperation and avoid resources being used on local negotiations at the time, national or regional rates would assist.

Recommendation 11: DHSC should consider the possible advantages and disadvantages of a national rate (with allowance for regional variations) for emergency placements and high dependency periods in residential homes. ADASS, NHS England and care provider representatives should be consulted and guidance would be required on local application of any emergency rates.

Some respondents also referred to permission to go outside of contracts. It is recognised that this may involve local decisions about spot purchasing beyond contract, or it may reflect restrictions in local contracts already let and the need for local procurement and legal services advice.

20.8. The duties of the whole Council: A recommendation made in other reports in this series asks DHSC and MHCLG to provide guidance to Local Authorities about the need for the wider Council to recognise the impact of a coming pandemic and create space for DASSs and the teams they need from across the Council to plan and manage the demands.

20.9. Rapid turnover of empty Care Home bedrooms: Commissioners will need Care Home Providers to reuse a room much quicker than usual after a death despite objections from grieving relatives. Many Care Homes have self-funder contracts requiring payment for a week or longer after a resident moves/dies, and funeral directors may have a backlog with delays in removing bodies.

20.10. Sheltered and Extra Care Housing: Local areas could stop normal allocations to free up capacity and require wardens and other staff to work differently to meet residents' needs.

20.11. Sourcing hot meals: To be delivered to people at home who need them – would decisions about suppliers need to be informed by 'Scores on the Doors' ratings, or an up to date environmental health inspection? Support small Care Homes with sickness amongst catering staff by supplying meals from larger Homes – managing the food hygiene aspects of this requires forethought.

20.12. Purchasing food and fuel cards for clients at home: An example given of a socially isolated disabled or elderly frail adult living at home who has flu and is unable to leave their home to obtain cash or buy food or electric meter keys/cards. How will visiting care agencies or voluntary agencies manage the process of buying necessary supplies/fuel cards and reclaiming the cost?

21. Easements suggestions from the Care Provider Alliance and the UKHCA:

Telephone interviews identified that Providers have much the same suggestions for easements as DASSs, except for their concerns about CQC. DASSs did not express concerns about CQC not being flexible. Provider representatives expressed a real willingness to work flexibly and very differently in a flu pandemic but require significant support to do so over a prolonged period when they may well have high sickness rates in their staff and current residents/clients.

The issues raised and recommendations arising from the telephone interviews are:

21.1 Care Quality Commission: The Provider representatives overriding concern is the view that CQC might take if, by working differently to provide additional bed and workforce capacity, providers deviate from current practice and environmental standards.

CQC support is important for care providers who are challenged by service users/relatives that they are not receiving the level of service being paid for/commissioned.

Care staff being asked by commissioners to act as Trusted Assessors during the pandemic with an abbreviated training for the role and without the formal qualifications or registrations normally expected of Trusted Assessors.

Accepting clients who are very unwell without the usual level of assessment and care planning and risk assessment documentation usually expected.

Working with or supervising volunteers recruited/requested from Voluntary Organisations by the local authority or NHS.

> *"Managers and staff need to feel confident that, if they act in good faith, and as they believe is in the best interests of people needing care, and with reasonable care and competence, they won't be subject to regulatory criticism if things go wrong; while regulators need to be confident that providers will do all they reasonably can to maintain normal regulatory standards."*
>
> *(Care Provider Alliance January 2018 telephone interview.)*

21.2. Sharing Confidential Personal Information: Clarity about information sharing protocols that provide them with justification to share, guidelines about how to do it and with whom. During a peak when there is overwhelming demand, information sharing may need to be outside of normal processes.

21.3. Prioritisation criteria and banding: Some providers have contracts with several local authorities. If each of these has their own prioritisation criteria, banding and forms there will be a significant burden on providers and the risk of confusion. If providers are to be asked to share work between providers, this is a further reason for consistent prioritisation approaches. Providers hope there might be a national set of criteria, banding and templates.

21.4. Staff absenteeism, accompanied by rising vacancy levels in social care: Provider representatives expressed caution about recruiting large numbers of new staff for the pandemic. They said it takes 13 weeks to recruit and train a care at home member of staff, so they can make visits alone. Recruitment and training is costly for providers. If the staff will not be required once the pandemic is over there is no incentive for providers to incur these costs and management time when they need to concentrate on providing care during the pandemic.

21.5. School and nursery closures: if education and child care establishments close there will be an immediate impact on the health and care workforce. See Section 23 for more information.

21.6. Disclosure and Barring Service (DBS) and Protection of Vulnerable Adult Checks: Providers asked for these to be faster to speed up recruitment and staff being able to work alone.

21.7. Financial instability amongst providers:

Their concerns are:

1) High levels of complications of flu causing higher dependency of clients and residents and higher costs.
2) Higher than normal death rates, including among self-funders who pay more.
3) Higher number of clients being admitted to hospital or transferred to a different care category and commissioner fees being suspended/stopped. Section 4.4 refers.
4) Inability to acquire new self-funder business because all beds and care at home capacity is required for flu pandemic prioritised care provision.

5) Requirement to accept new clients at v short notice but who are highly dependent due to flu, but payment for the work following slowly.
6) Self-funders demanding rebates due to not receiving contracted for level of service.

> *'providers will need to feel confident that, if they start providing care prior to a formal agreement, or if they are impacted by unavoidable additional costs, they will be paid; while commissioners will need to feel confident that providers won't exploit the situation with unreasonable excess fees.'*
>
> *(CPA)*

21.8. Delay in removing bodies of deceased residents from Care Homes due to Funeral Directors Delays: When commissioners want the room re-occupied that day or the next at the latest.

Recommendations

Recommendation 1: DASSs and their emergency planning teams should refresh and rehearse strategic and operational plans now, well ahead of a flu pandemic. To do so effectively they should engage with their Local Resilience Forum, the local health and social care resilience partnership and with social care providers and the voluntary sector in their local area.

Recommendation 2: DHSC should consider developing a national system of prioritisation of care and support at home during the escalation phase of a flu pandemic.

Recommendation 3: DASSs should, through their regional ADASS branches consider collaborating on a single regional system of prioritisation suitable for care at home to reduce the risk of confusion amongst providers serving more than one local authority area.

Recommendation 4: DASSs should work with local partners to compile a local health and social care communications plan suitable for the phases of a pandemic in the current national and local contexts of health and social care.

Recommendation 5: DASSs should ensure that there are local agreements on communication channels and the matters listed below are completed well ahead of a pandemic and refreshed bi-annually.

Preparation and Planning communication actions:

j) Establish communication links with partners
k) Brief staff, providers and other stakeholders on the phases of a pandemic and what the key communication themes will be at each phase
l) Emphasise the personal protection and hygiene messages
m) Listen to what partners need from health and social care commissioners and others to be confident about working to maximum effectiveness throughout a pandemic.
n) Plan local communications to take those matters into account
o) Plan to negotiate any contractual changes and flexibilities to apply in a pandemic with providers at this stage.
p) Recruit volunteer support via selected voluntary organisations
q) Ensure national information sharing protocols (confidential patient information) are understood and adopted at local level
r) Test plans/scenarios.

(Extract from DHSC Communications Strategy 2012)

Recommendation 6: DHSC should consult the UK Caldicott Guardian Council about what guidance it can give to facilitate information sharing during a pandemic and proper retrieval/deletion of information with reference to a severe impact in the community, when needs outstrip healthcare supply.

Recommendation 7: DHSC should, in consultation with DfE and Ofsted, encourage educational and child care establishments to work with the LRF to plan for both options of remaining open and closing, well ahead of a flu pandemic taking into account the impact of closures on the wider workforce, that is, parents of children who cannot attend due to closure.

a) Relevant government departments should update advice to education and child care establishments about flu pandemic and the role of public health advice. Where closures are threatened due to staff shortages there should be recommendations about cooperation between schools and adapting provision rather than closure if possible, in the interest of the local community.

b.) Pandemic guidance to Directors of Children's Services and local planners should consider how school closures might be minimised.

Recommendation 8: DHSC should support the use of shortened, electronic (tablet or smart phone app) or paper-based assessments: People authorised to assess during the pandemic would need briefing on the requirements and Care Act eligibility for services and full needs assessments may need to be set aside in favour of brief assessments followed by reviews, as necessary.

Recommendation: 9: DASSs, the NHS and Social Care Providers should consider a potential extension of the training and role of Trusted Assessors in a flu pandemic before a pandemic arises. Consideration should also be given to training an additional workforce of competent volunteers in formal organisations such as Age UK, the Red Cross, who could be authorised as assessors during the pandemic.

Recommendation 10: DASSs should work with local LRF partners to develop plans about how to commandeer a Care Home or hotel well in advance of a pandemic.

Recommendation 11: DHSC should consider the possible advantages and disadvantages of a national rate (with allowance for regional variations) for emergency placements and high dependency periods in residential homes. ADASS, NHS England and care provider representatives should be consulted and guidance would be required on local application of any emergency rates.