

MODULE

1



Pandemic influenza

Guidance for commissioners and providers of social care



Module 1: Introduction and key facts

DH INFORMATION READER BOX

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Pandemic influenza

Guidance for commissioners and providers of social care

Module 1: Introduction and key facts



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1 Context

Influenza pandemics are natural phenomena, which tend to occur two or three times each century. Pandemics arise when a new influenza virus emerges and spreads rapidly across the world, with widespread epidemics in different countries. The severity of pandemics varies, but in the last century there were three pandemics: the 'Spanish flu' of 1918/19, in which 20 million to 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 pandemics in 1957/58 and 1968/69 were much less severe, they also caused significant illness levels (mainly in the young and the old) and an estimated 1 million to 4 million deaths between them.

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 pre-emptive, coordinated and robust plans in place, the impact of a pandemic can be reduced and the recovery of services hastened.

Social care provides a critical public service, much of it a statutory responsibility for local authorities, and supports approximately 1.7 million adults and 0.4 million children. There are more than 5 million informal carers supporting adults. Some 1.1 million adults pay for their own support, 90% of them at home and 10% in care homes.

Social care is mainly commissioned by local authorities or private individuals. It is, however, provided by a mixed economy of statutory, voluntary and private providers. The extensive range of provision varies in size from the very large (25% of care home places for older people are operated by just four companies) to the very small (members of adult placement schemes will often be caring for just one person). Often described as a fragmented market, there is no single communications or reporting system and diverse accountability structures reflect the diverse nature of provision.

Social care services aim to support users to remain in their own homes and communities, with an increasing emphasis on personalisation through the provision of individual budgets, independent living schemes and supported housing, leading to increased control for users over how their needs are met. However, care home placements remain a key way of meeting some users' needs.

Approximately 0.8 million people are employed in adult social care, a third of them by local authorities and the remainder by private and voluntary agencies. Of the 0.8 million, two-thirds are frontline 'hands-on' care workers.

2. Purpose

This document is **Module 1** in a series of nine modules that support planning in social care for an influenza pandemic.

Module 1	Introduction and key facts
Module 2	Communication roles and responsibilities
Module 3	Planning (appendix: Impact calculator)
Module 4	Infection control
Module 5	Managing assessment, death and fair access to care
Module 6	Induction information for staff
Module 7	Surveillance
Module 8	Recovery
Module 9	Self-assessment

The nine modules are collectively entitled *Pandemic influenza: Guidance for commissioners and providers of social care*. This guidance builds on two key documents that have been published by the Department of Health: *Pandemic flu: A national framework for responding to an influenza pandemic* (November 2007) and *An operational and strategic framework: Planning for pandemic influenza in adult social care* (November 2007).

The aim of this guidance is to equip local authorities and other social care organisations with the tools and resources needed to plan for, and meet the challenges presented by, pandemic influenza. These challenges will be different from those posed by many other emergency response situations: it will not be confined to one area, and it will affect staff at all levels as well as users. All partner organisations – health services, emergency services, care providers, etc – are likely to be under considerable strain as a result of both increased demands and diminished human resources with which to meet those demands.

By providing a set of checklists, local authorities and other social care providers will be able to assure themselves that they have robust plans in place, rooted in joint working, supported by good-quality local information and underpinned by meaningful user involvement.

Further modules in this series will provide detailed guidance on preparing a social care response to pandemic flu. While primary care trusts (PCTs) have lead responsibility for local planning, it is essential that local authorities and private and voluntary providers take responsibility for ensuring that they have adequate and tested business continuity plans in place to ensure the continued provision of essential services through the peak period and possible subsequent waves of a pandemic.



3. Audience

This guidance is intended primarily for those responsible for preparing local authority social care services for an influenza pandemic. It is also of significant relevance to staff and providers of social care services in the voluntary and private sectors. Additionally, it will be of interest and use to other stakeholders, including local authority partners such as PCTs and acute health trusts.

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 in 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.

4. Pandemic influenza information and planning assumptions

4.1 What is a pandemic?

The word has its origins in 'pan' (meaning all) and 'demos' (meaning people), so a pandemic is an epidemic that affects 'all people'.

Pandemic influenza will arise when an emerging or re-emerging influenza (flu) virus is:

- markedly different from recently circulating strains
- able to infect people
- readily transmissible from person to person
- capable of causing illness in a high proportion of those infected
- able to spread widely because few, if any, people have natural or acquired immunity to it.

Influenza is an acute infectious viral illness which spreads rapidly from person to person by close contact via the respiratory route when a person talks, coughs or sneezes. It also spreads through hand-to-face contact if hands are contaminated. It is one of the most difficult infectious diseases to control. Symptoms include the sudden onset of fever, chills, a headache, muscle pain, the inability to move and a cough.

4.2 What an influenza pandemic might look like

Previous pandemics have varied in both size and severity, although in general their impact has been much greater than that of even the most severe seasonal flu epidemic. It is also important to understand that there have been differences in the age groups affected, the time of year when they occurred, and the speed of spread. Although little information is available on earlier pandemics, the three that occurred in the 20th century are well documented. The worst, often referred to as 'Spanish flu', occurred in 1918/19. It caused serious illness: as stated earlier, an estimated 20 million to 40 million deaths worldwide (228,000 in the UK), with peak mortality rates among those aged 20–45. The pandemics of 1957/58 and 1968/69 (often referred to as 'Asian flu' and 'Hong Kong flu') were much less severe, although they still caused significant illness levels, mainly in the younger and older sections of the population.

It is impossible to forecast accurately the exact characteristics, spread and impact of a new flu virus strain. Modelling work suggests that, from the time a pandemic begins (probably, but not necessarily, in a country in the Far East), it could take as little as two to four days to build from a few to around 1,000 cases and could reach the UK within a further two to four weeks. Once in the UK, it is likely to spread to all major population centres within one or two weeks, with an initial peak some five weeks after that. Pandemics can occur in waves, and any second or subsequent wave could be bigger than the first.

4.3 Predicting the impact on social care

For the purposes of planning within social care, impact assessments have been derived from a combination of current virology and clinical knowledge, expert analysis and mathematical modelling.

While information about previous pandemics provides some useful information, much has changed since the last one in 1968/69. A predicted increase in the number of people over pensionable age (from 11.4 million in 2006 to 12.2 million in 2011), improved health and social care outcomes and expectations and a reduction in surge capacity within the NHS are all likely to impact on the social care response.

Accurate mathematical modelling of the possible effects of a flu pandemic allows us to map the range of possible risks and inform planning by creating estimated impact predictions. It is important for those involved in planning at all levels to note that the actual shape and impact of a pandemic may be very different.

5. Key facts

5.1 Infection rates

In previous pandemics, the overall clinical attack rate was between 25% and 35% of the population (seasonal influenza normally attacks between 5% and 15%). Total cumulative clinical attack rates of up to 50% of the population are possible spread over one or more waves. Some 25% of those with symptoms are likely to develop complications.

5.2 Transmission of the virus

Flu is transmitted by close personal contact with an infected person. People are at their most infectious soon after they develop symptoms. Infected individuals pass the virus to others through large droplets when coughing, sneezing and even talking within a short distance (usually less than one metre). The virus can be passed on through direct contact with an infected person, eg shaking or holding hands, followed by touching the mouth, eyes or nose without first washing the hands. The virus can also spread via inanimate objects such as door handles and light switches. If an infected person touches such an object, the virus can remain on that object for 24 hours and is capable of infecting someone who touches the object and then touches their eyes, mouth or nose without first washing their hands.

5.3 Increase in deaths

Among those with symptoms, we expect a case fatality rate of between 0.37% and 2.5%. This gives an increase in the number of deaths across the UK of between 55,000 and 750,000.

For a small London borough with a population of 147,000, this could mean an additional 270 to 1,800 deaths over a possible 15-week pandemic period, with 20% of those deaths occurring in one peak week.

5.4 Pre-pandemic vaccine

Immunisation with an influenza vaccine – related but not specific to the pandemic strain – may offer some limited but nonetheless useful protection. Currently, very limited stocks of vaccine are held in the UK and the intention is that these would be used specifically for the protection of frontline healthcare workers.

5.5 Antivirals

Antiviral medications can reduce the duration of symptoms and their severity, as long as they are taken within 48 hours of the onset of symptoms. The UK has a current national stockpile of antivirals that is sufficient to treat 25% of the population; this will be increased to 50%.

5.6 Pandemic-specific vaccine

A pandemic-specific vaccine can be produced only after the specific virus has been identified and will take some six months to develop and manufacture following the emergence of a new virus. The UK already has contracts in place for the supply of such a vaccine in sufficient quantity to immunise 100% of the population.

5.7 Staff absentee rates

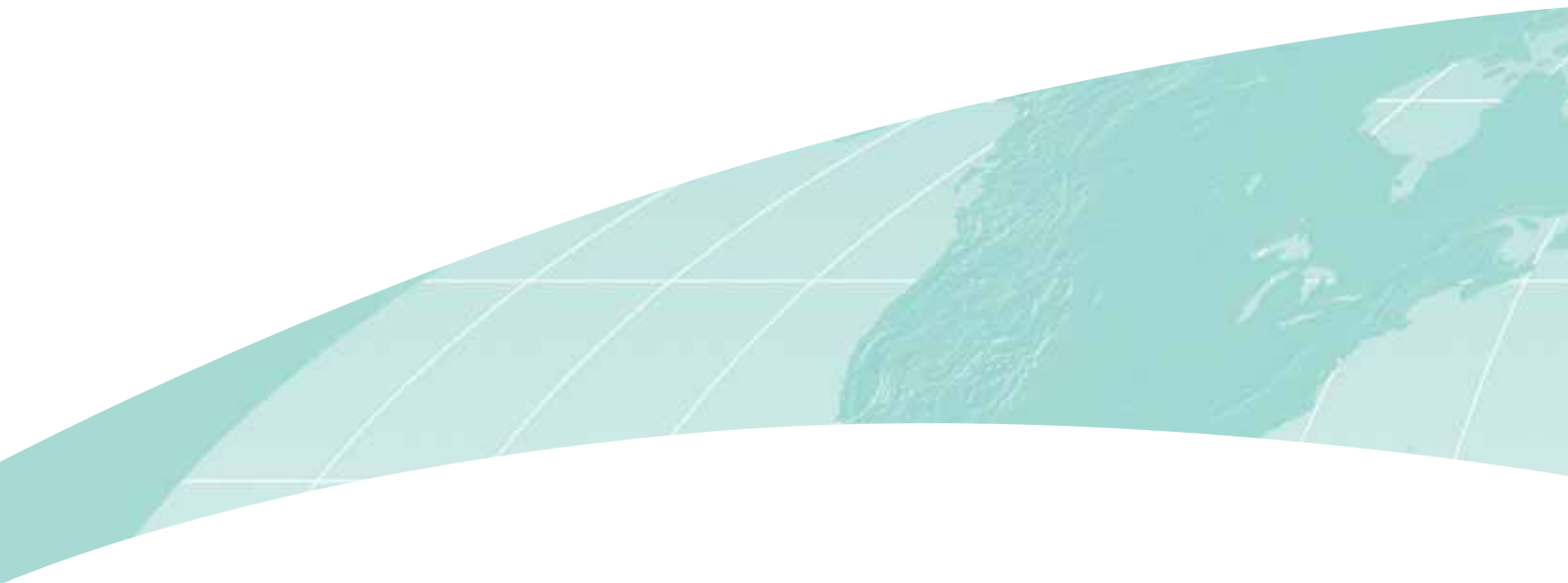
Staff absentee rates are likely to be high as staff take time off either because they have flu or because they need to care for dependants with flu or children whose schools have been closed. Some 50% of staff may require time off at some point during the entire period of a pandemic, with individuals absent for about seven to ten working days. Absentee rates as high as 35% may occur during the peak week of a pandemic, and, indeed, Department of Health advice is that individuals with symptoms should stay at home and not attend their workplace. Small organisations may be disproportionately affected, ie absentee levels may be even higher.

6. Key sources of information

World Health Organization – epidemic and pandemic alert and response
www.who.int/csr/disease/influenza/pandemic/en/

Department of Health – pandemic influenza preparedness project
www.dh.gov.uk/PandemicFlu

Cabinet Office – UK Resilience
www.ukresilience.gov.uk/



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