THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1997)72

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

15th October 1997

Dear Colleague

EMERGENCY PLANNING - PANDEMIC INFLUENZA

Summary

1. Guidance to the NHS in Scotland on emergency planning is presently being revised and will be issued shortly. Attached to this letter is an advance copy of the Appendix to the revised guidance relating to pandemic influenza.

Background

2. Some influenza occurs every year and mild to moderate epidemics cause significant morbidity and mortality every few years. Pandemics of influenza are rare and occur only when a radically new or changed strain of the virus emerges against which the population has no acquired immunity. Previous pandemics, in 1918, 1957 and 1968, were accompanied by very much increased levels of morbidity and mortality and caused widespread disruption to health and other services.

3. While there is no reason at present to believe that a pandemic is imminent, they are unpredictable and it is important that the NHS and others who would be involved in managing the consequences are well prepared. It is a contingency which Health Boards will need to take account of both in their emergency planning and in the development of Health Improvement Programmes (Priorities and Planning Guidance (MEL(1997)44), paragraph 9 refers).

4. The attached guidance is developed from an Influenza Pandemic Plan prepared by the UK Health Departments as a framework for contingency action at the national level. Copies of that plan have been made available to each Director of Public Health and to the Director, SCIEH, for their information, and are available on request through them. That plan and the attached guidance will be kept under review and adjusted as necessary.

Addressees

For action:
General Managers,
Health Boards

Chief Executives,
NHS Trusts

General Manager,
Common Services Agency

Director,
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For information:
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Action

5. Health Boards, NHS Trusts and the CSA should now ensure their emergency plans encompass the possibility of an influenza pandemic in accordance with the attached guidance.

6. The guidance will be reviewed next Spring to take account of experience during this Winter. Proposals for its amendment should be forwarded to the Emergency Planning Unit by 31 March 1998.

Yours sincerely

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Director of Strategy and
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NHS in Scotland

INFLUENZA PANDEMIC

THE THREAT

P1-1. Influenza is a viral infection caused by three types of virus: A, B and C. Influenza C is regarded as of relatively little importance. Influenza B assumes prominence periodically, usually affecting the young and the elderly. Epidemic influenza is usually caused by type A.

P1-2. The genetic make-up of influenza A is not constant. Previous exposure to, or vaccination against, one strain may give a person some degree of immunity against a new variant of that strain, but there is no cross-immunity between major strains. Emergence of a significantly different new strain occurs periodically and universal lack of immunity to it gives it the potential to cause a world-wide epidemic (pandemic). The greatly increased international movement of people in modern times now means that pandemic influenza may appear in Scotland with no or very little warning and at a time of the year not necessarily confined to the "normal" UK influenza season of November-March.

Basis for planning

P1-3. World Health Organisation advice is that plans should anticipate illness in at least 25% of the population. While most influenza activity can be expected to last 6-8 weeks, lower levels may continue for twice as long. The incubation period is likely to be 2-3 days, with adults being infectious for 4-5 days and children a bit longer. While a different pattern may emerge in a pandemic, in a lesser outbreak a higher proportion of children is likely to be infected than other age groups, though serious illness and death is more likely among older people with underlying chronic disease. Secondary bacterial infection, particularly of the lungs, is the main complication of influenza, staphylococcal pneumonia being the most serious.

NHS OBJECTIVE

P1-4. To minimise the impact on the population of an influenza pandemic by reducing morbidity and mortality.

PLANNING RESPONSIBILITIES

Co-ordinated, Phased Response

P1-5. The nature of the threat is such that surveillance of influenza and action to counter a pandemic must be undertaken on a co-ordinated basis and world-wide. The UK Health Departments maintain an outline contingency planning framework, The Influenza Pandemic Plan, which identifies the following phases:

Phase 0	The Interpandemic period, i.e. normal times.
Phase 1	The emergence of a new strain of virus outside the UK.
Phase 2	Outbreaks of influenza caused by the new strain outside the UK.

Phase 3	New influenza strain isolated in UK.
Phase 4	Pandemic influenza in the UK.
Phase 5	Return to background influenza activity.

P1-6. To achieve the objective, action is required in each Phase, including Phase 0. The interval between Phases 1 and 4 is impossible to predict. Successful emergency action during Phases 1 and 2 may reduce the severity of Phase 4, but if the new virus strain first appears in the UK, Phases 1 and 2 will be by-passed.

UK Health Departments

P1-7. Their Pandemic Influenza Plan details UK Health Departments' arrangements for international liaison and surveillance; for the mobilisation and direction of research, development, licensing, production and distribution of vaccines and anti-viral drugs; and for the formulation of clinical guidance and advice to the Government and the public. Copies of the UK Health Departments' Pandemic Influenza Plan have been supplied to each Director of Public Health and to the Director Scottish Centre for Infection and Environmental Health (SCIEH).

P1-8. The Scottish Office Department of Health, as in any other situation of actual or impending emergency, retains its responsibilities for the overall management of the NHS in Scotland.

NHS in Scotland

P1-9. Health Board emergency plans should include contingency arrangements for the local NHS response to an influenza pandemic. Boards should take the lead in establishing arrangements for co-ordinating NHS activity with that of local authorities, the police, voluntary and other organisations with a part to play in achieving the objective. Health Board plans should include details of:

P1-9-1. Responsibilities for the leadership, co-ordination and control of the local NHS response.

P1-9-2. Activation and operation of mechanisms for co-ordination with the local authority etc.

P1-9-3. How vaccine needs are to be established (see para. P1-16 below).

P1-9-4. Arrangements for the local distribution and administration of vaccine.

P1-9-5. Arrangements for issuing protocols for antibacterial and antiviral therapy.

P1-9-6. Contingency arrangements for co-ordinating use of resources in shortage e.g. :

- staff
- hospital beds
- supplies of drugs and equipment

P1-9-7. Mortuary arrangements.

P1-9-8. Provision of information to enable maximum public self-help, understanding of and assistance with NHS plans to secure the objective.

P1-10. SCIEH retains its responsibilities for influenza surveillance and its co-ordination. It should prepare and maintain an Influenza Pandemic Plan to enable the initiation and operation of increased surveillance of influenza activity in Scotland when required (see para P1-13 below).

SURVEILLANCE

P1-11. Key to preparedness is constant surveillance. SCIEH's responsibilities for the collection, collation and analysis of information on influenza activity includes morbidity data from influenza spotter general practices, mortality data from the General Records Office and relevant laboratory data. SCIEH maintains close collaboration with the Public Health Laboratory Service (PHLS) in England and has access to world-wide data through the WHO. SCIEH is responsible for providing timely information about influenza to The Scottish Office, Health Boards, NHS microbiologists and clinicians. This is done routinely through the SCIEH Weekly Report, augmented as necessary by use of EPINET.

P1-12. While selected General Practices contribute to this routine, Phase 0, surveillance as part of the spotter scheme, it is important that all General Practices report any unusual incidence of 'flu-like illness. Similarly NHS laboratories investigating such illness should routinely report the isolation of virus strains to SCIEH and submit viral isolates to PHLS Enteric and Respiratory Virus Laboratory, Colindale, for characterisation. Laboratories should also identify, and assess the antimicrobal sensitivities of, bacteria causing complications of influenza.

P1-13. At Phase 1, and with the approval of The Scottish Office Department of Health, SCIEH is to implement its Influenza Pandemic Plan for increased surveillance in Scotland, its co-ordination, and that of associated NHS laboratory activity. SCIEH should ensure the compatibility of its plan with that of PHLS. SCIEH's plan should detail:

P1-13-1. The increased monitoring and laboratory investigation of 'flu-like illness that will be required from Phase 2.

P1-13-2. Collection arrangements for information on antibiotic sensitivity and of resistance patterns of bacteria complicating influenza that will be required during Phases 3 and 4.

P1-13-3. Arrangements for disseminating regular information via the SCIEH Weekly Report, EPINET and other means, as well as for the immediate reporting to The Scottish Office, Health Boards and laboratories of important new data as it becomes available.

PREVENTATIVE MEASURES

P1-14. Prevention of influenza by immunisation and/or the use of anti-viral agents is likely to be possible only to a limited extent. Consideration will also need to be given to ways in which transmission might be reduced.

Influenza Vaccine

P1-15. Development of appropriately formulated vaccine cannot commence until Phase 2. Thus given high world-wide demand and the time necessary to produce vaccine, it is likely to be in short supply. In such circumstances, and to ensure equitability, central control of distribution will be established and guidance will be issued by The Scottish Office Department of Health on who should receive it. The need to keep health and other essential services running will mean that people involved in providing those services may need to take precedence for vaccine over the risk groups recommended for vaccine in interpandemic years. The following list of priority groups will form the basis for determining guidance on vaccine administration. The order of priority may be changed in the light of emerging information about the epidemiology of the pandemic:

Group 1	Healthcare staff with patient contact (including ambulance crews) and staff in residential homes for the elderly.
Group 2	Those providing essential public services which would be disrupted by excess absenteeism during an outbreak e.g. police, fire, security, communications, certain local authority services, undertakers, utilities, armed forces.
Group 3	Those with chronic respiratory or heart disease, renal failure, diabetes mellitus or immuno-suppression due to disease or treatment (a) those over 65 (b) those under 65
Group 4	Women in the last trimester of pregnancy.
Group 5	Residents of nursing homes, residential homes and other long stay facilities.
Group 6	All over 75.

Group 7	All over 65.
Group 8	Household contacts of individuals at risk (Group 3).
Group 9	Age groups likely to be particularly susceptible on evidence of population screening tests for antibodies or morbidity/mortality data including that from countries already affected.
Group 10	Other selected industries.
Group 11	Those aged 20-65.
Group 12	Those aged 6 months - 19 years.

P1-16. By Phase 3 Health Boards should be prepared to provide estimated numbers of people by priority group. Vaccine distribution will be organised centrally to ensure geographical equity, Health Boards should arrange for its administration to priority groups as advised by The Scottish Office Department of Health.

Anti-viral Drugs

P1-17. The anti-viral agent amantadine may be used prophylactically to control an outbreak or prevent nosocomial spread of influenza A. Doctors will be advised of national policy for the use of such drugs as knowledge of the pandemic and the sensitivity of the pandemic virus to the drug becomes available. Limited stockpiling of amantadine (shelf life 5 years) is under consideration. Worldwide demand from Phase 1 onwards is likely to outstrip manufacturers ability to supply.

Pneumococcal Vaccine

P1-18. Pneumococcal immunisation can reduce the incidence of pneumoccal pneumonia following influenza. Immunisation policy is contained in the Health Departments' memorandum "Immunisation against Infectious Disease". It is unlikely that manufacturers would be able to satisfy a sudden increase in demand at the time of a pandemic, so risk groups should be immunised during Phase 0.

Other Measures

P1-19. Some slowing of the spread of influenza might be achieved by reducing unnecessary, especially long distance, travel and by encouraging people suffering from the disease to stay at home. Consideration might be given to postponing sporting, entertainment or other public events likely to attract large crowds. Closing schools, particularly where staff sickness levels would otherwise require combination of classes, might also need to be considered.

P1-20. The risk of nosocomial spread may be reduced by isolation of cases. Cancellation of non-emergency hospital admissions and reduction of out-patient attendances, particularly of patients with high risk medical conditions, will need to be considered. As far as possible,

patients with influenza should only be admitted to hospital if they have medical complications. Rigorous application of infection control measures will be needed both within hospitals and other healthcare premises.

TREATMENT AND CARE

P1-21. There is no evidence that antibiotics have a place in the management of uncomplicated influenza, but protocols for the treatment of complications such as pneumonia should help ensure the provision of optimal care. SCIEH will issue guidance on prevalent organisms and their antimicrobial sensitivity patterns; local antimicrobial sensitivity patterns need to be taken into account.

Primary and Community Care Services

P1-22. General Practitioners and NHS Trusts which operate primary and community health services are responsible for ensuring the ability of those services to meet peak demand notwithstanding staff sickness. However the need to reserve hospital capacity for the most critically ill, sickness among those who would normally provide care for people at home (relatives, neighbours, home helps etc.), and intense competition for available locum health care staff, must be expected to overstretch these services.

P1-23. At Phase 0 Health Boards should take the lead in encouraging the development of collaborative contingency arrangements by practitioners (medical, dental, pharmaceutical) and NHS Trusts. Such arrangements might, for example, involve a pooling of health visitors, community and practice nurses, and their undertaking some home visiting which would usually be carried out by a general practitioner. Close liaison with Local Authorities (particularly Social Work and Environmental Health Departments), the Scottish Ambulance Service, community leaders and the voluntary sector is regarded as essential. At Phase 2 Boards should review and update such contingency arrangements, they should be activated at Phase 3.

P1-24. Community pharmacists will need to anticipate increased demand for home treatments such as simple linctus and antipyretics, and for a wider range of prescriptions, including antibiotics and oxygen. Reminders of the association of salicylates and influenza with Reye's syndrome in children under 12 should be considered.

Secondary Care Services

P1-25. Hospital emergency plans should be reviewed at Phase 2 in anticipation of large numbers of patients suffering from complications of influenza. Supplies of relevant drugs (e.g. antibiotics) and equipment (e.g. ventilators) will need to be secured and account taken of likely pressure on intensive therapy, laboratory and mortuary services.

MANAGING THE RESPONSE

P1-26. To maintain strategic control of the NHS response to the pandemic in their areas, Boards will require to assess priorities for, and co-ordinate the use of, scarce resources. Similarly, The Scottish Office Department of Health will monitor the situation across Scotland and act as necessary to ensure that resources are deployed to maximum effect.

PUBLIC INFORMATION

P1-27. Accurate, timely, authoritative and up-to-date information will be needed by the public at all stages. Boards should consult The Scottish Office Information Directorate (Health Desk 0131 244 2951) before releasing information to the media.