



PANDEMIC FLU

Scottish Guidance on Health Workforce

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Introduction

1. The NHS is in the process of preparing for a possible outbreak of pandemic flu. The *Scottish Framework for Responding to an Influenza Pandemic* (October 2007) sets out the Scottish Government's strategic approach to dealing with an influenza pandemic. The document provides information on the potential impact of a pandemic, sets out key planning assumptions and proposes a planning framework. It also updates the *UK health departments' UK Influenza Pandemic Contingency Plan* (October 2005) and expands upon that document to incorporate guidance for other non-health sectors, thereby creating the first cross-government guide for responding to an influenza pandemic.
2. Local planning for pandemic flu is well underway across the health and community care sector and individual NHSScotland organisations should refer to local pandemic influenza groups for details of plans. This draft Human Resources Guidance supplements local plans.
3. This guidance covers in more detail the workforce and human resource issues that may arise in a pandemic. It is designed to give an overall framework for NHS services to build on/work within and should be read alongside the overall planning documents. It covers NHS services and their links to community care. Key to the success of pandemic flu planning will be comprehensive communications between the various agencies.
4. This guidance has been developed in conjunction with planning throughout the UK.

Context

5. An influenza pandemic in the UK would be a major challenge to the operation of both NHS services and community care services. This guidance is designed to provide a framework for local decisions on employment issues. It aims to address some key issues and answer some common questions, whilst recognising the unpredictable nature of the challenge. NHS services have extensive experience of successfully dealing with a range of disasters and emergencies that will assist in the response to pandemic influenza. Pandemic influenza is however likely to be more sustained and widespread than other types of emergency. For example, the duration of the demand, the levels of absence and stress on staff may be unprecedented.
6. In general NHS services and community care services should seek to operate within its existing employment principles during a pandemic though with modifications suggested below. In particular NHS services and community care services will need to draw on a range of staff to offset the impact of absence, ask staff to work flexibly and support staff during the pandemic.

7. The guidance is split into three sections: Before, during and after the pandemic.

A) Before the Pandemic

8. Preparation for a pandemic is already well underway in most areas. On workforce issues the main areas where NHS Boards and services need to make preparation now are:

- mapping their workforce
- identifying the likely impact on absence
- putting in place support systems for staff
- consulting staff organisations at a local level
- communicating with staff
- developing training for staff to assist in responding to the pandemic.

Mapping the workforce

9. In order to tackle a pandemic it will be necessary to take pragmatic decisions to sustain services. For example, Boards may need to redeploy staff into different roles or locations, ask them to work in new ways or call on professionals, who are not currently working, to assist if existing staff are absent. In order to make most effective use of resources, Boards may therefore need to supplement existing information that they hold on staff. Many Boards will already have begun this process. Re-engaging staff who have retired is addressed in paragraph 27.

10. As a minimum it is recommended that NHS services have systems in place to gather data on:

- details of staff travel arrangements to and from work, as evidence suggests that staff with lengthy or complex journeys may be at high risk of not being able to attend due to transport problems. In addition, it may be useful to collect information from staff on whether they would be willing to work at another location or setting nearer to their home even if this is in another Board's area. Staff could also be asked if they could provide lifts or whether they would be willing to share transport with colleagues. Employers should also consider the benefits of assisting with transport and begin to put any practical arrangements in place as soon as possible. Lift - share web sites are now in operation and could prove a useful tool, e.g. web site <http://www.liftshare.org>
- staff contact details for use in an emergency, especially mobile numbers.
- whether staff have dependants, especially school age children or other dependants, who they would need to care for. During a pandemic these staff may face major difficulties in attending work if, for example, schools are closed as a means of countering the pandemic.

- staff who have skills that would be used during a pandemic. In particular Boards should seek to identify those staff who have such skills but are not currently using them in their current work role. These staff could be trained up in a relatively short period through refresher training. For example, most hospital medical staff will have generic skills in addition to their speciality and could be redeployed if their current work were to be suspended as may happen with elective surgery. Particular attention should be given to respiratory support skills and general skills in assessment. Most nursing staff should also be able to provide general nursing care. As well as dealing with flu itself, specialists will continue to be needed to deal with emergencies and ongoing long term conditions during the pandemic. Many community care staff will also have skills which will be vital during a pandemic and home care staff can assist in helping the elderly thereby preventing hospital admissions.
- Boards should seek to build up for themselves as detailed a picture as possible of the skills of their staff and assess likely capacity and need for skills. Plans are also being developed to create “surge capacity” to allow flexibility in meeting demand during the pandemic. Guidance on this will be available in due course at <http://www.scotland.gov.uk/Pandemicflu> .
- On leaving employment, staff should be asked whether they would be willing to return in the event of an influenza pandemic, this could form part of an exit interview.

NHS services will need to operate within the framework of the Data Protection Act in the collection and use of this data.

11. In addition, Boards should identify the workforce issues for any contractors who maintain essential services such as cleaning and IT systems. Contractors should be asked to ensure that they can provide adequate staffing during a pandemic, and there should be contingency plans to address critical areas, for example, by asking volunteers or NHS services staff who are not normally involved in services that would be essential to the frontline pandemic situation to assist contractors.

12. There will also be a need to assess the impact on other local partners such as independent sector providers, local authorities and voluntary agencies. In particular the impact on care home providers, hospices and respite centres should be taken into account. It will be in the interest of NHS services and community care services to seek to maintain these facilities in order to prevent admission of residents. This may require sharing of staff and other resources. NHS services should work with Local Authority partners to assess the impact on care homes. This may be especially challenging due to the large number of small owner operated care homes. Draft guidance for adult community care is also available on the pandemic flu web pages at <http://www.scotland.gov.uk/Pandemicflu>

13. All employers should be encouraged to undertake similar mapping work and pool information. In particular, CHPs or other NHS Board sponsored local pandemic coordination body should take responsibility for identifying issues for independent contractors in their area. For example, some single handed General Practices may be at high risk. General Practices should be encouraged to “buddy up” to share staff and other resources during a pandemic and there may be scope for CHPs to help coordinate this. It is not envisaged that CHPs would take over the employment of GP staff or operation of practices except in exceptional circumstances. The levels of staffing in community services and role of staff such as community nurses will need to be reviewed. The role of other contractors such as community pharmacists, dentists and optometrists also needs to be considered. Further pandemic guidance on providing Healthcare in community settings is available at <http://www.scotland.gov.uk/Pandemicflu>.

The impact of pandemic flu

14. Depending on the clinical attack rate (percentage of the population affected) the impact on NHS services will vary in intensity. A pandemic may involve one or more waves of around 15 weeks each, spread some weeks or months apart. While the cumulative clinical attack rate could be up to 50%, employers should be preparing for the reasonable worst case scenario of a clinical attack rate of 50% in a single wave [. Further information on the potential impact is available in “A Scottish Framework for Responding to an Influenza Pandemic” available at <http://www.scotland.gov.uk/Pandemicflu>

15. Pandemic influenza will affect NHS services and community care staffing in three ways:

- staff may themselves become infected and this is likely to lead to an unprecedented level of sickness absence due to the pandemic. Some staff may have fears of infection if they do come to work. In addition, stress levels will be high and this may increase absence.
- Staff with caring responsibilities may be adversely affected by public health measures such as the closure of schools. As a result these staff may wish to stay at home to care for dependant children or other family members or due to bereavement.
- Additional problems may be caused where staff are unable to travel to work due to local transport problems such as lack of fuel or staff shortages.

16. Research undertaken in England indicates that total absence rates could be increased by 15-18% to an average of 25% and in some smaller work groups up to 30% during the pandemic. This is based on a 25% clinical attack rate and even at this level would pose major challenges to the NHS and community care providers in sustaining services. Smaller work groups and “closed” institutions such as care homes could be at even greater risk due to faster spread in such conditions.

17. Advice on school closures will be provided by the Scottish Government but decisions to close schools and nurseries will be taken at local level and close liaison with Local Authorities will therefore be important. Private nurseries and other childcare services may also be affected.

Monitoring absence

18. Organisations will need to have robust information systems which will enable them to track the levels of absence during a pandemic. Further guidance will follow on what data needs to be collected. Current systems for reporting absence should be reviewed and clear guidance issued to staff on reporting arrangements. Where a member of staff exhibits flu-like symptoms including fever they should not go to work and if they do they should be sent home. It is essential that contact is maintained with affected staff so that an appropriate return date can be agreed. Those who do return will have some resistance to the initial influenza strain. Boards should be able to monitor flu related absence separately and will need to be able to report on this to the Scottish Government.

Sources of staffing

19. Due to the anticipated levels of absence it will probably be necessary to call on a number of different approaches to maintain staffing.

Internal redeployment

20. The main method of responding to absence will be internal redeployment. Some of the normal work of NHS services such as elective surgery is likely to be suspended and therefore staff working in these areas could be moved to deal with the pandemic. Local agreements on movement of staff will need to be reviewed to support a more flexible approach during the pandemic. There are some potential obstacles to redeployment of staff during a pandemic:

- staff may not have the right skills. This should be addressed by the skills audit and where practicable via retraining. In some cases staff may need to refresh their knowledge or need to work alongside colleagues. For example, most specialist medical staff will have had general training, which means that they can also provide general medical care. Pandemic flu patients will often have other conditions or complications and so a range of skills will be needed. Community care staff may also have useful skills to assist with care. Non clinical staff will also be essential to provide support and maintain services.

- staff may not be in the right location. Provided it does not compromise control of infection, staff can be asked to relocate as necessary. The needs of the situation may need to supersede usual work locations. Travel to work issues should be assessed and provision of transport considered. Existing local agreements on relocation may need to be reviewed to allow for changes of location. Where staff travel to work is disrupted, staff may ask to work at a more convenient location which may be with a different employer. Local discussions should take place on this. This needs to be done in a coordinated way and employers should ensure that staff can be used effectively in whichever location they work in.
- staff may be reluctant to be redeployed from their normal work area. In previous emergencies staff have generally been highly flexible. However, the nature of the pandemic may mean that there is a high level of staff fear of being moved to deal with pandemic patients. There needs to be work to explain the levels of risk and that NHS services will need all available staff resources.

It is important that all employers in an area work together to tackle the challenges of the pandemic. The Boards will have overall coordinating role and at local level individual employers should seek to reach agreement on sharing resources including staff during a pandemic. Where practicable local protocols should be agreed in advance of the pandemic.

Other sources of staffing

Staff Bank

21. Most Boards operate some form of internal staff bank. These staff can be called on to work additional hours during the pandemic. Part time staff could also be asked to work additional hours. However, both groups will also be affected by pandemic related absence and so may not provide as much additional cover as anticipated.

Sharing staff between organisations at local level

22. Local agreements should be considered to support the sharing of staff between organisations at local level. For practical reasons and to limit spread of infection, movements are likely to be only within a limited area. Staff moving between employers should be seconded on existing terms and conditions. Where there is a high degree of disruption to the journeys of staff it may be feasible to allow staff to work at another NHS services facility nearer their home as long as this is useful.

Drawing on new sources of staffing

23. At some point there may be a need to supplement current NHS services staff with others. At national level NHS services are working with a number of stakeholders to identify potential sources of staffing during the pandemic. For example, the BMA's Retired Members' Forum, NHS Retirement Confederation and the Red Cross may assist. Updates on this work will be issued in due course. In the interim, employers should concentrate on building up their own local pool of potential employees who could be called on to assist.

24. The Department of Health on behalf of UK Health departments/directorates is also working with regulatory bodies to tackle the issue of restoring staff to the register in order to allow them to practice. The General Medical Council and the Nursing and Midwifery Council have indicated that they would give priority to the restoration of staff to the register. Fees would still have to be paid and employers should consider reimbursement of these costs in order to allow staff to return to employment. Disclosure Scotland checks will continue to need to be undertaken and further guidance will be issued on this aspect in due course.

Working with Local Authorities

25. There may be limited scope for Local Authority staff to assist in maintaining NHS services. For example, some staff from Local Authority childcare services such as nursery nurses, home care staff and social workers could be of great assistance. Local discussions should take place on this issue to identify the scope for cooperation though in practice this will depend on the impact of a pandemic on local authority staffing. NHS services will also need to work closely with home care services to maintain services and provide support post-discharge.

26. Local Authorities and NHS services should work together to assess what areas of work could be suspended during the pandemic to allow for flexible use of resources and staff. In particular Local Authorities need to consider if services such as day care centres, libraries and other community facilities should remain open. Nurseries, Sure Start and other childcare facilities are likely to be closed which may release some staff to assist NHS services.

Building up a local pool

27. Staff who have only recently left are likely to be the most effective group to call on for the local pool. Employers will be familiar with these staff and their skills should be relatively up to date. If not still registered they can be restored to the register relatively easily. As an initial step all staff who leave employment from now on, whether due to retirement or for other reasons, should be approached and asked if they would be willing to assist during a pandemic. Employers should keep in contact with these staff and consider offering refresher training at appropriate intervals, as is done for staff on maternity leave. Employers should also consider contacting staff who have left their employment in the recent past especially those that have retired and have skills that would be needed. These staff can be added to the “pool” that could be called on in the pandemic. Employers should collect the minimum data referred to in para 10 above as well as a skills profile for the staff concerned. The skills needed should be determined in conjunction with relevant medical specialists based on the needs identified locally. There may be some scope for using specialists to train up other medical colleagues in advance of the pandemic. This local pool may be useful in other emergency situations as well as pandemic influenza.

Other Sources of staffing

28. NHS services may be able to call on assistance from healthcare workers currently outside the NHS. For example:

- during a pandemic independent providers may have staff who could be released to work in NHS services as some of their normal work is likely to be suspended. Local independent providers should be involved in local planning around staffing issues.
- Staff who are job ready and registered but not currently working, such as refugee doctors and nurses, could be a useful additional pool of staff if these staff have been cleared to work in the UK and are on the GMC and NMC registers. There would need to be careful matching between their skills and those that are needed.
- Local Authority staff such as childcare and social care staff. These staff could be seconded into NHS services. Their availability will depend on the impact of the pandemic on Local Authority staffing and numbers released may not be large.
- Temporary agencies will be facing the same staffing issues as NHS services and are therefore unlikely to be able to supply many additional staff. National procurement contracts on temporary staffing and use of agencies are held by National Shared Services Scotland.

- If educational institutions are closed, to limit the spread of the pandemic, then educational, research and academic staff could also assist, for example by providing professional supervision and other support for healthcare students. The potential role of healthcare students is discussed below.

Where additional staff are employed this would usually be on a temporary basis. All staff, including temporary staff, would still need to be Disclosure Scotland checked. How this system would work during the pandemic is being kept under review.

29. Members of the public are likely to volunteer to help during the pandemic and could provide invaluable additional support in non-clinical roles e.g. support services, general assistance and providing basic information under supervision. Existing volunteer organisations such as the St Andrews Ambulance Association and the Scottish Council for Volunteer Organisations may have a valuable role and help access appropriate networks. Volunteers will need to be health and Disclosure Scotland screened with appropriate references being taken up. Retirees and volunteers should be required to attend a special induction or Health and Safety training session to ensure the Board complies with its legal obligations. Volunteers are not normally paid though expenses should be met. There needs to be clarity about the remit of volunteers during the pandemic.

30. The Scottish Government Health Directorates recognise that local arrangements may not be sufficient if the pandemic has a very high clinical attack rate and it may be necessary to make a more general appeal to those with appropriate skills to make themselves available to assist during the pandemic. This needs to be done in a coordinated way and further advice will be issued in due course. In the interim Boards should build up data for their own workforce pools.

General Practice

31. Discussions are underway at UK level to ensure that the GMS contract is modified to allow GPs to focus on work to tackle the pandemic. It will also ensure that GPs are not financially penalized.

32. Boards and GPs need to work together to ensure adequate staffing during the pandemic. Practices should work together at local level to sustain services. Boards may also need to provide additional support especially for smaller practices and will need to keep in close contact.

33. Staff in community services are likely to be working under considerable pressure and there will be increased demand on primary care services due to levels of infection. In addition some patients will need to be treated in the community who would ordinarily be admitted to hospital. Discussions are underway on what type of work could be suspended within the community setting in order to free up resources to concentrate on priority roles. For example could Care Assistants undertake some vaccinations? How prescribing would work is also being looked at. General Practices will also need to work closely with local authority social services departments to maintain support for patients in the community.

Educational and training issues

34. It is anticipated that the pandemic could severely restrict availability of educational provision for medical students, nursing students etc. For example institutions could close as a public health measure, due to staff absence or redeployment of tutors. The clinical attachments of students to NHS services should be dealt with pragmatically to ensure clinical services are maintained. Depending on when the pandemic strikes this could affect more than one cohort of students and is particularly relevant to NHS services for the continuous supply of new healthcare professionals.

35. The General Medical Council is considering how best to deal with graduation of final year medical students. One option would be to allow these students to graduate without taking their final exam. They would be given provisional registration and would therefore be available to support employers. These steps would only be taken where the pandemic had reached a level where this approach would be beneficial. There would then need to be transitional arrangements for the operation of the Foundation Programme. The General Medical Council is continuing to work on policy proposals in this area. The Nursing and Midwifery Council is also looking at similar issues for nursing students.

36. Employers would need to consider how best to deploy medical students if feasible and beneficial to do so. Medical and other students already carry out a range of tasks and could therefore provide a range of assistance during a pandemic. They would supplement rather than substitute clinical staff. The level at which students could work will depend on the competencies they have at each stage of their studies. This varies widely depending on the medical school curriculum and to a lesser extent between nursing schools. It is therefore suggested that Medical and Nursing Schools and relevant employers agree a protocol on their expectations of the role of students during a pandemic. Students in the latter years of their course are likely to be the most useful and will probably be required to undertake a wide range of tasks from making initial assessment and observations to administering drugs through to putting in IV drips. For nursing students it could include elements of nursing that they have already experienced. Duties would need to be determined locally based on assessment of competence. Students should not be asked to take on duties outside their competence and should have appropriate supervision.

Working with the independent sector

37. One of the issues that need to be taken into account in a pandemic is how independent sector providers, and the Scottish Prison Service, may be affected. Independent sector providers that provide elective care will, like NHS providers in this area, probably have some of their work suspended during a pandemic. Their staff, or NHS staff with practicing privileges or attachments, would therefore become available for use in the NHS. As these staff are already in employment and have been Disclosure Scotland checked they would be an extremely useful reserve for NHS services to draw on. Independent providers should therefore be involved in workforce planning at local level and where possible agreements should be reached in advance to support use of these staff. Secondment arrangements are likely to be the easiest model. Those NHS staff currently attached to or working under “practicing privileges” to the independent sector may also be available. Many staff working for independent sector providers however also work in the NHS so these arrangements may not produce a large additional resource. Non NHS nursing and medical staff should however be available.

38. Some independent sector providers of services to the NHS will need to be maintained during a pandemic. For example, some residential mental health facilities and primary care services. Additional support may be required to maintain essential services. In these cases NHS Boards should make arrangements to second staff into these facilities if absence levels are affected by the pandemic. This may require some training for the staff affected e.g. to familiarize themselves with the locations and potential patient needs. The providers have the main responsibility to maintain services but NHS services need to make contingency plans to sustain these facilities.

39. Care home providers should also be supported. It is in the interests of NHS services and community care to maintain older people in care homes during a pandemic. It is likely that there will be outbreaks of pandemic influenza in care homes leading to increased rates of absence amongst staff. Because of the enclosed nature of the facilities, pandemic influenza could have a major impact in care homes. Secondment of staff into care homes should therefore be considered if this would prevent the home from being closed due to staff shortages. Care homes service continuity arrangements should be covered by community care plans. NHS services and Local Authorities need to work together to support homes providing long term care.

40. A range of other healthcare staff may also be available, such as dentists, optometrists and other independent contractors and staff in some parts of the private sector that may decide to suspend their business. This could free up staff to assist NHS services and NHS Boards should ensure that they discuss these issues with relevant contractors e.g. some type of basic dental and optometry services will need to be maintained even during the pandemic.

Issues in mental health services

There will be particular issues in mental health services in a pandemic. Acute psychiatric services in general and old age wards will need to continue to function, perhaps with reduced staffing and an emphasis on reducing admissions and managing more cases in the community. Long term residential facilities will need to be kept open to avoid transfer of residents to acute hospitals. As with other facilities, this will be a staffing challenge as these units are likely to be affected by staff absence and it may not be practicable to deploy staff from non-mental health areas into these units. Non residential facilities may need to be closed and redeployment of these staff into the acute and community sector could help address shortages in other areas of the NHS but may be challenging. Local Authority non residential facilities may need to be closed to limit infection risks. Learning disability facilities will need to be maintained in challenging circumstances.

41. Treatment may also be needed for residents with influenza and/or other acute conditions during a pandemic. Wherever possible this treatment should be given on site to limit infection risks. All staff will need familiarisation and appropriate training, for example in infection control. Non registered staff in mental health units can be trained up to undertake some tasks in order to use staff most effectively during absences but will need access to clinical supervision. It is possible that demand for mental health services could increase as a consequence of the stresses created by the pandemic. Further guidance on making pandemic arrangements for mental health services is being prepared and will become available in due course at <http://www.scotland.gov.uk/Pandemicflu>.

Other Areas

42. The issue of medical services in other institutional settings such as prisons and detention centres needs to be taken into account in Health Board's planning. Health Boards have overall responsibility for public health in their area and will need to work with the relevant organisations to ensure staffing is maintained. (DN Prison primary healthcare is the responsibility of SPS in Scotland).

B) During the pandemic

43. There will be a range of human resource issues that will emerge during the pandemic. The main issue will be to build resilience prior to the pandemic and to maintain morale and motivation over a sustained period. It is essential that close contact is maintained with staff side colleagues e.g. Staff Partnership Forum and a partnership working approach adopted. Discussion should take place at an early stage on likely issues with the local staff side. Staff and their representatives should be kept fully informed during the process and the issue should be approached on a partnership basis at local level. In Scotland, this guidance has been discussed within the Scottish Workforce and Staff Governance Committee which has representation from the Scottish Government Health Directorates, NHSScotland, trade unions and professions.

Absence management

44. NHS services and community care experience suggests that the vast majority of staff will approach the pandemic in a spirit of cooperation and commitment. Employers should seek to support and sustain morale during the pandemic and absence management will need to be handled with care and sensitivity.

45. Staff who display symptoms should be sent home and advised not to work until fully recovered. Infected staff would be paid under normal sick pay arrangements. Staff should notify their employer using agreed local procedures. It will be vital to track absence trends due to pandemic flu or due to other reasons. Statutory sickness certification arrangements are being kept under review.

46. Absence due to the impact of school closures should be dealt with on a supportive basis. There may be some scope for support via local networks of childcare coordinators or cooperation between parents, without developing large groups of children as in schools, thereby, facilitating the rapid spread of infection. Schools are however likely to be closed for several weeks and employers will therefore need to consider how best to respond. It is also likely that nurseries will close. It is not practicable or reasonable to expect parents to attend work if they have children who need to be looked after. A member of staff who is concerned about the welfare of their children is unlikely to work effectively.

47. It is therefore recommended that NHS employers should treat requests for paid leave for staff with children aged under 14 favourably under PIN policy guidance, in the event of pandemic related school closures. This should be provided where other arrangements are not practicable. Further extension should be a matter for local discussion. Paid leave should also be considered favourably under local carers' leave arrangements for other dependants. Other requests for leave should be considered on their merits e.g. for disabled or older relatives and bereavement. It should be made clear that any abuse of these provisions would be regarded as a serious disciplinary offence.

48. One particular issue that may arise is that some staff may not attend work due to fear of infection. Initially efforts should be made to convince staff to attend e.g. by direct approaches from clinical colleagues as this may elicit a better response than managerial intervention. It should be stressed that those staff not dealing directly with symptomatic patients are not a high risk. There is not a right to refuse to attend work unless there is a clear health and safety risk to the employee. Employers should however acknowledge the level of fear that a pandemic is likely to generate and seek to persuade rather than penalize. Employers should work with the trade unions and professions to encourage staff to remain at work and put patients' needs first. It is unlikely to be feasible to take disciplinary measures during the pandemic and the view of the staff side should be sought in such circumstances as they may be able to assist.

Disciplinary issues

49. Although agreed local disciplinary procedures will remain in place during the pandemic, NHS services employers should take a supportive approach to recognizing that instances of errors are likely to be greater than in a normal situation. Systems that allow for rapid learning from adverse incidents and sharing of information will be vital. The General Medical Council has indicated that it would expect to operate a “Good Samaritan” principle such that, provided a doctor acted in good faith within their skill and competence, it would not usually anticipate a disciplinary issue to emerge. The Nursing and Midwifery Council statement attached as Appendix One gives some guidance on its position. Staff will also be guided by the draft *Ethical Framework for the response to pandemic influenza* (available at <http://www.scotland.gov.uk/Pandemicflu>) on their decision taking during the pandemic. There will also be specific advice from the General Medical Council.

50. NHS Boards cannot prevent patients seeking legal options but should reassure staff that they will provide support in such circumstances. Discussions will be held with CNORIS concerning indemnity insurance issues. In England the NHS Litigation Authority has indicated that that it does not believe there would be a substantially greater risk of successful legal challenges to the NHS in the scenarios that may arise during a pandemic. The NHS Litigation Authority has also confirmed that:

- NHS staff will be covered by existing indemnity insurance arrangements during a pandemic. For staff employed in the NHS this means they will be covered by their employers insurance, GP staff are generally also covered by their employers insurance although some staff, e.g. some nurses, are covered by their own insurance. This will apply even if they are working on a different site or seconded to a different employer as long as management relationships were made clear. Temporary staff would also be covered provided there is a clear contractual relationship.
- The NHS Litigation Authority does not believe that there is a substantially greater risk of employers or employees being sued as a result of actions taken during a pandemic as long as a healthcare professional was able to show an appropriate degree of reasonableness in their actions. The Authority believes that the courts would take a sensible view on what was reasonable in the context of an emergency such as the pandemic. Staff should not expect to be at greater risk during a pandemic provided they have not behaved in a reckless way.
- Reasonable steps should be taken to maintain records as would happen normally but the courts will take into account the emergency nature of the context when making judgements. Staff should also seek to operate within the principles of the ethical framework as this will be seen as the governing set of principles during the pandemic

- Where staff or students are working outside their normal role they need to continue to work within their scope of competence and receive adequate training and supervision. Provided these are in place there should not be any greater risks for the employee. Students in particular should be properly supervised. Registered staff should be guided by the statement from the Nursing and Midwifery Council and the forthcoming statement on Good Medical Practice from the GMC.

51. Whilst taking a balanced approach, conduct that places staff, patients or the public at risk should be identified and dealt with robustly. Disciplinary procedures will remain in place and cannot be unilaterally altered. It may be useful to reach local agreements that allow for staff to be suspended, or have temporary restrictions on their practice, if necessary during the pandemic period pending investigations, as conducting hearings during the pandemic is unlikely to be practicable. This would be without prejudice in the interests of patient safety. It is vital for example that the NHS anti viral distribution system is not compromised and misconduct in this area should be treated as gross misconduct.

Working flexibly

52. The pandemic may lead to a need for staff to take on new roles or work in unfamiliar situations. The following guiding principles should be observed.

- training up non-registered staff to take on some tasks to free up registered staff for other duties. This should be discussed with local staff side organisations and appropriate protocols followed. It should follow training and be under some form of supervision or if this is not practicable some other clinical support. It should not set a precedent for longer term role changes as issues during a pandemic are very different. Registered staff may also need to take on new roles provided they are within their competencies. One possible example is a role for Care Assistants in administering a possible vaccine following training.

The Nursing and Midwifery Council has developed a statement based on its existing Code of Practice which sets out the general principles which should guide registered nursing staff in carrying out their role during the pandemic. This states for example that:

- “Registrants will not be professionally compromised provided they are competent (and have been assessed as such) to carry out any practice being requested of them. They remain answerable at all times for their actions or omissions”
- Employers should therefore seek to ensure that staff are competent before any duties are delegated to them and the Knowledge and Skills Framework (KSF) is a useful framework for assessing this. The KSF sets out the expected competencies of staff at various levels and this can be used to identify skills gaps and train up staff as appropriate.

53. There are however currently legal restrictions on some roles e.g. the ability to prescribe and these will remain in operation. For example employers will need to operate the system of Patient Group Directions and train up as many staff as possible to undertake this role. Protocols on this will need to be developed locally and operate within the overall framework of current legislation as highlighted by the NMC.

- The role of medical and other healthcare students during the pandemic will be as an additional resource able to take on tasks within their scope of competence. Local protocols will need to be developed on these issues.
- The General Medical Council is continuing to develop its advice on the principles that should guide medical staff during the pandemic and this will be issued in due course. It will be based on existing Code of Good Medical Practice. It will take into account the ethical framework for dealing with pandemic flu.
- The Health Professions Council has indicated that it would expect registrants to carry out roles as necessary within their competence.

Terms and conditions of service

54. NHS terms and conditions of service will remain in place and it is not intended to use powers to alter employment legislation. It will however be necessary to take a flexible approach at local level on some key issues such as the Working Time Regulations (see below). National guidance cannot anticipate all scenarios that may occur but it may be useful for local organizations to develop their response to the following framework of principles in discussion with local staff side.

-It may be necessary to limit annual leave to sustain services though there should not be a blanket ban on leave.

-Shift patterns and other working arrangements may need to be revised though unsocial hours provisions and payments will remain in force. This means staff should be paid at the appropriate rate for any hours worked.

-where staff are employed on a temporary basis during the pandemic this should be at appropriate rates of pay i.e. Agenda for Change terms where a job covered by the national job evaluation scheme is being undertaken, or other local terms as applicable.

Working Time Regulations

55. The key area where major changes to current practice will be made is in relation to the Working Time Regulations (WTR) 1998. The WTR will remain in force but their application during a pandemic will need to be reviewed. Legal advice to the Department of Health indicates that the night work limits (including the limit for special hazards), rights to rest periods and rest breaks under the WTR do not apply where the worker's activities are affected by –

(i) an occurrence due to unusual and unforeseeable circumstances, beyond the control of the worker's employer;

(ii) exceptional events, the consequences of which could not have been avoided despite the exercise of all due care by the employer.

56. It is the view of the Scottish Government Health Directorates and the Management Steering Group that a pandemic is covered by these exemptions. In the event of any dispute it would be for the courts and/or enforcement authorities to decide if action taken by an employer was justified taking account of the exceptions in the WTR. Regulation 23 of the WTR also allows for exceptions to certain rules by collective (employer and independent trade union) or workforce agreements. Most local employers in the NHS have agreements that apply the WTR. It is recommended that these should be reviewed to allow more flexibility on the night work limits, rights to rest periods and rest breaks. Some form of compensatory rest should be offered where practicable calculated over an extended reference period. Some form of rest breaks will be necessary if staff are to function effectively and employees need to be advised to take breaks in order to maintain safety. Discussions should take place with local staff side organizations on these issues to seek agreement on policy at local level.

57. Some areas have already developed local policies on these issues. For example, an existing local agreement in Camden and Islington suggests

“In general staff should not be asked to work in excess of 48 hours per week, nor work without appropriate rest breaks. In an emergency situation, it will be important to ensure that staff continue to receive appropriate rest breaks or compensatory rest and that they are not asked to work more than 48 hours on average over a 17-week reference period, in accordance with the Working Time Regulations.”

58. There may be some staff however for whom such an approach is not practicable as due to their specialist skills they are likely to be in heavy demand for example, medical staff but also maintenance and IT support staff. In addition, senior staff may be required to be available to provide guidance and leadership. In these cases it may be necessary to ask individual staff to voluntarily waive their right to not work more than 48 hours a week to allow for flexibility. This is allowed for under the provisions of the WTR. Staff would need to be approached at the earliest stage practicable once the need for them to work longer hours is identified. This “opt out” should be for the duration of the pandemic only and not applied unless necessary. In some cases staff may already be operating under opt out provisions. Staff should not be subject to any detriment if they choose not to comply with this request and inducements cannot be offered. It is accepted that this approach creates practical problems but it appears to be the best option within the regulations. Employers should start to identify such staff now though the opt out waivers should not be offered until the pandemic is underway.

59 The culture of NHS services and community care has traditionally been for voluntary working of as many hours as necessary during an emergency. Unlike other emergency situations in the recent past such as the July 7 bombings in London, a pandemic could last for many months. Excessive working hours cannot be a safe practice in such circumstances and managers have a responsibility to communicate this message to staff. Senior managers should also seek to observe these provisions to avoid making decisions when over tired. In particular the hours worked by staff involved in interventions, operating equipment and in key decision taking should be monitored to avoid excessive working even during the pandemic. In addition, staff should also be reminded of the risks of driving when over-tired and Boards should consider providing local accommodation or transport.

Health and safety

60. The health and safety precautions to be taken in the pandemic will be outlined in separate guidance (see links). As the aim is that all symptomatic people should receive antivirals it is not currently envisaged to give priority to healthcare employees in distribution of antivirals though this will be kept under review. Current policy is that if staff are affected by pandemic flu they should not attend work and should contact the flu line.

Pre-pandemic vaccination

61. Pre-first wave immunisation with an influenza vaccine related but not specific to the pandemic strain might offer some limited, but nonetheless useful, protection. Currently, the UK has very limited stocks of an A/H5N1 vaccine purchased specifically for the protection of healthcare workers.

Pre-pandemic vaccination would be initiated based on national and international expert advice and delivery would primarily be the responsibility of employers. Given sufficient additional stocks, a suitable vaccine could be used to provide partial protection for other workers likely to be frequently exposed to symptomatic patients or key staff crucial to the maintenance of essential services.

Pandemic-specific vaccination

62. As a pandemic will result from the emergence of a new or modified strain, vaccines which are routinely used to protect against seasonal influenza are unlikely to offer protection and it will not be possible to develop a matching vaccine until the emerging influenza strain has been identified.

The Government has finalised advanced supply contracts with manufacturers to make sufficient supplies of a matching vaccine available as soon as it is developed and is also working actively with the international community and pharmaceutical industry to speed development, testing and licensing. However, it may take four to six months before a matching vaccine is available and evaluated for safety, and considerably longer before it can be manufactured in sufficient quantities for the entire population given that international demand will be high.

Realistically, it is therefore unlikely that a matching vaccine will contribute much to dealing with the initial wave of a pandemic, unless its evolution, or the effectiveness of early control measures, result in a significantly slower developing pandemic than anticipated. However, it could be an important tool in preventing further cases, particularly if a second wave occurs.

63. Staff concerns over issues such as provision of face masks and prevention procedures should be discussed in local forums. Access to impartial advice and working with local trade unions will be vital to ensuring health and safety is maintained. The Health Protection Agency, Health Protection Scotland and the Health and Safety Executive are producing detailed guidance on key issues. At local level employers should set up arrangements to address health and safety concerns. Occupational health services should be able to provide counseling and other support services. A range of security issues may arise during the pandemic particularly in relation to the safety of ambulance staff and staff working in the community and in accident and emergency areas.

Support to those working in NHS services

64. Maintaining morale and motivation of staff will be essential during a pandemic. The NHS services have an exemplary record in sustaining services in emergency and stressful situations and responding to emergencies. Pandemic influenza outbreak will however create sustained pressure lasting weeks and possibly months.

65. Experience in previous international pandemics suggests that tackling staff fears will be vital. Clear communication from trusted sources, honesty and open discussion of fears have been shown to be the most effective methods of sustaining morale. Electronic communication methods may need to be used to reduce risks but face to face meetings will also have a key role in sustaining group morale. In practical terms NHS Boards should seek to ensure they will have some round the clock catering and other facilities for staff working on site. The possibility of sleeping in on-site accommodation should also be evaluated as some staff might need to stay on site for extended periods. Communication systems should be able to be used by staff to maintain contact with families. Counseling services and religious facilities may be in high demand due to the stress of the pandemic pressures. Staff may also need a means of exploring ethical concerns and getting support for taking decisions.

C) After the first wave

Recovery stage

66. After the first wave it will be vital to allow staff sufficient time and space to recover. However, the possibility of a second wave of a pandemic occurring has to be kept in mind and preparations made to cope with such an eventuality. There should be a formal way of recognizing the contribution staff have made during what will have been an extremely challenging period.

67. Once the pandemic is officially over, those staff that have been working beyond contracted hours should be given compensatory leave where appropriate. Annual leave requests should be reviewed. The provisions of the Working Time Regulations will need to be reinstated and any “opt outs” rescinded. Where staff have taken on new tasks these will need to be evaluated and discussion take place on whether they should be developed into longer term changes if they have had benefits.

68. Any disciplinary or grievance issues will need to be followed up using agreed local procedures. It is likely that this will take some time and it is vital that a “no blame” culture is maintained and due account taken of the circumstances that prevailed during the pandemic. A system for learning from any adverse events needs to be put in place.

69. It is likely that demand for occupational health, counseling and staff support services may increase after the pandemic has finished. Sickness absence levels may also continue to be higher than normal as stress related and other repressed conditions emerge. Emotional stresses may also come to the surface. Staff are likely to be tired and may need some time before they can return to ordinary performance and this should be taken into account.

70. It is essential to sustain morale during this period and learn any lessons from the first wave of the pandemic. For example could plans be strengthened, were gaps in training exposed and how flexible were they? It is not clear at what stage ordinary working would resume and in particular when targets would be re-imposed. Organisations do however need to plan to be able to resume normal working within two to three months of the end of the pandemic.

Draft guidance from the Nursing and Midwifery council on the role of registered nursing staff during an influenza pandemic

The Nursing and Midwifery Council (NMC) is the UK regulatory body for nurses and midwives. Our primary aim is to protect the public. The NMC is required by the Nursing and Midwifery Order 2001¹ (the Order) to keep a register of practitioners eligible to work in the UK, and to set standards for education, training and conduct for those on the register (registrants). Currently, there are more than 682,000 nurses, midwives and specialist community public health nurses on the register.

The Order also requires the NMC to establish, and keep under review, effective arrangements to protect the public from registrants whose fitness to practice is impaired.

1. Scope of practice for nurses, midwives and specialist community public health nurses ('registrants')

The NMC code of professional conduct: standards for conduct, performance and ethics informs the professions of the standard of professional conduct and provides a benchmark for practice.

There is no legal definition of a nurse or specialist community public health nurse. However, only a registered midwife with a current Intention to Practice (ITP) can provide care or advice to a woman in relation to her pregnancy, whether antenatally, intranatally or postnatally. Midwives can extend their scope of practice to provide nursing duties if they are competent to do so.

All registrants are expected to practice within their competency level and acknowledge the limitations of their professional practice. If faced with any aspect of practice that is either outside their area of registration or beyond their competency level, they must seek supervision or advice from a competent practitioner.

In accordance with the *NMC code of professional conduct*, all registrants are accountable for their actions or omissions regardless of advice or guidance given by another professional. As such, registrants are able to extend their scope of practice, within the healthcare legal framework, but must ensure they have the knowledge and skills to do so in a competent manner. If competency levels are not adequate, support and supervision must be sought from a competent practitioner.

If working outside their normal area or scope of practice, registrants must consider their duty of care to the public. Their first consideration in all activities must be in the interests and safety of the patient/client.

¹ SI 2002/253

Registrants will not be professionally compromised provided they are competent (and have been assessed as such) to carry out any practice being requested by the employer. They remain answerable at all times for their actions or omissions.

Medicine legislation is very specific about the administration of medications under Patient Group Directions (PGDs). Registrants **must not** delegate the administration of these medications; only the registrant identified on the PGD documentation can supply and administer them (*Add link to NPC*).

2. Registration

Nurses who are not registered with the NMC **cannot** work as registered nurses in the UK. They can, however, be utilised in a supportive capacity. If unregistered nurses are utilised in this way, their role must be clearly identified in order to protect the public.

Employers and managers are responsible for checking whether their employees are registered with the NMC. Further information on how to do this can be found on the Confirmation Services page of the website www.nmc-uk.org

3. Students

Students of nursing and midwifery are required to undertake the approved curriculum of the programme they join, and to complete that programme in five years full time or 7 years part time. Any minor modification of their programme can be made by the HEI, but where these modifications impact on regulatory requirements, the matter would need to be referred to the NMC.

Students should remain on their programme whenever possible but where contingency plans are activated, the action taken should not disadvantage them. Within contingency planning, where the situation is deemed safe and appropriate, it would be appropriate for students to participate in the giving of care as long as they are considered competent to do so. Similarly, they must be provided with an appropriate level supervision depending on their stage of training and the care they are providing. Should the experience not be considered suitable or safe, the decision should be taken to remove students from the situation until it is considered safe or appropriate for them to return. The usual approach would be for this time to be used for study.

It would be unacceptable for students to be temporarily removed from the programme and utilised as healthcare assistants. Should the student wish to provide volunteer work as a healthcare assistant in their own time, or apply for a role as such, they have the right to do so as a member of the general public. However, they should not feel compelled to undertake this role.

Disclosure Scotland Checks in a Pandemic

Current requirements

The Partnership Information Network (PIN) publication '*Safer Pre and Post Employment Checks – Policy for NHSScotland*' was launched on 17 December 2007. It describes the procedures for the entry of staff into NHS Scotland, and outlines the minimum requirements for NHS Scotland employers which organisations can develop further to meet local needs.

It is standard policy that Health Boards must request Disclosure Scotland Enhanced or Standard checks as appropriate. If a post involves unsupervised patient contact or has the potential to put patients at risk then an Enhanced check must be obtained.

In addition, Enhanced disclosure checks are required for all people working in a child care position to ensure compliance with the terms of the Protection of Children (Scotland) Act 2003. Under the Act, it is an offence for an organisation to offer work in a child care position to an individual who is disqualified from working with children.

Requirements during a pandemic

During an influenza pandemic, it is possible that Disclosure Scotland may be unable to process new disclosure requests due to a combination of increased demand and reduced capacity. This may impact upon NHS Boards' ability to keep core health services running as they may be unable to redeploy or employ staff or volunteers with lower level disclosure checks.

In the event that Disclosure Scotland is unable to process new requests, the Scottish Government will recommend that NHS Boards follow alternative procedures as outlined below. **HOWEVER, THERE WILL BE NO CHANGE TO THE LAW AND THE REQUIREMENT FOR PEOPLE WORKING IN CHILD CARE POSITIONS TO HAVE ENHANCED DISCLOSURE CHECKS WILL REMAIN IN PLACE.**

Where available staff do not have the requisite level of disclosure for an intended post (except child care posts), NHS Boards must ensure that a thorough risk assessment is carried out. This risk assessment should incorporate the following elements:

- What is the potential risk to patients
- Does the post involve unsupervised patient contact
- Does the post involve the staff member working with others who have had requisite disclosure checks
- Can adjustments be made to the post to reduce risks
- What is the most recent disclosure information available for the staff member
- Are there references which can be followed up

Redeployment/employment of staff on this basis will be temporary and the requirement for disclosure checks will be reinstated once Disclosure Scotland is again able to process requests.

Links

There are a range of links which employers may find useful. The main site for all Scottish government Pandemic Flu guidance is

<http://www.scotland.gov.uk/PandemicFlu>

General guidance produced by the Health and Safety Executive for employers and employees to use if the Chief Medical Officer declares a pandemic flu within the UK.

www.hse.gov.uk/biosafety/diseases/pandemic.pdf

HPS site gives more information

<http://www.hps.scot.nhs.uk/Search/default.aspx?search=pandemic>