Cabinet Office

PREPARING FOR PANDEMIC INFLUENZA

Guidance to Local Planners

Issued by:

Civil Contingencies Secretariat

Cabinet Office

Making government work better

This document replaces the previous CCS publication REVISED – Guidance: *Contingency Planning for a Possible Influenza Pandemic* from July 2006

The assumptions and modeling presented in this paper reflect those in the *National Framework for Responding to an Influenza Pandemic* and replace all previous figures.

Contents

Strategic approach

1.1 Aim

The primary aim of this document is to provide local and regional planners with additional guidance and information to support the development of local and regional level multi-agency plans. This document in particular describes the role of the local resilience tier and Category 1 responders given their duties under the Civil Contingencies Act 2004. It offers guidance on the content and scope of Local Resilience Forum (LRF) pandemic plans.

Although a strong lead from health organisations will be required during a pandemic, there are a large number of issues which require partnership management. These are highlighted in Annex A.

This document is intended to be read in conjunction with the *National Framework for Responding to an Influenza Pandemic* which was published in November 2007. The National Framework describes in detail the Government's strategic approach to and preparations for an influenza pandemic and sets out the UK planning assumptions for the different phases of a pandemic.

This document does not attempt to duplicate the information in the National Framework; however where necessary information has been summarised and included. Cross references to the relevant sections of the National Framework have been included where appropriate. The National Framework document should be referred to for information on the availability of medical countermeasures, reducing the risk of infection and proposed social measures.

This document also invites relevant organisations to consider and feed back to the Civil Contingencies Secretariat in the Cabinet Office via Regional Resilience Directors or Government Departments, their views on areas where they consider that additional specific information and advice would be valuable in improving their preparedness planning.

1.2 Audience

This guidance is intended primarily for those responsible for developing policies and strategies or coordinating, managing, maintaining or testing contingency arrangements for responding to an influenza pandemic. It is aimed at providing members of Local Resilience Forums with additional information to support the development of multi-agency plans.

As such, this document is mainly addressed to Category 1 responders, in particular in regard to:

– The preparation of emergency plans in relation to significant risks

– Business continuity planning

– Raising business continuity awareness among organisations in the community.

It is also relevant to the warning and informing duty in the Civil Contingencies Act 2004, which requires Category 1 responders to engage in pre-emergency awareness-raising work, and to warn and inform the public during emergencies.

In addition, the document provides advice relevant to Category 2 responders and to planners in the wider community to assist them in their preparations for a possible influenza pandemic.

1.3 Strategic objectives

In planning and preparing for an influenza pandemic, the Government's strategic objectives are to:

- protect citizens and visitors against the adverse health consequences as far as possible
- prepare proportionately in relation to the risk
- support international efforts to prevent and detect its emergence and prevent, slow or limit its spread
- minimise the potential health, social and economic impact
- organise and adapt the health and social care systems to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care
- cope with the possibility of significant numbers of additional deaths
- support the continuity of essential services and protect critical national infrastructure as far as possible
- support the continuation of everyday activities as far as practicable
- uphold the rule of law and the democratic process
- instil and maintain trust and confidence by ensuring that the public and the media are engaged and well informed in advance of and throughout the pandemic period

- promote a return to normality and the restoration of disrupted services at the earliest opportunity.

1.4 Operational response arrangements

Achieving these strategic objectives will require the development, maintenance, testing and, when necessary, implementation of operational response arrangements that are:

- able to respond promptly to any changes in alert levels
- developed on an integrated basis, combining local flexibility with national consistency and equity
- capable of implementation in a flexible, phased, sustainable and proportionate way
- based on the best available scientific evidence
- based on existing services, systems and processes wherever possible, augmenting, adapting and complementing them as necessary to meet the unique challenges of a pandemic
- understood by and acceptable to service providers and the general public
- adaptable to other threats, to the extent that this is practicable without compromising their effectiveness for pandemic influenza
- implemented in advance of a pandemic if this action has significant potential to mitigate the effects of a pandemic and, where possible, other threats or hazards
- designed to promote the earliest possible return to normality.

2. The risk

The Government judges that one of the highest current risks to the UK is the possible emergence of an influenza pandemic – that is, the rapid worldwide spread of influenza caused by a novel virus strain to which people would have no immunity, resulting in more serious illness than caused by seasonal influenza.

3. Key planning assumptions

This section should be read alongside Section 3 of the National Framework.

The use of common assumptions across the local resilience tier is important to avoid confusion and facilitate an integrated approach to preparation. However, one of the main challenges faced by those planning against an influenza pandemic is that the nature and impact of the pandemic virus cannot be known until it emerges.

It is therefore important to emphasise that all impact predictions are estimates – not forecasts – made to manage the risks of a pandemic, and that the actual shape and impact may turn out to be very different.

Response arrangements must be flexible enough to deal with a range of possibilities and be capable of adjustment as they are implemented. If the origin of a pandemic is outside the UK, emerging surveillance data might also allow the use of real-time modelling to confirm and/or refine these assumptions.

Until then, planning should be based on the assumptions set out in '*A National Framework for Responding to an Influenza Pandemic'* and as summarised below. These assumptions draw on the best information currently available (again, especially through scientific modelling) on the potential impact of a pandemic virus and on the feasibility and merits of specific response options. The assumptions have been derived from a combination of current virological and clinical knowledge, expert analysis, extrapolations from previous pandemics and mathematical modelling.

A brief summary of the planning assumptions presented, especially those related to local planning is given below.

3.1 Duration and timing

A future influenza pandemic could occur at any time. Plans therefore need to be in place that reflect the current level of national preparedness and guidance. These plans need to be flexible in order to incorporate future developments as more information becomes available.

Modelling suggests that from the time a pandemic begins in the country of origin it may take as little as two to four weeks to increase from just a few cases to around 1,000 cases and the pandemic could reach the UK within another two to four weeks. This will allow some time to compare planning assumptions against emerging data as the pandemic develops.

From the arrival of the pandemic in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters that will act as initiators of local epidemics are occurring across the whole country. i.e. once in the UK, it is likely to spread to all major population centres within one to two weeks. It is possible that the peak will be only 50 days after initial entry into the UK.

An influenza pandemic can occur either in one wave, or in a series of waves, weeks or months apart. To inform preparedness planning, a temporal profile based on the three pandemics that occurred in the last century and current models of disease transmission has been constructed (see Figure 1).

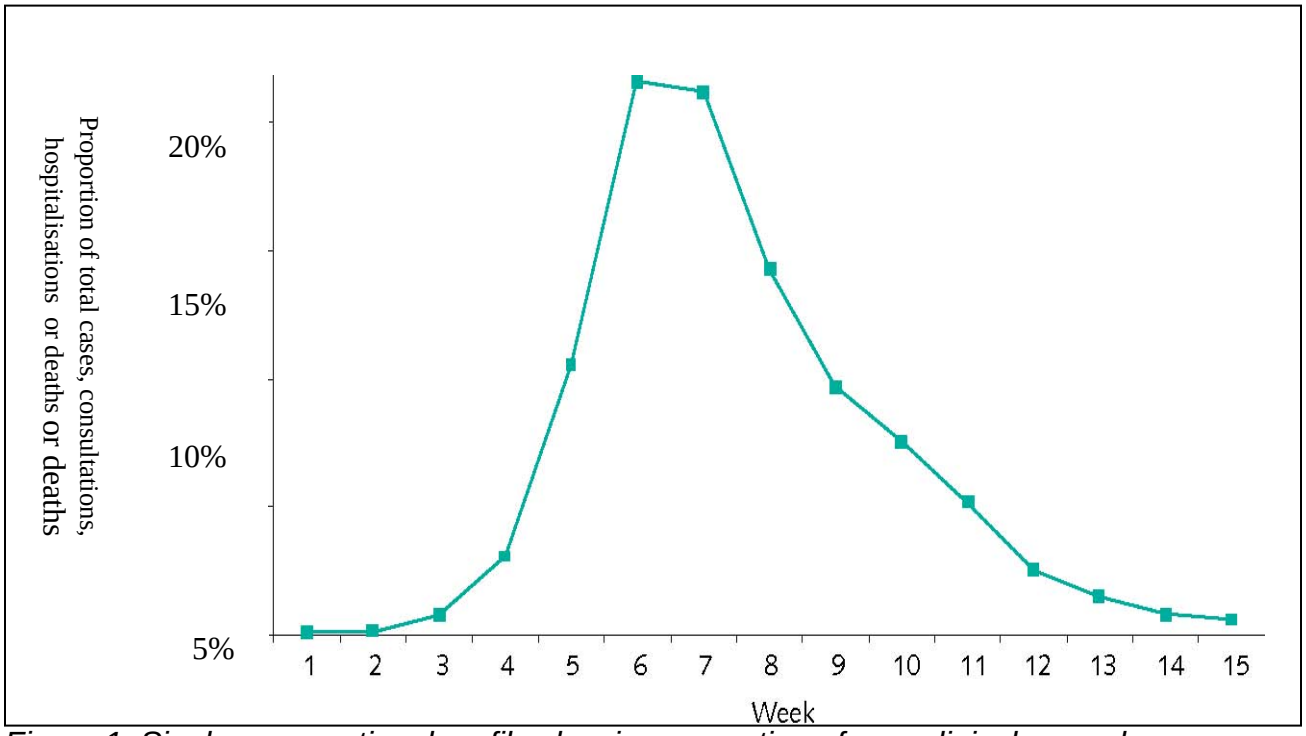

Figure 1: Single wave national profile showing proportion of new clinical cases by week. Note – more than one wave may be expected.

The planning profile reflects what we might expect to happen nationally; of particular importance is the rapid increase in the number of cases within the first few weeks of the pandemic. This planning profile is not a forecast of what will happen in every region or locality.

Local epidemics may be over faster and be more highly peaked than the national average. Local epidemics may only last for 6-8 weeks, or they may last longer. Experience from the 1918 pandemic shows a wide variation in the length of local

epidemics, the clinical attack rates[1] and the peak attack rates in areas similar to the size of modern Primary Care Trusts.

People are highly infectious for four to five days from the onset of symptoms (longer in children and those who are immunocompromised) and may be absent from work for up to ten days.

Local planners need to plan to the peak of the national profile assuming a 50% clinical attack rate. The 50% recommendation takes account of the possibility that local peaks may be higher. Local planners should expect between 10% and 12% of the local population to become ill each week during the peak of the local epidemic. It is not possible to make detailed forecast of when this might be.

Figure 2 shows the distribution of pandemic lengths for UK regions in the 1918 pandemic measured over the period of more than 1.2 deaths per 100,000. Using this threshold the planning profile would give an epidemic length of 12 weeks. As it is not possible to predict the length of the pandemic for each region, planners should assume a length of up to 12-15 weeks.

It is not possible to predict what proportion of the local population will become ill, need to go to hospital or die on a week to week basis during a pandemic. Therefore, planners should assume peak figures based on a 50% clinical attack rate sustained over a period of 2-3 weeks.

[1] Cumulative percentage (or proportion) of a population infected over a period of time, for example during an epidemic.

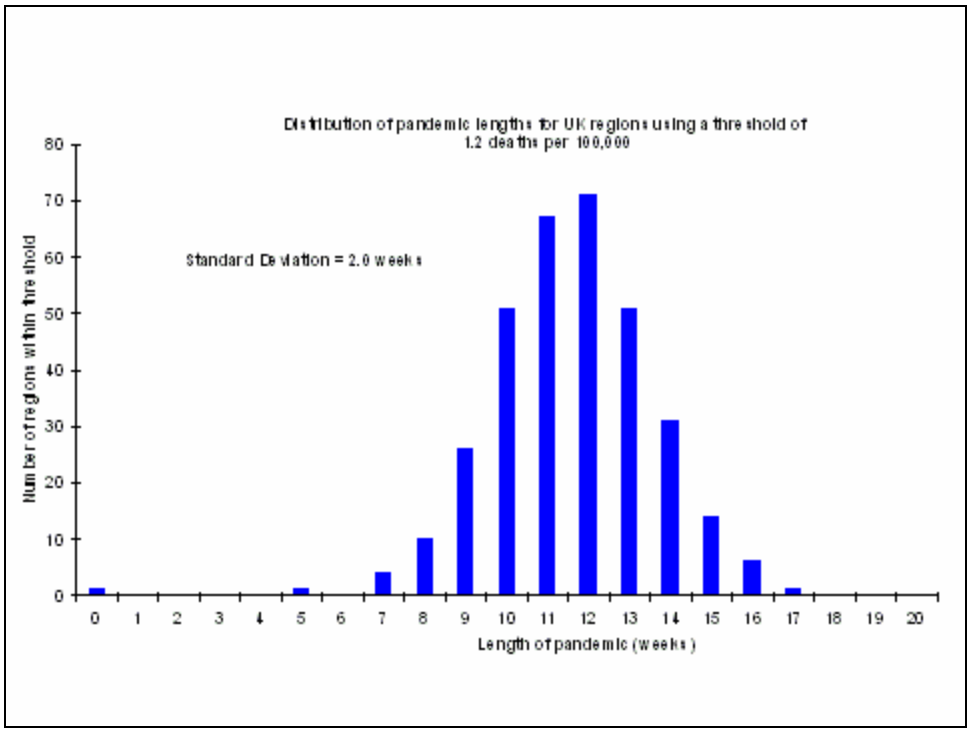

Figure 2: the distribution of pandemic lengths for UK regions in 1918 measured over the period of more than 1.2 deaths per 100,000.

3.2 Attack and Death rate

Depending upon the virulence of the influenza virus, the susceptibility of the population and the effectiveness of countermeasures, up to half the population could have developed illness and between 50,000 and 750,000 additional deaths (that is deaths that would not have happened over the same period of time had a pandemic not taken place) could have occurred by the end of a pandemic in the UK.

Until the characteristics of the pandemic are known, relevant planning should be carried out against the reasonable worst case set out below:

- Cumulative clinical attack rates of up to 50% of the population in total, spread over one or more waves each of around 12-15 weeks, each some weeks or months apart. If they occur, a second or subsequent wave could possibly be more severe than the first. Response plans should recognise the possibility of a clinical attack rate of up to 50% in a single-wave pandemic.

- Up to 4% of those who are symptomatic may require hospital admission.

- Up to 2.5% of those who are symptomatic may die.

To inform planning, the following table shows the potential impacts of a 25%, 35% and 50% clinical attack rate and overall case fatality rates of 0.4%, 1%, 1.5% and 2.5% of those with influenza symptoms.

Overall case fatality rate (%)	Range of possible excess deaths in the UK		
	25% clinical attack rate	35% clinical attack rate	50% clinical attack rate
0.4	55,500	77,700	111,000
1.0	150,000	210,000	300,000
1.5	225,000	315,000	450,000
2.5	375,000	525,000	750,000

Table 1: Range of possible excess deaths for various permutations of case fatality and clinical attack rates, based on UK population

Antiviral drugs are expected to reduce the duration of the illness (by about a day or so) and the likelihood of complications. These drugs are being stockpiled. For more information on the planned medical counter-measures, including antiviral drugs and pandemic-specific vaccines please refer to Sections 7 of the National Framework document.

3.3 Staff absenteeism

The level of staff absence from work during a pandemic will depend significantly on the nature of the pandemic virus when it emerges. The planning assumptions set out below are based on current knowledge, analysis of past pandemics, published evidence and scientific modelling. Given the inevitable uncertainties, a range of figures is given in some areas.

Organisations should ensure that their business continuity plans have the flexibility to accommodate these ranges.

During a pandemic, staff will be absent from work if:

a. They are ill with flu. Numbers in this category will depend on the clinical attack rate. If the attack rate is 25%, a quarter of staff in total will be sick (and hence absent from work for a period) over the whole course of the pandemic. If a pandemic occurs over one wave, this level of cumulative

absence could be experienced by employers over a period of around 3-4 months. But there may well be more than one wave, with absence from work being spread across those waves.

b. They need to care for children or other family members who are ill with flu.

c. They need to care for (well) children because of the closure of schools and group early years and childcare settings.

d. They have non-flu medical problems.

e. Their employers have advised them to work from home.

Business continuity planning against an influenza pandemic should have at its heart an estimate, through aggregation of data in each of the categories above, of the number of staff likely to be absent from work at the peak of the pandemic. This will differ for each organisation depending on the make up of staff.

As a rough working guide, organisations employing large numbers of people, with flexibility of staff redeployment, should ensure that their plans are capable of handling staff absence rates of up to 15-20% (in addition to usual absenteeism levels). Small businesses, or larger organisations with small critical teams, should plan for level of absence rising to 30-35% at peak, perhaps higher for very small businesses with only a handful of employees.

Finally, employers should note that:

a. Depending on the rate of spread of the virus within the UK, levels of staff absence from work are unlikely to be uniform across the country. Employers with sites spread across the UK may experience peak rates of absence at different times in different regions.

b. Absenteeism rates could be higher than the estimates given here if the nature of the virus means that people take longer to recover from infection than the assumption shown above, or if some age groups of the population are affected more severely than others.

4. Issues to consider in business continuity planning

LRFs should encourage business continuity planning to ensure all members and all organisations upon which they will rely during a pandemic have adequate planning. They will also want to consider their own business continuity planning

to ensure their responsibilities can continue to be carried out given the possible levels of staff absence.

In carrying out business continuity planning, organisations will wish to consider how best to:

a. Support the Government's efforts to reduce the impact of the pandemic by:

- Taking all reasonable steps to ensure that employees who are ill or think they are ill during a pandemic are positively encouraged not to come into work. Personnel policies may need to be reviewed to achieve this aim.
- Ensuring that employers and employees are made aware of Government advice on how to reduce the risk of infection during a pandemic.
- Ensuring that adequate hygiene (e.g. hand-washing) facilities are routinely available.

b. Put in place measures to maintain core business activities for several weeks at high levels of staff absenteeism, including options for remote working and expanding self-service and on-line options for customers and business partners.

c. Identify those essential functions and posts, and perhaps individuals, whose absence would place business continuity at particular risk.

d. Identify which services could be curtailed or closed down during all, or the most intense period, of the pandemic.

e. Ensure that health and safety responsibilities to employees continue to be fully discharged.

f. Identify inter-dependencies between organisations and ensure they are resilient, for example by ensuring that supplier organisations delivering services under contract have appropriate arrangements in place themselves to sustain their service provision.

g. Factor into their planning that medical counter-measures will not solve business continuity requirements because antiviral drugs for treatment will only lessen the severity of the illness. They will neither cure it nor significantly reduce absenteeism.

The Cabinet Office have produced a detailed checklist for businesses specifically relating to pandemic influenza. It identifies important and specific activities which organisations can do to prepare for a pandemic. This is available at Annex B.

5. Role and Responsibilities

The primary responsibility for developing preparedness plans for and an effective operational response to major emergencies in the UK rests with local organisations. However, given the national scale, complexity and international dimensions of a pandemic, strong central government coordination, explicit guidance and support will be critical at the planning and response phases.

All government departments are directly or indirectly involved in preparing for an influenza pandemic and play an active role in informing and supporting contingency planning in their areas of responsibility. Leading up to and during a pandemic, each remains responsible for its policy and business areas and for coordinating the response of its specific sectors. The roles of individual departments during a pandemic are outlined in the National Framework.

5.1 Role of the Local Resilience Forum

The Local Resilience Forum is the principal mechanism for the coordination of multi-agency planning at local level. Its membership includes all Category 1 responders (such as emergency services, local authorities and health bodies) which are subject to a range of civil protection duties under the Civil Contingencies Act 2004 and others such as Government Offices, Strategic Health Authorities, etc. In London, local influenza pandemic committees feed in at the Regional Civil Contingency Committee (RCCC) level.

In the event of a pandemic influenza outbreak, it is likely that Strategic Co-ordinating Groups (SCGs) will be convened. The purpose of the SCG is to take overall responsibility for the multi-agency management of an outbreak at local level. Membership of the SCG is likely to mirror the Category 1 membership at the Local Resilience Forum.

Local authorities play an important role in planning for and responding to a pandemic influenza outbreak. They have responsibility for a wide range of functions including social care and children's services and crucially exercise a community leadership role. Additionally, in the event of an emergency that exceeds existing mortuary provision, the local authority will liaise with the coroner's office to provide emergency mortuary capacity.

As most influenza sufferers will need to be cared for in a community setting, developing integrated health and social care plans is a particularly important part of local planning. In addition, sustaining the provision or commissioning of a range of services on which many vulnerable people rely, including residential and nursing homes, is also important.

Central–local reporting and coordination arrangements are outlined in figure 3

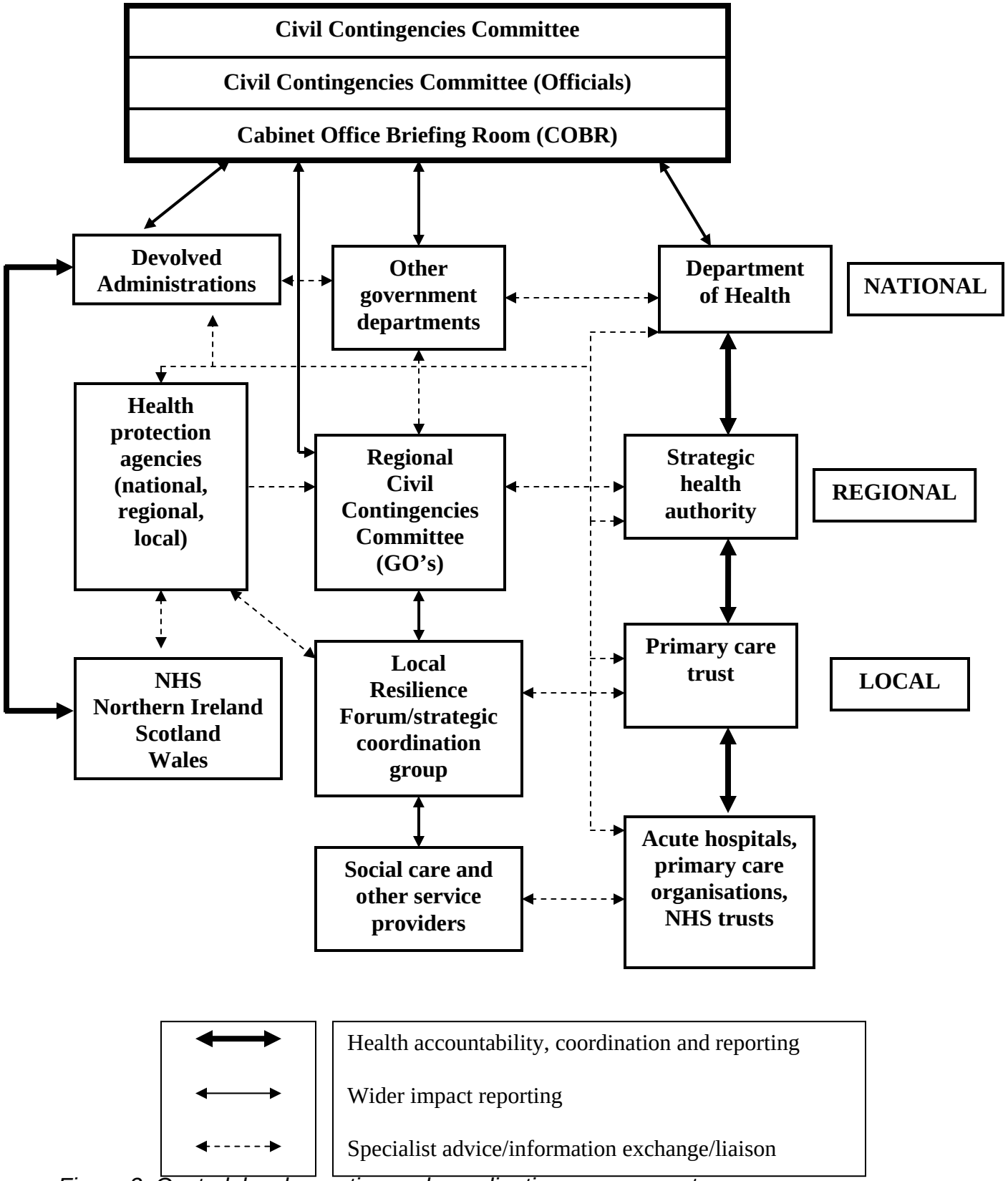

Figure 3: Central–local reporting and coordination arrangements

6. Local Resilience Forum Pandemic Plans

6.1 Overview

An effective local response will require the cooperation of a wide range of organisations and the active support of the public. As there may be very little time to develop or finalise preparations, effective pre-planning is essential. Many important features of a pandemic will not become apparent until after it has started (i.e. when person-to-person transmission has become sustained), so plans must be:

- constructed to deal with a wide range of possibilities
- based on an integrated, multi-sector approach
- built on effective service and business continuity arrangements
- responsive to local challenges (e.g. rural issues) and needs
- supported by strong local, regional and national leadership.

In the UK, the primary responsibility for planning for and responding to any major emergency rests with local organisations, acting individually and collectively through Local Resilience Forums (LRF) and Strategic Coordination Groups (SCG). All public and private organisations need to work with and through their local forum to develop plans for maintaining services and business continuity during a pandemic and to respond to the wider challenges that will result.

Achieving these strategic objectives will require the development, maintenance, testing and, when necessary, implementation of operational response arrangements that are:

- developed on an integrated and multi-agency basis
- able to respond promptly to any changes in alert levels
- combine local flexibility with national consistency and equity
- capable of implementation in a flexible, phased and proportionate way
- based on the best available scientific evidence
- based on existing services, systems and processes wherever possible, augmenting, adapting and complementing them as necessary to meet the unique challenges of a pandemic
- understood by and acceptable to service providers and the general public

- adaptable to other threats, to the extent that this is practicable without compromising their effectiveness for pandemic influenza

- implemented in advance of a pandemic if this action has significant potential to mitigate the effects of a pandemic and, where possible, other threats or hazards

- designed to promote the earliest possible return to normality.

6.2 Areas of focus

Planning for and responding to the health, social care and wider challenges of an influenza pandemic require the combined and coordinated effort, experience and expertise of all levels of government, public authorities/agencies and a wide range of private and voluntary organisations. Preparations require the active support of communities and, critically, that individuals take personal responsibility for protecting their own health, supporting each other and contributing to disease containment efforts. To ensure an effective response, each organisation needs to understand its responsibilities and those of others, plan adequately, prioritise its efforts and take proactive steps to ensure the continuity of its services as far as possible.

The main areas on which Category 1 (and indeed Category 2) responders should focus are:

a. **Business continuity** planning, so that relevant organisations can continue delivering their essential services during a pandemic, taking into account the key planning assumption that medical countermeasures against pandemic influenza (antiviral drugs and vaccines) should not be regarded as a “silver bullet” solution for business continuity, particularly during the first wave of a pandemic.

b. Co-ordinated multi-agency planning in LRFs to support central Government in **communicating public messages, implementing possible social measures and preparing for the wider impacts of a pandemic**.

c. Co-ordinated **multi-agency planning with the health service** (e.g. on the storage and distribution of antivirals; in due course, on planning and delivering mass vaccination programmes) consistent with any guidance from the Department of Health and devolved equivalents.

d. Co-ordinated multi-agency planning for handling **excess deaths**, including surveying local capacity at relevant stages of the process from death to burial or cremation.

Annex A provides a checklist to facilitate local planning and to provide additional information on the areas for inclusion in LRF plans.

6.3 Requirements under the Civil Contingencies Act

The Civil Contingencies Act 2004 places duties on individual Category 1 responders to prepare emergency plans. However, planning for emergencies is rarely an autonomous activity. There are occasions when Category 1 responders will want to cement integrated emergency management by developing multi-agency plans.

As set out in Chapter 5 of the guidance document, Emergency Preparedness certain types of emergency require additional knowledge or procedures, for which a generic sector plan is inappropriate. However, pandemic influenza is a risk where a generic plan is the most suitable option.

The Civil Contingencies Act legislation requires that Category 1 responders who have a duty in relation to the same emergency to consider whether a multi-agency plan should be developed (regulation 22) and permits Category 1 responders to cooperate for the purpose of identifying which of them will take lead responsibility where more than one of them had functions that are exercisable in relation to the same emergency or the same type of emergency (regulation 9).

Annex A Draft Check List for LRF Pandemic Flu Plans

Given the complexity of pandemic influenza, plans should be multi-agency and as such should draw together information from all Category 1 responders and relevant Category 2 responders.

A multi-agency plan should cover all organisations that need to coordinate and integrate their preparations for an emergency.

This checklist aims to provide LRFs with an indication of the issues which should be considered in an influenza pandemic plan and the information which should be included. This list can be used in order to carry out a self assessment of the current LRF plans in order to identify gaps. Where gaps are identified LRFs should consider when these will be addressed.

Development of a written multi-agency pandemic influenza plan

Ref	Issue / Action	Yes / No
1	A multi-disciplinary planning committee has been identified to specifically address pandemic influenza preparedness planning and preparedness testing?	
2	This committee consists of representatives from the following areas: a. HPA b. Strategic Health Authority representation c. Coroners d. Funeral services e. Neighbouring LRFs (or relevant links made by other means) f. GOs (GOs may be incorporated into planning via regional subgroups) g. Primary Care Trusts h. NHS organisation representatives i. Ambulance Service j. Police	

	k. Fire Service l. Prisons m. Court Service n. Local Authority Environmental Health Organisation representative o. Local Authority children's services representative p. Voluntary sector q. Other relevant Category 2 responders r. Port health (as appropriate)	
3	This committee has met on a regular basis to review and update plans?	
4	A multi-agency pandemic plan has been prepared?	
5	This plan has been reviewed in the last 6 months, particularly following publication of the *National Framework for Responding to an Influenza Pandemic* and exercise Winter Willow lessons identified?	
6	Staff with roles in the plan have been fully trained?	
7	This plan has been tested using desk top exercises?	
8	This plan has been tested using multi-agency exercises?	
9	Lessons from exercises have been identified and processes put in place to address them? Primary responsibilities have been identified, including the roles and linkages between the following organisations: a. HPA b. RCCC c. SHA d. PCTs	

	e. Hospital/foundation trusts f. community hospitals g. ambulance service h. NHS direct i. LAs j. Police k. Coroners l. Voluntary organisations. m. Port health n. GOs o. Independent health sector	
10	Copies of other relevant plans/guidance have been obtained and reviewed. This includes the following plans: a. A National Framework for responding to an influenza pandemic b. Home Office guidance for planners preparing to manage excess deaths c. Department for Children, Schools and Families guidance to help schools and other bodies d. Cabinet Office Business Continuity guidance e. Regional level plans f. Plans of boundary LRFs g. Health sector plans	
11	Dates to review plan has been identified	
12	Where gaps in the plan have been identified a timeline for closing them has been drawn up.	
13	Agreements with neighbouring LRFs have been formalised i.e. mutual aid and other cross-border needs.	

Roles and responsibilities

Ref	Issue / Action	Yes / No
14	Responsibilities of key personnel and organisations within the LRF for implementation of the plan have been identified. This should include responsibilities to cover the following issues: a. Management of Excess Deaths b. Data capture c. Reporting to RRFs and Nationally d. Comms (coordinated at a local, regional and national level) e. Communicating with the public f. Liaison with/assistance for health issues (vaccination centres, anti-viral distribution)	
15	Personnel who will serve as deputies in the event of staff shortages have been identified, trained and exercised.	

Required elements of an influenza pandemic plan

Ref	Issue / Action	Yes / No
16	A demographic profile of the population has been drawn up to identify groups of vulnerable people and those in priority groups for possible medical countermeasures or plans to identify vulnerable individuals following an outbreak.	
17	The plan should outline differences in the implementation of specific actions on the basis of the WHO pandemic phases, and UK government phases as outlined in the National Framework document. This should include when such actions would be taken and what the triggers would be.	

Communication		
18	Methods of communicating with the public have been identified and are appropriate for individuals with hearing, visual and other disabilities or limited English speaking	
19	A list has been created of health care entities, including points of contact, within the LRF region (e.g. hospitals, long-term care and residential facilities, clinics, GPs) with which it could be necessary to maintain communication and be able to report information in a timely and accurate manner during a pandemic.	
20	Local arrangements to support central Government in communicating advice to the local population and public messages have been established.	
Social Services		
21	The needs of specific patient populations that may be disproportionately affected during a pandemic or that may need services not provided by the hospital have been addressed. Populations considered should include: a. children and families, b. frail/elderly, c. young adults, d. patients with chronic diseases or pre-existing medical conditions, e. physically disabled or with learning difficulties, f. pregnant women, g. immuno-compromised children and adults. h. those in need of bereavement support.	
22	The following issues have been considered: a. need for specialised equipment, b. transportation, c. mental health concerns,	

	d. need for social services, e. antenatal classes f. cultural issues affecting behavioural response.	
Data reporting		
23	Methods for the collection of data have been established and to include: a. impact on coroners and funeral services b. impact on the emergency services c. impact on the essential services (utilities and food industry) d. impact on schools and services for children, young people and families e. Animal welfare issues f. local pressure points g. any major/news worthy issues	
Excess Deaths		
24	A contingency plan to manage an increased need for post mortem care and disposal of deceased patients and to minimise delays associated with handling excess deaths in accordance with the latest guidance available from the Home Office.	
25	Capacity of current mortuary and cremation facilities has been established and the gap to meet possible demand has been calculated in order to anticipate impact on coroners.	
26	Management of predicted levels of fatalities including provision of additional mortuary capacity, including areas to be used as temporary morgues have been identified	
27	Local arrangements to survey and report on local capacity at relevant stages of the pandemic have been established.	

28	Arrangements for local authority services (e.g. registrars, burial and cremation authorities) to work with the health response (e.g. GPs and NHS mortuaries) and engage with local businesses (e.g. funeral directors and private cemeteries and crematoria) and faith groups are in place.	
Social Measures		
29	Local arrangements are in place to support the implementation of possible social measures or to reduce social impacts, including a. Closure of schools and group early years and childcare settings b. voluntary isolation/quarantine c. support to prisoner handling and the judicial process d. maintenance of public order	
30	Port and airport operators, carriers and those authorities with specific responsibility for port and airport health consider how they might implement screening should Ministers decide that the medical benefits are worth the cost.	
31	Plans anticipate that operational or logistical assistance might be required to support health efforts to control the outbreak or treat patients, or to respond to civil disorder. In this regard, it should be recognised that any request for police support is likely to be in the context of reduced police availability through illness and the need to service similar requests for policing support from other sectors	
Health Measures		
32	Local arrangements are in place to support the health service.	
33	Plans have been established to sustain patients in the community, including community care such as: a. Delivery of medicines	

	b. Meals on wheels c. Community Nursing	
34	Plans to facilitate mass vaccination of the whole community, including enclosed communities e.g. residential care homes, prisons etc are in place. This includes: a. Identification of locations for vaccination to take place b. Identification of priority groups in line with Government proposals c. Plans to vaccinate vulnerable groups, i.e. those who are unable to travel	

Annex B – Links to further guidance

Department of Health

The following documents are available at www.dh.gov.uk/pandemicflu

A National Framework for responding to an influenza pandemic

Responding to pandemic influenza – The ethical framework for policy

Pandemic influenza: Guidance on preparing acute hospitals in England

Pandemic influenza: Guidance for ambulance services and their staff in England

Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England

An operational and strategic framework: planning for pandemic influenza in adult social care

Cabinet Office

The following documents are available at www.ukresilience

Overarching Government Strategy to respond to pandemic influenza – Analysis of the scientific evidence base

Planning for a possible pandemic influenza – A framework for planners preparing to manage deaths

Pandemic flu checklist for businesses

Department for Children, Schools and Families

The following documents are available at www.teachernet.gov.uk/humanflupandemic

Guidance for schools, providers of childcare, early years and other children's services, and local authority children's services departments

Guidance for FE colleges

Guidance for HE institutes

Information for parents

Model pandemic flu plan for schools

Model pandemic flu plan for FE colleges

Infection control guidance for day schools and early years/childcare settings

Infection control guidance for childminders

Infection control guidance for residential settings

Infection control guidance for HE and FE establishments