Cabinet Office

Preparing for Pandemic Influenza

Guidance for Local Planners

July 2013

This document replaces the previous CCS publication 'Preparing for Pandemic Influenza; Guidance to Local Planners', issued in 2007, and 'Preparing for Pandemic Influenza; Supplementary Guidance for Local Resilience Forum Planners', issued in May 2008.
The assumptions and modelling presented in this paper reflect those in the *UK Influenza Pandemic Preparedness Strategy 2011* and replace all previous figures.

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1. Introduction

1.1 Aim

The Government judges that one of the highest current risks to the UK is the possible emergence of an influenza pandemic[1] – 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.

Given the level of risk posed by an influenza pandemic, this document, aimed at Local Resilience Fora, provides additional guidance and information to support the development of local level multi-agency plans. It replaces the previous Cabinet Office guidance: *Preparing for Pandemic Influenza; Guidance for Local Planners;* and *Supplementary Guidance for Local Resilience Forum Planners* (and the Welsh equivalent *Preparing for Pandemic Influenza; Supplementary Guidance for Local Resilience Forum Planners in Wales*).

This document is intended to be read in conjunction with the *UK Influenza Pandemic Preparedness Strategy 2011*[2]*,* published in November 2011. The UK Strategy builds on, but supersedes, the approach set out in the 2007 *National Framework for Responding to an Influenza Pandemic, and* describes the Government's strategic approach to and preparations for an influenza pandemic and sets out the UK planning assumptions for a pandemic.

The development, maintenance and testing of local level multi-agency plans plays a crucial role in ensuring that the objectives set out in the UK Strategy can be met in the event of a pandemic. While a strong lead will be required from the health sector during a pandemic, there are many issues which will require close multi-agency working.

A link to the UK Strategy and scientific evidence base can be found at Annex A along with a list of helpful reference documents.

[1] National Risk Register, www.gov.uk/government/publications/national-risk-register-of-civil-emergencies

[2] UK Influenza Pandemic Preparedness Strategy 2011, www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic

2. Strategic Approach

2.1 Strategic objectives

As set out in the *UK Influenza Pandemic Preparedness Strategy 2011*[3], the overall objectives of the UK's approach to planning and preparing for an influenza pandemic are to:

1. Minimise the potential health impacts of a future influenza pandemic by:
    a. supporting international efforts to detect its emergence, and early assessment of the virus by sharing scientific information;
    b. promoting individual responsibility and action to reduce the spread of infection through good hygiene practices and uptake of seasonal influenza vaccination in high-risk groups; and
    c. ensuring the health and social care systems are ready to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care.
2. Minimise the potential impact of a pandemic on society and the economy by:
    a. supporting the continuity of essential services, including the supply of medicines, and protecting critical national infrastructure as far as possible;
    b. supporting the continuation of everyday activities as far as practicable;
    c. upholding the rule of law and the democratic process;
    d. preparing to cope with the possibility of significant numbers of additional deaths; and
    e. promoting a return to normality and the restoration of disrupted services at the earliest opportunity.
3. Instil and maintain trust and confidence by:
    a. ensuring that health and other professionals, the public and the media are engaged and well informed in advance of and throughout the pandemic period and that health and other professionals receive information and guidance in a timely way so they can respond to the public appropriately.

[3] UK Influenza Pandemic Preparedness Strategy 2011, Chapter 3 – The Strategic Approach to Pandemic Preparedness.

Given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles should underpin all pandemic preparedness and response activity:

- Precautionary: the response to any new virus should take into account the risk that it could be severe in nature. Plans must therefore be in place for an influenza pandemic with the potential to cause severe symptoms in individuals and widespread disruption to society.
- Proportionality: the response to a pandemic should be no more and no less than that necessary in relation to the known risks. Plans therefore need to be in place not only for high impact pandemics, but also for milder scenarios, with the ability to adapt them as new evidence emerges.
- Flexibility: there will need to be local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection, within a consistent UK wide approach to the response to a new pandemic, and accounting for the different healthcare systems in the four countries that make up the United Kingdom.

2.2 Changes to the previous approach

As stated in the *UK Influenza Pandemic Preparedness Strategy 2011*[4], this approach is not substantially different from that of the 2007 National Framework. However there are a number of important differences:

- an emphasis on the need for rapid and accurate assessment of the nature of the influenza virus and its effects. Given the uncertainty about the quality of early information relating to the virus, and its applicability to the UK, the initial response will need to reflect the levels of risk based on this limited evidence (i.e. the precautionary principle outlined above). Good quality data from early cases in the UK will be essential in tailoring the response;
- plans should be put in place that ensure a response proportionate to meet the differing demands of pandemic influenza viruses of milder and more severe impact, rather than just focussing on the 'reasonable worst case' planning assumptions (i.e. the proportionality principle outlined above);
- a more flexible approach should be adopted, with the timing of introduction and cessation of response measures determined by local indicators, rather than the WHO phases previously used (i.e. the flexibility principle outlined above). However a consistent overall approach needs to be maintained, in part to ensure optimum use of limited resources and to maintain public confidence. Decisions about the nature of the national response to the pandemic (e.g. who should be given priority for vaccination and how antivirals should be used) will therefore continue to

[4] UK Influenza Pandemic Preparedness Strategy 2011, Chapter 1 – pages 7-8

be taken by Ministers based on expert scientific and clinical advice. There will be local flexibility in how these policy decisions are implemented, although this brings with it a responsibility to ensure local decisions do not have a detrimental effect on other areas; and

- better use should be made of behavioural science to understand how people may behave during a pandemic. Some of the expertise relating to this has fed into chapter 5 of the UK Influenza Pandemic Preparedness Strategy 2011, and should be consulted in the development of communications and public engagement plans.

In light of the above, a new UK approach to the indicators for action in a future pandemic response has been developed. This takes the form of a series of phases, named: **Detection, Assessment, Treatment, Escalation** and **Recovery**. The phases are not numbered as they are not linear, may not follow in strict order, and it is possible to move back and forth or jump phases. It should also be recognised that there may not be clear delineation between phases. More detail on the new phases can be found in the UK Strategy[5].

Local level multi-agency plans should fit within the overall strategic approach set out above. Chapter 4 sets out further guidance on the development of Local Resilience Forum pandemic plans. The development and testing of these plans will play a vital role in ensuring that the objectives as set out above can be met in the event of a pandemic.

[5] UK Influenza Pandemic Preparedness Strategy, Chapter 3.

3. Key planning assumptions

This section should be read alongside Section 2 of the UK Influenza Pandemic Preparedness Strategy.

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. There are no genetic markers that will predict the pathogenicity or spread in the human population, and until the virus emerges and has affected a significant number of people, it is not possible to determine many of the factors of the disease that will be important in assessing its severity or impact.

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 adaptable for a wide range of scenarios, not just the "reasonable worst case" (which is detailed below). During a pandemic, the assumptions on which to base the response will be updated in the light of emerging evidence about the range of likely scenarios at the time.

Until then, planning should be based on the assumptions set out in The *UK Influenza Preparedness Strategy 2011* (and National Resilience Planning Assumptions) and as summarised below (paras 3.1-3.4). These assumptions draw on the best information currently available 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 and follow from the reasonable worst case which states:

- 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 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; and

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

3.1 Attack rate, duration and timing

Any presumption that the relatively mild H1N1 (2009) influenza pandemic is representative of future pandemics or reduces the likelihood of a further pandemic in the near future is incorrect. A future – and more severe – influenza pandemic could still 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:

- regardless of where or when an influenza pandemic emerges, it is likely to reach the UK very quickly. From the time of arrival in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters of disease are occurring across the country;

- an influenza pandemic can occur either in one wave, or in a series of waves, weeks or months apart. Each wave may last between 12-15 weeks. Some of this activity may occur even after the WHO has declared the pandemic over. If they occur, second or subsequent waves could be more severe than the first;

- figure 1 below shows a temporal profile to inform preparedness planning. 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. The planning profile is not a forecast of what will happen in every locality;

- the planning profile is based on the reasonable worst case of a 50% clinical attack rate (i.e. half the population displaying symptoms of some kind (ranging from mild to severe));

- as the H1N1(2009) pandemic showed, the demands of the pandemic are unlikely to be uniform, but different areas will be under pressure at different times (and some not at all), requiring flexibility of approach;

- local epidemics may even 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;

- whilst there is likely to be local variability, local planners should plan to the peak of the national profile shown in figure 1, with between 10-12% of the local population becoming ill each week during the peak of the local epidemic;

- it should be assumed that peak figures (based on the 50% clinical attack rate) could be sustained over a period of 2-3 weeks;

- the incubation period will be in the range of one to four days (typically two to three). Adults are infectious for up to five days from the onset of symptoms. Longer periods have been found, particularly in those who are immunosuppresed. Children may be infectious for up to seven days. Some people can be infected, develop immunity, and have minimal or no symptoms, but may still be able to pass on the virus; and

- all ages are likely to be affected, but those with certain underlying medical conditions, pregnant women, children and otherwise fit younger adults could be at relatively greater risk. The exact pattern will only become apparent as the pandemic progresses.

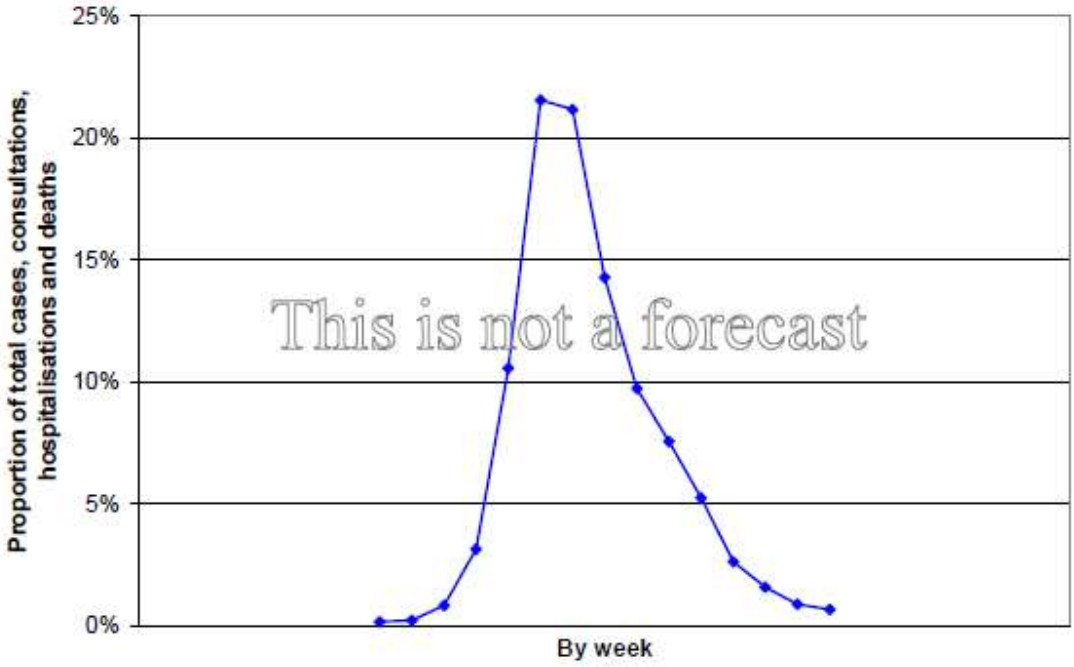


Figure 1. Single wave national profile showing proportion of new clinical cases by week. Note – more than one wave may be expected. The above chart is also not a forecast. Its purpose is to provide a reasonable worst case for planning purposes.

3.2 Death rate

Depending upon the virulence of the influenza virus, the susceptibility of the population and the effectiveness of countermeasures, up to 2.5% of those who are symptomatic may die. That is up to 750,000 additional deaths (i.e. 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. However, given the relatively low likelihood of a virus with both a high attack rate and severe disease, and against which medical countermeasures are ineffective, it was agreed (and communicated) in late 2009[6] that local planners should focus on ensuring that robust arrangements are in place for managing excess deaths in a lower range. This range has been set at 210,000-315,000 nationally (i.e. approximately 0.4-0.5% of the population), possibly over as little as a 15 week period and perhaps half of these over three weeks at the height of the outbreak.

The possibility remains however that a future pandemic may result in deaths above the 210,000-315,000 range. Such circumstances may require the local response to be augmented with short term measures to manage an exceptional situation, such as additional temporary body storage, facilitated by central government.

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 the 50% figure given in the reasonable worst case, half of staff in total will be sick (and hence absent from work for a period) at some point during the course of the pandemic. This could give absence rates of 15-20% in the peak weeks of the pandemic assuming it occurs in one wave over a period of 12-15 weeks. But there may well be more than one wave, with absence from work being spread across those waves. Absence is likely to be 7 working days for those without complications, and 10 for those with;

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

[6] Letter from Home Office Crime and Policing Group 'Managing Deaths during the Swine Flu pandemic' – 20 November 2009.

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; or

e. their employers have advised them to work from home and therefore unable to carry out tasks required in the work place itself.

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 the 15-20% set out above (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; and

c. someone who has contracted the virus and recovered is likely to have developed some immunity and is unlikely to be infected again.

3.4 Countermeasures

The figures above might be expected to be reduced by the impact of countermeasures but the effectiveness of such mitigation is not certain. Countermeasures include the use of antiviral drugs. The UK will continue to maintain stockpiles and distribution arrangements for antiviral medicines and antibiotics sufficient for a widespread and severe pandemic. For more information on the use of medical counter-measures, including antiviral drugs and pandemic-specific vaccines please refer to chapter 4 of the *UK Influenza Pandemic Preparedness Strategy*. This chapter also includes information on the use of non-medical countermeasures

to reduce the risk of infection.

A useful tool to assist in developing a picture of the possible impact of a pandemic within a locality, based upon the national planning assumptions, is provided at the link below. This includes the possible number of pandemic influenza cases and additional deaths within a locality.

www.gov.uk/government/publications/pandemic-flu-national-planning-assumptions-assessments-tool.

Using the planning assumptions set out in this chapter to develop a local picture of the potential impacts will be essential in supporting the development of a local pandemic plan.

Further information on the modelling of a potential influenza pandemic can be found at https://www.gov.uk/government/publications/spi-m-publish-updated-modelling-summary.

Summary table of key planning assumptions

Clinical attack rate	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.
Peak clinical attack rate	Locally, 10% - 12% of population per week
Hospitalisation rate	Between 1% - 4% of those who are symptomatic may require hospital admission.
Case fatality rate	Up to 2.5% of clinical cases Local level planning target of excess deaths in the range of 210,000-315,000 nationally (approximately 0.4-0.5% of the population)
Peak absence rate	Up to 15% - 20% of workforce (Large Organisations) Up to 30% - 35% of workforce (Small Organisations)

4. Local Resilience Forum Pandemic Plans

4.1 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). Given this, achieving the UK's strategic objectives will require the development, maintenance, testing and, when necessary, implementation of operational response arrangements that are:

- flexible and scalable to respond to a range of pandemic scenarios;
- developed on an integrated and multi-agency basis;
- based on existing systems and processes wherever possible, augmenting, adapting and complementing them as necessary to meet the unique challenges of a pandemic;
- built on effective service and business continuity arrangements;
- combine local flexibility with national consistency and equity;
- capable of implementation in a phased and proportionate way;
- based on the best available scientific evidence;
- 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;
- responsive to local challenges (e.g. rural issues, age profiles) and needs; and
- supported by strong leadership.

In England and Wales, the primary responsibility for planning for and responding to any major emergency rests with local organisations, acting individually and collectively through Local Resilience Fora (LRF) and Strategic Coordinating Groups (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.

In the event of a pandemic influenza outbreak, it is likely that 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.

A Response Coordinating Group (ResCG) may be convened in England where the response to an emergency would benefit from some coordination or enhanced support at a cross-SCG level. ResCGs would be convened by DCLG and bring together appropriate representatives from LRFs or SCGs. ResCGs are most likely to take place via teleconference. In Wales, co-ordination of any outbreak will be managed using the principles and structures established under the Pan-Wales Response Plan with the Welsh Government convening a Civil Contingencies Group and establishing its Emergency Coordination Centre (Wales).

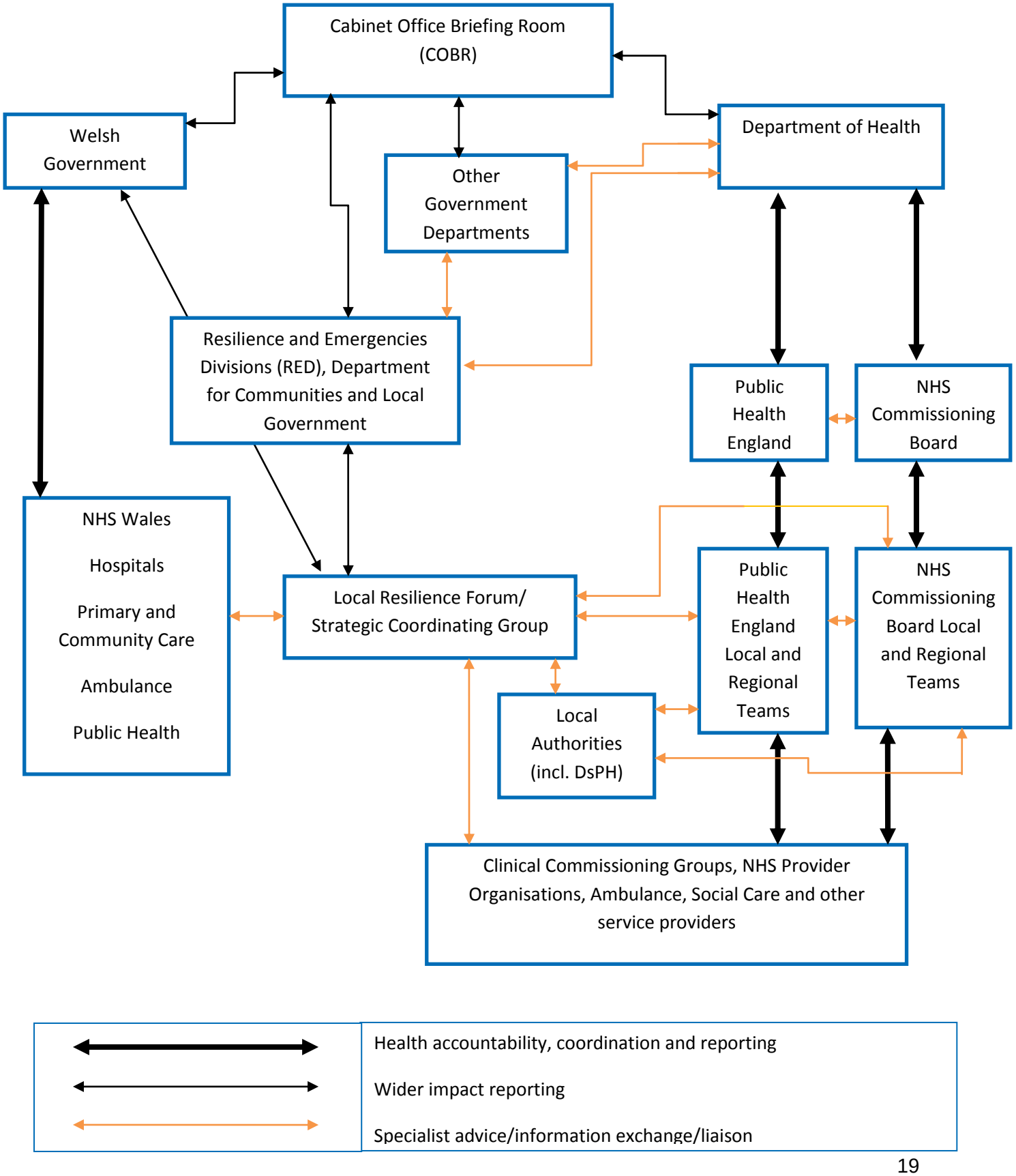
4.2 Roles and responsibilities

Whilst the primary responsibility for developing preparedness plans for and an effective operational response to major emergencies rests with local organisations, 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. 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.

Much of the health sectors' contribution to LRF multi-agency planning in England is expected to be coordinated by the Local Health Resilience Partnerships (LHRPs). The LHRPs provide a strategic platform bringing together the health sector organisations involved in emergency preparedness and response to a pandemic at the local level. This will include the Local Area Teams of the NHS Commissioning Board, Public Health England, and Directors of Public Health in Local authorities. LHRPs are not however statutory organisations and accountability for emergency preparedness and response remains with individual organisations, in line with their respective statutory duties. Local authorities will also contribute more widely to multi-agency plans given their range of responsibilities which also include social care and children's services, and their community leadership role. Wales LRFs have multi-agency planning groups that address planning for major infectious diseases.

An overview of central-local reporting and coordination arrangements in England and Wales is provided below:

Figure 2: Central-local reporting and coordination groups in England and Wales



At the UK level, the Department of Health is the lead government department and will lead on the health response in England with the wider cross- government response co-ordinated through COBR. SAGE (Scientific Advisory Group in Emergencies) will support COBR by providing the scientific and technical advice to inform decision making. The four Chief Medical Officers will guide the health response for their respective countries, including advising on allocation of health countermeasures.

4.3 Areas of focus

Local responders should pay particular attention to:

a. **business continuity** planning, so that relevant organisations can continue delivering their essential services during a pandemic, noting that medical countermeasures such as antiviral drugs and vaccines will not significantly ease business continuity challenges. LRFs should look to support and encourage business continuity planning by all members and organisations upon which they rely. The main arrangements in place to maintain essential services are set out in Chapter 7 of the UK Strategy. Further information on this, and on business continuity management, can be found on the Cabinet Office website;

b. co-ordinated multi-agency planning to support central and devolved Government in **communicating public messages** (Annex B), **implementing possible social measures** (Annex C) and **preparing for the wider impacts of a pandemic**;

c. **working 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 (Annex D);

d. multi-agency planning for handling **excess deaths**, including surveying local capacity at relevant stages of the process from death to burial or cremation (Annex E); and

e. ensuring effective local multi-agency **situational awareness** so that potential problems can be identified early and addressed or, where necessary, raised nationally (Annex F).

Engagement of the public in the development of plans and ensuring that expectations are realistic and that advice and information are readily available prior to and during a pandemic is a key element of planning.

Annex A – Links to further guidance

Emergency Planning Guidance

- Emergency Preparedness – provides guidance on Part 1 of the Civil Contingencies Act 2004, its associated Regulations and non-statutory arrangements.
- Emergency Response and Recovery – accompanies Emergency Preparedness, together setting out the generic framework for civil protection.
- CONOPS – sets out the arrangements for the response to emergencies requiring co-ordinated UK central government action.
- National Risk Register – provides advice to the public and businesses on the Government's current assessment of the likelihood and potential impact of a range of different civil emergency risks. It also provides information on how the UK and emergency services prepare for these emergencies.
- National Planning Assumptions Assessments Tool – a tool to facilitate the application of national pandemic influenza planning assumptions to the local setting.
- Pan-Wales Response Plan – sets out the arrangements for the Pan-Wales level of Welsh response to a major emergency in or affecting Wales.

UK Strategy

- UK Influenza Pandemic Preparedness Strategy 2011 – describes the Government's strategic approach for responding to an influenza pandemic.
- Review of the Evidence Base Underpinning the UK Influenza Pandemic Preparedness Strategy – supporting documents underpinning the UK Influenza Pandemic Preparedness Strategy.
- UK Pandemic Influenza Communications Strategy 2012 – provides a communications framework for the UK government's response to an influenza pandemic. It is a companion document to the *UK Influenza Pandemic Preparedness Strategy 2011*, and guidance for the health and social care community (see below).

Excess Deaths

- Planning for a possible influenza pandemic: a framework for planners preparing to manage deaths – sets out proposals on planning for the management of potentially large numbers of deaths during a pandemic influenza outbreak.
- Pandemic influenza: Guidance for coroners and planners in England and Wales – intended to assist coroners, local authorities and LRFs to prepare for and mitigate the effects of an influenza pandemic.
- Pandemic Influenza: Guidance on the management of death and cremation certification – relevant to planners in local authorities, the NHS, funeral directors, registrars, coroners, LRFs and other service providers.

Guidance for the Health Sector

- Health and Social Care Influenza Pandemic Preparedness and Response – intended to support local preparedness and response planning in England during the transition period through to 2013.
- Health Emergency Preparedness, Resilience and Response from April 2013 – a summary of the principal roles of health sector organisations following the Health and Social Care Act 2012 coming into force.
- Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance – intended to support local pandemic preparedness and response planning in health and social care organisations in Wales.

Social Measures

- Identifying People who are Vulnerable in a Crisis; Guidance for Emergency Planners and Responders – advice for local responders concerning the definition and identification of vulnerable people, and on planning to support them in an emergency.
- Faith Communities and Pandemic Flu – reference to those involved at various levels in all faith communities when considering the impacts that a pandemic will have on society.

Business Continuity

- Business Continuity, Cabinet Office webpage – background on good practice in BCM and links to other organisations.
- Business Continuity for Dummies – Cabinet Office, in partnership with the Business Continuity Institute and Emergency Planning Society has worked to produce an essential 'survival' guide for small and medium sized enterprises (SMEs).
- Pandemic flu checklist for businesses – checklist identifying important and specific activities which organisations can do to prepare for a pandemic as well as where more general guidance will be provided by the Government.

Annex B - Communications

Notification of a pandemic
The Department of Health will inform the Cabinet Office, the health departments of the devolved administrations and Public Health England (PHE) and Public Health Wales (PHW) should the World Health Organization (WHO) declare a pandemic or there is a significant change in the threat assessment. The Cabinet Office will alert other government departments and work with the Department of Health to develop, update and circulate top-line briefings via the News Coordination Centre (NCC). The Department of Health will also alert health and social care organisations and professionals in England. The Department of Communities and Local Government will alert LRFs in England, and the Welsh Government will alert LRFs in Wales. LRFs should in turn cascade information to their members. Other government departments will arrange sector-specific briefings.

National communications
The Department of Health will be the primary source of central government's health-related public messages and will work closely with the Cabinet Office, the devolved administrations, other government departments and Public Health England and Public Health Wales to deliver a nationally coordinated communication strategy.

Effective internal two-way communication will also be vital to an effective response in a pandemic. NHS Commissioning Board / Health Boards will play a key part in linking to health services and will support and coordinate the activities of NHS service providers in delivering locally tailored press notices and key fact sheets, and in identifying suitable spokespeople in England together with the Directors of Public Health. Appropriate arrangements will also be put in place by the devolved administrations.

All mainstream information and campaign materials need to be accessible to the widest possible audience, including the vulnerable, hard-to-reach groups and those with special needs. During a pandemic, the UK Government and devolved administrations will use a wide range of media to communicate information effectively to the public, to engage in discussions and to identify areas of concern. Information may also be made available directly to the public through telephone help lines and other interactive channels. The Department of Health will increase its digital 'outreach' – engaging with people online, in places outside of the Government and NHS web presence.

Communication plans need to remain flexible and pragmatic. They should also be scalable and straightforward to implement. During an influenza pandemic the Government will track public awareness and attitudes through market research to find out how effectively messages are working and to measure engagement.

Where possible, communication about regular winter flu should be compatible with core objectives of pandemic communication, encouraging positive behaviours such as good respiratory hygiene practices and vaccination uptake. Messaging should avoid "one size fits all" approaches and instead by targeted to segments of the population so as to achieve the greatest level of engagement with any

communications campaigns.

Further information on health communication in a pandemic is available in the *UK Pandemic Influenza Communications Strategy 2012* (see Annex A) and in Section 5 of the *UK Influenza Pandemic Preparedness Strategy*.

Local communications
Ensuring that communication plans are an integral part of all local responders' pandemic plans is essential and the checklist below covers the main areas that LRFs should consider.

For example, as most influenza sufferers will need to be cared for in a community setting, developing integrated health and social care plans will be a particularly important part of local planning, and consideration will need to be given about how messages get out to this group. 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.

Communication checklist	
1	Methods of communicating with the public have been identified and are appropriate for individuals with hearing, visual and other disabilities or limited English speaking. In Wales the Welsh Language Act must be taken into consideration regarding the provision of public advice bilingually.
2	The message has been tailored for different audiences (internal or external audiences, stakeholders, public, the media, business, the vulnerable).
3	Local media have been engaged, and the channels of communication have been considered (web, social media, in-house productions, local newsletters).
4	A list has been created of health care entities, including points of contact, within the LRF locality (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.
5	Local arrangements to support central and devolved Government in communicating advice to the local population and public messages have been established.
6	Individuals have been identified within organisations with responsibility for coordinating the information.

Annex C - Social Measures – Education

As set out in the UK Influenza Pandemic Preparedness Strategy 2011, there is data highlighting the potential benefit of school closures in certain circumstances, both in terms of protecting individual children from infection and in reducing overall transmission of the virus in the population. However, to be effective prolonged closures are required. This would involve schools over a wide area, but carries a risk that social mixing of children outside school would defeat the object.

The impact of closure of schools and similar settings would have substantial economic and social consequences and have a disproportionately large effect on health and social care because of the demographic profile of those employed in these sectors. Such a step would therefore only be taken in an influenza pandemic with a very high impact and so although school closures cannot be ruled out, it is unlikely to be a major feature of local planning.

However, under some circumstances the decision may be made by head teachers (and their Board of Governors where relevant) to close establishments temporarily. Such closures should be guided by the following planning principles:

a. using a precautionary approach in the early stages of an influenza pandemic and depending on the public health risk assessment, public health may advise localised closures (individual schools or catchment areas). The purpose would be to reduce the initial spread of infection locally while gathering more information about the spread of the virus; and

b. once the virus is more established in the country, the general policy would be that schools should not close – unless there are specific local business continuity reasons (staff shortages or particularly vulnerable children). This policy will be reviewed in light of information about how the pandemic is unfolding at the time.

Unless the Government issues advice to close, there is probably no role for LRFs or SCGs in Department for Education sectors or devolved equivalents.

If the Government considers the pandemic severe enough to advise schools and group early years and childcare settings to close, then the procedures are as set out below:

1. Communicating initial decision

The Department for Education will advise local authorities who are responsible for ensuring that all maintained schools and settings are told of the decision. The Department will inform Independent schools, academies and free schools directly. The DCLG RED team will advise SCGs of the decision so they can consider the wider implications locally.

In Wales, both health and education are devolved functions and the actions to be taken will be a matter for the Welsh Government. However, the Welsh Government will work closely with the UK Government in determining the policy approach to be

taken. As in England, any decisions will be cascaded through the SCGs or, where appropriate for immediate action, directly with the local authorities with the SCGs being informed simultaneously.

2. When the pandemic reaches an area

The DfE policy is that advice to close would be activated on the basis of LRF areas, with all schools and group early years and childcare settings being advised to close when the pandemic reached their area – the advice might be activated in several LRF areas at the same time.

Public Health England (PHE) will notify CCS that the pandemic has been identified in a given LRF area, and the process followed will be as set out above. In most cases, we would expect schools and settings to close at the end of the day when they get the message and remain closed until advised that it is judged safe to re-open.

In Wales, Public Health Wales will work closely with the Welsh Government on the policy to be adopted in respect of school closures and the appropriate geographical scope of closures. Public Health Wales is expected to also sit on SCGs in Wales and advise directly on local operational issues and the implementation of health policy.

3. Re-opening after closure

Based on evidence from the local Health Protection Unit, Public Health England/Wales would decide that the infection rate in an area has fallen to a level where schools and early years and childcare settings could be advised to re-open in relative safety (it can never be 'safe' in absolute terms as it is possible that there will be further cases).

In Wales, Public Health Wales will work with the Welsh Government in advising on re-opening schools.

LRF/SCGs should:

- effectively communicate decisions around the closure and re-opening of schools and group early years and childcare settings; and
- assess the impact of school closures on the locality ensuring the effective implementation of mitigating activities.

LRF plans should cover:

- roles and responsibilities with regard to school closure and re-opening; and
- reporting lines as data on school closures/reopening will need to be gathered each day in any areas subject to closures. In most cases, we anticipate that these data will be provided direct from schools to the Department of Education in England via the relevant local authority for maintained schools, although we would expect arrangements to be in place to ensure that this information is also available to SCGs.

Annex D - Social Measures – Vulnerable people

Vulnerable people are defined as those 'that are less able to help themselves in the circumstances of an emergency'. In the event of a pandemic, these may include: children (the situation may be exacerbated by school closures), older people, mobility impaired, mental/cognitive function impaired, sensory impaired, individuals supported within the community, immuno-compromised children and adults, those with underlying health conditions, individuals cared for by relatives, homeless, pregnant women, and those in need of bereavement support.

LRFs should work through the four key stages of establishing an emergency plan for identifying people who are vulnerable in a crisis as set out in the *Identifying People who are Vulnerable in a Crisis; Guidance for Emergency Planners and Responders* (see Annex A):

Determining the Scale and Requirements

By building networks of organisations holding up-to-date records of potentially vulnerable people and their likely needs, and agreeing data sharing protocols, the potential scale of requirements of vulnerable people can be estimated in advance of an emergency, **without divulging information about individuals**. This information can then feed into pandemic planning in terms of likely resources and equipment requirements.

Based on this generic information, LRFs pandemic plans should:

- document the overall lead agency for vulnerable people in emergencies and the roles and responsibilities of agencies involved in the care of vulnerable people;
- contain contact details for organisations in their area providing social care, including those in the voluntary and private sectors;
- document Terms of Reference, membership and responsibilities of any subgroups set up to manage vulnerable persons during a pandemic;
- include an estimate of the number and type of potentially vulnerable people for a locality and their needs during a pandemic (e.g. specialised equipment or care). Ideally these estimates should be accompanied with geographical information of where key groups are located;
- set out how the needs of these vulnerable groups will be met and how any potential barriers (e.g. cultural or transport) will be addressed, and how the additional burdens that will be placed on social care by the pressures on hospital places, patient illness and staff absenteeism will be managed;
- describe steps to be taken to undertake urgent assessments and support or adapt services to reduce the possibility of inappropriate hospital referral; and
- summarise communication methods and messages for vulnerable people within the LRF area.

Annex E - Support to the Health Response

Antiviral distribution

The Government plans to maintain a stockpile of antiviral medicines for use in a new pandemic. In line with current scientific advice, both oseltamivir and zanamivir have been stockpiled to ensure the response can be as flexible and resilient as possible. In the light of scientific and clinical advice at the time, antiviral treatment may be limited, for part or all of the pandemic, to those in at risk groups if the pandemic proved to be very mild in nature or if antiviral medicine supplies were being depleted too rapidly.

For maximum treatment benefit, antiviral medicines need to be taken as soon as possible. Operational plans are built on the basis of treating all symptomatic patients within 7 days of symptom onset and ideally within 48 hours. Depending on the severity of a pandemic, a National Pandemic Flu Service (NPFS) may be available to provide symptomatic members of the public with rapid access to assessment, advice, triage and if appropriate, authorisation of antiviral medicine treatment. NHS Direct will set up and manage this service.

In England, during the pandemic, the Department of Health will:

- distribute a quantity of the UK antiviral medicine stockpile to points of issue identified by local areas. The quantities of antiviral medicines and points of issue will vary depending on local needs; and

- establish a National Incident Coordination Centre (NICC) to control the initial distribution and the subsequent replenishment of stock, to coordinate the transportation of antivirals to the collection points and other identified points of use, and to monitor and manage the national antiviral stockpile.

In Wales, during the pandemic, the WG DHSS&C will:

- pre-distribute to Health Boards initial allocations of antivirals in consultation with Health Board representatives. After the initial supply of antivirals, further allocations will be made on an ordering and re-supply basis, and will be adjusted to reflect the attack rate, transient populations, supply position and demand; and

- co-ordinate arrangements relating to management of antiviral supply through the Health Response Team within the Wales Emergency Co-ordination Centre (ECC(W)).

Local

LRFs will need to understand local plans for the delivery of antivirals and support the NHS as appropriate. It is likely that depending upon the attack rate, each country's arrangements for providing antivirals will build on normal structures through primary care services as far as possible. In addition, it is the responsibility

of local NHS commissioners and providers in England and Health Boards' in Wales responsibility to also:

- identify collection points (the locations from which antivirals can be collected on referral from the National Pandemic Flu Service (NPFS) or a healthcare professional), and other locations that may need antiviral medicines on their premises. All antiviral collection points and points of use must have appropriate operational, business and resilience procedures in place which are kept under review. They must also be properly risk assessed for suitability with police advice as appropriate;

- make arrangements for the issuing of antiviral medicines at these local collection points (e.g. on referral from the NPFS), monitor consumption of antivirals across the locality (in England by using a nationally developed stock management and reporting system);

- ensure plans are in place to enable authorisation and delivery of antivirals locally where people are unable to access antivirals via the NPFS or do not have a FluFriend to collect their antivirals for them and ensure a 'back up' plan is in place in the event that the NPFS is not functioning as required; and

- nominate a team of appropriately skilled staff who are responsible for antiviral distribution coordination with the local NHS organisation. This team should be part of the NHS Organisation/Health Board coordination centre.

Vaccine

There are two distinct types of pandemic vaccine; pre-pandemic vaccine and pandemic-specific vaccine.

Pre-pandemic vaccine

The UK has limited stocks of an A/H5N1 vaccine purchased specifically for the protection of healthcare workers. This vaccine would not necessarily be well-matched to the specific pandemic strain once it emerges and so the level of protection offered by the vaccine would not be known until a new pandemic virus emerges. Taking account of this, Government policy is that these vaccines, if useful, would be prioritised for the protection of frontline healthcare workers and those in clinically at-risk groups.

NHS occupational health departments should provide the professional lead in planning for, and ensuring the delivery of, immunisation of those NHS staff groups for whom they are responsible. Immunisation and screening coordinators, PHE staff operating alongside the NHS Commissioning Board, will play an important role in developing local pandemic vaccination plans. SCGs should support these arrangements as required.

Pandemic-specific vaccine

The UK will plan to secure sufficient pandemic-specific vaccine to protect the population as soon as it is available (it is likely to be at least four to six months before it starts to become available, i.e. well after the first wave of the pandemic

strikes the UK). Once vaccine production has started, it will take some time to receive delivery of the full quantity of vaccine so initial clinical prioritisation will be necessary. Responsibility for the choice of priority groups lies at national level and would be prioritised to groups of the population to reduce morbidity and mortality as far as may be possible, and for the protection of front-line health and social care workers.

Adult Social Care

Local Authority Adult Social Care Provision will have a crucial role to play in support to the health response during a pandemic and should be adequately represented in the development of all written multi-agency pandemic influenza plans. LRFs may wish to be aware of arrangements that LAs have put in place for the assessment and subsequent provision of services including, for example, domiciliary care and care home placements during a pandemic. This should include the ability to regularly obtain and update information on the day-to-day capacity of domiciliary care and care home providers to accept, assess and provide services to new referrals. See Annex D for more information on vulnerable people.

Health Measures checklist	
1	Local arrangements are in place to support the health service
2	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
3	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) Plans to vaccinate vulnerable groups, i.e. those who are unable to travel
4	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.

Annex F - Excess Deaths

The Local Authority is the organisation responsible for leading on the planning for excess deaths. However, Local Authorities' plans should be carefully coordinated with those of other Category 1 and 2 responders and private organisations. It is suggested that the coordination of plans should be undertaken in meetings of the Local Resilience Forum. An over-arching multi-agency plan should be drawn up and agreed by the LRF planning committee.

The national planning assumptions for pandemic influenza as set out in the *UK Influenza Pandemic Preparedness Strategy* advise local planners to focus on ensuring that robust arrangements are in place for managing excess deaths in the range of 210,000-315,000 nationally. A useful tool for calculating the impact of an influenza pandemic on local services is provided at:

www.gov.uk/government/publications/pandemic-flu-national-planning-assumptions-assessments-tool

LRFs should therefore:

- set up planning arrangements including all personnel that are involved in the death management process. In addition to relevant Category 1 and Category 2 responders, LRFs should involve coroners, funeral directors, mortuary managers and burial and cremation authorities. Faith communities should also be invited to contribute to the planning process;

- identify potential difficulties in the death management process, and consider how these problems will be addressed;

- produce a multi-agency plan which aims to mitigate the effects of an influenza pandemic upon the death management process through:

    i. bringing together the analysis of local capabilities and identifying the points at which it will be necessary to depart from normal ways of working in order to meet demand; and

    ii. formalising the agreement of ALL those engaged in the death management process to move to different ways of working while complying fully with European Union or UK competition laws (see www.oft.gov.uk).

- establish a basis and schedule of communications between the LRF and its membership, and between the LRF and DCLG RED/Welsh Government teams; and

- encourage business continuity planning in all organisations involved in the management of excess deaths.

LRF Plans should:

- document the predicted impact of the pandemic influenza national planning assumptions on their locality. This should include a projected number of additional deaths per week over a 15 week period and the total number of

excess deaths for a locality based on population figures;

- document the different ways of working which may be implemented locally to alleviate the pressure on the death management process. This should include information on how these will be implemented, triggers for doing so and agreements between sectors;
- document roles and responsibilities;
- include details of any relevant contracts or memoranda of understanding between Forum members and other parties;
- include plans for the gathering of local information and data from relevant organisations in order to inform the local and national response;
- set out the mechanism by which the SCG will monitor the effectiveness of these arrangements;
- indicate how public messages will be communicated;
- forecast the possible financial consequences of managing excess deaths resulting from an influenza pandemic, and how any action will be funded; and
- contain a schedule for the regular review and testing of the plan itself.

Annex G – Situational Awareness

The national pandemic flu battle rhythm will be determined at the time and will be dependent upon among other things a) the severity of the pandemic, b) the scale of the challenges arising, and c) available resources. However, planners should assume that a UK situation report will be produced daily and will require input from:

- DH, NHS Commissioning Board and Public Health England (UK health coordination reporting);
- DCLG RED teams/Welsh Government in Wales (wider impacts reporting);
- other departments and the devolved administrations; and
- news updates from the Government News Network and Media Monitoring Unit.

The DCLG RED team input will consist of one situation report which will cover the information requirements of all central government departments. In general terms, the DCLG RED team is required to provide information on the local picture, whereas departments will provide information on the national picture, details of emergency arrangements in place and regulations being considered for action, and major issues arising from sponsored sectors such as transport and energy. In Wales, the Welsh Government will co-ordinate this work and provide reports for Welsh Ministers and the UK Government on the local picture.

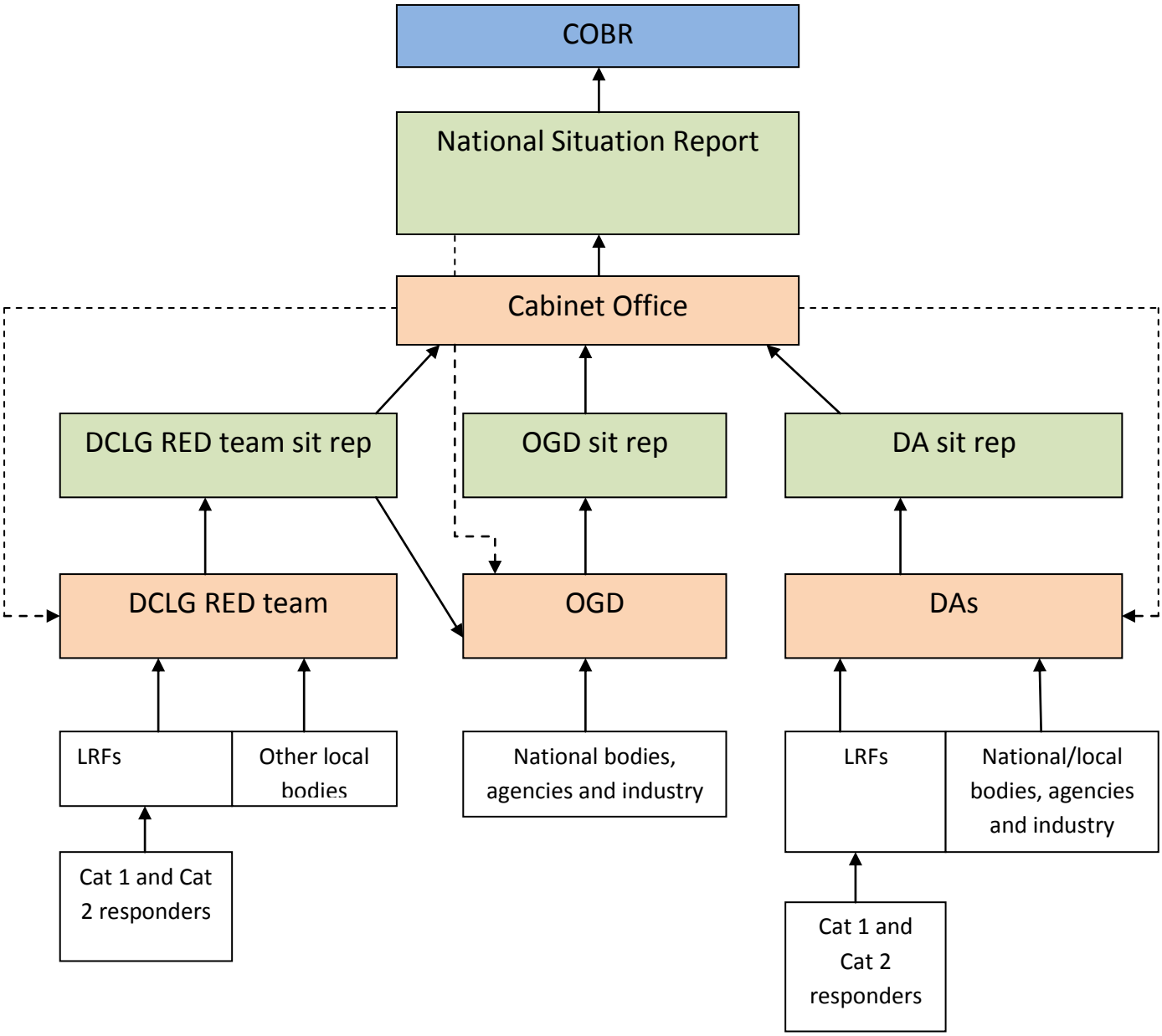
Given the nature of a pandemic, it is difficult to predict with absolute accuracy the exact information requirements that DCLG RED/Welsh Government teams will have for SCGs. However, the information required nationally from DCLG RED/Welsh Government teams is likely to include that in the list below and should be used as the basis to agree local situational awareness reporting:

- impacts on essential services in the locality (e.g. fuel, food, water, waste management etc);
- impacts on cremation and burial services;
- community concerns;
- business issues;
- local support to the health service – antiviral points, agency support including voluntary and community inputs and mutual aid issues and solutions;
- social care provision;
- public communication activity and media coverage; and
- requests for assistance.

It is not expected that all the information requested will need to be updated daily in every part of the country as this will depend on the nature of the virus, its spread, and arising issues. Much of this information will be required on an exception basis (i.e only when/if problems arise). As the pandemic picture develops and issues arise, the information requirements may change. The list above therefore acts as guidance on the type of information that will be requested and/or made available during a pandemic influenza outbreak and is subject to change as more information on the nature of the pandemic becomes available.

Once the national situation report has been compiled by the Cabinet Office it will be distributed by the COBR Situation Cell to Ministers and Departments. The DCLG RED/Welsh Government in Wales teams will in turn cascade the information to local operational levels.

The diagram below outlines the information flows for non-health surveillance data during an influenza pandemic.



LRF plans should include:

- agreed responsibilities for collecting information;
- agreed LRF reporting templates to facilitate the sharing of consistent and validated information in a timely fashion;
- agreed information flows to ensure the effective two-way communication of local and national information;
- agreed arrangements for obtaining health information which is relevant to the LRF response; and
- systems and mechanisms for data collection and dissemination which are regularly exercised.

Data reporting checklist	
1	Methods for the collection of data have been established.
2	Reporting lines between SCGs, subgroups, DCLG RED/Welsh Government agreed.
3	Situation reports have been predetermined.