Pandemic Influenza Response Framework

Author:	Suffolk Local Health Resilience Partnership on behalf of SRF
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DOCUMENT MANAGEMENT

Freedom of Information Act 2000

This document will be made publicly available through the SRF website. Where content has been redacted under the freedom of Information Act 2000 (FOI) in the publically available version, the paragraph number will be highlighted to show there has been a redaction and the relevant section of FOI referenced.

Data Protection Act 1998

This plan does not include personal data that has been shared under the Data Protection Act 1998. It does include data relevant to achieve planning arrangements and identifies how more specific personal data will be used during any emergency.

Review

This plan will be reviewed by the Suffolk Local Health Resilience Partnership on behalf of Suffolk Resilience Forum at least every 3 years. Earlier reviews will take place if there is a change in legislation or guidance, or information from exercises where lessons are identified.
Any amendments will be issued by way of replacement page(s). Should significant changes be required, a complete re-issue of the plan will take place.

Contents

FOREWORD

This framework was originally produced by the Cambridge & Peterborough Local Health Resilience Partnership Working Group and has been adapted by the Suffolk Local Health Resilience Partnership for Suffolk Resilience Forum use.

This framework replaces the SRF Pandemic Influenza Plan published in January 2013, reflecting changes required as a result of NHS restructuring brought about by the Health & Social Care Act 2012 and subsequently published guidance.

Consultation with other Category 1 and Category 2 Responders (Civil Contingencies Act 2004) has taken place via the Suffolk Resilience Forum Working on Wednesday Group.

This document is the strategic multi-agency response plan for high risk pandemic influenza in Suffolk.

REFERENCES

This plan has been produced by reference to:

- Department of Health (DH) Influenza Pandemic Preparedness Strategy 2011
- Health and Social Care Influenza Pandemic Preparedness and Response
- DH Pandemic Influenza Communications Strategy 2012
- PHE Pandemic Influenza Response Plan
- PHE Pandemic Influenza Strategic Framework
- NHS England Guidance for Pandemic Influenza
- NHS England roles and responsibilities of CCGs
- Cabinet Office Pandemic Influenza LRF Guidance

This Plan should also be considered in conjunction with:

Suffolk LHRP Pandemic Flu Plan
SRF Generic Response plan
SRF Generic Recovery Plan
SRF Communications Plan
Individual Agency Operational Pandemic Influenza Plans
Individual Agency Business Continuity Plans

Amendments

AMENDMENT	DATE OF ORIGINAL	AMENDED BY	SIGNATURE

DISTRIBUTION

Public Health England
NHS England
East of England Ambulance Service
Suffolk Constabulary
Suffolk Fire & Rescue Service
Suffolk CCGs
Suffolk Local Authorities
Norfolk LRF
Essex LRF
Cambridgeshire LRF

ABBREVIATIONS AND GLOSSARY OF TERMS

This section contains a generic glossary of terms and the abbreviations and terms relevant to this document

Abbreviation / Acronym	Description
ACP	Antiviral Collection Point
BCM	Business Continuity Management
CCA	Civil Contingencies Act, 2004.
CfI	Centre for Infections, Health Protection Agency
CMO	Chief Medical Officer – the Government's most senior medical adviser
COBR	Cabinet Office Briefing Room – central Government's emergency committee with national responsibility for managing an emergency
CRIP	Common Recognised Intelligence Picture
DCLG	Department of Communities and Local Government
DH	Department of Health - the lead Government department overseeing the response to an influenza pandemic.
GLO	Government Liaison Officer – provided by DCLG RED to link Suffolk's SCG with national crisis management structures
HAC	Humanitarian Assistance Centre – 'One Stop Shop' centre for provision of advice and guidance established by RCG.
IMT	Incident Management Team – Health services tactical command, responsible for overseeing NHS operational response to an influenza pandemic
IHT	Ipswich Hospital Trust
NPFS	National Pandemic Flu Service – telephone service to be established in treatment phase of a pandemic
NSFT	Norfolk & Suffolk NHS Foundation Trust
Oseltamivir	Antiviral Medicine – trade name "Tamiflu", an antiviral medicine that interrupts the propagation of the influenza virus in the respiratory tract and used as a potential effects limiting drug in influenza pandemics
PGD	Patient Group Directive. A process that allows the mass distribution of drugs without individual prescriptions
PPE	Personal Protective Equipment
RCG	Recovery Coordinating Group – established by SCG to plan recovery from a major incident such as an influenza pandemic
Res CG	Response Coordinating Group – multi SCG group convened where coordinated response required by SCGs to a common threat
SCC	Suffolk County Council
STAC	Science and Technical Advice Cell
Strat CC	Strategic Coordinating Centre – based at Suffolk Constabulary HQ, Martlesham Heath, Ipswich
WHO	World Health Organisation
WSFT	West Suffolk Foundation Trust

Reference can also be made to the Government LEXICON of Emergency Terms available at https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

1. OVERVIEW

1.1 Introduction

1.1.1 An influenza pandemic will present unique international, national and local challenges. These challenges may be most severe for health and social care services but all service providers will be faced with maintaining essential services at a time when up to a third of their workforce may be absent; suffering from influenza or caring for children and / or someone suffering from influenza.

1.1.2 Following the 2009 pandemic, all guidance in relation to pandemic influenza has been revised to take account of the lessons learned.

1.2 National Risk

1.2.1 The Suffolk Community Risk Register has recorded Risk ID: H23 Pandemic Flu as having a risk rating of 'Very High', a likelihood of 'medium-high' (> 1 in 20 chance) and an impact of 'catastrophic'. Additionally, the Health and Social Care Act 2012 and Civil Contingencies Act 2004 along with their associated regulations and guidance place an onus upon Category One and Category Two Responders to develop, maintain and test local level multi-agency plans to ensure that the objectives set out in the UK Influenza Pandemic Preparedness Strategy 2011 can be met in the event of a pandemic.

1.2.2 This multi-agency plan summarises the Suffolk response to an influenza pandemic in order to enable co-ordinated contingency planning to take place within individual agencies. This plan is supported by and should be read in conjunction with the detailed plans of each individual agency involved, and in the Suffolk Local Health Resilience Partnership Pandemic Influenza Plan.

1.3 Purpose of This Plan

The response to pandemic influenza requires actions before, during, and after the pandemic. This document provides a framework for influenza pandemic preparedness and response in Suffolk.

1.4 Strategic Aims and Objectives of the Multi-Agency Response

The aim and objectives of this plan is to:

- Provide the strategic framework for pandemic influenza preparedness and response in Norfolk
- Document roles and responsibilities within NRF and Local Health Resilience Partnership (LHRP)
- Set out command, control, co-ordination and communication arrangements for an integrated pandemic response in Suffolk

1.5 Planning Assumptions and Likely Impacts

The worst case scenario could be a cumulative clinical attack rate of 50% of the population with the possibility of all cases occurring in a single wave. Up to 4% of those who are symptomatic may require hospital admission and up to 2.5% of those who are symptomatic could result in excess death over a period of three to four months.

Further information on the modelling of a potential influenza pandemic can be found at Department of Health modelling-summary.

1.5.1 Summary 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 wave lasts around 12-15 weeks and subsequent waves could be weeks or months apart. If a subsequent wave occurs it could be possibly more severe than the first.
Peak clinical attack rate	10% – 12% of population per week
Hospitalisation	Between 1% - 4% of those who are symptomatic may require hospital admission
Case fatality	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)

Source of assumptions: Cabinet Office Pandemic Influenza LRF Guidance July 2013

For the distribution of clinical cases, deaths and staff absences across Suffolk over a 15 week period see **Appendix A**

1.6 Pandemic Influenza UK Response Phases (DATER)

The World Health Organisation (WHO) identifies a series of phases (8) to describe and monitor the progress of a pandemic at a global level. Following the 2009/10 H1N1 influenza pandemic the UK has adopted a 5 phase approach which is not directly linked to the WHO phases. The UK phases are not numbered as they are not linear, may not follow in strict order, and it is possible to move non-sequentially back and forth across them. The UK phases, collectively referred to as **DATER** are:

- **Detection** - triggered on the basis of reliable intelligence or if an influenza related "Public Health Emergency of International Concern" (PHEIC) is declared by the WHO or by the WHO declaring a 'Pandemic Alert Phase'. Enhanced public health surveillance will be undertaken at this phase

- **Assessment -** the collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK

- **Treatment –** the move from **Assessment** to **Treatment** will occur when there is evidence of sustained community transmission of the virus. The focus at this stage will be on the treatment of cases, possibly using the National Pandemic Flu Service (NPFS). Targeted vaccination may also take place during this period, but it should be recognised that the vaccine will not be available for 5-6 months after the decision to order vaccine is given

- **Escalation –** the focus at this stage will be on the implementation of surge management arrangements across the health economy in order to ensure the continued delivery of prioritised (critical) activities

- **Recovery** – the move to the **Recovery** phase will occur when influenza activity has significantly reduced from the peak level, or when the activity is considered to be within acceptable parameters. This phase will focus on the restoration of business as usual activities and planning and preparation for a resurgence of influenza, including a resumption of activities carried out in the detection phase.

To compare WHO phases with DATER see **Appendix B**

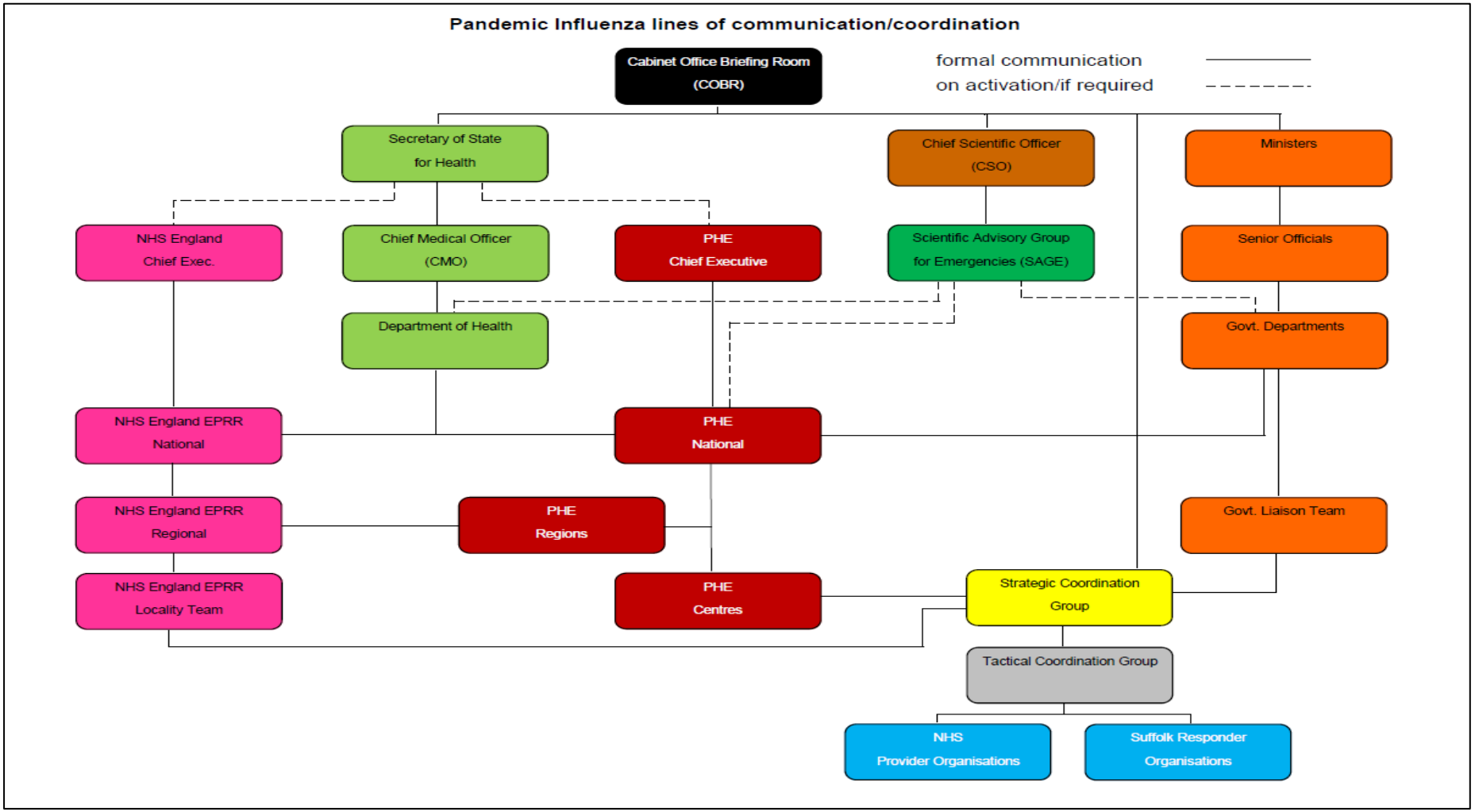
2. ALERTING AND ACTIVATION

2.1 Alerting

The Department of Health is the lead government department for pandemic flu response and will lead the declaration of a pandemic as well as coordinate the strategic health response in England, with the wider cross-government response co-ordinated through COBR, the government crisis response committee. SAGE (Scientific Advisory Group in Emergencies) will support COBR by providing the scientific and technical advice to inform decision making. Following a national declaration of an influenza pandemic (at the **Detection** phase), the notification will be cascaded from NHS England, via NHS England Regional Teams to NHS providers. Multi-agency partners will be notified by DCLG/RED, via the Suffolk Resilience Forum.

Figure 1 below shows the formal lines of communication and coordination with health and multi-agency responders.

Figure 1


Pandemic Influenza lines of communication/coordination
formal communication
on activation/if required
Cabinet Office Briefing Room (COBR)
Secretary of State for Health
Chief Scientific Officer (CSO)
Ministers
NHS England Chief Exec.
Chief Medical Officer (CMO)
PHE Chief Executive
Scientific Advisory Group for Emergencies (SAGE)
Senior Officials
Department of Health
Govt. Departments
NHS England EPRR National
PHE National
NHS England EPRR Regional
PHE Regions
Govt. Liaison Team
NHS England EPRR Locality Team
PHE Centres
Strategic Coordination Group
Tactical Coordination Group
NHS Provider Organisations
Suffolk Responder Organisations

2.2 Strategic Coordinating Group

Activation of the plan will be by local agreement of NHS England, Public Heath England and the Suffolk County Council Director of Public Health (DPH). The DPH will act as the SCG Chair for the duration of the response, unless by mutual agreement the extent of the pandemic reaches proportions/ a scale whereby the impact is not generally confined to health and has wider and more significant implications. If this decision is taken, the chair will revert to Suffolk Constabulary.

It is likely that the initial meeting of the SCG will be undertaken via teleconference.

The purpose of the initial meeting will be to brief all partners on the extent of the pandemic (all known facts at that stage), resultant SCG actions which need to be taken and the frequency and operation of the SCG meetings to follow, and to produce and publish a local pandemic flu response strategy

All organisations will also be reminded to activate their individual agency pandemic response and business continuity plans as appropriate.

2.3 SCG Subgroups/Cells

2.3.1 Media Cell

Will be activated at the outset (**Detection** phase) along with the SCG. PHE does not have sufficient staff to lead every SCG media cell. The media cell will therefore be led by a local communications officer.

NHS England and PHE will participate in the opening SCG meeting.

A communications strategy, led by NHS England and PHE, will be devised to ensure consistency of messaging in line with national communications messages. In accordance with the DH Pandemic Influenza Communications Strategy 2012, the aims of the strategy should be to:

- Explain the outbreak
- Establish confidence

Information on how people may behave during a pandemic can be found in Chapter 5 of the DH Influenza Pandemic Preparedness Strategy 2011, and should be consulted in the development of communications and public engagement plans.

2.3.2 STAC

During an influenza pandemic, scientific and technical advice cells (STACs) are not expected to be activated at local level, However public health interpretation of Scientific Advisory Group for Emergencies (SAGE) advice and guidance to partners will be provided by PHE centres.

2.4 Tactical Coordinating Group

The Suffolk Local Health Resilience Partnership will operate a pandemic influenza coordinating group, including social care representation, chaired by a Chief Officer from Ipswich & East Suffolk and West Suffolk CCGs.

This group will also be activated on declaration of the **Detection** phase. The function of the LHRP coordinating group is to monitor the impact of the pandemic on the local health and social care economy, to ensure the coordination of surge management arrangements and to ensure the activation of antiviral distribution/ collection arrangements and vaccination programmes (when appropriate).

2.5 TCG Subgroups/Cells

2.5.1 Information/ Intelligence Cell

Will be activated at the point when a DH/NHS England or DCLG RED situation reporting requirements begin. The Information/ Intelligence Cell will be led by the CCG Head of Corporate Intelligence

Subject to the requirements from COBR, the Department of Health and NHS England, the Information/ Intelligence Cell will be responsible for the collation and submission of all SitReps for Suffolk, utilising Resilience Direct, or any other prescribed means

All SRF partners will be expected to contribute to the SitRep.

Until otherwise stipulated, it would be reasonable to expect information to be required in relation to:

- impacts on local critical services
- social care provision;
- impacts on cremation and burial services;
- community concerns;
- business issues;
- local support to the health service/voluntary and
- community inputs and mutual aid issues and solutions;
- public communication activity and media coverage; and requests for assistance.
- impacts on service delivery
- staff absenteeism

2.5.2 Excess Deaths Cell

Will be activated when the number of deceased cannot be managed using normal mortuary arrangements, led by the Local Authority

2.6 Systems Resilience Group

Systems Resilience Groups operate within the NHS to deal with capacity and demand planning, and to put in place plans to deal with surges in activity, especially over the winter period.

The specific mechanisms in these plans, by which CCGs and provider organisations respond to and escalate operational capacity issues that the local health economy may experience, can be used to address the increased demand and reduced staffing brought about by a flu pandemic.

Systems Resilience Groups will lead the management of pressure surge arrangements with their commissioned services as part of the overall response and their capacity and resilience plans should be read in conjunction with this plan.

2.7 Response Coordinating Group (ResCG)

A Response Coordinating Group (ResCG) may be convened in England where the response to an emergency would benefit from 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. The SCG Chair will determine the representation to any ResCG where established. Figure 2 below illustrates the interaction between the SCG, TCG and ResCG.

3. ROLES AND RESPONSIBILITIES

[In addition to those outlined in the SRF Generic Response plan]

3.1 NHS England

- National Coordination of the NHS response
- Provision of antiviral/antibiotic counter measures
- Provision of vaccine and consumables

3.2 Public Health England

- Coordination of public health advice
- Collection and analysis of clinical and epidemiological data
- Liaison with the appropriate national bodies regarding public health advice and guidance
- Co-ordinate public health activities nationally and locally – which includes the issuing of timely and accurate infection control guidance including the use of PPE.

3.3 Clinical Commissioning Groups

- Plan for surges in demand
- Identification of local providers to support the delivery of the pandemic flu response
- Identification of vulnerable persons known to the NHS
- Identification of community pharmacies suitable for use as antiviral collection points
- Together with the Local Authority, identification of locations suitable for use as mass anti-viral collection points or mass vaccination centres

3.4 Local Authorities

- Coordination the social care response
- Care of patients in care homes and care facilities
- Identification of vulnerable persons known to Social Care
- Provision of information, advice and guidance to education providers
- Provision of business continuity advice and guidance to businesses
- Coordination of the response to excess deaths, liaising with the Coroner as required
- Together with Clinical Commissioning Groups, identification of locations suitable for use as mass anti-viral collection points or mass vaccination centres

3.5 Suffolk Constabulary

- Support the initial and continuing multi-agency response to the outbreak
- Coordination of the response to any community unrest

More detailed NHS roles and responsibilities are in the Suffolk LHRP Pandemic Influenza Plan.

Impacts and actions cards for SRF during the phases of pandemic influenza are at **Appendix C**

4. ANTIVIRAL COLLECTION POINTS (ACP)

Current guidance is that community pharmacies should be used as the first line response for antiviral collection points (ACPs). These will be established in a staged escalation/de-escalation process to match the required demand as it fluctuates.

NHS England is negotiating with the Pharmaceutical Services Negotiating Committee (PSNC) on a national basis to establish a framework for the contracting and payment of this service.

CCGs will develop a list of suitable pharmacies for Suffolk, based on potential willingness, taking into account population density and geography.

Specific information on the distribution and operation of ACPs will be referenced within the Suffolk LHRP Pandemic Influenza Plan as guidance is published by NHS England.

In extremis, it may be necessary to operate ACPs from non-pharmacy premises, particularly where mass distribution facilities are required. During the 2009/10 pandemic premises such as community centres and sports halls were earmarked for use. Local Authority support will be sought to assist in identify and securing access to such premises.

Closed communities such as prisons will be specifically identified by NHS England during planning to ensure the direct delivery of antivirals and vaccines.

Primary Care providing services for military bases in Norfolk will be engaged by the HSCCG to ensure that service personnel have appropriate access to antivirals

The NPFS will be activated to enable antivirals to be distributed in a controlled and consistent manner to symptomatic individuals during an influenza pandemic. The NPFS supplements the response provided by primary care when it is no longer practical for all those with symptoms to be individually assessed by a doctor or other prescribers.

It is likely that NPFS will be aligned with the 111 number.

5. VACCINATION

There are two distinct types of pandemic vaccine; pre-pandemic vaccine and pandemic-specific vaccine. For the general public 'at risk groups' vaccination will be undertaken through primary care. 'At risk' groups will be defined/ identified during the pandemic based on the epidemiology of the pandemic strain.

It is the responsibility of NHS England, supported by the CCG to have local vaccination arrangements in place in advance of a pandemic. In extremis, there may be a requirement to establish mass vaccination centres. As with anti-viral collection points, Local Authority support will be sought to assist in identify and securing access to such premises.

5.1 Pre-pandemic vaccine

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

5.2 Pandemic-specific vaccine

Pandemic-specific vaccine is likely to become available within four to six months of the pandemic being declared. The Joint Committee on Vaccination and Immunisation (JCVI) will agree the prioritisation of vaccination to reduce morbidity and mortality as far as possible.

The presumption is that frontline health and social care workers and the usual seasonal influenza "at-risk" groups will be offered the vaccine first. The list would be modified as dictated by the nature of the specific flu strain and upon advice from JCVI. The expert advice from the JCVI will take into account availability of vaccine supplies, extent of the spread of the pandemic virus and severity of illness caused.

6. SCHOOLS AND CHILDCARE SETTINGS

Due to the substantial economic impact and social consequences, closure of schools and similar settings would only be considered in an influenza pandemic with a very high impact. Schools and childcare settings closure may be necessary, during a pandemic, either because of inadequate staffing levels or in order to reduce the spread of infection. Detailed information is contained in the published Department for Education and Skills guidance National Archives for Human Pandemic Influenza planning.

Recent research suggests (*Impact of School Closures on an Influenza Pandemic Scientific Evidence Base Review – Department of health – May 20154)* that there is currently insufficient evidence to recommend a particular school closure policy (e.g. proactive or reactive) over another. School closure may form a useful component of a mitigation strategy during pandemic influenza, but the timing and duration of closure needed to produce an effect is unclear. Policy should be responsive to the features of a new pandemic virus. For example, if transmission occurs mainly in schools (as during the 2009 pandemic), there is stronger justification for school closure than in the situation where much transmission occurs in adults.

In the early stages of a pandemic a precautionary approach (i.e. closing schools in the absence of strong evidence that this will reduce transmission) may be considered, particularly if the virus is believed to be highly pathogenic. School closure should be accompanied by advice that children should avoid meeting in large groups.

The benefit of school closure in reducing clinically important outcomes needs to be balanced against secondary adverse effects which may not affect all sections of society equally. For example, such adverse effects may be particularly prominent where free school meals are an important source of nutrition or where parents are unable to take time off work or work from home.

The Department for Education will advise Suffolk County Council. It is the responsibility of Suffolk County Council to alert all maintained schools and settings 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.

7. VULNERABLE PEOPLE

It will be essential to ensure communication with and the needs of vulnerable individuals/ difficult to reach groups/ closed communities are considered. The SRF Vulnerable People Protocol should be used for this purpose.

8. SOCIAL DISTANCING

National guidance will be issued on public health and 'social distancing' measures to reduce the spread of flu during a pandemic. The implications of these measures should be taken into account when considering public gatherings, such as football matches etc.

Symptomatic persons will be asked to stay at home or in their place of residence whilst ill. Voluntary quarantine of contacts of known cases will also be encouraged. National messages for the public will be communicated during a pandemic and coordinated by the Media Cell.

9. PUBLIC ORDER

Maintenance of public order is the responsibility of Suffolk Constabulary. It is recognised that any request to Suffolk Constabulary for support (e.g., to respond to civil disorder surrounding the distribution of antivirals) is likely to be made in the context of reduced staff resources. Requests for Police assistance should, except in an emergency situation, be via the SCG/TCG process.

10. FAITH AND VOLUNTARY SECTOR

Any assistance relating to pandemic flu response provided to Cat. 1 or Cat. 2 responders by faith or voluntary sector groups will be coordinated by the Suffolk Voluntary Organisations Group, acting as a cell of the Local Authority response.

11. PORTS

Suffolk Coastal Port Health Authority is responsible for enforcement of Environmental, Public and Animal Health Controls at the Ports of Felixstowe and Ipswich.

Each facility has a port health plan which will guide screening and information for potentially infected people arriving in the country.

During a pandemic, the Foreign and Commonwealth Office (FCO) and DH will provide advice to travellers departing the UK. Once the UK is affected this may include 'exit screening' under PHE recommendation.

12. INFECTION CONTROL

As a part of business continuity planning all agencies/ organisations of the SRF should support 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 to 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.

Infection control guidance in the event of a flu pandemic is available for some non-NHS sectors (funeral directors, the hospitality industry, fire and rescue services, cleaning and refuse staff and the police). Each document explains what pandemic flu is, how it is spread and how individuals can protect themselves and others from it. It also addresses issues relevant to the particular sector. This is in addition to the NHS: Guidance for infection control in hospitals and primary care settings.

Guidance documents can be found at http://www.dh.gov.uk/PandemicFlu.

The Health and Safety Executive (HSE) has published Pandemic Flu Workplace Guidance.

http://www.hse.gov.uk/biosafety/diseases/pandflu.htm

FAQs for infection control should also be provided to SRF members at the Detection phase, as supplied by PHE.

13. EXCESS DEATHS

In a worst case scenario, with death rates up to 2.5% of those contracting influenza, there may be as many as 9,000 excess deaths in Suffolk during an influenza pandemic. In the peak weeks of the pandemic there could be 250 deaths a day, every day for about a fortnight.

Planning advice suggests that, with modern treatments and care, the maximum death rate is unlikely to exceed 1% of those contracting influenza – resulting in about 3,600 deaths, or 100 a day at the peak of the pandemic.

The Local Authority will develop operational plans to deal with excess deaths during a pandemic.

The following alternatives may (depending upon the severity of the pandemic) become available at World Health Organisation (WHO) Phase 6, UK escalation phase:

- The legal requirement that a death must be referred to the coroner if the registered medical practitioner (who must have attended the deceased during their final illness) who certified the cause of death had seen neither the body after death nor the patient within 14 days preceding their death will be relaxed to refer to 28 days.

- The good practice requirement that all deaths which occur within 24 hours of admission to hospital (unless purely for terminal care) are reported to the coroner should cease insofar as it concerns deaths caused by pandemic influenza or complications thereof.

- The requirement to report all deaths in certain custodial establishments to the coroner, and for the coroner to hold an inquest (in some cases with a jury), will cease for deaths that an independent medical practitioner certifies as being due to pandemic influenza or its complications. The requirement for the coroner to hold an inquest will cease for other natural deaths.

- Legislative amendments will be made that allow a registered medical practitioner who has not attended the deceased in their final illness to provide a medical certificate of cause of death (MCCD) for those who appear on the balance of probabilities to have died of pandemic influenza.

Appendix A

Distribution of clinical cases, deaths and staff absences across Suffolk over a 15 week period

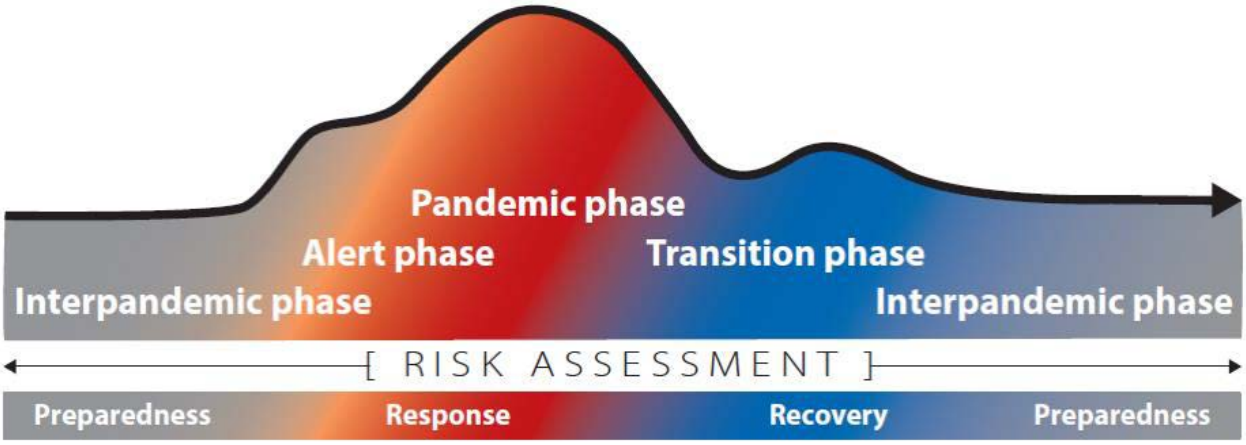
Week	% of occurrences	Cases	Deaths[1]	Staff absence/100 staff
1	0.1	360	4	0
2	0.2	720	7	0
3	0.8	2880	29	1
4	3.1	11160	112	3
5	10.6	38160	382	11
6	21.6	77760	778	22
7	21.2	76320	763	21
8	14.3	51480	515	14
9	9.7	34920	349	10
10	7.5	27000	270	8
11	5.2	18720	187	5
12	2.6	9360	94	3
13	1.6	5760	58	2
14	0.9	3240	32	1
15	0.7	2520	25	1

Appendix B

Comparing WHO phases with DATER

The 2011 UK Strategy recognises the need to disassociate the UK response from the global WHO Phases and instead refers to five phases named: Detection, Assessment, Treatment, Escalation and Recovery.

The continuum of pandemic phases is as below



[a] This continuum is according to a "global average" of cases, over time, based on continued risk assessment and consistent with the broader emergency risk management continuum.

UK Phases

Detection ----------→
Assessment ----------→
Treatment ----------→
Escalation ----------→
Recovery ----------→

Appendix C

Impacts and actions cards for SRF during the phases of pandemic influenza

DATER Phase/ Impact	Nature and scale of illness	Impact on wider society	SCG & LRF partner actions	Public messages
DETECTION AND ASSESSMENT PHASE **(Initial Response)** **Note: Pandemic impact unknown at this stage**	Sporadic influenza cases may be reported from the community Possible limited local outbreaks (schools, care homes) Possible increased proportion of critical care cases with influenza National Pandemic Flu Service (NPFS) NOT activated and normal health services continue	Possible public concern arising from media reporting of cases at home or abroad Possible disruption to international travel and concern among intending / returning travellers Possible school closures to disrupt the spread of local disease outbreak, based on public health risk assessment	**Actions for SCG:** • Convene the SCG & Media Cell. Agree meeting frequency and communications • Review the NRF Pandemic Response Framework • Ensure that reporting mechanisms for DCLG/ RED are in place & functioning & that partners are prepared for reporting requirements • Ensure that the Media Cell is ready to disseminate the relevant pandemic flu communications to 'warn & inform' the public, in line with PHE 'lines to take' • Identify a Recovery lead to plan for recovery on commencement of the Treatment phase (or sooner if deemed necessary) **Actions for all LRF agencies:** • Ensure the notification of all staff and specifically those with pandemic flu responsibilities. • Review and update pandemic response and business continuity plans • Prepare and test reporting systems • Check vulnerable persons identification system • Confirm arrangements for vaccination of priority staff • Ensure a coordinated approach – where possible – to staff returning to work following sickness • Ensure appropriate PPE and infection control guidance for frontline responder staff	Advice on good respiratory and hand hygiene Advice about how to obtain further information e.g. to consult Government and NHS websites and other local channels/ media for up to current information Establish transparent approach to communicate the science of uncertainty, severity and impact, and the likely evolution of the situation

DATER Phase/ Impact	Nature and scale of illness	Impact on wider society	SCG & LRF partner actions	Public messages
TREATMENT AND ESCALATION **LOW IMPACT**	Similar numbers of cases to moderate or severe seasonal influenza outbreaks AND In the vast majority of cases – mild to moderate clinical features **NPFS activated at Treatment Phase**	Increase in staff absence due to sickness – similar to levels seen in seasonal influenza outbreaks No significant or sustained impact on service and business capacity	**Actions for SCG:** • Review the meeting frequency and mode of operation of the SCG to ensure that it can address the scale of the pandemic • Commence situation reporting as required by DCLG/ RED • Ensure the Media Cell continues with the 'warning and informing' effort in line with NHS England/ PHE guidance and instruction • Invoke excess deaths strategy as necessary • Commence recovery planning (if not done sooner) • Ensure the engagement of the voluntary/ independent sector to support the response • Unless a ResCG is established, undertake close communication with neighbouring SCGs to ensure a coordinated response **Actions for all LRF agencies:** • Support health partners to ensure antiviral collection in the community • Consider own arrangements for sickness absence surveillance • Continue the promotion of hygiene messages to staff and ensure adequate infection control consumables are available • Promote self-isolation for ill staff • Ensure the continuity of prioritised (critical) activities • Identify priority staff for vaccination. Note that this will be focused on frontline health and social-care workers first, along with 'at-risk' member of the public • Invoke business continuity plans • Ensure situation reporting to SCG when implemented	As for **Detection/ Assessment** phase Information on the pandemic and the clinical effects of infection, and what to do. Information about antiviral medicines and tailored messages for children, pregnant women, elderly and other at risk groups (in liaison with expert bodies and support groups). Encourage the use/ adoption of 'flu friends' to collect antivirals How to use your local health services. Employers planning in advance for sickness absence, service reprioritisation and alternative ways of working

DATER Phase/ Impact	Nature and scale of illness	Impact on wider society	SCG & LRF partner actions	Public messages
TREATMENT AND ESCALATION **MODERATE IMPACT**	Higher number of cases than large seasonal epidemic. Young healthy people and those in at-risk groups severely affected AND/OR more severe illness	Supplies of electricity, gas and fuel will remain at near-normal levels with routine maintenance at a lower level of priority if there are staffing shortfalls. Essential repairs expected to continue. Potential disruption to general supplies if peak staff absence coincides with technical or weather related supply difficulties. Concern among teachers and parents about infection spread in educational settings may lead to increased absence. Supply chain companies implement business continuity plans. Justice system affected by absence of staff, judiciary and other parties. Increased generation of general waste based on use of disposable PPE and pandemic related consumables	**Actions for SCG:** • As for LOW • Increase SCG meeting frequency as necessary • Review the requirement to hold large-scale public events and ensure that appropriate infection control measures are in place if held **Actions for all LRF agencies:** • As for LOW • Environment Agency to advise on waste disposal and licensing arrangements where the amount of waste exceeds quotas	Information on the pandemic and the clinical effects of the infection. Advice on seeking medical assessment when not improving or getting worse Information on NPFS Information on collection of antivirals/ medicines Information about antiviral medicines and tailored messages for children, pregnant women, elderly; and other at-risk groups (in liaison with expert bodies and support groups) Infection control and business continuity advice for specific occupations. e.g. funeral directors, registrars, cemetery and crematorium managers, police etc. as appropriate Managing expectations of Critical Care

DATER Phase/ Impact	Nature and scale of illness	Impact on wider society	SCG & LRF partner actions	Public messages
TREATMENT AND ESCALATION **HIGH IMPACT**	Widespread disease in the UK AND/OR most age-groups affected AND/OR severe, debilitating illness with or without severe or frequent complications	Emphasis on maintaining supplies and staffing Transport, schools, shops affected by sickness and family care absences Numbers of deaths putting pressure on mortuary and undertaker services Possible implementation of national legislative changes to facilitate changes in working practice (e.g. death certification, drivers' hours, sickness self-certification requirements, Mental Health Act, benefits payments) Justice system affected by absence of staff, judiciary and other parties.	**Actions for SCG:** • As for LOW/ MODERATE • Consider change of chair to Suffolk Constabulary • Consider messaging about cancellation of large-scale public events **Actions for all LRF agencies:** • As for LOW/ MODERATE	Messages about progress of the pandemic, availability of healthcare and other services. Advice on how to minimise risks of transmission Information on how to support family members and neighbours Advice on where to get help for emergencies Truth about how services are coping and what they are doing to cope Explanation of triage systems to align demand and capacity Some civil contingencies advice, including advice to specific occupations such as paramedics, funeral directors, registrars, cemetery and crematorium managers, police etc. as appropriate

DATER Phase/ Impact	Nature and scale of illness	Impact on wider society	SCG & LRF partner actions	Public messages
RECOVERY **NOTE: The recovery phase is also about preparation for possible subsequent pandemic waves**	Impact of pandemic wanes and gradual return to 'business as normal' NPFS and ACPs closed	Reduced access to skilled staff and their experience due to staff fatigue Organisational fatigue including essential supplies/ raw materials, facilities, maintenance backlog, income loss, loss of customer base, etc.	**Actions for SCG:** • Implement the recovery strategy • Assess the impact of the pandemic by undertaking comprehensive hot and cold debriefs • Ensure a post-incident debrief report is compiled • Review the pandemic response framework off the back of lessons identified • Acknowledge contributions to the response effort, particularly from the voluntary/ faith sector • Ensure readiness is maintained across the LRF partners • Review data collection arrangements for any subsequent pandemic waves **Actions for all LRF agencies:** • Implement individual agency recovery strategies • Conduct agency debriefs • Acknowledge staff contributions and review welfare arrangements • Ensure readiness is maintained for subsequent waves • Review agency business continuity and pandemic plans • Ensure staff are 'upskilled'/ trained to fill gaps which support the delivery of prioritised (critical) functions • Undertake a stock-take of PPE • Ensure the return of unused countermeasures to the national stockpile as requested • Engage in the post-pandemic vaccination strategy where appropriate	Messages about promoting vaccine uptake amongst 'at-risk' groups Ensure preparedness of the general public for subsequent waves Acknowledge examples of public support for vulnerable persons through the pandemic

Appendix D

Agenda for SCG teleconference

1		Attendance & Apologies
	1.1	Terms of Reference & Membership (for first meeting)
	1.2	Battle Rhythm (for first meeting)
2		Urgent Actions
3		Decisions & Actions from Previous Meeting (meeting 2 onwards)
4		Update on Strategic Situation (CRIP)
5		Updates from Agencies/Sub Groups
6		Set/Review Strategy & Priorities
7		Agreed Actions, Timescales and Responsibility
8		A.O.B.
9		Next Meeting