



CHESHIRE, HALTON & WARRINGTON LOCAL RESILIENCE FORUM

INFLUENZA PANDEMIC PLAN

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Document Name	Cheshire, Halton & Warrington Local Resilience Forum Pandemic Influenza Plan
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SUMMARY OF ALERT PHASES AND ACTIVATION OF THE PLAN

Phase	WHO international phases	Overarching public health goals
Inter-pandemic period		
1	No new influenza virus subtypes detected in humans	Strengthen influenza pandemic preparedness at global, regional, national and sub national levels Minimise the risk of transmission to humans; detect and report such transmission rapidly if it occurs
2	Animal influenza virus subtype poses substantial risk	
Pandemic alert period		
3	Human infection(s) with a new subtype, but no (or rare) person-to-person spread to a close contact	Ensure rapid characterisation of the new virus subtype and early detection, notification and response to additional cases Contain new virus or delay its spread transmission to gain time to implement preparedness measures, including vaccine development Maximise efforts to contain or delay spread, to possibly avert a pandemic and to gain time to implement response measures
4	Small cluster(s) with limited person-to-person transmission but spread is highly localised, suggesting that the virus is not well adapted to humans	
5	Large cluster(s) but person-to-person spread still localised, suggesting that the virus is becoming increasingly better adapted to humans	
Pandemic period		
6	Increased and sustained transmission in general population UK alert levels (if activated) 1 Virus / cases only outside the UK 2 Virus isolated in the UK 3 Outbreak (s) in the UK 4 Widespread activity across the UK	Minimise the impact of the pandemic

ACTIVATION OF THE PLAN

Trigger levels

The World Health Organisation (WHO) international phases and UK alert levels (if activated) can be used as triggers for the initiation of specific actions and ultimately the implementation of this plan.

WHO Phase 5

WHO Phase 5 will be declared when large cluster(s) but person-to-person spread is still localised, suggesting that the virus is becoming better adapted to humans. At this stage, the LRF Pandemic Influenza Group will meet to review the current guidance and prepare advice for the Strategic Coordinating Group (SCG) which will also arrange to meet at this phase. A discussion should take place between the Police (who normally chair the SCG) and the Lead Primary Care Trust (NHS Western Cheshire) as to who should chair the SCG at this phase of any pandemic outbreak.

The SCG will include the most senior officers from each appropriate organisation. Action cards for the SCG have been developed from WHO Phase 5 and are included in the appendix. Communication will be vital and all appropriate information and guidance will be cascaded to Category 1 and 2 responders within the area. The SCG will be prepared for possible activation. This plan will be initiated by the Chair of the SCG.

All organisations should consider the preparation of information materials relating to the services that will be delivered and whether there will be any change to the normal service. In addition, the health service and associated professions will be alerted to enhance surveillance and diagnostic capability

WHO Phase 6

The Government will decide whether or not to activate the UK Alert Levels in response to a WHO Phase 6 declaration, or it may decide to implement an alternative system, such as for the Swine Flu Outbreak in 2009.

If the Government implements UK Alert Levels then this will trigger the following actions by the SCG.

- **WHO Phase 6 – UK alert level 1**

The SCG will be reconvened to confirm the strategy that Cheshire, Halton & Warrington LRF will follow during the pandemic. This plan will be implemented by the Chair of the SCG. The HPA will provide a daily update to the SCG on the local situation, including a seasonal flu update (where appropriate)

- **WHO Phase 6 – UK alert level 2**

Antivirals will be delivered to PCTs at WHO Phase 6, UK alert level 2. The Lead PCT will liaise with all PCTs to ensure that there are agreed procedures for the safe storage

of antivirals, together with distribution mechanisms. The Lead PCT will also link with the SHA to ensure that there is consistency in the cascade of any messages.

SCG meeting arrangements will be finalised in conjunction with reporting mechanisms. All essential services will be reviewed.

- **WHO Phase 6 – UK alert levels 3 and 4**

The SCG will consider virtual meeting / video conferencing and regular updates that must be provided by all agencies. Key decisions will be undertaken with regard to delaying the spread of the disease

The Government may decide not to implement the UK Alert Levels, dependant upon the situation, the nature of the pandemic disease and its spread across the UK. During the Swine Flu Outbreak of 2009 the Government implemented the following activation levels

- **WHO Phase 5/6 – UK Containment**

The SCG will be reconvened to confirm the strategy that Cheshire, Halton & Warrington LRF will follow during the pandemic, subject to advice from the Department of Health. This plan will be implemented by the Chair of the SCG. The HPA will play a lead role in containing any disease outbreak (through laboratory testing all cases and active contact tracing). Due to the different patterns of disease across the country, the LRF area may only be experiencing a low number of confirmed cases. The SCG will ensure that all organisations are at a heightened state of preparedness, actively reviewing, testing and exercising plans. SCG meeting and reporting arrangements will need to be agreed. SCG should consider the use of teleconferences and LRF-wide briefing.

- **WHO Phase 6 – UK Outbreak Management**

This level is similar to the Containment level above, but recognises that certain parts of the country may be experiencing higher levels of disease – or ‘hot spots’. Such ‘hot spots’ would be granted greater flexibility, subject to approval from the Secretary of State for Health. The pattern of disease locally may mean the LRF does not need to move to this stage. The SCG would be need to be supportive of any application for ‘hot spot’ status, subject to advice from the HPA and local NHS. Should the LRF achieve ‘hot spot’ status, a heightened response involving the HPA, local NHS and local authorities would be required. SCG meeting and reporting requirements are likely to increase should the LRF be declared a ‘hot spot’. SCG should consider the use of teleconferences and LRF-wide briefing.

- **WHO Phase 6 – UK Treatment**

Due to the increasing number of ‘hot spots’ the Government moves to the treatment stage. Management responsibility for the pandemic shifts from the HPA to the NHS. Responses need to be **proportional** to the pattern of disease being experience locally. If a low number of cases are reported locally when the treatment stage is declared nationally, a heightened response will initially be required from the local NHS and local authorities. As the disease spreads across the LRF, the multi-agency involvement will

increase. SCG meeting and reporting requirements are likely to increase as the disease becomes more prevalent within the local community. SCG should consider the use of teleconferences and LRF-wide briefing.

Dependent upon the nature of the pandemic, the Government may well decide to respond in a different manner to those described above. The SCG may therefore need to meet to decide how this plan should be implemented in light of the Government's response.

Inter wave period

When the first wave of the pandemic is over, a review of actions will be required including updates from each agency. This plan must be reviewed and preparations need to be put into place for the next wave of pandemic influenza.

PART A – STRATEGIC OVERVIEW

1. INTRODUCTION

1.1 Aim of the plan

The aim of the Cheshire, Halton & Warrington Local Resilience Forum (LRF) Pandemic Flu Plan is to describe the arrangements in place in Cheshire, Halton & Warrington to respond to an influenza pandemic outbreak. The aim of the plan is to reduce and manage the impact of such an outbreak.

1.2 Objectives of the plan

The objectives of this plan are to give an overview of the following:

- The mechanisms which would be put in place in the event of an influenza pandemic being declared;
- How the mechanisms would be activated;
- The key responsibilities of the LRF responding organisations;
- Prioritisation of essential services within Cheshire, Halton & Warrington;
- Coordination of the multi agency response;
- Communication requirements;
- Needs of vulnerable groups;
- Arrangements for antiviral distribution and mass vaccination;
- Management of excess deaths;
- Data collection requirements; and
- Recovery

1.3 Government's Strategic Objectives

This plan also supports the Government's strategic objectives which are to:

- Protect citizens and visitors against the adverse health consequence as far as possible;
- Prepare proportionately in relation to the risk;
- Support international efforts to prevent and detect its emergence and prevent, slow or limit its spread;
- Minimise the potential health, social and economic impact;
- Organise and adapt the health and social care systems to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care;
- Cope with the possibility of significant numbers of additional deaths;
- Support the continuity of essential services and protect critical national infrastructure as far as possible;
- Support the continuation of everyday activities as far as practicable;
- Uphold the rule of the law and the democratic process;

- Instil and maintain trust and confidence by ensuring that the public and the media are engaged and well informed in advance of and throughout the pandemic period;
- Promote a return to normality and the restoration of disrupted services at the earliest opportunity.

1.4 Scope of the plan

This plan covers all aspects of the local multi agency response to an influenza pandemic outbreak. It is intended to be read in conjunction with '*A national framework for responding to an influenza pandemic*' which was issued by the Department of Health in November 2007.

This plan may also be used to respond to an infectious disease outbreak that spreads rapidly from person to person contact and requires a multi-agency coordinated response.

This plan does not cover the planning for, or response to any incident involving the prevention or control of avian influenza or other animal influenza virus infection in birds or humans

This plan is not intended to be a substitute for each organisations own individual response plan. Each LRF organisation will have its own plan which dovetails with this one.

1.5 Plan update

This plan is a dynamic document prone to change. The plan will be subject to review every year or earlier in the event of new or updated guidance being issued or as appropriate following any incident, exercise or comments received. Any review or update will be subject to the LRF Pandemic Flu Group meeting and agreeing the changes.

1.6 Training and exercising

All agencies are responsible for familiarising their staff with their own plans. In addition, each organisation is responsible for ensuring that their staff are aware and familiar with the contents of this plan where appropriate.

Any staff who may be required to undertake a role outlined within this plan must receive appropriate training and be involved in the testing of this plan with multi-agency partners. This plan will be tested and validated through a local exercise once it has been approved.

1.7 Publication and distribution

This plan will be made available to all responder organisations listed. It is important that the classification of the document is recognised and that it is stored appropriately.

1.8 Freedom of Information and Data Protection

Release of information contained in this document should be considered with regard to Freedom of Information and Data Protection legislation. Classification of this document will be reviewed on an ongoing basis.

2. CONTEXT

2.1 Background information to influenza pandemics

Influenza pandemics are natural phenomena which occurred three times in the last century. Their severity has ranged from something similar to seasonal influenza to a major threat, with many millions of people worldwide becoming ill and a proportion of these dying. No country can expect to escape the impact of a pandemic entirely, and when it arrives most people are likely to be exposed to an increased risk of catching the virus at some point. Influenza pandemics therefore pose a unique international and national challenge.

As well as their potential to cause serious harm to human health, they threaten wider social and economic damage and disruption. Measures to prevent, detect and control them require coordinated international effort and cooperation, with one country's action – or inaction – potentially affecting many others.

Pandemic influenza occurs when an influenza A virus subtype emerges or re-emerges which is:

- Markedly different from recently circulating strains;
- Able to infect people;
- Readily transmissible from person to person;
- Capable of causing illness in a high proportion of those infected;
- Able to spread widely because few – if any – people have natural or acquired immunity to it.

Influenza is one of the most difficult infectious diseases to control because the virus spreads easily from person to person via the respiratory route when an infected person talks, coughs or sneezes. It is also spread through hand to face contact if hands are contaminated.

2.2 World Health Organisation (WHO) international phases and UK alert levels

WHO has defined phases in the evolution of a pandemic (see page 6) which allow for a step wise escalation in planning and response that is proportionate to the risk from first emergence of a novel influenza virus. WHO will inform its member states of any change in the alert phase, and this classification is used internationally.

If a pandemic were declared, action would depend on whether cases had been identified in the UK and the extent of the spread. The Government will decide whether or not it will activate the UK alert level system (for UK purposes, four additional alert levels have therefore been included within WHO Phase 6) or whether it will implement an alternative system dependent upon the nature of the pandemic.

As international phases change, the Government will monitor developments, reassess national risk and review preparedness arrangements at all levels across each sector. The general aim is to accelerate, consolidate and test preparedness efforts before the WHO Phase 4, and to be fully prepared to initiate and implement response actions during any phase thereafter.

Should the virus originate in the UK, rapid detection, isolation and treatment of sufferers, the application of stringent containment measures and the use of antiviral prophylaxis for all close contacts may possibly contain or limit its spread. However, if the virus enters the UK through travellers from infected areas, such internal containment efforts are considered unlikely to succeed due to the large number of initial contacts expected.

The Department of Health supports preparedness in the NHS and this has been recognised in *The Operating Framework for the NHS in England 2008/2009* and *The Operating Framework for the NHS in England 2009/2010*.

2.3 Local influenza pandemic planning arrangements

In the UK, the primary responsibility for planning for and responding to any major emergency rests with local organisations, acting individually and collectively through LRFs and Strategic Coordinating Groups (SCGs).

A local multi-disciplinary planning group has been identified to develop this plan and ensure preparedness through training and exercising. The group consists of representatives from the following areas:

- Health Protection Agency
- Lead Primary Care Trust for Emergency Preparedness
- Primary Care Trust representative
- Acute Trust representative
- North West Ambulance Service
- Cheshire Police
- Warrington Borough Council (liaising with the Coroner)
- Cheshire East Council (also representing Cheshire West and Chester Council)
- Halton Borough Council

Not all agencies are represented on the planning committee but local resilience arrangements are monitored regularly by the group. The planning group currently meets frequently (quarterly), to ensure that planning and response arrangements are agreed and consistent with national guidance. When this plan has been updated (to reflect the latest guidance) and tested, the need to meet will reduce.

2.4 Risk assessment

Cheshire, Halton & Warrington LRF has produced a community risk register as required by the Civil Contingencies Act 2004. It can be accessed at:

<http://www.cheshirefire.gov.uk/Assets/partnerships/crrpublicreportjuly07v2.pdf>

A risk matrix has been used to score hazards and identify where the highest risk is. An influenza type disease – pandemic – has been scored as 4 for likelihood and 5 for impact. The risk of an influenza pandemic is therefore rated as very high.

2.5 Planning assumptions

Response arrangements must be flexible enough to deal with a range of possibilities and be capable of adjustment as they are implemented. The planning assumptions are as follows:

- A future pandemic could occur at any time. Intervals between the most recent pandemics have varied from about 10 to 40 years with no recognisable pattern, the last being in 1968/1969;
- A new virus may emerge at any time of the year;
- Initially, pandemic influenza activity in the UK may last for three to five months, depending on the season. There may be subsequent waves, weeks or months apart;
- Spread from the country of origin is likely to follow the main routes of travel and trade;
- Spread from the source country to the UK through movement of people is likely to take two to four weeks;
- From arrival in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters that will act as initiators of local epidemics are occurring across the country;
- The incubation period is in the range of one to four days (typically two to three). People are highly infectious for four to five days from the onset of symptoms and may be absent from work for up to ten days;
- Some people may be infected without showing symptoms, but nevertheless may shed the virus and pass on the infection;
- Without intervention, and with no significant immunity in the population, historical evidence suggests that one person infects about 1.4 to 1.8 people on average. This number is likely to be higher in closed communities such as prisons, residential homes or boarding schools;
- More severe illness than the usual seasonal influenza is likely in all population groups, with a higher number of people than usual developing severe prostration and rapidly fatal overwhelming viraemia, viral pneumonia or secondary complications;
- To inform planning, response plans should consider the potential impacts of a 25%, 35% and 50% clinical attack rate and overall case fatality rates of 0.4%, 1%, 1.5% and 2.5% of those with influenza symptoms;

- Up to 28.5% of symptomatic patients (including all children under three) will require assessment and treatment by a general medical practitioner or suitably experienced nurse;
- Up to 4% of those who are symptomatic may require hospital admission if sufficient capacity were to be available;
- Up to 22% of influenza cases can be expected during the 'peak week' of a pandemic wave;
- Average length of stay in hospital of six days for patients not requiring critical care;
- Average length of stay in hospital of ten days for patients requiring critical care;
- The UK case fatality rate in previous pandemics was between 0.2% and 2%;
- Evidence from previous influenza pandemics suggests a maximum case fatality of 2.5% is a reasonable worst case scenario for planning purposes

2.6 Potential impact on Cheshire, Halton & Warrington LRF area

The potential impact of an influenza pandemic on Cheshire, Halton & Warrington has been modelled. The data has been calculated for the population of each Local Authority area – Cheshire West and Chester, Cheshire East, Halton Borough Council and Warrington Borough Council.

Table 1 - Modelling data over the course of the local pandemic

Clinical cases	25% attack rate	35% attack rate	50% attack rate
Cheshire West	81,875	114,625	163,750
Cheshire East	89,725	125,615	179,450
Halton BC	29,688	41,563	59,376
Warrington BC	48,551	67,972	97,103
Total	249,839	349,775	499,679

Hospital admissions (4%)	25% attack rate	35% attack rate	50% attack rate
Cheshire West	3275	4585	6550
Cheshire East	3589	5025	7178
Halton BC	1188	1663	2375
Warrington BC	1942	2719	3884
Total	9,994	13,992	19,987

2.7 Impact on health and social care

Many workers will take some time off during the pandemic period. They may need to care for family, sick relatives or dependants and/or suffer bereavement. Absenteeism may be higher because of difficulties (or fear of) travelling to work on public transport. Health care workers may possibly have a higher sickness absence rate than other population groups because they have a higher risk of exposure.

An outbreak of an infectious disease may spread rapidly in closed communities such as schools and colleges. In 1957, up to 50% of school children developed influenza and in residential schools attack rates reached 90%, often affecting the whole school within two weeks. This will affect working parents, but closing schools also has a significant effect on business continuity and maintenance of essential services. Similar spread is likely in other closed communities such as:

- Prisons
- Military barracks
- Care homes
- Educational establishments

Surge capacity will also affect all organisations providing essential services. Surge capacity can be described as 'the ability to expand provision beyond normal capacity to meet transient increases in demand e.g. to provide care or services above normal capacity, or to expand manufacturing capacity to meet increased demand'.¹ Surge capacity will be reviewed when further guidance is issued.

The impact of an outbreak on health and social services may be intense, sustained and the services may become overwhelmed with no mutual aid available from neighbouring organisations. Some of the likely issues resulting from an outbreak are shown in the table overleaf:

Table 2 – issues resulting from an influenza pandemic

All workforces	<p>Staff sickness or death, bereavement and workforce depletion</p> <p>Disruption to supplies and utilities</p> <p>Business continuity</p> <p>Communications with staff</p> <p>Domestic pressures on staff if schools close of children ill</p> <p>Surge capacity</p>
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¹ Pandemic flu: A national framework for responding to an influenza pandemic. London: Department of Health, 2007.

Health services	<p>Existing patients affected</p> <p>Complexity of added infection control measures</p> <p>Managing demand for antivirals / vaccine</p> <p>Need to draft in volunteers (indemnity / CRB checks)</p> <p>Communications with staff, patients and clients</p>
Acute hospitals	<p>Higher A&E attendance</p> <p>Pressure on Intensive Care beds, equipment and staff</p> <p>Infection control processes</p> <p>Bed blocking because of reduced community capacity</p>
Intermediate care	<p>Pressure on admissions</p> <p>Difficulty in admitting patients to secondary care</p> <p>Higher transmission among residential institutions</p> <p>Primary care (GPs, District Nurses)</p> <p>Illness and deaths at home</p> <p>Difficulties in arranging hospital admissions / increase in early discharges</p> <p>Staff sickness – especially in single handed practices</p>
Social care	<p>Sickness in clients / carers</p> <p>High transmission in residential homes / day care</p> <p>Children whose parents are too ill to care for them</p>
Others	<p>Pressure on mortuary, crematoria and cemetery facilities</p> <p>Pressure on funeral directors and body transportation capacity</p> <p>Logistical problems due to interruption of supplies, utilities and transport;</p> <p>Contracted services;</p> <p>Long term effects on the national and world economies and societal structures</p>

2.8 Options for mitigating the impact

a) International travel, border restrictions and screening

Modelling suggests that the imposition of border closures needs to be considered in the context of practicality, proportionality and potential effectiveness of imposing them. As an integral part of their preparation, port and airport operators, carriers and those authorities with specific responsibility for port health should review their arrangements for screening individuals with suspected illness on arrival, protecting their staff and rapidly implementing wider entry or exit control measures if required.

b) Pre pandemic vaccine

Pre first wave immunisation with an influenza vaccine related but not specific to the pandemic strain might offer some limited, but nonetheless useful, protection. Currently, the UK has very limited stocks of an A/H5N1 vaccine purchased specifically for the protection of healthcare workers. The identification of the pandemic strain will determine whether existing vaccine will be effective or whether a new vaccine has to be developed and manufactured. Pre pandemic vaccination would be initiated based on national and international expert advice and delivery would primarily be the responsibility of employers.

c) Isolation, voluntary quarantine and social distancing

Influenza is likely to spread rapidly in closed establishments such as prisons, residential homes and boarding schools where people are in close contact and where they may also be in higher risk groups. Such establishments may also be more vulnerable to higher levels of staff absence, supply disruption or transport difficulties. As opportunities for closure, quarantine, isolation or social distancing may be limited, it is vital that resilient arrangements are developed in advance of an outbreak

d) Antiviral medicines

When used to treat seasonal influenza, antiviral medicines reduce the length of symptoms and usually their severity, as long as they start to be taken within two days of the onset of symptoms. Whilst it is impossible to predict whether antiviral medicines will be equally effective against a new or modified pandemic virus, it is reasonable to anticipate a similar effect and associated substantial reductions in severe morbidity.

The UK has established national stockpiles of oseltamivir (Tamiflu). The existing stockpiles allow for the treatment of all symptomatic patients at clinical attack rates of up to 25% and arrangements to make it rapidly available are a critical part of the health response. Scientific advice confirms that prompt treatment of all symptomatic patients is currently the most effective use of the antiviral stocks available. Operational plans should aim to make antiviral medicines available to all patients who have been symptomatic for less than 48 hours, preferably within 12 and no more than 24 hours from reporting symptoms indicative of influenza. National guidance has also been developed to allow treatment up to 7 days, for those patients who were not diagnosed early but still are displaying treatable symptoms (subject to clinical discretion).

e) Infection control and personal hygiene

Applying basic infection control measures and encouraging compliance with public health advice are likely to make an important contribution to the UK's overall response. Simple measures will help individuals to protect themselves and others. The necessary measures are:

- Staying at home when ill
- Covering the nose and mouth with a tissue when coughing and sneezing
- Disposing of dirty tissues promptly and carefully
- Washing hands frequently with soap and warm water
- Cleaning frequently touched hard surfaces regularly using normal cleaning products
- Avoiding crowded gatherings where possible, especially in enclosed spaces
- If suffering influenza symptoms, wearing a disposable face mask to protect others should you need to go out (e.g. To the hospital)
- Making sure that children follow this advice

f) Use of face masks and respirators

Although the perception that wearing a face mask in public places may be beneficial is widely held, there is little actual evidence of proportionate benefit from widespread use. The Government will not be stockpiling face masks for general use. Face masks can be used to help protect those who may, for example, be at occupational risk from close or frequent contact with symptomatic patients.

g) Internal travel restrictions

Modelling suggests that internal travel restrictions would have little positive impact on the total number infected by influenza over the entire course of the pandemic. The public may be advised to minimise non essential travel as a personal precautionary measure but to continue using public transport for essential journeys, adopting good personal hygiene measures.

h) Restrictions on public gatherings

For planning purposes, the Government is unlikely to recommend a blanket ban on public gatherings. However, informed judgements by the event organiser may become necessary at the time.

i) School closures

The Government would take decisions on whether or not to advise closures on the basis of an assessment of the emerging characteristics and impact as the pandemic develops. The trigger for advice to close would be confirmation of initial cases in the area

j) Pandemic specific vaccination

The Government has finalised advance supply contracts with manufacturers to make sufficient supplies of a matching vaccine available as soon as it is developed. However, it may take four to six months before a matching vaccine is available and evaluated for safety and considerably longer before it can be manufactured in sufficient quantities for the entire population. It is therefore unlikely that a matching vaccine will contribute much to dealing with the initial wave of a pandemic, but it may be possible that once manufacturing starts, limited doses of a vaccine start to appear in the initial wave of a pandemic. Should this occur its use will be prioritised dependent upon guidance issued by the Department of Health.

3. RESPONSE PLANS

3.1 National Plans

All the national plans and guidance documents referred to below can be found on the websites listed in Appendix E.

3.1.1 Influenza Pandemic

The Department of Health / Cabinet Office published *Pandemic Flu – A National Framework for responding to an influenza pandemic* in November 2007. The Health Protection Agency (HPA) last updated its *HPA Influenza Pandemic Contingency Plan* in September 2006. In addition to these plans, various national guidance documents have been produced, or are in the process of being produced, covering specific aspects of an Influenza Pandemic response. These are listed in Appendix E.

3.1.2 Smallpox

The Department of Health published its *Guidelines for Smallpox Response and Management in the Post Eradication Era (Smallpox Plan)* on 15 December 2003.

3.1.3 Severe Acute Respiratory Syndrome (SARS)

The HPA published its *HPA Contingency Plan for SARS* on 6 December 2003.

3.2 Regional plans

This plan describes the arrangements in place in the North West area to respond to any infectious disease outbreaks that require multi-agency co-ordination on a regional basis (i.e. this plan should be used whether the outbreak is of pandemic influenza, smallpox, etc). This plan builds upon the generic response structures described in the *North West Generic Regional Response Plan* and should be read in conjunction with it.

A number of other Regional Capability Co-ordination Plans commissioned by the North West Regional Resilience Forum are currently in place or under development. These plans provide agreed procedures for dealing with specific consequences that may arise during an emergency that impact across much, or all, of the region or that overwhelms a single locality. Some of these plans are particularly relevant to an infectious disease situation.

3.2.1 North West Mass Fatalities Plan

The *NW RRF Mass Fatalities Plan* outlines the arrangements in place in the North West region to respond to a mass fatalities incident(s). Whilst the plan is not specifically designed to cater for fatalities arising from a region-wide infectious disease outbreak, aspects of the plan may be useful in such an incident.

3.3 Local Resilience Forum Plans

All LRFs have identified pandemic influenza as a potential risk in their Community Risk Register (CRR) and are developing LRF level plans in accordance with the priorities set out by the CRR. These plans are consistent with the national and regional plans; the plans which potentially dovetail with this plan are outlined below:

- CHWLRF Multi-Agency Emergency Response Manual
- CHWLRF Emergency Mortuary Plans
- CHWLRF Crisis Support Plan
- CHWLRF Media Plan

3.4 Individual Organisational Plans

Many organisations have developed their own pandemic influenza plans that can be called upon in the event of an outbreak. In particular, all NHS organisations must have robust pandemic influenza plans in place by the end of December 2008, as outlined by the *Operating Framework for the NHS in England 2008/2009*. This has also been identified as a priority for the NHS for 2009/2010.

These arrangements are in addition to the Business Continuity Plans and mutual aid arrangements that all emergency responders are encouraged (and in some cases required by the Civil Contingencies Act 2004) to have in place.

PART B – OPERATIONAL PLAN

4. SUMMARY OF ORGANISATIONAL ROLES

4.1 Multi-agency planning

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 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. This section describes the roles and responsibilities of the main participants in the Cheshire, Halton & Warrington Local Resilience Forum Plan and who we would work with during a pandemic.

4.2 Department of Health

The Department of Health is the pre-designated lead government department to respond to an influenza pandemic. It has overall responsibility for the following:

- Developing and maintaining the UK's contingency preparedness for the health and social care response;
- Establishing national stockpiles of clinical countermeasures to support that response;
- Maintaining liaison with international health organisations; and
- Providing the information and guidance that other government departments, organisations and agencies need to develop their own plans and responses

In the event of a pandemic, the Department of Health will initiate and direct the government health response, providing specialist advice and information to ministers, other government departments and responding organisations. It will also be responsible for the effectiveness of the health response, procuring a suitable vaccine, securing and distributing supplies of clinical countermeasures, maintaining international links to WHO and the European Centre for Disease Prevention and Control, and leading and coordinating NHS activity in England.

4.3 Health Protection Agency (HPA)

The HPA in England is the lead agency responsible for providing public health advice to the Department of Health and supporting all aspects of the public health response to an influenza pandemic. The HPA has a key role in international and national surveillance and intelligence gathering, informing public health policy development, contributing to global efforts to prevent or detect the emergence of a new virus and supporting NHS planning at

all levels. In any period of heightened alert and as the pandemic develops, the HPA will provide the following:

- Reference virological and microbiological services;
- Coordination of and advice on the investigation and management of early cases and contacts;
- Detailed epidemiological data on the emerging virus at the stage determined by Government and aggregate data thereafter;
- Data for national decisions such as a choice of vaccine or antiviral strategy;
- Expertise, advice and operational support to the NHS through local and regional teams;
- Coordination of the collection and publication of UK wide influenza surveillance data;
- A real time modelling capability.

4.4 Strategic Health Authority (SHA)

SHAs act as the regional headquarters of the NHS. In the event of an influenza pandemic, it is anticipated that some central decision making powers – including decisions on service priorities and suspension of targets – will be delegated to them. SHA decisions will need confirmation by the Department of Health, which will also discuss any effect on annual health checks with the Healthcare Commission and liaise with Monitor where there is an impact on foundation trusts. During a pandemic, each SHA will:

- Coordinate the strategic response across its health economy via NHS Western Cheshire (as Lead PCT for Emergency Preparedness in Cheshire, Halton & Warrington);
- Be responsible for the general oversight and coordination of the delivery of healthcare;
- Ensure the most effective deployment of available resources;
- Provide health advice and information to Regional Civil Contingencies Committees (RCCCs);
- Act as reporting links to the Department of Health;
- Collate and forward monitoring information;
- Provide a communications link; and
- Support media handling and the provision of public information.

4.5 Primary Care Trusts (PCTs)

PCTs are responsible for assessing local risk and for commissioning, supporting and monitoring the development of integrated health response plans. They are also responsible for developing arrangements to maintain and support patients in a community setting and for ensuring that health plans take account of the needs of military bases, prisons or other establishments that may require specific planning in their area.

In the event of a pandemic, PCTs will coordinate and oversee the local health response and mobilise general practice and primary care resources. They will also provide advice and public information, collate and report operational information to the SHA (via the Lead PCT), act as the health link with the local SCG and make contingency arrangements for the distribution or collection of antiviral medicines and delivering population-wide vaccination if required.

All local PCTs (Central & Eastern Cheshire, Halton & St Helens, Warrington and Western Cheshire) will have a coordination centre (or control centre) in place. This will allow PCTs to do the following:

- Act as a focal point, providing a link to and oversight of the local health and social care response;
- Monitor and coordinate the overall local health response on an integrated, pan-organisational, whole systems basis;
- Support the continuity of general practice, community pharmacy and other primary care services both in and out of hours;
- Collect, collate and disseminate information on the local health situation, to inform local and national control measures and response arrangements;
- Coordinate the supply of antiviral medicines in the locality, monitor antiviral use and recommend follow up where local use is not in line with expected take up and use;
- Ensure that a pandemic specific vaccine programme (if it becomes necessary) is coordinated, monitored and effectively delivered across the locality;
- Liaise with key partners such as local authorities to ensure a coordinated response;
- Liaise with commissioning partners to ensure they are able to deliver their commissioning obligations;
- Ensure that local partners such as NHS Direct are fully informed of the arrangements for the management of pandemic influenza in the community;
- Link with social care and other agencies and sectors to support the delivery of care and maintain patients at home;
- Ensure that national messages are cascaded and reinforced and that the public is well informed and advised of local response arrangements;

- Provide advice and information to staff, contractors and other partners in conjunction with the strategies of national, regional and local stakeholders

NHS Western Cheshire has been designated as the Lead Primary Care Trust by the Strategic Health Authority and as such will provide command and co-ordination to any response in which two or more of the local Primary Care Trusts are involved. Details of these arrangements can be found in the Lead Primary Care Trust Activation Plan.

4.6 Acute Trusts (including Foundation Trusts)

Foundation and other hospital trusts, primary care trusts and specialist health trusts are directly responsible for the provision of a wide range of health services. Plans in these areas will pay particular attention to the following:

- Projected requirement for significant surge capacity;
- Increased demand for specialist beds;
- Patient transport;
- Support to maintain patients in community settings;
- Redeployment of staff at short notice;
- Staff protection; and
- Strict infection control.

4.7 Ambulance Trusts

Ambulance services must develop a coordinated and consistent approach towards responding to patients. Linked to the coordination of methods of handling calls is the need for appropriate assessment that takes account of the patient's reported needs and the availability of resources according to the availability of care. Particular attention will be paid to the following:

Ambulance trusts will play a vital role in acting as one of the main gateways to healthcare;

- Key, pre-prepared questions will need to be asked to ensure that the limited resources available are targeted to those most in need;
- Staff in ambulance control centres will play a vital role in providing consistent and accurate advice and information;
- Contribute to the planning and scheduling of healthcare to vulnerable patients in the home setting;
- The aim should be to transport to hospital only those patients who are most critically ill, in parallel with maintaining services to other patients, for example those receiving life-sustaining outpatient treatment or those injured as a result of an accident; and

- Ambulance trusts will also play a vital role in the safe transport of patients away from acute settings.

4.8 Mental Health Trusts

In the event of an influenza pandemic, the key role of mental health and other relevant trusts is to ensure that core mental health services are maintained and provided at safe levels. This includes inpatient care and care provided in the community. Mental health trusts will face specific challenges during a pandemic, for example, as some inpatient environments, particularly those that provide care in security, are closed; there is a risk of more rapid spread of influenza in both patients and staff

4.9 NHS Direct

Demand for health advice and information is likely to increase significantly during a pandemic. NHS Direct will continue to play an important role in providing health advice and information through their normal telephone numbers, the NHS Direct Online website and NHS Direct Interactive on digital satellite television, therefore alleviating pressures on other parts of the system.

In the event of a pandemic threat increasing, the Government will also activate a National Flu Line service from WHO Phase 5. Initially, the service will provide advice, updated information and access to literature. When requested by the Government, the service will expand to provide rapid assessment and where necessary access to antiviral treatment for symptomatic patients.

4.10 Government Office North West

Government Offices represent central government in the English regions. Each has established a Regional Resilience Team and formed a Regional Resilience Forum, allowing key responders to plan together and improve the coordination and flow of information across and between regions and the centre. In response to wide scale civil emergencies such as an influenza pandemic, Regional Civil Contingencies Committees (RCCCs) are likely to be established.

Working closely with SHAs, the RCCCs will collate a regional picture of the evolving situation, provide an information channel between central and local tiers, identify issues that cannot be resolved locally, facilitate mutual aid, coordinate wider response efforts, advise on priorities, monitor progress and minimise disruption.

4.11 Local authorities

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

As most influenza sufferers will need to be cared for in a community setting, developing integrated health and social care plans is particularly important. 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. Local authorities will also take a leading role in facilitating the strategic recovery of their community.

4.12 Police

The Police, on behalf of the Coroner will administer the requirements of legislation and policy in relation to any deceased. They will advise on matters of security where appropriate and provide security of persons, premises and property as prioritised by the Strategic Co-ordinating Group (SCG). The Police will also use intelligence to gauge community tensions in relation to public order issues to prevent further injury to persons or property.

4.13 HM Coroner

In the event of unnatural death or sudden death the cause of which is unknown, the Coroner would have jurisdiction. It is the responsibility of the Coroner to authorise all procedures pertaining to the handling of the deceased, from the time of death, to the time they are released to the next of kin, and to make decisions in relation to their movement to a mortuary and their examination by a Pathologist. It should be noted that the Coroner has possession of the body, not ownership. A deceased person cannot be property.

Coroners are independent judicial officers whose duty is to enquire into violent or unnatural deaths, sudden deaths the cause of which is unknown or deaths in custody. The coroner, supported by coroner's officers and administration staff, will usually investigate the deaths reported to them, possibly holding a post-mortem and holding a formal inquest.

As influenza is a natural cause of death these cases should not theoretically require investigation by a coroner. However, it is anticipated that there will be a significant number of cases where a doctor is unable to complete a medical certificate of cause of death because no doctor has attended the deceased within the necessary period prior to death, and therefore an increase in the number of referrals to the coroner.

Latest guidance available suggests that different ways of working need to be implemented in the event of a pandemic. The Ministry of Justice issued a consultation document – *Pandemic Influenza – Guidance on the operation of the coroner system in England and Wales*. The latest information may be found on the Ministry of Justice web site.

4.14 Voluntary sector organisations

Voluntary organisations offer a wide range of skills and experiences and their membership often includes retired professionals. Many are routinely engaged in the provision of services to very vulnerable sections of the community and will therefore need to develop their own service continuity arrangements for a pandemic.

Although voluntary aid assistance is generally coordinated and activated through local authorities, direct engagement between voluntary agencies and statutory providers in developing response plans will encourage realistic expectations.

4.15 Independent Health Sector

The Independent Healthcare Sector will:

- Maintain business continuity;
- Support the NHS, especially by assisting with hospital discharge, or by redeploying any non-essential staff; and
- Ensure the welfare of staff, especially those in contact with patients with the infectious disease

4.16 Educational establishments

The pandemic virus may spread readily in schools and colleges – attack rates of up to 90% (pupils and staff) were reported in some boarding schools in previous pandemics. If this is confirmed as a characteristic of the virus, the Government Health Department will inform the Government Education Department to advise the local education authorities and the education sector about measures to slow down spread of the virus.

This advice would particularly apply to younger children, childcare settings and educational establishments and may include closing down for a short period and management of pupils travelling within, to and from the UK. The decision of such closures will normally remain for local determination having regard for the possibility that such establishments may have insufficient staff and / or pupils to remain open and for the possible implications for increased work absence because of workers child-care responsibilities.

4.17 Military aid

42 (NW) Brigade is a regional brigade with its headquarters at Fulwood Barracks in Preston. HQ 42 (NW) Brigade is responsible for the tri service planning and co-ordination of UK Operations in the North West of England.

Military planning for graduated responses to meet a wide range of contingencies in the UK in peace, tension / crisis and war is conducted under the umbrella title of “UK Operations” which encompasses Military Aid to the Civil Authorities (MACA). MACA may be requested because the Armed Forces structure, organisation, skills, equipment and training can be of benefit in time of emergency to fill civil authority capability gaps. However, it must be understood that the Armed Forces are funded for defence purposes and the responsibility for dealing with civil emergencies clearly lies with the civil authorities.

However, the Armed Forces may be required to assist the civilian authorities when there is a threat to life, or when the community is in danger of being deprived of the essentials of life.

4.18 Mutual aid

Uncertainties about the effects and spread of pandemic influenza may mean that any normal mutual aid agreements, both internally and externally, may not be achievable and should not be relied upon. Depending on the geographical spread of the pandemic it may

result that different areas are experiencing the peak weeks of the pandemic at differing times and some mutual aid capacity may exist.

Similarly, it may be that certain areas could be bypassed or receive lesser illness spread than others. Requests for mutual aid, together with offers of any assistance, will be collated in the first instance at local level by the SCG and secondly by the RCCC throughout the pandemic.

5 COMMAND AND CONTROL

5.1 Strategic Coordinating Group (SCG)

The LRF level response will be through the operation of the Strategic Co-ordinating Group at Police Headquarters in Winsford. The SCG will be the main control mechanism to coordinate and deliver the local multi-agency response. Efforts must focus on making the local SCG structure work from the start and continue through the whole pandemic period. The role of the SCG will be:

- To provide an effective multi-agency response to pandemic influenza;
- Support the maintenance of health and other essential services;
- Minimise social and economic disruption; and
- Ensure the provision of timely, accurate, non-health related information for professionals, public and the media (health advice being covered by the Department of Health, NHS and HPA); and
- Facilitate the strategic recovery of its community.

Membership of the SCG will be decided locally but is likely to mirror the Category 1 membership at the LRF and will include police, NHS, local authorities and other essential services representation. The chair of the SCG will be agreed locally but is likely to be:

- Police ACPO rank officer;
- Local Authority Chief Executive or Director; or
- NHS Chief Executive / Director from the NHS Gold Commander rota

Consideration will be given, at the time, to using the appropriate technology to manage the emergency in line with reducing the spread of the disease. The mechanisms to support the SCG to undertake its responsibilities are outlined below (see paragraph 5.3).

Action cards for the SCG can be found at Appendix A.

5.2 Activation of sub groups for the SCG

The SCG will consider the timely establishment and activation of whatever subgroups are appropriate to the response required. It should be noted, however, that subgroups will only be initiated if the need for it is absolutely imperative. All organisations will be affected by absence and so resourcing of subgroups may be difficult. Subgroups which may be considered include:

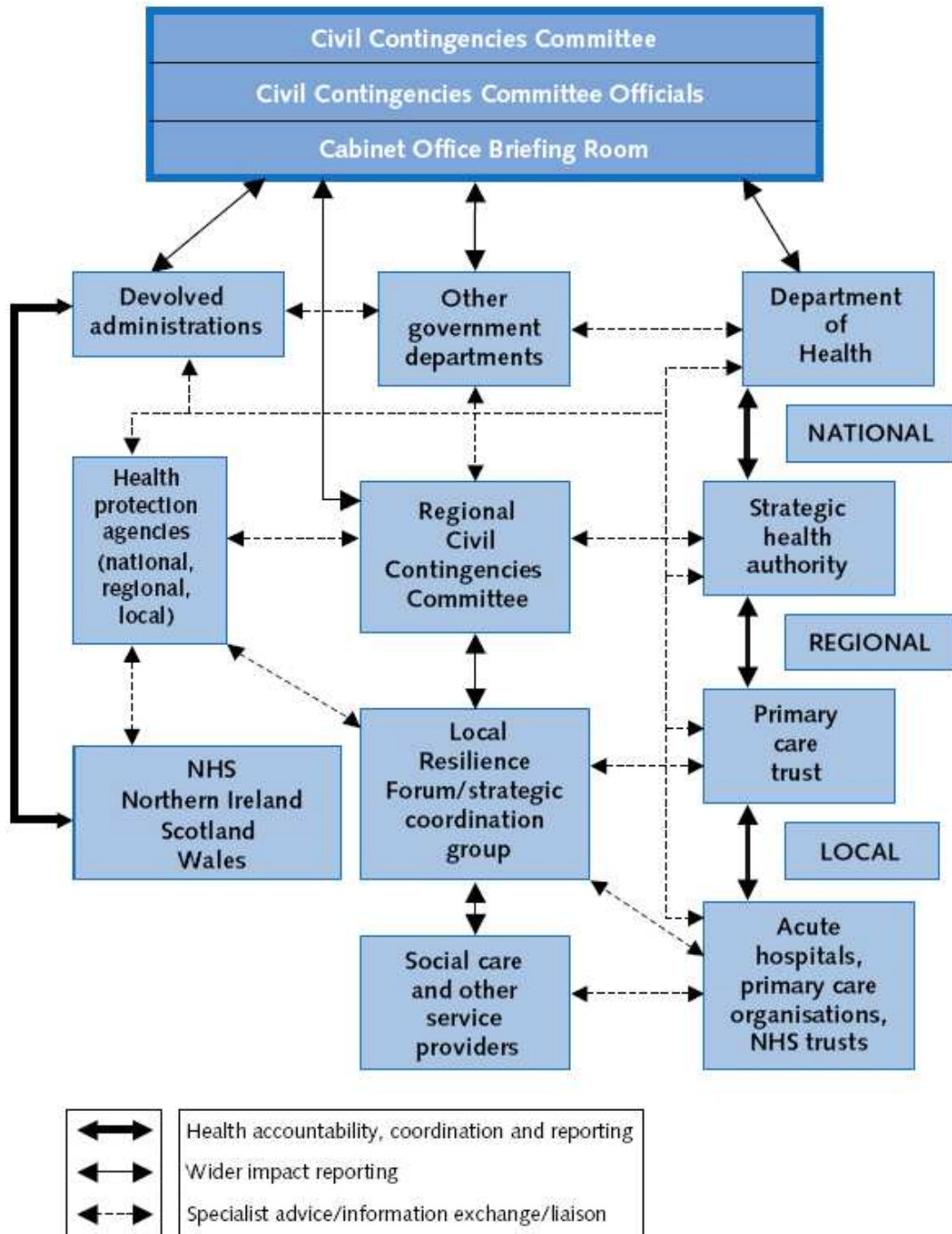
- Communications Group;
- Dealing with Excess Deaths Group (where appropriate and where services become overwhelmed)
- Health Group (for the NHS Gold Commander to coordinate the NHS)

5.3 Battle rhythm (meeting frequency)

The frequency of meetings and reports will need to be established by the SCG to reflect the national and regional response routine. Meetings held too frequently could affect the business continuity of organisations and may prove unsustainable. In addition we must retain the capability to respond to a major incident during this period.

As a result the SCG will be required to operate within the national and regional response arrangements, detailed in diagram 1 below

Diagram 1 – National / Regional Reporting Coordination Arrangements



The Civil Contingencies Committee (CCC) is likely to meet mid-morning. Officials of the CCC are likely to meet at 0900 to prepare the ground, to consider papers for Ministers and / or to consider other issues as directed by the CCC. To service the battle rhythm, a consolidated report will be provided in time for each meeting of the CCC officials. Inputs will therefore be sought from the following:

- From the Department of Health and HPA by 0700 summarising the most up to date UK situation (health effects);
- From Regional Resilience Directors (GO) by 1900 reporting the situation in their region as at 1700;

Compiled national situation reports will be distributed by the Cabinet Office Briefing Room (COBR) Situation Cell to Ministers, Departments and to regional and local operational levels. In general terms, GONW is required to provide information on the regional and local picture whereas Departments will provide information on the national picture and details of emergency arrangements in place / regulations being considered for relaxation. Both GONW and Departments will be expected to include status on business continuity.

A situation report template can be found at Appendix B.

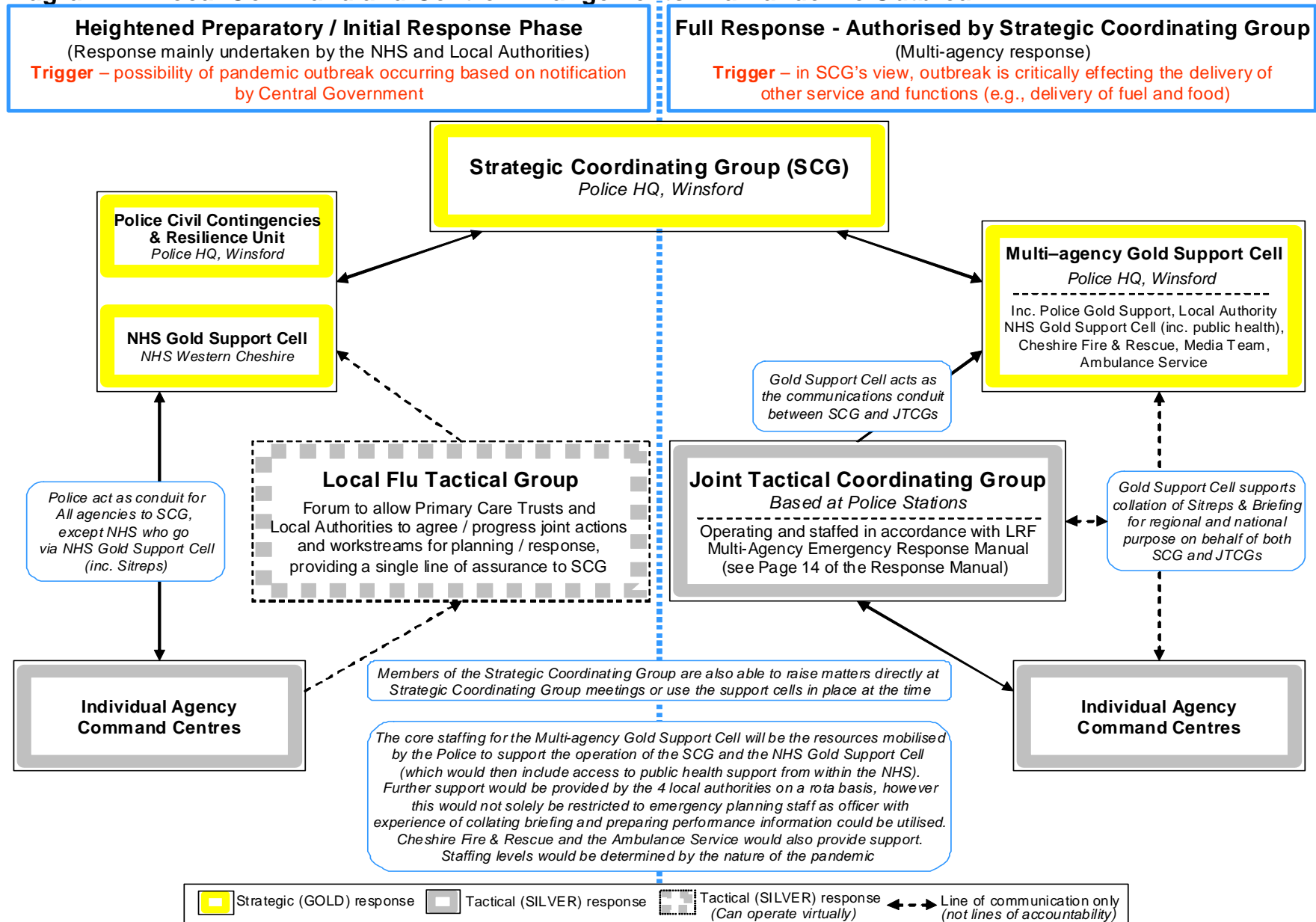
5.4 Supporting the Strategic Coordinating Group (SCG)

The nature and spread of the pandemic disease will impact on the frequency and type of SCG meeting, but also on the support required and the command and control arrangements that need to be instigated. It is of course for the SCG to confirm the level of response it requires, but two systems are proposed to support the work of the SCG and ensure an effective and proportional response from LRF multi-agency partners.

Level of Responses	Characteristics
Heightened Preparatory / Initial Responses	<ul style="list-style-type: none"> • no / low numbers of pandemic cases locally • preparations (reviewing, testing and exercising plans) are ongoing • NHS able to manage number of cases within existing resources (albeit at a heightened response) • response limited to health and social care systems and schools (and managed by the NHS and Local Authorities) • limited effect on other multi-agency partners (apart from increased preparations, minor effect on workforce)
Full Response	<ul style="list-style-type: none"> • rising numbers of pandemic cases locally • pandemic affects not only health, social care and education services but the delivery of other public sector services • NHS only able to manage number of cases with external support • pandemic affecting delivery of other services, e.g., fuel, food • wide-scale disruption to all multi-agency partners

Diagram 2 overleaf outlines the possible arrangements to support an SCG during these two phases of a response to a pandemic. Other outbreaks may require different structures

Diagram 2 – Local Command and Control Arrangements in a Pandemic Outbreak



5.5 Heightened Preparatory / Initial Response Phase

5.5.1 Daily Support Arrangements

During the Heightened Preparatory / Initial Response Phase it is unlikely that SCG will be meeting on a daily basis to support the processing of daily situation reports and distribution of latest guidance from COBR / RCCC / GONW / SHA. To reflect the different communication and reporting channels that will be in operation, two separate support mechanisms will be in place to support the SCG / LRF:

- **Police Resilience Team** – based at Police HQ in Winsford it will be responsible for:
 - keeping records of SCG meetings and actions
 - cascading information from SCG, COBR, the RCCC and GONW
 - collating GONW's daily situation report from multi-agency partners (excluding the NHS) and forwarding this to GONW
- **NHS Gold Support Cell** – based at NHS Western Cheshire's HQ in Chester, it will be responsible for:
 - supporting the NHS Gold Commander in their command and control role of local NHS organisations
 - acting as the single point of contact between the local NHS, the NHS Gold Commander, and the SHA / Regional STAC within the NHS command and control structures
 - preparing briefing and papers for SCG / LRF
 - cascading information from the Department of Health, the SHA and the HPA to local NHS organisations, Local Authorities and other agencies as appropriate (including information from the SCG, COBR, RCCC and GONW forwarded from the Police Resilience Team)
 - collating the FLUCON daily situation report (and other health and social care focussed reports) from local NHS organisations and forwarding this to SHA

Please Note – both these teams would form part of the Multi-agency Gold Support Cell once it became operation (see paragraph 5.6.1 below)

5.5.2 – Local Flu Tactical Group (LFTG)

It is expected that in the Heightened Preparatory / Initial Response Phase of a pandemic, the main impact will fall upon Primary Care Trusts and Local Authorities. A LFTG should be established within each Primary Care Trust / Local Authority area to allow the tactical coordination of any joint preparations and response to a pandemic.

LFTGs, either meeting face-to-face or virtually, would normally be chaired by the PCT and would involve representatives from adult social care, children's services (both local authority and NHS), local hospitals, mental health service providers, community service providers, GP practices together with public health and prevention and control specialists.

The role of the LFTGs will be to:

- adapt health and social care systems to provide treatment and support for the large numbers likely to suffer from pandemic influenza or its complications *whilst maintaining other essential care*
- identify vulnerable people and agree arrangements to streamline health and social care support to them should this be required
- agree arrangements to establish, maintain and support anti viral centres, including the operation of local flu lines
- provide assurance on the robustness of these arrangements through PCTs to the NHS Gold Commander
- maximise the opportunity for mutual support across delivery of all business critical functions
- co-ordinate responses, activity and agree actions (where necessary) which impact upon health and social care services
- take action, as necessary, for implementing decisions and directives from the SCG or NHS Gold Commander
- provide situation reports on local health and social care preparations via the PCTs to the NHS Gold Support Cell

Please Note - LFTGs will cease to operate if Joint Tactical Coordinating Groups are established (see paragraph 5.6.2 below)

5.6 Full Response Phase

A Full Response phase would be implemented as a result of a decision by the SCG dependent upon the impact on local services (see the trigger points identified paragraph 5.4 above). The SCG can activate this stage at any time, even if it has not already activated the Heightened Preparatory / Initial Response phase.

5.6.1 Multi-agency Gold Support Group (GSG)

Operating from Police HQ in Winsford, the GSG would provide the day-to-day support necessary for the operation of the SCG in the Full Response phase. The GSG will keep the SCG informed of developments and seek strategic decisions on matters arising. The GSG will have multi agency representation, initially comprising of the NHS Gold Support Cell (including access to public health advice), Local Authorities, the Police, the Fire and Rescue Service and the Ambulance Service with additional support as requested or directed by the

SCG. Local Authorities will provide support on a rota basis from across the four Local Authorities.

The main tasks of this group will be to:

- Coordinate the process;
- Disseminate information;
- Act as a focal point;
- Keep records of decisions and strategy updates;
- Arrange alternative communications if required;
- Compile situation reports if required; and
- Report to the Regional Tier (on behalf of the SCG).
- In addition the NHS Gold Support Cell, whilst part of the GSG, will need to continue to act as the focal point for the local NHS / production of NHS situation reports

It is expected that those officers who support the Gold Commanders from each organisation will form the GSG. Although some members of the GSG will require an emergency planning background (especially in a leadership role), staff with experience of collating briefing, producing performance information and of taking / preparing minutes should also be considered as suitable to join the GSG.

It is also expected that the GSG will continue to operate to support the Recovery Working Group even after the stand down of the SCG.

5.6.2 Joint Tactical Coordinating Group (JTTCG)

In the event of an influenza pandemic, gold strategy will be delivered through the multi agency tactical teams operating from police stations and in accordance with the Multi-Agency Emergency Response Manual which has been agreed by the appropriate organisations in Cheshire, Halton & Warrington. Up to four JTTCG's could be established across Cheshire, Halton and Warrington.

Representation at the JTTCG for a pandemic will include the NHS (represented by the local PCT),⁷ local authorities, police and other representation deemed appropriate. Given that a Regional STAC will be in operation, no representative will be available from the HPA nor will public health officers from the local PCT be in attendance. All requests for public health advice should in the first instance be made to the local PCT. If they are unable to

answer the queries, the local PCT should forward a request to the NHS Gold Support Cell within the GSG (who will then forward it through the appropriate channels to the Regional STAC).

The chair of the JTCCG will be determined by the SCG. In order to coordinate the response effectively, key representatives from the required organisations must co-locate and work together. This approach is intended to ensure that information is available, shared and used in determining appropriate actions to be taken in the mitigation of any effects of the emergency.

The JTCCG will monitor the wider social impact of the disease and provide daily reports to the SCG, particularly on the following;

- Local transport and traffic systems;
- Impact on the delivery of key community services;
- Fuel distribution;
- Distribution of food and drink;
- Utilities (gas, electricity and water)
- School / college closures;
- Business closures;
- Postal services;
- Bereavement services; and
- Tourism.

5.7 Operational command

Many organisations have developed their own pandemic influenza plans that can be called on in the event of an outbreak. In the event of a pandemic flu outbreak, local arrangements will be activated to coordinate individual agency responses, including the prioritisation of resources and services and implementation of business continuity plans.

5.8 Regional Civil Contingencies Committee (RCCC)

An RCCC is a multi-agency group including representatives from across the region of the emergency services, local authorities, SHA, Government Office North West (GONW) and others as applicable. It will be charged with

improving the co-ordination of the response to an emergency across a given region.

The precise role of an RCCC is likely to vary depending on the nature of the emergency at hand. However, generic aspects of the role are likely to include:

- Collating and maintaining a strategic picture of the evolving situation within the region, with a particular focus on consequence management and recovery issues;
- Assessing whether there are any issues that cannot be resolved at a local level;
- Facilitating mutual aid arrangements within the region and, where necessary, between regions to resolve such issues;
- Ensuring an effective flow of communication between local, regional and national levels, including the co-ordination of reports to the national level on the response and recovery effort;
- Raising, to a national level, any issues that cannot be resolved at a local or regional level;
- Ensuring that the national input to response and recovery is coordinated with the local and regional efforts;
- Guiding the deployment of scarce resources across the region by identifying regional priorities; and
- Providing, where appropriate, a regional spokesperson

An RCCC is most likely to be required where a number of local SCGs are established within a region and a need for the co-ordination of the response across the region has been identified, or where the response is nationally managed with limited local coordination.

5.9 Concurrent incidents and emergencies

In the event of another major incident during a pandemic flu outbreak, responders will be severely stretched for resources. Every attempt will be made to provide a minimum but adequate responses will be based on a dynamic risk assessment of the incident, in conjunction with responders' business continuity plans.

A separate SCG for the incident will be formed in order to coordinate the response to the incident. Typically, it will be chaired by the police and operate from the SCG at Police HQ in Winsford.

6 COMMUNICATIONS

6.1 Introduction

Cheshire, Halton & Warrington LRF has produced a Media Plan (January 2009). Further information can be found at Appendix C.

The Cheshire, Halton & Warrington LRF also recognises that irrespective of its own media strategy that National and Regional media strategy plans are in place and that they will seek to avoid unnecessary duplication and seek consistency of approach along with other partner agencies and organisations.

6.2 Government Media Strategy

Key messages from the Government during a pandemic will be that people who are well should carry on with normal activities as far as possible, at the same time taking personal responsibility for self-protection: and those that are unwell, or think they are unwell should take social responsibility to lessen the spread of the virus and thus protect others.

The Department of Health have produced a *Pandemic Flu Communication Toolkit* (January 2006).² This document provides guidance on the roles and responsibilities of various health organisations during a flu pandemic, as well as some generic fact-sheets and Questions & Answers material for the public.

6.3 Communication with the public during a pandemic

Accurate, timely and consistent communications with the public during an infectious disease outbreak will be vital. The public will want to receive specialist public health advice from the health community, but they will also need to be informed about any other non-health consequences that may arise during an outbreak (e.g. closure of schools).

Figure 1 overleaf illustrates the types of information that will need to be communicated to the public in the event of an outbreak and who will provide this

6.4 LRF Press Officers Group

The Cheshire, Halton & Warrington LRF recognises that it will have to supplement these higher-level approaches to the public with key information relevant to the local situation. As such the LRF Press Officers Group will convene in an operational role to prepare the strategy on behalf of the SCG and oversee communications with the public. See Appendix C.

² Pandemic Flu Communication Toolkit, Department of Health, January 2006

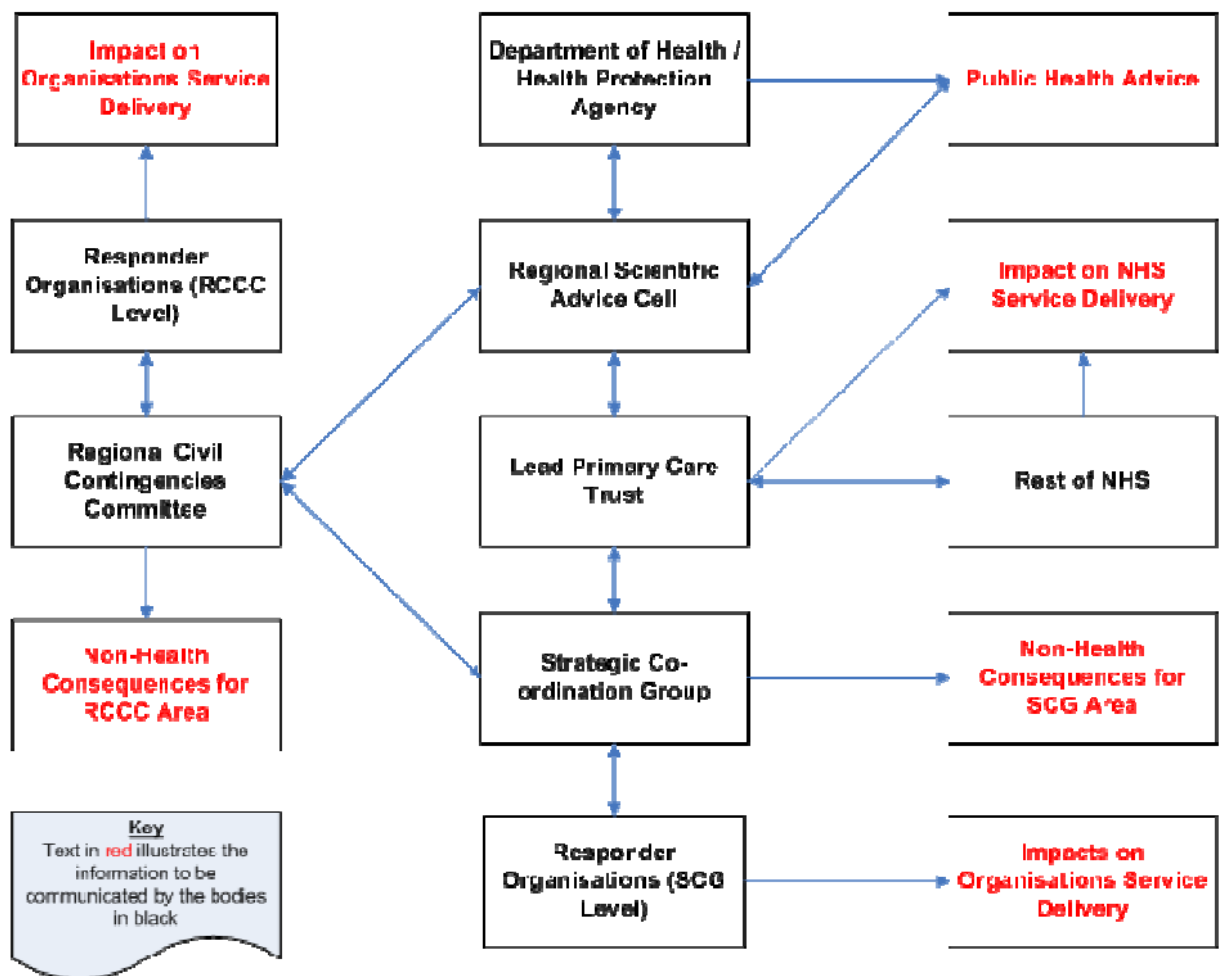


Figure 1 – communication with the public during a pandemic

6.5 Liaising with the Strategic Health Authority

The Lead PCT (NHS Western Cheshire) has agreed a protocol with the SHA (NHS North West) for communications with the public during a pandemic. The SHA will institute command and control arrangements across the NHS and the local NHS will be required to implement the national communications strategy as notified to the Lead PCT by the SHA.

6.6 Liaising with the Regional Civil Contingencies Committee

The Cheshire, Halton & Warrington LRF will liaise with the Regional Civil Contingencies Committee (RCCC) to ensure a consistency of messages across the region. The LRF Press Officers sub-group will monitor regional initiatives and liaise with them regarding consistency of messages.

6.7 Government Information Requirements

The likely information requirements for Government during a pandemic will be

split into two parts: health and social care (number of cases, spread of disease, etc) and non-health (wider social impacts of the outbreak).

6.8 Health information

Mechanisms are in place for collecting health information between the SHA and Lead PCT. These standard procedures will be used in the event of an influenza pandemic.

6.9 Non health information

The Regional Resilience Team (with support from the Government Office for the North West (GONW) staff) will provide daily reports (sit-reps) to the Civil Contingencies Secretariat (CCS - for onward transmission to the national Civil Contingencies Committee), as soon as Local Strategic Co-ordinating Groups / Regional Civil Contingencies Committee are established.

The reports will highlight particular impacts on, and issues arising across, the region, in particular focusing on any expected or actual disruption to:

- Local transport and traffic systems
- School / college closures
- Business closures
- Provision of food and drink
- Utilities provision (e.g. electricity, gas supplies)
- People with specific needs or those who may develop specific needs as a result of the outbreak, and
- Any other impact on the delivery of key community services (e.g. waste collection, social services).

The intelligence for the daily regional sit-rep report will be gathered from the Regional Civil Contingencies Committee (RCCC) and Local Strategic Co-ordinating Groups (Local SCGs). The regional reports will need to be submitted in a standard format to CCS by the Regional Resilience Team by 07:00 at the latest each morning, reporting on the situation as of 17:00 the previous day. These reports will be copied to Local SCG and RCCC members for information. A copy of the standard reporting template will be circulated to Local and Regional Resilience Forum members for information once agreed and will be held by the Regional Resilience Team.

6.10 Communication between various response groups

A list of communication toolbox options will be developed including contact

directories for linking with all partner agencies and groups. The use and exchange of e-mails between various groups provides a useful update tool to ensure that all partners are kept abreast of developments.

The need to link regularly by other means other than attending face-to-face meetings will have to be addressed by remote or virtual meetings, especially at UK Alert Level 3 - (Outbreaks in the UK), to help minimise the spread of the disease.

The LRF Resilient Telecommunications Task Group will:

- Document and circulate what options for virtual meetings exist within Cheshire between the various groups, and
- Whether it is achievable to easily overcome firewall protection on individual organisation computer systems that precludes the use of webcams between partners if needed or desired.
- For virtual meetings, experience has shown it may be easier to use tele-conferencing rather than video conferencing, particularly due to the limited availability of video conferencing equipment across the LRF. Audit of available equipment to be carried out at Alert Level 1.

6.11 Communication mechanisms

The LRF Public Warning Task Group will investigate using the following mechanisms to provide information to the public.

- Existing phone help-lines, e.g. LA general enquiries phone lines, NHS Direct
- Websites
- Media – TV / Radio / Teletext / Newspapers
- Doctors surgeries
- Health Centres
- Libraries
- Health Visitors
- Schools
- Work Places/Networks/Intranet
- Public Notice Boards

- Local Councillors

6.12 Equality and diversity issues

The LRF Public Warning Task Group will have to consider how they intend to overcome any barriers in communicating issues relative to

- Physical Impairment
- Ethnic minority groups
- Language
- Religious Groups
- Key Contacts with community groups
- Rural and isolated communities

7 DEALING WITH EXCESS DEATHS

7.1 Introduction

There is no recent experience in handling deaths resulting from an influenza pandemic. It is recognised that the whole process following on from deaths occurring - through to final disposal would cause problems for those involved. They could be expected to have to deal with a 50% increase in activity whilst faced with a 50% staffing reduction. Those services involved in the whole process include Mortuary Services within Acute Trusts, Funeral Directors, Cemetery and Crematoria staff, Registrars and coffin makers etc.

7.2 National Planning Assumptions

The document, **A National Framework for Responding to an Influenza Pandemic** projects a range of clinical attack and case fatality rates. This seeks to provide planning assumptions for the percentage of the population who may fall ill – and the percentage that may subsequently die.

Three projected scenarios have been given. However, it should be noted that the national planning assumptions are meant only to be estimated projections. Therefore, plans need to be flexible and be able to adapt to locally emerging scenarios.

- The base case scenario may see around 1000 additional deaths across Cheshire, based on a clinical attack rate of 25% and a case fatality rate of 0.4%.
- A prudent worst case scenario may result in around 6,246 additional deaths across Cheshire, based on a clinical attack rate of 25% and a case fatality rate of 2.5%.
- The reasonable worst case scenario could produce around 12,492 additional deaths across Cheshire, based on a clinical attack rate of 50% and a case fatality rate of 2.5%.
- Local planners are advised to plan for all additional deaths occurring in one wave – or for additional deaths to be spread over two or more waves.

7.3 Yearly Normal Deaths Occurring in Cheshire, Halton & Warrington

During year 2007/2008 there were 6,698 deaths for Cheshire, 2,285 in Warrington and 573 in Halton (information from Registrars).

7.4 Projected Excess Deaths Figures

Table 4 shows the modelling of pressures should additional deaths occur in one wave.

Local Authority area	0.4% fatality and 25% clinical attack rate	2.5% fatality and 25% clinical attack rate	2.5% fatality and 50% clinical attack rate
Cheshire East Council	359	2243	4486
Cheshire West and Chester Council	328	2047	4094
Halton Borough Council	119	742	1484
Warrington Borough Council	194	1214	2428
Total	1000	6,246	12,492

7.5 Single Wave Pandemic Wave

Charts have been produced to show the effects of a single wave pandemic (see charts above).

7.6 Multiple Wave Pandemic Waves

No projections have been done within this plan on multiple pandemic waves. Intelligence gleaned from the original source of any initial outbreak will be heavily monitored by world-wide health authorities. Once there is an indicator of the emergence of a second wave then information will be being gathered that will influence the preparations for that second or subsequent waves. Recent pandemics have indicated that a second or subsequent wave may be worse than the initial wave. Until the scientific projections are available it is felt sufficient that:

- The plan has highlighted that there may be more than one wave;
- That Business Continuity Plans also recognise there may be more than one wave;
- The SCG and the Recovery Working Group monitor developments worldwide

7.7 Organisational arrangements for dealing with excess deaths

It is intended that the SCG will form a GSG. The GSG will put in place networking arrangements locally to identify pressure points associated with the following:-

- Completion of Medical Certificates of Cause of Death –

registered medical practitioners and coroners;

- Death registration and certification (including disposal certificates) – GPs, Registrars and Coroners;
- Police or others responsible for resourcing coroners' officers;
- Funeral Directors;
- Faith representatives;
- Burial authorities and privately owned cemeteries;
- Cremation authorities and privately owned crematoria; and
- Bereavement and other support organisations and groups.

7.8 Excess deaths in an acute trust setting

There is a high risk that existing mortuary facilities will be overwhelmed by an excess number of deaths. However, Acute Trusts must ensure that business continuity plans are developed to ensure they are capable of handling large numbers of bodies over a prolonged period.

Each organisation should have risk assessment procedures in place to escalate capacity levels within the mortuary services. These should indicate to the LRF that a specified number of fatalities has been received and also highlight, using a green, amber, red system, whether mortuary capacity is about to be exceeded. This will enable the LRF Excess Deaths Plan (when developed) to be assessed and activated if necessary.

7.9 Virus Profile

One of the first issues to address will be to produce a profile of the effects of the particular strain of the pandemic influenza virus on the population of Cheshire. These projections will give an indication of the likely impact in dealing with excess deaths arising as a result of the pandemic.

Once the likely impact has been explored that information needs to be passed out to those local service providers identified above, together with information as to the reporting of pressure points that arise in that service delivery.

7.10 Business Continuity Management (BCM)

Each of the service providers within the death process should consider invoking whatever Business Continuity procedures are appropriate to the level of expected demand identified by the virus profile. These Business Continuity procedures provide the main response to any increased workload and staff absences issues. However, a worse-case scenario attack rate will inevitably

cause pressure points on existing working practices and any BCM procedures introduced.

7.11 Emergency Contact Point

It has been recognised that the benefit of having an emergency contact point will be that local difficulties can be identified quickly – which will increase the likelihood for rapid solutions to be found. The GSG will put in place an emergency contact point that provides for local service providers to effectively report:

- Pressure points as they arise, or
- To raise awareness of pressure point issues that will shortly arise.

A daily monitoring system will be operated on all the identified potential pressure points and if solutions cannot be found the GSG will raise the issue to the SCG for them to endeavour to broker a multi-agency resolution.

7.12 Temporary body storage

Acute Trusts as part of their “normal” winter planning arrangements identify areas / measures to provide additional short term body storage. These arrangements will be reviewed and enhanced where possible, in the event of a flu pandemic.

Local Authorities are working with funeral directors to promote business continuity planning in general and to specifically raise awareness of the risk and impact of a potential flu pandemic within their area. A key point for local planning has been the identification of potential sites for the location of facilities for the temporary storage of bodies, prior to funerals taking place.

One very practical solution is to encourage Funeral Directors to fully utilise their funeral car garaging facilities to extend their existing body storage capacity. Depending on the time of year this may provide an adequate solution without resorting to special measures. Also the Funeral Directors retain “ownership” of the bodies they are dealing with. Any mutual aid on body storage between neighbouring Funeral Directors would again be administered by themselves.

The death management process relies on a number of key services, each interdependent, to ensure there is no break in the continuity to be able to dispose of the dead, always where possible trying to maintain individual faith requirements and rituals. In the event that the process is totally overwhelmed and unable to cope within any of the Local Authority areas in Cheshire, Halton & Warrington, special measures would have to be introduced which would

introduce the opening of a body storage facility at the Sandbach emergency mortuary facility.

It should be noted that this measure should be considered when all other options have been exacerbated; if introduced it will raise a number of logistical problems which would require the involvement of the key organisations involved to work through to agree a workable solution.

This can be activated via Local Authority Duty Officers; contact arrangements as for Emergency Mortuaries activation. However, this should only be done following agreement with the Coroner. It should be highlighted that there is still work ongoing in this area and that issues may not be resolved until the situation arises.

Local Authority pandemic influenza plans will contain the operational detail of how each Local Authority intends to manage the potential number of excess deaths (inclusive of the registrars and bereavement services and liaison with HM Coroner). There will be daily reports provided to the Gold Support Group which will provide early opportunities to identify whether the contingency arrangements are working effectively or whether there will be a need to consider "special measures".

8 ANTIVIRAL DISTRIBUTION

8.1 Access to antivirals

The UK currently has a stockpile of oseltamivir (Tamiflu) built on the basis of a 25% clinical attack rate. The stock levels are currently under review, but on the basis of the current stockpile, scientific advice confirms that it is best used for:

- Treatment rather than prophylaxis, and
- Treating all symptomatic patients who have an acute influenza like illness and a fever and have been symptomatic for no more than 48 hours at a clinical attack rate of 25% or less. National guidance has also been developed to allow treatment up to 7 days, for those patients who were not diagnosed early but still are displaying treatable symptoms (subject to clinical discretion). If the attack rate was greater than 25% if there were higher levels of wastage, prioritisation of treatment will be necessary.

Most people currently access treatment via their general practice or by going directly to their community pharmacist for advice and treatment. However, given the volume of appointments that will be required during an influenza pandemic, providing rapid face-to-face clinical assessment to all symptomatic patients by a GP or other health professional is unlikely to be feasible. In addition, one of the key planning principles is to encourage symptomatic patients to remain at home and so it is important that patients can access care from their home as far as possible.

Prior to the opening of a National / Local Flu line, and dependent upon the pattern of the pandemic then anti viral medication may be authorised

- In the containment phase by the Health Protection Agency
- In the outbreak management or the treatment phase, by local GPs making a clinical decision

8.2 The National Pandemic Flu Service

A model for accessing antiviral medicines that is based upon primary care augmented with a telephone service has the benefits of enabling prompt assessment and rapid access to antiviral medicines from the home. It will also help to ensure that primary care services are able to meet the needs of those patients who have higher or more complex healthcare needs.

Once a WHO Phase 6 has been declared, the Government will decide whether or not to activate the National Pandemic Flu Service. This Service

incorporates which will be used to provide symptomatic influenza patients rapid access to antiviral medicines. However if the Government determines the national situation does not warrant the opening of the National Flu Line, Local Flu Lines may need to become operational.

The objective of the National / Local Flu Line will be to:

- Assess patients to determine their eligibility for antiviral treatment;
- Authorise antiviral treatment if appropriate; and
- Refer eligible patients to an antiviral collection point to collect their antiviral medicines, or another part of the health and social care system, as appropriate

In terms of how the National / Local Flu Line service will work, from a patient perspective this is as follows:

- Before and during WHO Phase 6, national messages will ask everyone to identify friends, relatives and / or informal carers (flu friend) whom they could ask to collect antiviral medicines or other medicines for them should they become ill;
- Anyone with symptoms will be advised to stay at home and telephone the National / Local Flu Line hotline number for assessment and advice;
- Callers will be taken through a clinical algorithm to determine their suitability for antiviral treatment;
- If a caller is found to be suitable for treatment, the caller will be authorised with a unique reference number and given advice;
- They will be advised where the medicines can be collected from locally by their Flu Friend and if they have no one available to collect their medicines, a locally organised courier will be provided to deliver their medicine to their home;
- If the caller has higher level needs (i.e. Complications), or is part of a high risk group (e.g., a child under 1 years old or a pregnant woman) they will be referred to another healthcare professional or service for further advice / to determine if anti virals can be administered

Once activated the National / Local Flu Line service will be the first port of call for the assessment and triage of influenza patients. It is intended to triage routine cases to the antiviral assessment and collection points with minimum or no impact upon practices, whilst allowing those with higher level needs to

be referred on to a GP or other health or social care professional for further care and treatment.

8.3 Distribution of antiviral medicines

Once instructed by the SHA, PCTs may have as little as 6 hours to open either an anti viral collection point or an anti viral assessment and collection point. Anti viral medication may be delivered either directly to these anti viral assessment / collection point from national supplies or will be supplied by warehouses established by PCTs (which will receive supplies from national sources)

A national coordination centre will be established to receive orders for further supplies of antivirals, to coordinate the transportation of antivirals to either PCT warehouses or collection points and to monitor and manage the national antiviral stockpile. PCTs will have a key role in coordinating and monitoring the distribution of antiviral medicines within their locality. PCTs are responsible for:

- Risk assessing and identifying antiviral assessment and / or collection points and other points of use within their locality;
- Ensuring that all antiviral assessment and / or collection points and points of use have appropriate operational, business and resilience procedures in place and that they are kept under review;
- Ordering further supplies of antivirals from the national coordination centre to the collection points and other points of use as appropriate and monitoring their use;
- Ensuring adequate access to antiviral assessment and / or collection points across the locality;
- Coordinating the delivery of antiviral medicines from the collection points to a patient where they do not have a representative who can collect the medication for them; and
- Nominating a team of appropriately skilled staff who are responsible for antiviral distribution coordination within the PCT

8.4 Antiviral Collection Points / Antiviral Assessment and Collection Points

Subject to national requirements, and also to the response phase initiated by Government, PCTs are expected to make arrangement for the operation of either

- antiviral collection point - simply to distribute antiviral to Flu Friends of symptomatic patients who have been approved access to antivirals by a GP and given a voucher
- antiviral assessment and collection points – whose role it is to either
 - distribute antivirals to Flu Friends of symptomatic patients who have been given a unique reference number by the National / Local Flu Line
 - distribute antivirals to Flu Friends of symptomatic patients who are part of a high risk groups and have been given a voucher from a GP
 - assess Flu Friends attending the collection point on behalf of a symptomatic patient who has not contacted the National / Local Flu Line to see if the symptomatic patient warrant antivirals. If they do the collection point will then issue the Flu Friend antivirals for the symptomatic patient

Antiviral collection points are the locations from which family, friends or carers of symptomatic patients can collect their antiviral medicines. The local PCTs (Central & Eastern Cheshire, Halton & St Helens, Warrington and Western Cheshire) have identified appropriate antiviral collection points with support from the local authorities. The minimum requirements for an antiviral collection point include:

- Ability to store cases containing antiviral capsules (one case contains 440 packs and is approximately 595mm x 390mm x 360mm in dimension);
- Ability to store antiviral solution;
- Appropriately trained staff to supply the medicines;
- Computers;
- Printers;
- Internet connection;
- Access to the internet;
- Access to local IT support;
- Telephone line(s);
- Fax machine(s);

- Accessible to the public;
- Accessible to GPs and healthcare professionals where they wish to access antivirals for home visits;
- Access to pharmaceutical advice;
- Secure site; and
- Business continuity and resilience procedures

The Head of NHS Resilience (from the Lead PCT for Emergency Preparedness) will maintain a list of proposed antiviral collection points.

8.5 Process for collecting antiviral medicines

When a representative of a patient collects the antiviral medicines from the antiviral collection point, they will need to present the unique reference number (URN) or the voucher from the GP to the person issuing the medicines. On presentation of the URN / Voucher, the person issuing the medicines will need to:

- Access the National Flu Line service database (if operational) and reconcile the URN with the patient details to:
 - Determine whether the URN is legitimate and matches the correct patient
 - Log that the antiviral medicine has been collected on their behalf
- Confirm the identity of both the Flu Friend and the symptomatic patient by viewing appropriate forms of identity (e.g. passport , drivers licence etc)
- Write the name of the person and the date the medicine is supplied on the label of the antivirals medicines course;
- Supply the antiviral medicines, with a patient information leaflet;
- Offer any further information, advice and / or treatment as appropriate and where trained to do so.

9. MASS VACCINATION

9.1 Pre-pandemic vaccine

Pre first wave immunisation with an influenza vaccine that is related but not specific to the pandemic strain – **a pre pandemic vaccine** – might offer some limited, but nonetheless useful, protection. Currently, the UK has very limited stocks of an A/H5N1 vaccine purchased specifically for the protection of healthcare workers. Given sufficient stocks, the pre-pandemic vaccine could be used to provide partial protection for others likely to be frequently exposed to symptomatic patients and/or who are crucial to the maintenance of essential workers.

More widespread immunisation with a pre-pandemic vaccine would require large stocks of such a vaccine and is not currently part of the UK health departments' plans. Anticipating a suitable vaccine strain has the inherent risk of it being ineffective against the ultimate pandemic strain. The Department of Health is continuing to monitor the evolution of viral strains and options for pre-pandemic vaccination. NHS planners will be informed if this policy changes.

9.2 Pandemic specific vaccine

It is not possible to develop a matching vaccine until the emerging influenza strain has been identified. The Government has awarded contracts to Baxter and GlaxoSmithKline to secure production capacity for the manufacture of pandemic specific vaccine for the UK population. However, it may take four to six months before an effective vaccine is available and evaluated for safety, and considerably longer before it can be manufactured in sufficient quantities for the entire population.

Realistically, it is therefore unlikely that a specific vaccine will contribute much to dealing with the initial wave of a pandemic, unless its evolution, or the effectiveness of early control measures, result in a significantly slower developing pandemic than anticipated. It may be possible that once manufacturing starts, limited doses of a vaccine start to appear in the initial wave of a pandemic. Should this occur its use will be prioritised dependent upon guidance issued by the Department of Health. It could, however, be an effective intervention during the latter stages of the first wave and/or for subsequent waves should they occur

9.3 Delivery of pandemic specific vaccine

PCTs have overall responsibility for the protection of public health within their geographical area and are responsible for planning the response to an influenza pandemic in that area, including the delivery of vaccination. All PCTs have a responsibility to plan for situations where it would be necessary

to deliver treatment to large numbers of patients as quickly as possible. Local PCTs are currently reviewing their arrangements and ensuring that mass vaccination plans are developed.

At WHO Phase 4, a review will be needed not only of vaccination policy but also of delivery plans. A Department of Health vaccination implementation group will be established to coordinate the national response. Policy decisions on vaccination made in advance of a pandemic will inevitably have to be reviewed. However, the likely parameters of pandemic vaccination policy are as follows:

- Two doses of influenza vaccine will be needed in order to increase the chance of adequate immunity against a novel virus;
- These doses would need to be given at least three weeks apart;
- Vaccine production capacity is finite, and production of sufficient vaccine for the whole population will take several months;
- Provision of a specific pandemic vaccine in part during a second wave of a pandemic is possible, given this lengthy timescale;
- Priority groups will need to be agreed (at national level) in some detail, particularly over the first few weeks of vaccination;

The choice of priority groups would be based on a number of factors – including ethical considerations as well as scientific factors – such as the incidence and risk of clinically severe disease in different population groups, and the possible impact on slowing the spread of disease by prioritising particular population groups; and

It may not be possible, on the population scale needed, to reliably distinguish those who have been infected with pandemic influenza previously.

10. SURVEILLANCE DURING THE PANDEMIC

10.1 Purpose of surveillance

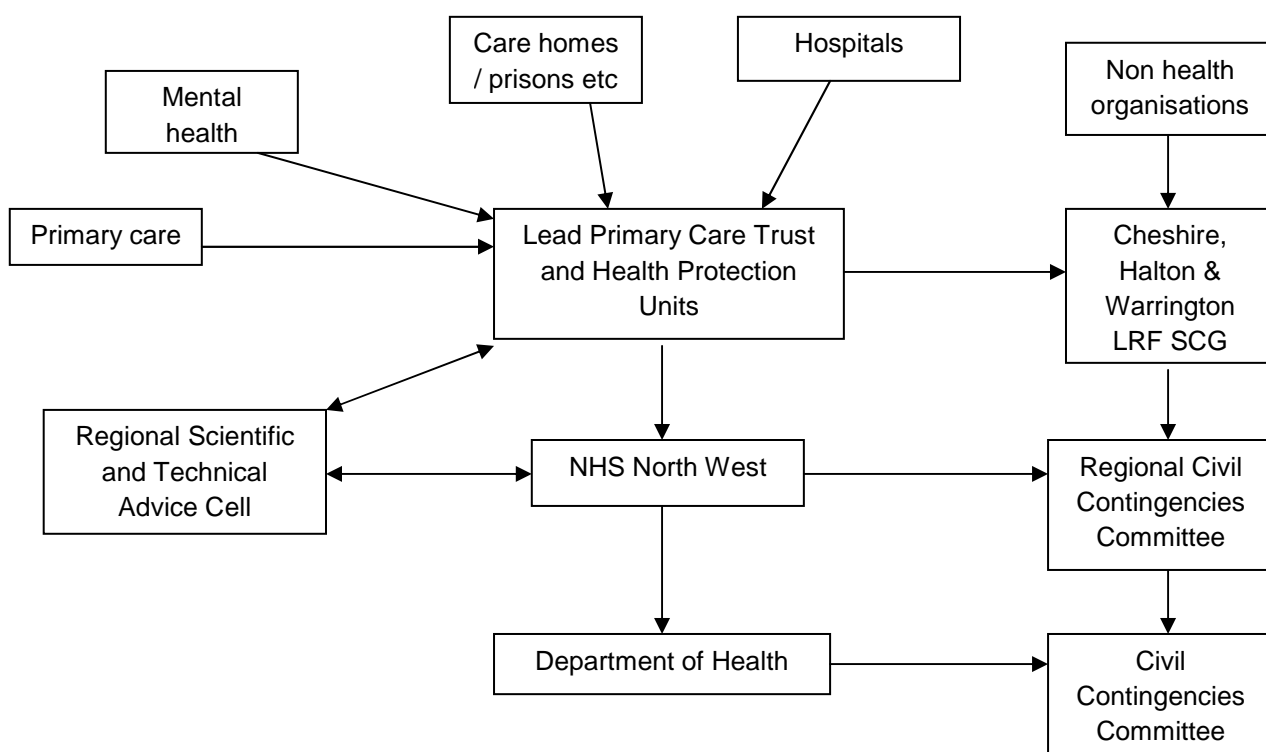
Maintaining surveillance to detect the emergence of a novel virus strain or any illness attributable to it, as well as information on the impact and effectiveness of interventions will be critical in informing the response to a pandemic.

The purpose of the pandemic influenza surveillance programme is to ensure that information is available in a timely, systematic and accurate manner to assess the impact of a pandemic in the UK and to inform national and local planning. Surveillance and information gathering requirements will take into account the capacity pressures that will exist in the pandemic and will be built upon existing systems wherever possible (in particular, seasonal flu surveillance).

The key questions that the surveillance dataset will need to answer will be in relation to epidemiology (type and strain of virus, impact, clinical features etc), clinical countermeasures (antivirals and antibiotics used, safety and effectiveness and antiviral distribution arrangements) and service capacity (are primary, secondary and social care services coping).

Situation reports will be required by the SHA (via the NHS) and regular reporting will be needed. This will be used to monitor how health services are coping.

The following diagram illustrates the mechanisms for the flow of health surveillance and wider impact (non-health related) data:



11. BUSINESS CONTINUITY

Contingency planning for a range of disruptive risks is a key business activity, and maintaining adequate staffing levels is critical to every organisation's ability to maintain its essential functions. A major infectious disease outbreak such as an influenza pandemic will place considerable pressure on all organisations and most individuals. Although business continuity plans made for other disruptive challenges provide a solid base, contingency arrangements for an influenza pandemic need to recognise the unique nature of some of its characteristics, particularly its likely duration and the fact that higher levels of staff absence are likely to be a major factor.

Cheshire, Halton & Warrington LRF recommends that all organisations develop robust, flexible and specific business continuity plans which will help them to ensure that the impact of disruptions caused by an influenza pandemic will be minimised. In the event of a pandemic, organisations will have a key role in reducing the risk to employee's health and safety as far as possible, as well as maintaining critical services.

Given the highly uncertain nature of an influenza pandemic, we cannot know in advance how serious it will be and who will be most affected; it is therefore important that plans are developed which can address a range of scenarios.

12. VULNERABLE PEOPLE

Vulnerable people may be less able to help themselves in an emergency than self-reliant people. Whilst this will continue to be the case during a pandemic, the impact of a pandemic may also mean that there are more individuals and groups who become temporarily vulnerable. There may be groups that are at risk because of underlying health or social conditions or because of their seldom heard status, e.g. those who do not speak or understand English and those who are not registered with a GP.

All agencies have a responsibility to consider how they will identify the vulnerable in an emergency. All agencies are looking at the latest guidance³ to assess what action needs to be taken.

³ Identifying People Who Are Vulnerable in a Crisis, Guidance for Emergency Planners and Responders, Cabinet Office February 2008

13. RECOVERY PHASE: RETURNING TO NORMALITY

As the impact of the pandemic wave subsides and it is considered that there is not a threat of further waves occurring, the UK will move into the recovery phase. Although the objective is to return to inter-pandemic levels of functioning as soon as possible, the pace of recovery will depend on the residual impact of the pandemic, ongoing demands, backlogs, staff and organisational fatigue, and continuing supply difficulties in most organisations. Therefore, a gradual return to normality should be anticipated and expectations shaped accordingly.

Plans at all levels should recognise the potential need to prioritise the restoration of services and to phase the return to normality in a managed and sustainable way. Health and social care services are likely to experience persistent secondary effects for some time, with increased demand for continuing care from:

Patients whose existing illnesses have been exacerbated by influenza;

- Those who may continue to suffer potential medium or long term health complications;
- A backlog of work resulting from the postponement of treatment for less urgent conditions

The reintroduction of performance targets and normal care standards also needs to recognise the loss of skilled staff and their experience. Most others will have been working under acute pressure for prolonged periods and are likely to require rest and continuing support. Facilities and essential supplies may also be depleted, resupply difficulties might persist and critical physical assets are likely to be in need of backlog maintenance, refurbishment or replacement. Impact assessments will therefore be required.

At an early stage during the pandemic, the SCG will make arrangements for a Recovery Working Group to be activated to oversee the eventual return to normality. This activation will take account of the potential of subsequent waves of the pandemic occurring and any priority preparations that may need to be addressed before any subsequent wave occurs.

APPENDIX A**ACTIONS CARD FOR SCG**

Dependent on how the Pandemic is classified by Central Government the action cards below may be used in the form given or amended as appropriate

Declaration of WHO Phase 5

Large cluster(s) but person to person spread still localised, suggesting that the virus is becoming increasingly better adapted to humans

Ref	Action	Owner
1.1	LRF Pandemic Influenza Group meet and prepare guidance for the SCG	
1.2	SCG meets to ensure that all key organisations are prepared for an escalation in alert levels	
1.3	Inform all key organisations that normal service levels should continue until situation escalates	
1.4	Public information will be increased. Leaflets will be posted to all addresses, emphasising good hygiene measures and reassuring the public. Ensure all messages are reflected in local plans and replicate national messages given	
1.5	Advise all organisations to ensure that essential training takes place	
1.6	Place all response and co-ordination arrangements on standby	
	Place arrangements for dealing with additional deaths on standby	

Declaration of WHO Phase 6 - UK alert level 1 / UK Containment

Increased and sustained transmission in general population – virus / cases only outside the UK

Ref	Action	Owner
2.1	Information received of UK alert level 1 declaration	
2.2	Inform SCG Chair of UK alert level 1 declaration	
2.3	Set meeting time, date and venue for SCG to convene	
2.4	Inform LRF partner agencies that the response plan has been activated and give details of SCG meetings.	
2.5	SCG will meet (LRF Press Officers Group represented)	
2.6	Establish an initial strategy and keep records i.e. agree the common purpose of the SCG	
2.7	Agree each agency's essential services	
2.8	Agree the communications strategy, to the public and internally	
2.9	Review and update contact directories for linking with all partner agencies and groups	
2.10	Establish e-mail distribution groups to ensure that all partners are kept abreast of developments	
2.11	Establish and maintain a list of communication toolbox options for communicating key messages. These should address equality and diversity issues	
2.12	The need to link regularly by other means other than attending face-to-face meetings will have to be addressed by remote or virtual meetings	
2.13	Give all partners instructions as to how future virtual meetings would operate	
2.14	Review options and practicalities of holding virtual meetings between partner agencies as the pandemic escalates	
2.15	Provide all partners with instructions as to how future virtual meetings would operate	
2.16	SCG to determine the priority workers for pre pandemic vaccine and ensure that a programme is implemented. This will be in line with national guidance	
2.17	Arrangements for antiviral collection centres to be confirmed	

2.18	Agree the chair of the GSG and deputies	
2.19	Consider what sub groups may need to be activated	

Declaration of WHO Phase 6, UK alert level 2 / UK Outbreak Management

Increased and sustained transmission in general population – virus isolated in the UK

Ref	Action	Owner
3.1	SCG will meet	
3.2	Confirm strategy and record policy log	
3.3	Review each agency's essential services	
3.4	Review communications strategy	
3.5	Agree future format of SCG including sub groups and chairs	
3.6	Activate sub groups to tasks as appropriate	
3.7	Initiate public information output, especially on the effects, expected or real, on services	
3.8	Ensure that antiviral collection centres are prepared for immediate implementation	
3.9	Receive updates on disease and local health service planning	
3.10	Maintain record of all actions taken and decisions made	
3.11	Ensure equality and diversity issues are being addressed in public information	
3.12	Test video conferencing facilities and links with partners	
3.13	Prepare regular situation reports	
3.14	Review policy on personal protective equipment	
3.15	If Cheshire, Halton & Warrington has the first outbreak within the UK, refer also to Action Card for Phase 6, UK Alert Level 3	

Declaration of WHO Phase 6, UK alert level 3 / UK Treatment

Increased and sustained transmission in general population – outbreak(s) in the UK

Ref	Action	Owner
4.1	SCG to consider virtual / video conferencing	
4.2	Virtual meeting organised by a coordinator from the SCG who will manage the process	
4.3	Receive updates from all agencies as to how they are coping and receive any requests for mutual aid / support	
4.4	Receive updates on disease and local health service planning	
4.5	Review and confirm strategy regularly and record	
4.6	Use strategy to prioritise resources	
4.7	Coordinate response to keep essential services going	
4.8	Colour code issues as they arise	
4.9	Review command and control arrangements	
4.10	Have business continuity arrangements in place for command and control	
4.11	Maintain public information supply, especially on the effects of services. The overall aim will be to maintain normal services and continue social and economic activities for as long as possible	
4.12	Identify public events coming up in Cheshire, Halton & Warrington	
4.13	Establish communication links with the Regional Civil Contingencies Committee if established	
4.14	Appoint Recovery Working Group Chair	
4.15	Maintain information exchange links with partners via the GSG	
4.16	Prepare regular situation reports	

Declaration of WHO Phase 6, UK alert level 4 / UK Treatment

Increased and sustained transmission in general population – widespread activity across the UK

Ref	Action	Owner
5.1	SCG to consider virtual meeting / video conferencing	
5.2	Virtual meeting organised by a coordinator from the SCG who will manage the process	
5.3	Receive updates from all agencies as to how they are coping and receive any requests for mutual aid / support	
5.4	Receive updates on disease and local health service planning	
5.5	Co-ordinate response to keep essential services going	
5.6	Monitor staff absence	
5.7	Activate any business continuity arrangements for command and control as necessary	
5.8	<p>Maintain public information supply, especially on the effects of services. The types of non health information that may need to be issued relative to the following:</p> <p>What is the impact on key services – e.g. local transport and traffic systems, waste collection, postal services etc</p> <p>Have any schools, colleges, local businesses closed</p> <p>Has there been any disruption to local fuel supplies</p> <p>Has there been any disruption to food and drink supplies</p> <p>Public order reassurance issues</p> <p>Cancellation of public events / impact on tourism</p>	
5.9	Assess impact of public events due to take place in Cheshire, Halton & Warrington	
5.10	Prepare daily situation reports for the RCCC	
5.11	Activate Recovery Working Group	
5.12	Maintain record of all actions taken and decisions made	
5.13	Consider and agree the handover process from SCG to the Recovery Working Group (if appropriate). Consider whether the SCG will need to continue to support the Recovery Working Group	

Inter wave period / Recovery Phase

Ref	Action	Owner
6.1	SCG review actions carried out	
6.2	Review of business continuity plans and adjust in light of staff already exposed to the virus	
6.3	Receive updates from all agencies as to how they are coping with recovery issues and preparations	
6.4	Receive updates on disease and local health service response	
6.5	Set debrief strategy, hold debrief and record findings	
6.6	Continue to work towards normality	
6.7	Review communications strategy	
6.8	Maintain public information supply, especially on the effects of services returning to normal and preparations for the next wave	
6.9	Review plans	
6.10	Prepare for the next wave of pandemic influenza	

APPENDIX B

SITUATION REPORT

The situation report summarises the information that will be required from GONW. It is not expected that all of the information presented will need to be updated daily; this will depend on the emerging situation and arising regional issues. Much of the information will be required on an exception basis i.e. only if and when problems arise. It will be the responsibility of the Gold Support Group to gather the information when it becomes available

Guidance for completing the situation report⁴

This provides some guidance on how to complete the influenza pandemic situation report which follows after the guidance:

- Daily reports will be required before 1700;
- Reports will be exception reporting and are likely to be qualitative rather than quantitative;
- The information will be present situation and can be shared across agencies;
- A traffic light system (as per page 71) should be used to describe the local situation for the relevant sections;
- Reports will be required from Category 1 and 2 responders;
- GONW will summarise LRF reports and send to the CCC and will share with all other LRFs in the area

Section 1: Departmental / Government Office Key Issues

This section is used to provide Cabinet Office / COBR Situation Cell and agencies with the key issues that the reporting agency is currently dealing with or require wider visibility i.e. that assistance may be called for. This section should also note if there are any restrictions on the report's distribution.

Section 2: Key Issues for the Common Recognised Information Picture (CRIP)

This section is used to direct the Cabinet Office / COBR Situation Cell to specific issues that the author believes should be reflected in the incident

⁴ Preparing for Pandemic Influenza – Supplementary Guidance for Local Resilience Forum Planners, Cabinet Office May 2008

CRIP produced by the Situation Cell. It will be for the Situation Cell to decide whether the information recommended is incorporated.

Section 3: Current Situation

This section is used by the Cabinet Office / COBR Situation Cell and agencies with the key issues relating to the situation. It should describe the current situation in sufficient detail for, if necessary, decisions to be made. An indication of the information which is likely to be needed here includes information / data on:

- Essential services;
- Cremation and burial services; and
- Transport

Section 4: Operational Response

This is used to provide Cabinet Office / COBR Situation Cell and agencies with the reporting agency's operational response in sufficient detail for, if necessary, decisions to be made. An indication of the information which is likely to be needed here includes information / data on:

- Education (school closures);
- Cremation / burial services;
- Military support; and
- Mutual aid

Section 5: Resources and Readiness

This section is used to provide the Cabinet Office / COBR Situation Cell and agencies with any resourcing and readiness issues that the reporting agency is currently dealing with or require wider visibility.

Section 6: Next Steps / Forward Look

This section is used to provide Cabinet Office / COBR Situation Cell and agencies with information relating to what action is planned to take place over the coming reporting period or longer as appropriate.

Section 7: Political / Policy

This section is used to provide the Cabinet Office / COBR Situation Cell and agencies with the key political or policy issues. Issues reported should have relevance to either central government and / or the wider responding community.

Section 8: Media and Communications

This section is used to provide the Cabinet Office / COBR Situation Cell and agencies with the key media and communications issues. Issues reported should have relevance to either central government and / or the wider responding community.

Section 9: Manpower and Staffing Issues

This section is used to raise any manpower or staffing issues related to the incident either centrally or in responding agencies. Information should be supplied in the form of a red, amber, green status, with supporting / supplementary information.

Section 10: Other Issues not covered elsewhere

This section will be used to provide other information that does not fit well elsewhere in the report.

Section 11: Information Requirements / Requested Clarification

This section is used to seek information or clarification from the Cabinet Office / COBR Situation Cell or other agencies. This section does not negate the need to contact agencies directly but does provide a record of requested information or matters for clarification.

Section 12: Background / Overview

This should be used to provide any background details that would assist the reader in understanding the situation or specific key issues being reported.

Section 13: Next SITREP will be issued at

This should be used to indicate when the next situation report is due. If it is the last report, then this should be stated.

Section 14: Contacts

This section should contain key contacts that can be contacted 24/7. Where a contact is not available 24/7, this should be clearly stated and their availability listed. At least one out of hours contact must be provided.

Section 15: Attached tables, maps etc.

Where maps and images are of a large size, they should be provided as separate compressed files so as not to be blocked by an agency's firewall. All attachments should be uniquely identified (with a clear linkage to the relevant situation report) and listed to ensure that data is not lost.

The template shown below is that currently being used by Central Government

SITUATION REPORT TEMPLATE

SITREP Number:	n/a	Information /data is correct as at 1700	
Date:		Time (24hr):	17.00
Lead Official:			
Office hours contact:			
Mobile/Out of hours:			
Email:			

This Situation Report provides key information and data on the present situation it has been validated by the relevant departmental / agency officials. The information contained herein can be disseminated to other agencies as necessary – where clarification is required the lead official should, in the first instance, be contacted.

Please fill in relevant information under each blue heading ON AN EXCEPTION BASIS ONLY
Add new information using red text. State 'Nil' if nothing to add.

1. GOVERNMENT OFFICE/DEVOLVED ADMINISTRATION KEY ISSUES

2. CURRENT SITUATION & OPERATIONAL RESPONSE

Please give details of any local/regional impact of swine flu and operational responses in place to address them. This could include details of antiviral distribution planning, regional shortages/panic buying, business continuity/supply chain issues etc.

Health – Including details of AV and vaccine distribution planning and operational response.

Education – Add relevant text only here but also complete table at Annex 1.

[Electricity](#)

[Gas](#)

[Fuel](#)

[Oil](#)

[Food](#)

[Water](#)

[Telecoms](#)

[Postal Services](#)

[Transport](#) - Regional rail disruptions (details of any station closures, line closures, cancelled services etc.) Road Issues (details of regional or local road disruptions.

[Waste Management](#)

[Social Care/Welfare Homecare, Vulnerable People/Groups](#)

[Cremation and burial services](#) - Details of impacts on cremation services, funeral services, burials, coroners, registrars and funeral arrangements.

[Business Issues](#) - Businesses affected

[Tourism](#) - Details of impact on local/regional tourism industry (hotel cancellations impact on visitors attractions.)

[Broadcasting \(inc. print media\)](#)

[Judicial Process](#) - Details of impact on regional/local judicial processes.

[Community Cohesion](#) - Details of community Safety/Community Cohesion Issues

[Animal Health](#) - Details of impact on Animal health and welfare.

[Mutual Aid / Military Support](#) - aid requested and/or in place

3. RESOURCES AND READINESS (inc REGIONAL AND LOCAL STAFFING ISSUES) – Details of RCG/SCG meetings and any regional or local staffing issues.

4. FORWARD LOOK – Details of upcoming issues/events that may impact on response.

5. POLITICAL/POLICY – Details of parliamentary statements/Ministerial visits etc.

6. MEDIA AND COMMUNICATIONS

[Level and tone of media coverage](#)

[Public messages issued regionally/locally](#)

[Other media issues](#)

8. OTHER INFORMATION NOT COVERED ELSEWHERE

9. INFORMATION REQUIREMENTS/REQUIRED CLARIFICATION

Next sitrep to be provided at (time) (Date)

APPENDIX C

LRF Media Strategy and Communications Plan

Introduction

The Cheshire, Halton & Warrington LRF has recognised the importance of the criticality and consistency of media messages during emergencies and the need for communication strategies and procedures for warning and informing the public (pre, during and post emergency periods). See Cheshire, Halton & Warrington LRF Media Plan.

Media Strategy

Working in conjunction with the SCG, the LRF Press Officers Group will address communication strategies and procedures for wider consequence issues arising during an influenza pandemic. The LRF recognises that irrespective of its own media strategy that National and Regional media strategy plans are also in place and that they will seek to avoid unnecessary duplication and seek consistency of approach along with other partner agencies and organisations.

Key messages from the Government during a pandemic will be that people who are well should carry on with normal, essential activities as far as possible, at the same time taking personal responsibility for self-protection: and those that are unwell, or think they are unwell should take social responsibility to lessen spread and thus protect others.

Department of Health have produced a *Pandemic Flu Communication Toolkit* (January 2006). This document outlines the roles, responsibilities and relationships of the various threads of the Health Service organisations in relation to how they intend to carry out warning and informing of the public. It also provides details of national strategies and timetable for publicity and public awareness campaigns that will be carried out by the Health Service, as well as some generic fact-sheets and Q&A material for the public.

APPENDIX D - OTHER INFECTIOUS DISEASES

AN OVERVIEW OF SMALLPOX

Smallpox is an acute contagious disease caused by the variola virus. Smallpox used to be both a common disease and a common cause of death worldwide, however, following a worldwide vaccination campaign, smallpox was declared eradicated from the world in 1980. The last case caught in the community was in Africa in 1977. There are no animal reservoirs for the infection.

If an outbreak of smallpox were to occur, several factors could contribute to a more rapid spread of smallpox that was routinely seen before this disease was eradicated. These factors include:

- low population immunity in the absence of naturally occurring disease and the discontinuation of routine vaccination
- delayed recognition of smallpox by health professionals who are unfamiliar with the disease, and
- increased mobility and crowding of the population.

Spread of the disease

- Smallpox is most often spread by inhaling virus particles through close contact with an infected person, but transmission via clothes and bedding is also possible. Neither animals nor insects are involved in transmission.
- The incubation period for smallpox is usually 10-16 days but varies from 7-17 days. A rash starts to appear about 2 days after the first symptoms (taken as the onset of fever).

Treatment of the disease

- There is no specific treatment for the disease and caring for patients essentially involves treating their symptoms. However, antiviral drugs have recently been developed and have been shown to be effective against other poxviruses and may therefore have a role in cases of smallpox. Cases must be isolated to prevent transmission of the disease.
- There is an effective vaccine against smallpox, worldwide use of which was the basis of smallpox being eradicated. Because there is no longer any possibility of naturally acquiring the disease, smallpox vaccine has not been given to the general public. Vaccination can cause serious side effects and it should not be given to pregnant women, those with impaired immunity or those with eczema.

Deaths

- When smallpox occurs in a non-immune person or population it is a particularly serious illness, and is fatal in up to 30% of cases.
- Vaccination given up to 4 days after exposure can modify the course of the disease and reduce mortality by about 50%.

Smallpox phases

Alert Levels have been identified to assist planning according to the actions required. Alert Levels generally proceed in a stepwise fashion, but may proceed directly to level 2 or higher.

Alert levels status will be announced by the Chief Medical Officer, DH.

Alert Level	Smallpox Phases
Alert Level 0	Smallpox remains eradicated: No credible threat of a release.
Alert Level 1	Heightened threat: Case confirmed outside UK. Confirmation of virus found outside the WHO designated repositories and intelligence suggests a credible and imminent threat of a release.
Alert Level 2	Case confirmed in the UK.
Alert Level 3	Outbreak occurring in the UK.
Alert Level 4	Large or multiple outbreaks not controlled by ring vaccination.
Alert Level 5	Outbreak controlled: No further cases occurring.

AN OVERVIEW OF SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

SARS is a severe respiratory disease caused by SARS coronavirus (SARS CoV). It was first recognised in Guangdong Province in China in November 2002, and spread worldwide before being contained by 5 July 2003.

Between July 2003 and May 2004, four small and rapidly contained outbreaks of SARS were reported; three of which appear to have been linked to laboratory releases of SARS-CoV. The source of the fourth outbreak remains unclear, although epidemiological investigations focused on an animal source.

Hospitalised SARS cases experience a relatively high case fatality ratio (average 15%) and, because of the high need for intensive care and the potential infection of health care staff, can quickly overwhelm healthcare facilities. Spread can be very rapid through international travel. The possibility of SARS re-emergence remains and there is a need for continuing vigilance.

Planning assumptions

The current contingency plans are based upon the presently existing epidemiological data, information from the World Health Organisation (WHO) and the experience of countries affected by SARS.

A number of assumptions concerning SARS based on the worldwide 2003 outbreak have been made that underpin the current contingency plans:

Nature and spread of the disease

- The main symptoms of SARS are high fever (>38° C), cough, shortness of breath or difficulty in breathing. Symptoms should be severe enough to warrant hospitalisation and chest X-ray changes should show pneumonia or respiratory distress syndrome
- SARS is predominantly spread by contact with infectious respiratory droplets
- SARS appears to be less infectious than influenza. The incubation period is believed to be short, around two to seven days (maximum 10 days).
- Transmission of SARS is uncommon when cases are isolated within 5 days of the onset of illness
- Cases that have more severe illness are considered to be more infectious and risk of transmission of SARS is greatest at around the 10th day of illness

- Children, especially those under age 10, have almost no risk of acquiring SARS and they do not spread the disease
- The majority of SARS cases seem to result in no further transmission however 'Super-spreading events' do occur (where one case causes many others). These events are difficult to predict but are most likely in very ill people in hospitals undergoing 'high-risk' procedures, which include incubation, nebulisation therapy and taking specimens from lower respiratory tract
- Health care workers are at particular risk of infection
- Close contacts (e.g. household or face-to-face (within one metre) contacts of cases) are also at particular risk. However, droplet precautions and strict personal hygiene is effective in controlling spread

Identification and treatment of the disease

- At present there are no early tests for SARS, and no vaccine or specific treatment; supportive treatment is the mainstay of clinical management and may include intensive care.

Deaths

- Based on data from affected countries, the overall case fatality is 15%, though this is dependent on the age of the patient and co-morbidity. The case fatality is estimated to be less than 1% in persons aged 24 years or younger, 6% in persons aged 25 to 44 years, 15% in persons aged 45 to 64 years, and greater than 50% in persons aged 65 years and older.

Absence from work

- People who are thought to have been exposed to SARS and are on 10 days active surveillance (i.e. are not on home 'self' quarantine or isolation) do not need to remain at home and may go to work and undertake normal communal activities during the period of active surveillance

SARS phases

The phases of the response and associated Alert Levels for SARS are as set out below.

Alert level status will be announced by the Chief Medical Officer, DH.

Alert Level	SARS Phases
Alert Level 0	No cases internationally
Alert Level 1	No cases in the UK, but SARS cases occurring elsewhere in the world
Alert Level 1a	Sporadic cases abroad
Alert Level 1b	Chains of transmission abroad
Alert Level 1c	Importation of cases into other countries
Alert Level 1d	Chains of transmission from imported cases
Alert Level 2	Sporadic imported cases from affected areas outside the UK
Alert Level 3	One or more outbreaks of SARS in the UK within hospital(s) and/or limited community transmission within definable groups
Alert Level 3a	Only one generation arising from direct contact with known imported case(s)
Alert Level 3b	More than one generation arising from known imported cases(s)
Alert Level 4	Outbreaks of SARS in the UK with extensive community transmission (cases occurring with no known link to known SARS cases)
Alert Level 5	Post outbreak and de-escalation of SARS response

APPENDIX E**LIST OF WEBSITES FOR FURTHER INFORMATION**

These documents are available at www.dh.gov/en/PandemicFlu/index.htm

Department of Health	<p>A national framework for responding to an influenza pandemic</p> <p>Responding to pandemic influenza – the ethical framework for policy</p> <p>Pandemic influenza: Guidance on preparing acute hospitals in England</p> <p>Pandemic influenza: Guidance for ambulance services and their staff in England</p> <p>Pandemic influenza: Guidance for primary care trusts and primary care professionals on the provision of healthcare in a community setting in England</p> <p>An operational and strategic framework: planning for pandemic influenza in adult social care</p> <p>Pandemic influenza: guidance on preparing mental health services in England</p> <p>Pandemic influenza: human resources guidance for the NHS</p> <p>Pandemic influenza: guidance on the management of death certification and cremation certification</p> <p>Pandemic influenza: guidance for planning for vulnerable groups (draft)</p> <p>Pandemic influenza: guidance on preparing maternity services in England (draft)</p> <p>Pandemic influenza: guidance for Dental Practices</p> <p>Pandemic influenza: Surge capacity and prioritisation in health services (draft)</p> <p>Pandemic influenza: Guidance on the delivery of and contract arrangements for primary care dentistry</p> <p>The NHS In England: The Operating Framework for 2008/2009</p>
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These documents are available at www.ukresilience.info

Cabinet Office	<p>Overarching Government Strategy to respond to pandemic influenza – analysis of the scientific evidence base</p> <p>Preparing for Pandemic Influenza – Guidance to Local Planners (including checklist for Local Resilience Forum plans)</p> <p>Preparing for Pandemic Influenza: Supplementary Guidance for Local Resilience Forum planners</p> <p>Planning for a possible influenza pandemic – a framework for planners preparing to manage deaths</p>
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APPENDIX F

GLOSSARY OF TERMS

A&E – Accident & Emergency

ACPO – Association of Chief Police Officers

BCM – Business Continuity Management

CCC – Civil Contingencies Committee

CHWLRF – Cheshire, Halton & Warrington Local Resilience Forum

COBR – Cabinet Office Briefing Room

GO – Government Office

GONW – Government Office North West

GP – General Practitioner

GSG – Gold Support Group

HPA – Health Protection Agency

JTCG – Joint Tactical Co-ordinating Group

LFTG – Local Flu Tactical Group

LRF – Local Resilience Forum

MACA – Military Aid to the Civil Authorities

NHS – National Health Service

PCT – Primary Care Trust

RCCC – Regional Civil Contingencies Committee

SCG – Strategic Co-ordinating Group

SHA – Strategic Health Authority

STAC – Scientific and Technical Advice Cell

URN – Unique Reference Number

WHO – World Health Organisation

APPENDIX G**PLAN DISTRIBUTION LIST**

Organisation	Date Issued	Date Response Received
AMBULANCE SERVICE		
North West Ambulance Service		
FOUNDATION TRUSTS		
Cheshire & Wirral Partnership Foundation Trust		
Countess of Chester Hospital Foundation Trust		
Mid Cheshire Hospitals Foundation Trust		
Warrington & Halton Hospitals Foundation Trust		
ACUTE TRUSTS		
East Cheshire NHS Trust		
PRIMARY CARE TRUSTS		
NHS Central & Eastern Cheshire		
NHS Halton & St Helens		
NHS Warrington		
NHS Western Cheshire		
MENTAL HEALTH TRUST		
5 Boroughs Partnership Trust		
HEALTH PROTECTION UNIT		
Cheshire & Merseyside		
FIRE & RESCUE SERVICE		
Cheshire		
POLICE FORCE		
Cheshire		
LOCAL AUTHORITIES		
Cheshire East		
Cheshire West and Chester		
Halton Borough Council		
Warrington Borough Council		
PORT HEALTH AUTHORITY		
Manchester Port Health Authority		
HM CORONER		
Cheshire		
STRATEGIC HEALTH AUTHORITY		
NHS North West		
GOVERNMENT OFFICE		
Government Office North West		
OTHER ORGANISATIONS		
Environment Agency		
Met Office		
Health and Safety Executive		
HQ42 Brigade		
Highways Agency		