Pandemic Flu Plan: Health and Wellbeing Board note

The risk of and potential impact from pandemic influenza is such that it remains the top risk on the UK Cabinet Office National Risk Register of Civil Emergencies (2017 edition) and continues to direct significant amount of emergency preparedness activity on a global basis. In the event of the World Health Organisation declaring a pandemic flu, North East Lincolnshire Council would be responsible for coordinating and planning the local response in North East Lincolnshire. The pandemic influenza plans of other key partner organisations in the Borough should therefore be guided by this document. As such the document has undergone consultation with the partner organisations that sit on the North East Lincolnshire Emergency Planning and Response Group (EPARG). Other organisations in the Borough will develop their pandemic response plans under the influence of this document.

The plan lays out the approach, responsibilities, and plans within North East Lincolnshire Council in responding to a pandemic event. International, national, regional and local collaboration, communication and partnerships will be vital in responding to a pandemic, to provide accurate information to the public and professionals and enable an effective response to be mounted.

A Pandemic Influenza will have implications for:

- Managing ill health and deaths
- Business continuity (maintaining essential services)
- Consequence management (the broader social disruption)

This plan deals largely with the first set of issues but also draws attention to the requirement to have business continuity plans in place. It also makes reference to the wider social impacts of a pandemic. It describes the local structures, relationships and command and control arrangements for the Council in partnership with the Humber area health and social care communities. It has been written with reference to and in line with other local and national plans including:

Local and Regional

- The Yorkshire and Humber Local Resilience Forums (LRFs) and Local Health Resilience Partnerships (LHRF) Pandemic Influenza Plan
- North East Lincolnshire Emergency Planning and Business Continuity Plans
- Local NHS plans

National

- Public Health England Pandemic Influenza Response Plan
- Department of Health UK Influenza Preparedness Strategy
- Guidance on the Roles and Responsibilities of Clinical Commissioning Groups (CCGs) in preparing for and responding to an influenza pandemic

Further relevant documents include:

- UK Pandemic Influenza Communication Strategy
- Guidance for local planners
- WHO Pandemic Influenza Guidance

- Health and Social Care Influenza Pandemic Preparedness and Response
- Scientific Basis for planning assumptions
- UK National Risk Register

This plan will be activated by the Director of Public Health and ongoing management of the health and social care response will be by the North East Lincolnshire Pandemic Influenza Committee working with multi agency partners through the Humber LRF Pandemic Influenza Plan.

North East Lincolnshire Council Pandemic Flu Plan 2019-2022

1. Context

The risk of and potential impact from pandemic influenza is such that it remains the top risk on the UK Cabinet Office National Risk Register of Civil Emergencies (2017 edition) and continues to direct significant amount of emergency preparedness activity on a global basis. This document lays out the approach, responsibilities, and plans within North East Lincolnshire Council in responding to a pandemic event. International, national, regional and local collaboration, communication and partnerships will be vital in responding to a pandemic, to provide accurate information to the public and professionals and enable an effective response to be mounted.

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Local and Regional

- The Yorkshire and Humber Local Resilience Forums (LRFs) and Local Health Resilience Partnerships (LHRF) Pandemic Influenza Plan[1]
- North East Lincolnshire Emergency Planning and Business Continuity Plans
- Local NHS plans

National

- Public Health England Pandemic Influenza Response Plan[2]
- Department of Health UK Influenza Preparedness Strategy[3]
- Guidance on the Roles and Responsibilities of Clinical Commissioning Groups (CCGs) in preparing for and responding to an influenza pandemic[4]

Further relevant documents include:

- UK Pandemic Influenza Communication Strategy[5]

[1] Yorkshire and Humber LRFs and LHRPs Pandemic Influenza Framework 2017.
[2] https://www.gov.uk/government/publications/pandemic-influenza-response-plan
[3] https://www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic
[4] https://www.england.nhs.uk/wp-content/uploads/2013/12/roles-resps-panflu-ccgs.pdf
[5] https://www.gov.uk/government/publications/communications-strategy-for-uk-flu-pandemics

- Guidance for local planners[6]
- WHO Pandemic Influenza Guidance[7]
- Health and Social Care Influenza Pandemic Preparedness and Response[8]
- Scientific Basis for planning assumptions[9]
- UK National Risk Register[10]

This plan will be activated by the Director of Public Health and ongoing management of the health and social care response will be by the North East Lincolnshire Pandemic Influenza Committee (see section 8) working with multi agency partners through the Humber LRF Pandemic Influenza Plan.

2. Strategic Approach

1. Minimise the potential public health risks and health impacts of a future influenza pandemic by:

a) supporting national, regional and local efforts to detect its emergence, and early assessment of the virus by sharing information;

b) promoting individual responsibility and action to reduce the spread of infection through good hygiene practices and uptake of seasonal influenza vaccination in high-risk groups;

c) ensuring the health and social care systems are ready to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care.

2. Minimise the potential impact of a pandemic on society and the economy by:

a) supporting the continuity of essential services, including the supply of medicines, and protecting critical infrastructure as far as possible;

b) supporting the continuation of everyday activities as far as practicable;

[6] https://www.gov.uk/guidance/pandemic-flu#guidance-for-local-planners

[7] https://www.who.int/influenza/preparedness/pandemic/GIP_PandemicInfluenzaRiskManagementInterimGuidance_Jun2013.pdf

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf

[9] https://www.gov.uk/government/publications/review-of-the-evidence-base-underpinning-the-uk-influenza-pandemic-preparedness-strategy

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/644968/UK_National_Risk_Register_2017.pdf

c) upholding the rule of law and the democratic process in conjunction with LRF partners;

d) preparing to cope with the possibility of significant numbers of additional deaths;

e) promoting a return to normality and the restoration of disrupted services at the earliest opportunity.

3. Instil and maintain trust and confidence by:

a) ensuring that local authority, health and other professionals, the public and the media are engaged and well informed in advance of and throughout the pandemic period and that local authority, health and other professionals receive information and guidance in a timely way so they can respond to the public appropriately.

3. Objectives

This Pandemic Flu Plan has four key objectives:

Inform preparations to cope with large numbers of ill people in a variety of settings

Ensure there is expert advice provided to professionals and the public

Maintain essential council services (business continuity) in health and social care provision

Prepare for increased numbers of deaths

3. Scope of operation

This plan is for North East Lincolnshire Council but is also intended to shape the plans of partner organisations in North East Lincolnshire.

3.1 Key principles of the response

Given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles laid out by the Cabinet office should underpin all pandemic preparedness and response activity[11]:

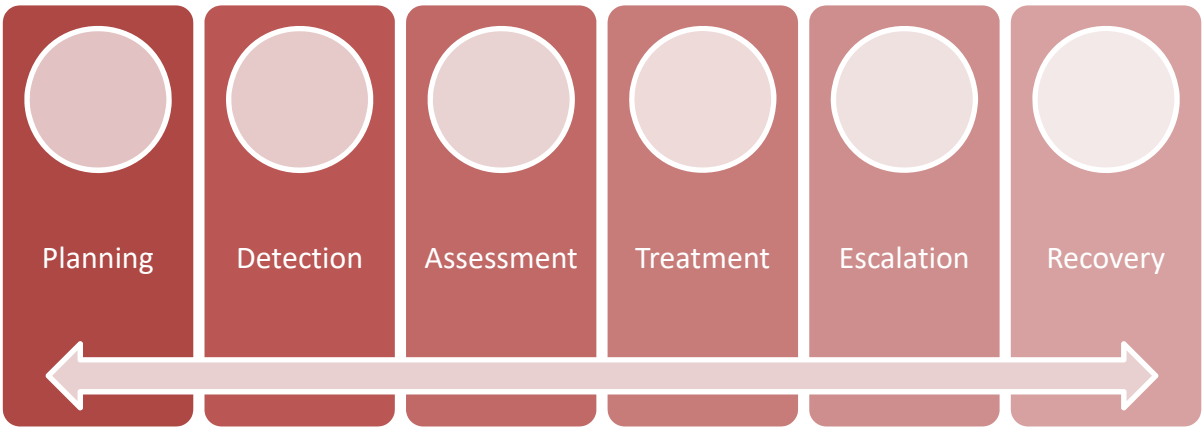
Precautionary: the response to any new virus should take into account the risk that it could be severe in nature. Plans must therefore be in place for an influenza pandemic with the potential to cause severe symptoms in individuals and widespread disruption to society.

Proportionality: the response to a pandemic should be no more and no less than that necessary in relation to the known risks. Plans therefore need to be in place not only for high impact pandemics, but also for milder scenarios, with the ability to adapt them as new evidence emerges.

Flexibility: there will need to be local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection, within a consistent UK wide approach to the response to a new pandemic, and accounting for the different healthcare systems in the four countries that make up the United Kingdom.

4. UK Phases of a Pandemic

The phases of the UK approach in a future pandemic response are outlined below. The phases are not numbered as they are not linear, may not follow in strict order, and it is possible to move back and forth or jump phases. It should also be recognised that there may not be a clear delineation between phases, particularly when considering regional variation and comparisons.



Planning
Existing plans should be re-reviewed every two years and updated at least every four years. Plans should be in line with the strategic approach and objectives outlined above.

11 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

Detection
This phase would commence on either the declaration of the current WHO phase 4 or earlier on the basis of reliable intelligence or if an influenza-related "Public Health Emergency of International Concern" (a "PHEIC") is declared by the WHO. Notification to Local Authorities would come from Public Health England. The focus in this stage would be:

- Intelligence gathering from countries already affected.
- Enhanced surveillance within the UK.
- The development of diagnostics specific to the new virus.
- Information and communications to the public and professionals.

The indicator for moving to the next stage would be the identification of the novel influenza virus in residents in the UK.

Assessment
The focus in this stage would be:

- The collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK.
- Reducing the risk of transmission and infection with the virus within the local community by:
  - actively finding cases;
  - self-isolation of cases and suspected cases; and treatment of cases / suspected cases and use of antiviral prophylaxis for close / vulnerable contacts, based on a risk assessment of the possible impact of the disease.

The indicator for moving from this stage would be evidence of sustained community transmission of the virus, i.e. cases not linked to any known or previously identified cases.

These two stages – Detection and Assessment - together form the initial response. This may be relatively short and the phases may be combined depending on the speed with which the virus spreads, or the severity with which individuals and communities are affected. It will not be possible to halt the spread of a new pandemic influenza virus, and it would be a waste of public health resources and capacity to attempt to do so.

Treatment
The focus in this stage would be:

- Treatment of individual cases and population treatment via the National Pandemic Flu Service if necessary
- Enhancement of the health response to deal with increasing numbers of cases
- Consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localised school closures based on public health risk assessment

- Depending upon the development of the pandemic, to prepare for targeted vaccinations as the vaccine becomes available

Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases and deaths. When demands for services start to exceed the available capacity, additional measures will need to be taken. This decision is likely to be made at a regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity.

Escalation

The focus in this stage would be:

- Escalation of surge management arrangements in Local Authority, health and other sectors.
- Prioritisation and triage of service delivery with aim to maintain essential services.
- Resiliency measures, encompassing robust contingency plans.
- Consideration of de-escalation of response if the situation is judged to have improved sufficiently.

These two stages form the Treatment phase of the pandemic. Whilst escalation measures may not be needed in mild pandemics, it would be prudent to prepare for the implementation of the Escalation phase at an early stage of the Treatment phase, if not before.

Recovery

The focus in this stage would be:

- Normalisation of services, perhaps to a new definition of what constitutes normal service
- Restoration of business as usual services, including an element of catching-up with activity that may have been scaled down as part of the pandemic response, e.g. reschedule routine operation
- Post-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt
- Taking steps to address staff exhaustion
- Planning and preparation for a resurgence of influenza, including activities carried out in the Detection phase
- Continuing to consider targeted vaccination, when available
- Preparing for post-pandemic seasonal influenza.

The indicator for this phase would be when influenza activity is either significantly reduced compared to the peak or when the activity is considered to be within acceptable parameters.

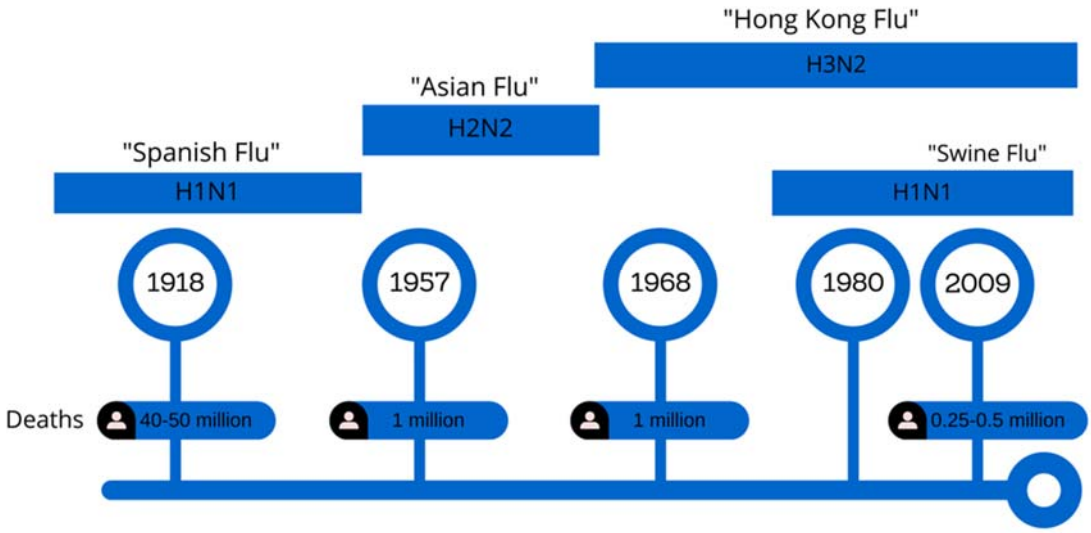
An overview of how services' capacities are able to meet demand will also inform this decision.

5. Planning Assumptions

Pandemic strains arise from a sudden change in an existing human type A 'flu virus, or from the mixing of the genes of human and animal strains of 'flu virus to form a new strain. H5N1 Avian Influenza in South East Asia is therefore a possible source of the next pandemic strain. The 2009 'flu virus strain was identified as H1N1, called Swine Flu and was classified as a Pandemic strain by the World Health Organisation (WHO) in June 2009.

Regular Influenza Pandemics have been documented from the 16th century with four pandemics in the last hundred years (Figure 1):

Figure 1. Influenza strains in humans and pandemics in the last century



The estimate for deaths in Figure 1 is worldwide. Within England and Wales the 1918 Pandemic had a 23% attack rate with 200,000 excess deaths, mainly affecting healthy young adults. The 1957 Pandemic had a 17% attack rate with 30,000 excess deaths (0.13-0.35% case fatality rate), mainly affecting children and young adults. The 1968-70 Pandemic had a 21% attack rate with 78,000 excess deaths over three years. The 2009 H1N1 Pandemic (Swine Flu) had a 12% attack rate mainly affecting children and especially those under the age of 5 years. It is believed there were under 1000 deaths in England and Wales, which in part at least was due to effective advance planning

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Influenza pandemic planning in the UK has been based on an assessment of the "reasonable worst case". This is derived from the experience and a mathematical analysis of the influenza pandemics described above and from close monitoring of seasonal influenza. This suggests that, given known patterns of spread of infection, up to 50% of the

population could experience symptoms of pandemic influenza during one or more pandemic waves lasting 15 weeks, although the nature and severity of the symptoms would vary from person to person.

For deaths, the analysis of previous influenza pandemics suggests that we should plan for a situation in which up to 2.5% of those with symptoms would die as a result of influenza, assuming no effective treatment was available.

The use of common assumptions across the local resilience tier is important to avoid confusion and facilitate an integrated approach to preparation. However, one of the main challenges faced by those planning against an influenza pandemic is that the nature and impact of the pandemic virus cannot be known until it emerges. There are no genetic markers that will predict the pathogenicity or spread in the human population, and until the virus emerges and has affected a significant number of people, it is not possible to determine many of the factors of the disease that will be important in assessing its severity or impact.

There is further detail on planning assumptions in Appendix A

6. North East Lincolnshire Council Emergency Planning and Business Continuity Policy

The main challenge during a Pandemic will be maintaining essential services whilst suffering a reduction in workforce alongside many more ill residents. Each element of health and social care should have a separate Business Continuity Plan that outlines the essential services to be maintained throughout the course of the Pandemic. Blanket decisions may be unhelpful. It would be better to re-evaluate the local situation each day through individual teams with oversight by existing management structures and the North East Lincolnshire Pandemic Influenza Committee, North East Lincolnshire Pandemic Response Group and other local and regional structures as appropriate.

Each council department has produced a Business Continuity Plan to enable maintenance of essential services in response to an emergency incident. Plans are updated in response to national and regional guidance, local incidents, and lessons learned from exercises.

Business as normal should be maintained for as long as possible. When this becomes impossible services should be prioritised according to the business continuity plan and the situation in hand.

Service Business Continuity Plans are available through departments and are accessible at all times via the network drive- \\Nelincs-Dat3\NELCData\Emergency Planning NELC

In performing business continuity planning it is important to realise that the sickness absence rate will not be uniform over the Pandemic period and that the attack rates refer to the whole period not just any one point in time. An Incident Manager may be appointed to co-ordinate a corporate business continuity approach if there is significant disruption to services. Alternatively, Leadership Team may carry out this role.

7. The Challenges

In all sectors:

- Increased workload from new and existing patients/residents with influenza and its complications
- Staff sickness and other workforce issues due to school closures and looking after ill relatives
- Potential disruption to supplies, utilities and transport systems
- The need to continue working including escalation of business continuity plans
- Communicating with staff, patients/residents, contractors, users of services and NELC commissioned providers
- Pressure on mortuary facilities.

Workforce issues

- Staff falling ill with influenza, some perhaps dying
- Staff being at higher personal risk than if not at work

More complex procedures to avoid cross-infection

- Having to work in different ways
- Working with volunteers
- Domestic pressures on staff, especially if schools close, family and relatives are ill.

Family illness

- Logistics of getting to work and domestic commitments
- Agency colleagues may be being paid at a high premium.

Acute care

- Increased attendances at Accident and Emergency departments
- Increased demand on intensive care and for ventilation
- Increased demand for high dependency care
- Use of time and resources consuming anti-infection procedures
- Quarantine into ‘clean’ and ‘infected’ areas/wards
- Difficulties in discharging to the community
- All the usual emergencies continuing
- Pressure on laboratories.

Community and Intermediate care

- People falling ill at home and sometimes dying there
- Many people having to be looked after at home who would normally be looked after in hospital/ more difficult to arrange hospital admission
- Receiving and supporting patients discharged prematurely from hospital
- Front line staff to solve problems for patients denied their usual or expected services
- Possible need for duty rotas to ensure patients can access antivirals within 48 hours of exposure/onset
- Pressure to receive more patients
- Difficulty in getting patients admitted to hospital
- Residential settings may see increased transmission.

Primary care

- Coping with increase in consultations. This increase will be exacerbated by anxiety and potentially some people coping with bereavement
- Staff sickness especially problematic in single-handed practices
- Community staff and practice premises may contribute to an increase in transmission

Social care

- Clients and/or their usual carers ill
- Residential homes may see enhanced transmission
- Some clients may not be able to understand what is happening
- More children whose parents can no longer care for them
- People who become ill and are unable to return home.

8. North East Lincolnshire Pandemic Committees (*TBC- Internal group to be established once a pandemic has been declared*)

An internal NELC/ NELCCG (Union) group (comprising of senior officers and other key officers from the council and the CCG) and an external group which will bring together representatives of the Union with senior officers of key partners will be convened immediately following the declaration of an influenza pandemic. These will be known as the North East Lincolnshire Pandemic Influenza Committee (Internal Group) and the North East Lincolnshire Pandemic Response Group (External Group). In practice it is likely that the meetings will be convened to take place one after the other

8.1 Pandemic Influenza Committee (Internal Group)

The internal Union Pandemic Influenza Committee (PIC) will normally be established and led by the Director of Public Health or the delegated responsible person. The Union PIC could be constituted from the NELC Emergency Coordination Centre procedure in responding to emergencies for this defined Public Health emergency.

It is envisaged that the PIC will meet on a weekly basis (daily if required) in the early stages of the first wave and then review the frequency as the Pandemic progresses. The PIC will

be supported by a number of Working Groups who will oversee the detailed response planning, e.g., Task Planning Group, Antiviral Planning Group.

Indicative Membership/Representatives

- Director of Public Health
- Deputy Director of Public Health, Health Protection Lead
- Director of Children's Services
- Director of Adult Services
- Director of Quality & Nursing
- Medical Director (CCG)
- Children, Family and Schools senior representation
- Environment and Neighbourhood services
- Emergency Planning Managers (HEPS) (including other Local authorities as appropriate)
- Emergency Planning Lead (CCG)
- Corporate resources: Human Resources, Humber Emergency Planning Service, Democratic Services, Registrations Services
- Bereavement services manager
- Communication leads
- Administration support

The Committee will meet to co-ordinate the Health and Social Care North East Lincolnshire Council response. The Committee will:

- Implement national guidance with local direction (including antivirals, vaccines, etc)
- Receive and disseminate updates from the Council services
- Make strategic decisions and plans on the Council response
- Co-ordinate *the Council's* media response
- Share information and coordinate with the North East Lincolnshire Pandemic Response Group, Humber Local Resilience Forum, Strategic Co-ordination Group and other local and regional responses.
- Share information with Parish and Town Councils
- Ensure relevant portfolio holders are briefed

8.2. North East Lincolnshire Pandemic Influenza Response Group (Partnership Group)

The Pandemic Influenza Response Group (PIRG) will be the main partnership group for the coordination of activities across a range of organisations that will be critical during the flu pandemic. It is also likely to be chaired and led by the Director of Public Health or his/her delegated responsible person. Meetings are likely to commence after the PIC meeting has completed. Membership should consist of those organisations, groups and individuals most appropriate given the circumstances of the pandemic but is likely to include some or all of the following:

- Director of Public Health (Chair)

- Deputy Director of Public Health, Health Protection Lead.
- Director of Children's services
- Children, Family and Schools
- Director of Adult Services
- Director of Quality & Nursing
- Medical Director (CCG)
- Planning and Economic Regeneration
- Environment and Neighbourhood services
- Emergency Planning Managers (including other Local authorities as appropriate)
- Corporate resources including Human Resources
- Communication leads
- Administration support
- Consultant in Communicable Disease Control (as appropriate)/ Public Health England representative
- NHS England representative
- Medicines Management
- Winter Planning Lead/Adult services
- Provider Operational manager representatives from across North East Lincolnshire, e.g. Care Plus, NLaG.
- Care Homes
- Domiciliary care
- Voluntary sector
- Healthwatch

The PIRG will meet to co-ordinate and inform the North East Lincolnshire wide response in conjunction with the LRF/SGC. It will:

- Implement national guidance (including antivirals, vaccines, etc)
- Receive and disseminate updates from the regional and national levels
- Receive and disseminate updates from local providers
- Provide technical advice and information to service providers
- Make local strategic decisions
- Provide health advice to the public
- Provide environmental and animal health advice
- Co-ordinate the media response in collaboration with the Strategic Co-ordination Group and other local and regional responses.

Typical agendas for the Pandemic Influenza Committee and Pandemic Influenza Response Group are shown in Appendix B.

9. Supporting Self Care

It is envisaged that the large majority of people who catch new strain of influenza will be able to care for themselves in their normal environment. There is an expectation that generally

health intervention will be unnecessary unless there is either an exacerbation of an existing illness or a complication.

All aspects of the Council's services are likely to be under pressure, especially as there is likely to be a reduction in staff at a time when services are under greater pressure from residents. The generic public message should be:

- Go home
- Go to bed
- Drink plenty of fluids
- Take Paracetamol
- Treat symptoms (sore throat, etc)
- Contact the 'flu line' (National Flu Service) for advice
- Only seek medical help if the patient/resident/client has complications

10. Managing Surge

There will be a need to constantly re-evaluate capacity and priorities throughout each wave of the Pandemic. The threshold by which patients can be admitted to hospitals or community hospitals and clients to care homes will alter through the course of the Pandemic. Therefore it is important to re-evaluate what can and cannot be provided on a daily basis. The normal principles within the council's business continuity policies will apply. Blanket decisions to shut down services for long periods of time may be unhelpful, especially as the pandemic is likely to last up to 30 weeks (in two waves).

Communication between Local Authority, community, primary and secondary services is important so that each can understand the pressures. It is likely that, because of capacity problems, people will have to be treated at home who in normal circumstances would be admitted to hospital. Hospital admission will be on the basis of no alternative being possible, i.e. a need for specific technical intervention or a specialist environment.

11. Communication with the Public

The UK Pandemic Influenza Communications Strategy 2012/13 lays out the national strategy for communication during a pandemic[12]. It lays out how key messages (detailed overleaf) will be disseminated to the public and professionals and the need to maintain a flexible and proportional approach. The core focus of communication will be to:

- explain the outbreak
- establish confidence in the response
- minimise the risk of infection.

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213268/UK-Pandemic-Influenza-Communications-Strategy-2012.pdf

In North East Lincolnshire the Director of Public Health and other key spokespersons identified by the Pandemic Committee will strengthen the national messages. The approach will be coordinated in conjunction with NHS England, Strategic Coordinating Group (SCG), North East Lincolnshire CCG, local NHS Trusts and the Local Resilience Forum Communication Cell. The important thing will be to ensure that information for the public is as accessible as possible, and circulated widely, not just through NELC channels. The press team will work with local media to reiterate the key messages in the Communication Plan with any appropriate local or reasonable adjustments as needed. The Communication Services team, including the social media team should be fully involved in providing information and responding to queries. Feedback on broad trends and problems from customer facing teams (most notably social media) could also be useful for the Pandemic Committee to inform situational awareness.

The language used during pandemics should aim to accurately convey the aims of the response efforts and the levels of risk. In particular, the use of the terms 'containment' and 'reasonable worst case' should be avoided as they are easily misunderstood. In line with the recommendations of the Hine review of the 2009 Swine Flu pandemic, the media should be kept informed with daily briefings, Q&A sessions and regular releases of facts and figures[13].

Communication with the public will also take into account the accessibility of information for those with sensory impairments or disabilities as well as those residents who communicate in languages other than English. Engagement activities early in the pandemic, such as seminar with suitable communities (e.g. head teachers and leaders of residential care) could be valuable in raising awareness of prevention measures and understanding of the key messages overleaf.

12. Advice and communications to Schools and Childcare Settings

Briefings will be arranged for Head Teachers following the announcement of a pandemic by the World Health Organisation. Advice on school/ academy closures will be provided by the DPH in conjunction with PHE and by the LRF / SCG. It is also likely that the Department for Education will provide advice directly.

Advice that will usually be provided to schools includes:

- Remind schools to review their own contingency plans, and in particular, actions to be taken when a pupil has died
- Remind schools of appropriate policies, procedures and reporting mechanisms
- Advice on infection control if schools remain open
- Advice on supporting employees, and staff who are ill or need time off as carers
- Advice on providing a reasonable level of education at home if children are not in school (for example, through remote learning)
- Advice to schools planning to re-open for pupils who have recovered from the virus

13 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61252/the2009influenzapandemic-review.pdf

13. Suggested key public messages

Preparing in Advance

A flu pandemic can strike at any time so it is essential that you are prepared to look after yourself and members of your family. If you are in a high risk group, ensure that you are vaccinated routinely against seasonal influenza and pneumonia because you are at greater risk of becoming seriously ill. To reduce the risk of spreading a virus, cover your mouth and nose with a tissue when coughing or sneezing, dispose of tissues quickly, and regularly wash your hands with soap and water, or use a sanitising gel.

During a Pandemic

Follow public health advice and consider how you and your family might prepare for disruption to schools or childcare facilities due to staff absence or shortages. Do your best to minimise the spread of infection by maintaining a hand hygiene routine. Make sure you have supplies of over-the-counter cold and 'flu medicines and other basic necessities and that you can care for any existing health conditions.

Familiarise yourselves with local arrangements for accessing health and social care support early should you need them, including getting antiviral medicines if needed. Support friends and family who are ill, they might need you to pick up medicines for them or help in other practical ways. Be a good neighbour - you may know of those in your community who are vulnerable or could be made vulnerable due to a pandemic. You can help them by checking if they are all right or need help. If infected with influenza, stay at home, keep warm and drink plenty of fluids. If you have influenza and your symptoms are getting worse, or you have a long-term medical condition, you should contact your GP practice or other health professional for assessment and advice immediately.

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A flu pandemic can strike at any time. It is essential that you are prepared to look after yourself and members of your family.

If you are in a high risk group, ensure that you are vaccinated routinely against seasonal influenza and pneumonia because you are at greater risk of becoming seriously ill.

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During a pandemic

Follow public health advice and consider how you and your family might prepare for disruption to schools or childcare facilities due to staff absence or shortages.

Do your best to minimise the spread of infection by maintaining a hand hygiene routine.

Make sure you have supplies of over-the-counter cold and 'flu medicines and other basic necessities and that you can care for any existing health conditions.

Familiarise yourselves with local arrangements for accessing health and social care support early should you need them, including getting antiviral medicines if needed.

Support friends and family who are ill. They might need you to pick up medicines for them or help in other practical ways. Be a good neighbour - you may know of those in your community who are vulnerable or could be made vulnerable due to a pandemic. You can help them by checking if they are all right or need help. If infected with influenza, stay at home, keep warm and drink plenty of fluids.

If you have influenza and your symptoms are getting worse, or you have a long-term medical condition, you should contact your GP or other health professional for assessment and advice immediately.

14. Key Actions at Each UK Phase

UK Planning Description	UK Phase	Action	Local Lead Responsibility
No cases worldwide ***Priority*** *Robust planning in place*		Increase Awareness and Plan • Maintain up to date Pandemic Plan • Take part in preparedness exercises • Monitor national guidance and implement actions as necessary	Deputy Director of Public Health (Health Protection Lead)
Human cases of new influenza sub-type identified not in the UK. ***Priority*** *Prevent the spread to (and within) the UK*	Detection	Continue to follow national guidance re contributing to preventing spread to UK.	Director of Public Health/ Deputy Director of Public Health (Health Protection Lead)
Person to person spread in several countries but not UK Arrival of new virus in UK is imminent ***Priority*** *Prevent the spread to (and within) the UK*	Detection	National Influenza Pandemic Co-ordination Committee will be established. • Humber LRF will meet • Yorkshire & Humber Pandemic Command, Control and Co-ordination Group (C3) will meet • NELC Pandemic Committee to meet. • NEL Pandemic Response Group to meet	Humber LRF Strategic Co-ordinating Group NELC Pandemic Committee NEL Pandemic Response Group

UK Planning Description	UK Alert Level	Action	Lead Responsibility
Virus has now entered the UK. There are sporadic cases in the country. There are sporadic cases in North East Lincolnshire. ***Priority*** *Surveillance and containment*	Assessment	• Ensure intensive control measures (isolation of case(s), quarantine of contacts in addition to antiviral treatment of cases and prophylaxis for contacts) • Investigate possible reservoirs of infection • Issue guidance on other control measures including travel advice as appropriate • NHS/PHE 'Flu Line' to be established	Strategic Co-ordination Group NELC Pandemic Committee NEL Pandemic Response Group
Sustained community transmission of the virus i.e. cases not linked to known previous cases. ***Priority*** *To provide treatment and care whilst maintaining essential services*	Treatment	• Activate the local Health and Social Care arrangements when necessary • Cancel non-urgent work if necessary • Prioritise social care and clinical workloads as necessary • Implement the antiviral strategy locally • Implement any new national guidance	Strategic Co-ordination Group NELC Pandemic Committee NEL Pandemic Response Group National Pandemic Flu Service
Pandemic established with widespread activity across the UK ***Priority*** *Provide treatment and care whilst maintaining essential services*	Escalation	• As action in box above • Review effectiveness of measures to date and change as necessary • If available implement vaccine administration	Strategic Co-ordination Group NELC Pandemic Committee NEL Pandemic Response Group National Pandemic Flu Service

UK Planning Description	UK Alert Level	Action	Lead Responsibility
End of first wave U.K.		Review response and prepare for re-emergence of a second wave including vaccination if a vaccine is available.	Strategic Co-ordination Group to lead on business continuity and the wider social impacts NELC Pandemic Committee NEL Pandemic Response Group
Subsequent waves		Repeat as per level 1 and 2	Strategic Co-ordination Group to lead on business continuity and the wider social impacts NELC Pandemic Committee NEL Pandemic Response Group
Pandemic over (strain established)	Recovery	Return to normal Review plan Constant surveillance	Strategic Co-ordination Group to lead on business continuity and the wider social impacts NELC Pandemic Committee NEL Pandemic Response Group Recovery Group

15. Epidemiology

An Influenza Pandemic might consist of one or more waves. For planning purposes the national framework considers possible clinical attack rates of up to 50%, the actual attack rate will not be known until the start of the Pandemic. However, other 20th century pandemics had attack rates of less than 25% and the 2009 Pandemic had a 12% attack rate.

Figure 3 shows the likely number of cases, impact on services and additional deaths expected at different attack rates and case fatality rates based on Department of Health plan assumptions. Excess mortality due to Influenza Pandemic is expected to be higher than that due to seasonal influenza in inter-pandemic years (when 12,000 excess deaths are estimated to occur). The impact overall case fatality rates between 0.37% (based on inter-Pandemic and 1957 experience) and 2.5% has been considered. The Department of Health is now considering an attack rate of up to 50% of the UK population.

Average deaths from all causes in the UK are normally around 12,000 per week. In a Pandemic deaths resulting from influenza are likely to gradually rise to 50% higher than normal at the peak of a Pandemic wave and then gradually decline. However, there is the potential, based on the worst case scenario modelled, for as many deaths in 12 weeks of a pandemic as there would be over the course of a whole year. Mortality rates are likely to vary considerably between different age groups. At least a third of the total excess deaths are likely to be in people under 65 years compared with less than 5% in inter-Pandemic years.

Figure 3 – Estimated cumulative burden of illness and death Based on 25%/(50%) attack rate and 0.4% to 2.5% case fatality rate and 2011 census data for populations**.**

Resident Population	Clinical cases	Excess deaths (0.4%)	Excess deaths (2.5%)
North East Lincolnshire 159,800	39,950 (79,900)	160 (320)	999 (1998)

16. Access to Medicines

Antiviral drugs will be used primarily for patient treatment in the absence of, or as an adjunct to, vaccination. They may lessen the severity and duration of illness, reduce the need for antibiotics and lower demand for hospital care by up to 50%. Although stockpiles are intended to provide treatment for all influenza patients who might benefit at a cumulative clinical attack rate of 50%, small amounts may be devoted to controlling or limiting the spread of a pandemic in the initial stage.

Although a pandemic virus is likely to affect some groups more severely than others, it will be impossible to identify them until the virus starts circulating. National decisions on treatment priorities will be taken if consumption threatens to exceed available supplies but plans should assume that antiviral treatment will initially be available for all patients – including non-residents and non-UK nationals – who meet the agreed national influenza case definition and have been symptomatic for less than 48 hours. Supplementary arrangements will be necessary to ensure that patients have 24/7 access to antiviral medicines within the community, to ensure hospitals and GPs are not overwhelmed with milder clinical cases.

Detailed guidance on provisions for access to antiviral and antibiotic medicines are included in Appendix C.

17. Vaccines

A pandemic is caused by a new strain of influenza virus and this by definition will be different to the strains used to produce the seasonal flu vaccines used each year to protect at risk groups and the elderly. A suitable vaccine is unlikely to be available at the start of a Pandemic and development could take 4-6 months.

Assuming a vaccine is available for the second wave of a pandemic, supplies are likely to be limited initially and priorities will have to be determined nationally, depending on the epidemiology of the pandemic. Delivery plans will take account of the priority groups and volume of vaccine and may use primary care route or mass vaccination plans depending on circumstances.

As part of the experience and good practice identified from the 2009 H1N1 Pandemic (Swine Flu) the approach to vaccination planning will include the following elements:

- Establishment of a Vaccination Planning Group to oversee the detailed vaccination planning requirements with oversight and strategic direction from Pandemic Committee
- The Council's Public Health Team will work with suitable providers to ensure systems are in place to offer vaccinations to Health and Social Care staff
- The Council's Public Health Team will work with suitable providers, NHS England Public Health and the Yorkshire & Humber SCG to offer vaccinations to the population, as determined by the Department of Health
- The council will work with suitable providers, NHS England Public Health and the Yorkshire & Humber SCG to offer vaccinations to housebound, homeless/rough sleepers, children and those with special requirements, e.g. egg allergy
- The council will work with suitable providers, NHS England Public Health and the Yorkshire & Humber SCG to offer vaccinations within Special Schools
- Agree process with the provider of the Child Health Department to oversee children vaccination clinic appointments
- Agree storage of vaccinations at a suitable location, for example, through a local pharmacy and Child Health Department

- Agree delivery requirements for vaccinations
- Ensure vaccination delivery points are registered on ImmForm and have 'Movianto' vaccine ordering accounts in place
- Establish workforce training programme plan with all NHS Provider Trust staff (or alternative Provider as appropriate) specific to new pandemic vaccine utilising available materials in conjunction with NHS England Public Health
- Ensure governance arrangements are in place for Cold Chain assurance and Medicine and Healthcare Products Regulatory Agency Compliance
- Establish a clear system and process for data and information management reporting arrangements.

18. Infection Control

As the virus can be acquired from contaminated surfaces via hands good personal and environmental hygiene, including hand washing are important control measures for the general public as well as health workers. In addition to standard universal precautions infection control guidance from the Department of Health and Public Health England recommends the use of surgical masks for health and social care workers that are involved in close patient contact (closer than three feet). FFP3 respirators are recommended for use when carrying out aerosol-generating procedures (these include intubations, nasopharyngeal aspiration, tracheotomy care, chest physiotherapy, bronchoscopy and nebuliser therapy).

The NHS may be requested coordinate the issue facemask supplies across the Health and Social Care sector. In this instance North East Lincolnshire Council will be required to identify arrangements for storage, receipt of supplies, and collection logistics.

	Entry to cohorted area but no patient contact[a]	Close patient contact (<3 feet)	Aerosol generating procedures[b,c]
Hand Hygiene	✓	✓	✓
Gloves	✗[d]	✓[e]	✓
Plastic apron	✗[d]	✓	✗
Gown	✗	✗[f,g]	✓[g]

Surgical mask	✓	✓	✗
FFP 3 respirator	✗	✗	✓
Eye protection	✗	**Risk Assessment**	✓

a. Standard infection control principles apply at all times.
b. Examples of aerosol generating procedures include intubations, nasopharyngeal aspiration, tracheotomy care, chest physiotherapy, bronchoscopy, nebuliser therapy and autopsy of lung tissue.
c. Wherever possible aerosol generating procedures should be performed in side rooms or other closed single-patient areas with minimal staff present.
d. Gloves and apron should be worn during certain cleaning procedures.
e. Gloves should be worn in accordance with standard infection control principles. If glove supplies become limited or pressurised this recommendation may need to be relaxed. Glove use should be prioritised always for contact with blood and body fluids, invasive procedures, and contact with sterile sites.
f. Consider gown in place of apron if extensive soiling of clothing or contact of skin with blood and other body fluids is anticipated (e.g. during intubations or caring for babies).
g. If non-fluid repellent gowns are used a plastic apron should be worn underneath.

19. Humber Local Resilience Forum Co-ordination Arrangements for Pandemic Influenza (System Groups)

If a Pandemic Influenza outbreak is declared the Director of Public Health will represent the Council at the Humber LRF. There are two co-ordination groups within the LRF:

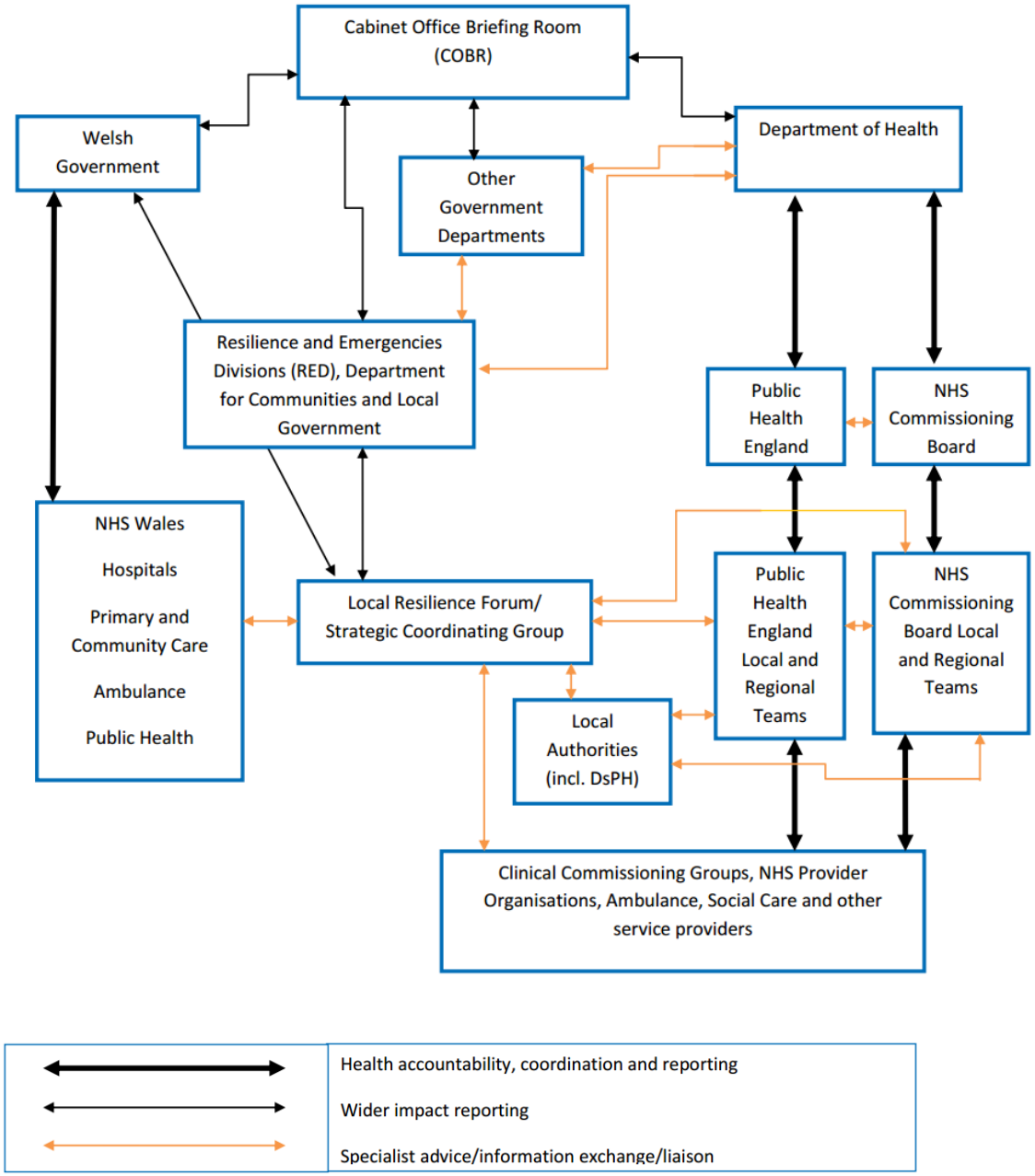
1. The Humber Pandemic Command, Control and Coordination Group (Tactical Group)
There will be one Pandemic Committee for the Humber area. This group will co-ordinate the **Health and Social Care** elements of the pandemic. It will normally be chaired by a Director of Public Health (potentially Lead DPH). The frequency of meetings will be determined according to local infection rates and need and Public Health England will provide technical advice. All key health and social care organisations will have a place at the table. In addition it is expected that each organisation will have its own internal co-ordination group. The Pandemic Committee will begin to meet at UK Detection Phase (person to person spread outside the UK).

2 The Strategic Co-ordination Group (SCG)
This group will be concerned with the issues outside health and social care relating to the **wider society**, e.g. school closures, essential supplies, transport, etc. It will be chaired following Local Resilience Forum (LRF) arrangements and would serve the same geographical area as the LRF. The group will meet less regularly than the Pandemic Committee.

20. Key organisations and relationships in a response

The proposed national structure and its links to local arrangements for coordination and reporting in a flu pandemic is shown in Figure 3.

Figure 3: Central-local reporting and coordination groups in England and Wales[14]



21. Dealing with Deaths

[14] Preparing for Pandemic Influenza: Guidance for Local Planners Page 19, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

The Yorkshire and Humber LRFs and LHRPs Pandemic Influenza Plan details arrangements for dealing with deaths during a Pandemic (See www.humberemergencyplanning.gov.uk). In summary, the normal procedures should be adhered to including death certification. As there is likely to be an excessive number of deaths, crematoriums, funeral directors, etc. may be unable to deal with the increased capacity within the usual timescales.

North East Lincolnshire Council will make arrangements as appropriate with local facilities to maintain cold storage of bodies until safe burial or cremation is possible. The Local Authority plan will include planning assumptions regarding the likely number of deaths over the time period of the outbreak and take into account the capacity of existing mortuary, burial and cremation facilities. The plans also identify any potential gaps that may arise during the response to an influenza pandemic. Local Authority planning for the management of excess deaths includes consultation and liaison with a range of internal and partner organisations. These include:

- Specific Local Authority departments
- Coroner (or Coroner's representative);
- Medico-Legal;
- Registration Births, Marriages, Deaths;
- Executor Services;
- Bereavement Services;
- Partner organisations;
- Private Sector delivering burial cremation services where appropriate;
- Funeral Directors; and
- Faith Groups.

Appendix A – Summary of planning assumptions for pandemic preparedness[15]

A pandemic is most likely to be caused by a new subtype of the Influenza A virus but the plans could be adapted and deployed for scenarios such as an outbreak of another infectious disease, e.g. Ebola, Severe Acute Respiratory Syndrome (SARS), with a different pattern of infectivity.

An influenza pandemic could emerge at anytime, anywhere in the world, including in the UK. It could emerge at any time of the year. Regardless of where or when it emerges, it is likely to reach the UK very quickly. It will not be possible to stop the spread of, or to eradicate, the pandemic influenza virus, either in the country of origin or in the UK, as it will spread too rapidly and too widely.

From arrival in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters of disease are occurring across the country. Initially, pandemic influenza activity in the UK may last for three to five months, depending on the season. There may be subsequent substantial activity weeks or months apart, even after the WHO has declared the pandemic to be over.

Following an influenza pandemic, the new virus is likely to re-emerge as one of a number of seasonal influenza viruses and based on observations of previous pandemics, subsequent winters are likely to see a different level of seasonal flu activity compared to pre-pandemic winters.

Although it is not possible to predict in advance what proportion of the population will become infected with the new virus, previous studies suggest that roughly one half of all people may display symptoms of some kind (ranging from mild to severe).

The transmissibility of the pandemic virus and the proportion of people in which severe symptoms are produced will not be known in advance.

Infectivity and mode of spread

Influenza spreads by droplets of infected respiratory secretions which are produced when an infected person talks, coughs or sneezes. It may also be spread by hand-to-face contact after a person or surface contaminated with infectious droplets has been touched. Spread of the disease may also be possible via fine particles and aerosols but the contribution to spread is, as yet, still unclear with the latest evidence suggesting this mode of transmission may be more important than previously thought.

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

[15] From pages 14-17 of UK Influenza Pandemic Preparedness Strategy 2011.

is likely that members of the population will exhibit a wide spectrum of illness, ranging from minor symptoms to pneumonia and death. Most people will return to normal activity within 7 to 10 days. All ages are likely to be affected but those with certain underlying medical conditions, pregnant women, children and otherwise fit younger adults could be at relatively greater risk as older people may have some residual immunity from previous exposure to a similar virus earlier in their lifetime. The exact pattern will only become apparent as the pandemic progresses.

Responding to an influenza pandemic

The UK will continue to maintain stockpiles and distribution arrangements for antiviral medicines and antibiotics sufficient for a widespread and severe pandemic. Health services should continue to prepare for up to 30% of symptomatic patients requiring assessment and treatment in usual pathways of primary care, assuming the majority of symptomatic cases do not require direct assistance from healthcare professionals. Between 1% and 4% of symptomatic patients will require hospital care, depending on how severe the illness caused by the virus is. There is likely to be increased demand for intensive care services.

For deaths, the analysis remains that up to 2.5% of those with symptoms would die as a result of influenza if no treatment proved effective. These figures might be expected to be reduced by the impact of countermeasures but the effectiveness of such mitigation is not certain. The combination of particularly high attack rates and a severe disease is also relatively (but unquantifiably) improbable. Taking account of this, and the practicality of different levels of response, when planning for excess deaths, local planners should prepare to extend capacity on a precautionary but reasonably practicable basis, and aim to cope with a population mortality rate of up to 210,000 – 315,000 additional deaths nationwide, possibly over as little as a 15 week period and perhaps half of these over three weeks at the height of the outbreak. More extreme circumstances would require the local response to be combined with facilitation or other support at a national level. In a less widespread and lower impact influenza pandemic, the number of additional deaths would be lower.

Staff Absence

Up to 50% of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic, affecting 35-50% of the population, this could be even higher as some with caring responsibilities will need additional time off. Staff absence should follow the pandemic profile. In a widespread and severe pandemic, affecting 50% of the population, between 15% and 20% of staff may be absent on any given day. These levels would be expected to remain similar for one to three weeks and then decline.

Some small organisational units (5 to 15 staff) or small teams within larger organisational units where staff work in close proximity are likely to suffer higher percentages of staff absences. In a widespread and severe pandemic, affecting 50% of the population, 30-35% of staff in small organisations may be absent on any given day. Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, to look after children in the event of schools and nurseries closing, family bereavement, practical difficulties in getting to work and/or other psychosocial impacts.

Appendix B – Typical Standing Agendas for Pandemic Committees

Pandemic Influenza Committee (Internal Group) Standing Agenda

- Update on national picture
- Update on local picture
- Public Health Services
- Adult Services
- Children & Young people Services
- Public Protection
- Transport Services
- Other Services
- Travel Restrictions
- Supplies
- School closures
- Mass gatherings
- Health and safety
- Communications
- Media management
- Key actions
- Next meeting

Pandemic Influenza Response Group (external group) Standing Agenda

- Update on national picture – spread, infection rates
- Update on local picture
- NHS pressures – summary:
- General Practitioners
- Hospitals
- Ambulance
- Community
- Mental Health/Learning Disabilities
- NHS 111
- Dental Practices
- Pharmacies
- Public Health Services
- Adult Services
- Children & Young people Services
- Public Protection
- Transport Services
- Other Services
- Travel Restrictions
- Supplies
- School closures
- Mass gatherings
- Other updates including: Health and safety, Military, Police, Port Health, Port functions, Prisons
- Communications
- Media management
- Key actions
- Next meeting

Appendix C – Access to Antiviral Medicines

Although a Pandemic virus is likely to affect some groups more severely than others, it will be impossible to identify them until the virus starts circulating. National decisions on treatment priorities will be taken if consumption threatens to exceed available supplies but plans should assume that antiviral treatment will initially be available for all patients, including non-residents and other nationals, who meet the agreed national influenza case definition and have been symptomatic for less than 48 hours. Supplementary arrangements will be necessary to ensure that patients have 24 x 7 access to antiviral medicines whilst allowing hospitals and GPs to focus on the greatest clinical need.

The public will access through:

1. Call to the national 'flu line by a 'flu friend.
2. Telephone diagnosis and, if fit the case definition, the caller will be given a unique reference number.
3. 'Flu friend' will attend an antiviral distribution centre with unique ID number and proof of identity/address for patient.

- Pharmacists and other health professionals supplying under a Patient Group Directive (PGD) at antiviral distribution points.
- Antiviral Distribution Centres will be situated in a small number of locations in North East Lincolnshire identified with the commissioned provider of community services (currently Care Plus Group) as part of contract schedule or through Local Authority Asset Team. One centre will be open 24/7.
- In addition some community pharmacists will dispense antivirals within their normal opening hours.
- The Local Authority will identify Antiviral Points in line with national guidance in conjunction with North East Lincolnshire Medicines Management Team (for Pharmacies). Antiviral Collection Points (ACPs) will be notified to the 'Flu Line'.
- Establishment of an ACP Steering Group to oversee the detailed antiviral planning requirements.
- ACP Control Room to oversee day to day business[16].
- Delivery of antivirals to infected members of the public with no 'Flu Friend' through local taxi firm or Local Authority transport.
- Stock of antivirals to be available at Unscheduled Care (Out of Hours) Centres to support 24 hour access.
- Pharmacy distribution for antiviral vouchers or FP10 tokens.
- Pharmacy ACPs in low to medium demand periods.
- PCT ACPs in high demand periods supported by Pharmacy distribution for antiviral vouchers or FP10 tokens.

[16] This is likely to be the Fred Smith Room in the Fishing Heritage Centre which is specially kitted out for providing an emergency response.