

# Leicester, Leicestershire & Rutland

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Local Resilience Forum

## PANDEMIC INFLUENZA – CONTINGENCY PLAN

DEVELOPED BY HEALTH AGENCIES EMERGENCY  
PLANNING GROUP

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**CONTENTS**

INTRODUCTION ..... 3

OWNERSHIP ..... 3

LEGISLATION ..... 4

ACTION MATRIX – CURRENT LEVEL IS PHASE 3 ..... 5

BACKGROUND ..... 11

ACTIVATION ..... 13

COMMAND AND CONTROL ..... 15

COMMUNICATIONS ..... 18

SURVEILLANCE ..... 19

PUBLIC HEALTH RESPONSE ..... 20

HEALTH AND SOCIAL CARE RESPONSE ..... 21

BUSINESS CONTINUITY PLANNING ..... 23

RECOVERY PLANNING ..... 23

TRAINING AND EXERCISING ..... 26

AUDIT AND REVIEW ..... 26

APPENDIX 1 – MEETING MEMBERSHIP ..... 27

APPENDICES TO BE INCLUDED ..... 29

ACTION CARDS ..... 30

## ***Introduction***

This plan outlines the action to be taken to produce a robust local response to an outbreak of pandemic influenza in Leicester, Leicestershire and Rutland (LLR). It is developed by the LLR Pandemic Influenza Planning Executive (PIPE), ultimately accountable to the LLR Local Resilience Forum (LRF). The particular focus of this plan is on the healthcare response, which will inform the pandemic influenza plans from other agencies in LLR.

In making this response, the LRF will contribute to the national aims of:

- Ensure clear leadership
- Reducing illness and saving lives
- Identifying pandemic flu and monitoring its spread and impact, to inform actions
- Containing the spread of infection to the extent that this is possible
- Creating the organisational arrangements for an effective response

This plan is a live document, and will be amended as new guidance leads to amendments in plans of partner organisations or the community as a whole

## **Objectives**

This document identifies workstreams for organisations in maintaining and developing their readiness for a pandemic. By the nature of the threat, the plans of these organisations will be constantly developing. They are:

- Developing effective internal and external communications
- Developing data systems for the monitoring of a pandemic
- Good infection control
- Interpandemic vaccination campaigns and pandemic flu vaccination when possible
- Resilience in Primary and Secondary Care
- Distribution and application of clinical guidelines, including the use of antivirals
- Flexible use of workforce in all organisation
- Business continuity planning

## **Ownership**

This plan is owned and maintained by the Health Agencies Emergency Planning Group, one of the Local Resilience Forum groups for Leicester, Leicestershire and Rutland. Each organisation that forms part of the LRF is responsible for developing and maintaining their own service and sector specific plans

## ***Legislation***

There is no specific legislation relating to this contingency plan. However, where relevant, Public Health powers in the UK are provided by the Public Health (Control of Disease) Act 1984. Powers to direct the exercise of functions are contained in the National Health Service Act 1977

**Action matrix – Current level is Phase 3**

Objective	Phase 1 / 2  (Risk of human cases)	Phase 3  (No or limited human to human transmission)	Phase 4  (Increased human to human transmission)	Phase 5  (Significant human to human transmission)	Phase 6 – UK Phase 1  (Sustained human to human transmission – outside the UK only)	Phase 6 – UK Phase 2  (Sustained human to human transmission – isolated cases in the UK)	Phase 6 – UK Phase 3+  (Sustained human to human transmission – outbreaks / widespread activity in the UK)
<b>Command and Control framework</b>	Develop framework	Communicate framework to partners	Test communications for activation	Initial meeting at Gold	Initial meeting at Gold – regular meeting at Silver	Meet at Gold Level – regular meeting at Silver	Full activation – Gold meets 2 – 3 times per week, Silver daily

<b>External Communications</b>		Develop Comms framework	Test communications for activation	Regular contact within group and with media. National outputs to include public information film, national door drop, and advertising campaign	Activate Comms hub. National outputs to include Video News Release to camera, TV / Press / Radio advertising campaign. Others to include travel advice, treatment advise leaflet, antivirals leaflet and information via Teletext / internet		
<b>Internal Communications</b>		Raise staff awareness of pandemic flu		Weekly briefings for staff	Increased frequency of briefings	Initiate daily contact between organisations and teams	
<b>Surveillance systems</b>		Ensure arrangements in place to identify, report and manage any novel influenza virus					End of specific surveillance stage – move to cohort surveillance

<b>Capacity &amp; demand monitoring</b>		Develop requirements of monitoring	Testing of framework in sample practices	Confirm functionality of system across community	Enhanced daily reporting on capacity and demand introduced		
<b>Social distancing</b>		Develop plans for dealing with consequences of closures	Check, refine and prepare to activate plans		Activate plans as required in response to situation		
<b>Infection Control guidelines</b>		Ensure current version of guidelines available to all staff		Reconfirm guidelines		BMA GPC Guidelines come into force	
<b>Mass vaccination plans</b>		Develop plans for setting up mass treatment / vaccination centres			Prepare to set up centres if vaccine available		

<b>Interpandemic influenza vaccinations</b>		Annual influenza vaccination campaigns implemented and reviewed			Consider withdrawal of routine vaccination – on HPA advice		
<b>Primary Care resilience</b>		Develop systems for buddying / clustering of GP Practices		GPs to ensure vulnerable patients identified		Cancel non-essential services	
<b>Out –of Hours services resilience</b>		Ensure all providers of out of hours services work together to ensure resilience					
<b>Secondary Care resilience</b>		Prepare and distribute Acute Trust resilience plan		Confirm admission avoidance plans			Activate plan

<b>Use of clinical Guidelines</b>		Ensure current version of guidelines available to all staff		Confirm guidelines are in place and clinicians awareness raised		BTS / HPA guidelines come into operation	
<b>Antiviral Medication systems</b>		Develop systems for storage and distribution of antivirals	Prepare to receive AV supply		Receive and distribute AV supply as required	Commence supply and administration of Antivirals	
<b>Caring for people at home</b>		Develop systems for supporting people in their homes	Commence identification of vulnerable groups				
<b>Planning for higher number of deaths</b>		LRF Capability group to develop plan			Activate plans to avoid backlog in systems		Activate full plan
<b>Supporting closed communities</b>		Work with communities to develop plans for dealing with pandemic		Organisations to confirm with communities on preparedness			

<b>Supporting clinical services by use of additional skills</b>		Skills audits within organisations	Review audit results – identify staff for redeployment			Commence redeployment of staff	
<b>Business continuity planning</b>		Promote the development of BCP within organisations	Organisations to review and reconfirm Business Continuity plans			Activate business continuity plans	
<b>Recovery planning</b>		Identify systems for recovery following a pandemic			Initiate group for recovery planning		

## ***Background***

Influenza pandemics have occurred at irregular intervals throughout history, three in the last century: in 1918 ('Spanish flu'), 1957 ('Asian' flu) and 1968 ('Hong Kong' flu). Each of these events was associated with illness, deaths and general societal disruption far in excess of that experienced in a 'normal' winter. The 1918/19 pandemic, for instance, is estimated to have caused over 20 million deaths worldwide with 200,000 deaths in the UK. However, recent studies from Africa and Asia suggest that the number of victims worldwide might have been closer to 50-100 million. A further pandemic is thought to be inevitable. There may not be much warning and therefore advanced planning is essential for a smooth response.

The outbreaks or epidemics of influenza, which occur most winters, affect some 5 to 10% of the population. The vast majority will have an unpleasant but self-limiting illness or even no symptoms, with less than 0.05% consulting their GP. Those most at risk of serious illness or death (the elderly, and those with chronic underlying diseases) are offered annual vaccination. Death from flu is usually due to complications such as secondary bacterial infections, e.g. pneumonia, or exacerbation of an underlying disease, rather than the direct effects of the influenza virus itself. An influenza pandemic arises when an entirely new strain of influenza virus emerges to which most people are susceptible. Thus it is able to spread widely. Some important features of influenza pandemics are:

- They are unpredictable;
- They may occur at any time of year;
- They are most likely to start in Asia, or at least outside the UK, and gradually spread;
- Some 20 to 30% of the population or even more may be affected over a 1-2 year period, including children and normally fit young adults;
- A far greater proportion of people are likely to require hospitalization or die than is usually experienced with seasonal flu.

The World Health Organisation (WHO) monitors influenza across the world. Once a new influenza virus has been identified and shown to have pandemic potential, the WHO will announce the various phases of a pandemic and inform national Governments. The UK Government will then put its own plans into action through the Department of Health, supported by the Health Protection Agency. This will include guidance and advice from Health Departments and/or the Health Protection Agency for the public and for planners across all sectors.

History shows that each influenza pandemic is different. We cannot confidently predict what the impact of the next pandemic will be. Much will depend on the characteristics of the virus, such as its clinical attack rate, the severity of the illness it causes and the resulting case fatality rate. These parameters will not be known until the pandemic virus emerges.

For planning purposes, the **base scenario** is for:

- A cumulative clinical attack rate of 25% of the population over one or more waves, each of around 15 weeks duration, weeks or months apart. The second wave may be the more severe. This compares with a usual seasonal influenza attack rate of 5-10%.
- A case fatality rate of 0.37% (analogous to the 1957 pandemic).

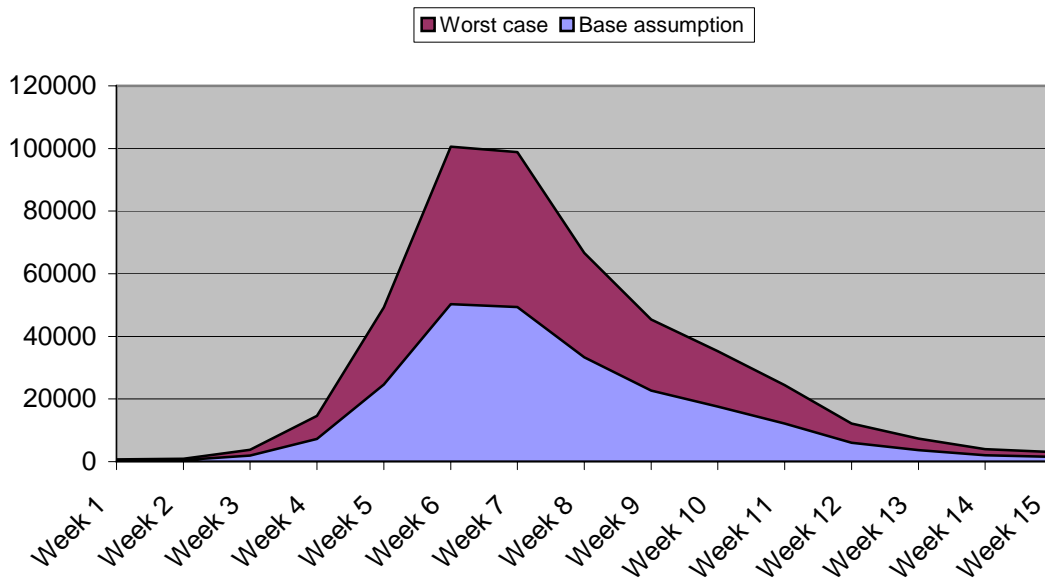
This combination would give rise to an estimated 53,700 excess deaths in the UK across the whole period of the pandemic, spread across one or more waves, compared with 12,000 excess deaths per year from seasonal flu. For Leicester, Leicestershire and Rutland this implies 925 excess deaths and 1,400 additional hospitalisations

For planning purposes, the **reasonable worst-case scenario** is for:

- A cumulative clinical attack rate of 50% of the population, again spread over one or more waves.
- A case fatality rate of 2.5% (analogous to the 1918 pandemic).

Therefore, the range of contingencies to prepare for is shown below:

### Pandemic flu cases for LLR



**Table 1 – Profile of number of new cases per week**

This combination would give rise to an estimated 709,300 excess deaths in the UK across the whole period of the pandemic, spread across one or more waves. For Leicester, Leicestershire and Rutland this implies 11,700 excess deaths. The variation in scale of mortality will mean that existing mortuary and funeral director facilities may become overloaded and unable to cope. Arrangements for mass fatalities and associated problems are the responsibility of the LRF Mass Fatalities group, whose plans is in development.

For GP practices with a range of sizes, the implications are:

Size of practice	Base Assumption		Worst Case Scenario	
	<i>Number of cases per week at peak</i>	<i>Number of deaths per week at peak</i>	<i>Number of cases per week at peak</i>	<i>Number of deaths per week at peak</i>
<b>5,000</b>	270	1	540	14
<b>10,000</b>	540	2	1080	28
<b>15,000</b>	810	3	1620	42

## **Activation**

The World Health Organisation would undertake monitoring of outbreaks of a potential pandemic virus. As information becomes available, the Department of Health will provide a UK alert level.

	<b>Planning phase</b>	<b>Response phase</b>
<b>Description of UK Alert Level</b>	0 – No cases anywhere in the world 1 – Cases only outside UK	2 – New virus isolated in UK 3 - Outbreak(s) in UK 4 – Widespread activity across UK

**Figure 1 - UK Alert levels**

The Department of Health will advise the Cabinet Office of a change in the alert level. This information will be communicated to national NHS Services via the Health Protection Agency and the Strategic Health Authorities. As the information is received by the lead PCT, they will inform the LRF co-ordinator for communication to LRF partners.

## **Roles and responsibilities**

During an influenza pandemic, the Government's overall aim will be to encourage people to carry on as normal, as far as possible, if they are well, while taking additional precautions to protect themselves from infection and to lessen the risk of spread to others.

The main objectives of the Government's response to an influenza pandemic will be to:

- Limit illness and death arising from infection.
- Provide treatment and care for those who become ill.
- Minimise disruption to health and other essential services.
- Maintain business continuity as far as possible.
- Reduce as far as possible disruption to society.

**Primary Care Trusts (PCTs)** are responsible for developing, supporting and monitoring NHS and public health response arrangements at the local level and for involving and mobilising general practice and primary care resources.

PCTs must also co-ordinate their plans with neighbours; ensure that key non-health partner organisations - including those in the private sector - are involved. They must develop protocols for sustaining patients in the community and make contingency arrangements for mass vaccination or the distribution of antiviral drugs should that be necessary. In the event of a major epidemic of influenza, primary care services will bear the brunt of the burden of illness in the community, in part because staff will be as likely to be victims of the flu as their patients but chiefly because the majority of sick patients will be nursed in the community, putting extra pressure on reduced resources. **Leicester City PCT** as lead NHS organisation for Emergency Planning will lead the co-ordination of the NHS response to the pandemic.

In the acute sector, **University Hospitals of Leicester (UHL)** will continue to provide the inpatient beds for admission of patients who are unable to be cared for in their own homes or in Primary Care. It will also endeavour to maintain services for non-flu patients who will require hospital care during the pandemic period. To support this, UHL will consider the creation of an isolation hospital at one of their sites. Planning and response includes a requirement for significant surge capacity, increased demand for specialist beds, staff protection and redeployment, and strict infection control.

**Leicestershire Partnership Trust (LPT)** will continue to provide services for patients with enduring mental illness who require specialist mental health services. It will endeavour to treat/care for those patients already inpatients or residing in small group homes who develop influenza. LPT will provide support/ advice to UHL as required for LPT patients who are admitted to acute wards with severe flu symptoms and likewise to PCTs in the event that specialist support is required for a patient in the community.

**East Midlands Ambulance Service (EMAS)** will continue to provide emergency response to both flu and non-flu patients. Demand on Ambulance services is likely to increase significantly in a pandemic. There will be a need to support timely admission, transfer and discharge, as well as supporting the delivery of home care to influenza sufferers.

**Leicestershire Police** will support health services if needed, particularly if public order issues arise around the distribution of antiviral medication. Response plans will anticipate logistical and operational support for health services and manage civil disorder. Any request for police support will be in the context of reduced police availability through illness and the need to service similar requests for support from other sectors

The **Health Protection Agency (HPA)** will have a central role in planning and response to a pandemic. The Local and Regional Services Division (LaRS) will discharge the HPA's responsibilities at local and regional levels by supporting local and regional emergency planning arrangements. This will include working with PCTs, SHAs And Government Offices regarding pandemic planning; reviewing the availability of appropriate laboratory containment facilities; reviewing local diagnostic capacity; communicating with professional colleagues in primary care and acute trusts; assisting with

coordination of control measures including use of antivirals and vaccine; gathering local epidemiological information.

**Local Authorities** have specific civil protection duties and responsibilities under the Civil Contingencies Act 2004 and are directly responsible for the provision of a wide range of functions that will be essential to respond to the health and wider impacts of an influenza pandemic. They also exercise a crucial community leadership role, and those councils with social services responsibilities bear responsibility for planning and preparing to maintain that care in a pandemic scenario.

The **Voluntary Agencies** can provide a wide range of operational skills and services to support and ease the pressure on statutory responders. They can offer particular expertise and experience. Helping to provide social support to maintain sufferers in a community setting or assisting those suffering stress, anxiety and grief are examples where voluntary support will be invaluable. They would support the statutory services either by expanding or suspending current services, as required, to provide support where necessary. This is mindful of the impact that an influenza pandemic would have on volunteers and staff. The focus of work with the voluntary sector is to enable them to maintain their current arrangements in support of health, social care and community groups, rather than a greater level of support than is currently provided. This may include mutual aid agreements between voluntary sector organisations.

Many **private sector** organisations are responsible for providing supplies and healthcare services that are critical to the response to an influenza pandemic and efforts to minimise its social and economic effects. Planning to ensure the maintenance of those supplies and services as far as that is possible is an essential part of developing effective response arrangements. In LLR, BUPA and Nuffield Hospitals will be included in the response to a pandemic

Well prepared and informed communities and **community leaders** can play a major role in supporting the response to and recovery from an influenza pandemic. Community networks can be particularly effective in such areas as disseminating information, providing reassurance, identifying/supporting those who are particularly at risk and will be fully involved in developing response plans

### ***Command and Control***

Effective command and control will be maintained by clear leadership and appropriate representation at a range of fora, as described in the regional Concept of Operations.

### **Strategic Co-ordinating Group**

This will meet as required through the outbreak, and will be based at Leicestershire Police HQ. It will, in the initial stages of a pandemic, be chaired by the lead PCT Chief Executive, but this will change as the circumstances

change. Health will be additionally represented by a Director of Public Health (DPH), a Consultant in Communicable Disease Control (CCDC) from the HPA, and a communications lead.

### **LLR Health Group**

This group is likely to meet frequently though a pandemic. It would cover LLR, and be chaired in the first instance by the lead PCT Chief Executive (or their deputy). It would include senior representatives from Public Health, both PCTs, UHL and LPT, as well as EMAS, City and County Social Services and the HPA. Additionally, representation would be sought from the voluntary agencies, Metal Health Secure hospital (Arnold Lodge) and local private health care providers (BUPA / Nuffield).

Its role would be to provide advice to the lead PCT Chief Executive for representation at SCG, and for input to and communicate with the Regional NHS Co-ordination Group, and to link with the Multi-Agency Silver group. Its role is to ensure a co-ordinated and mutually supportive NHS response locally, and to interpret national and regional guidance into local action, particularly around public health issues and advice from the Regional Health Advisory Team (RHAT). The group would meet at Conference Room 2, Lakeside House, Grove Park (County PCT HQ).

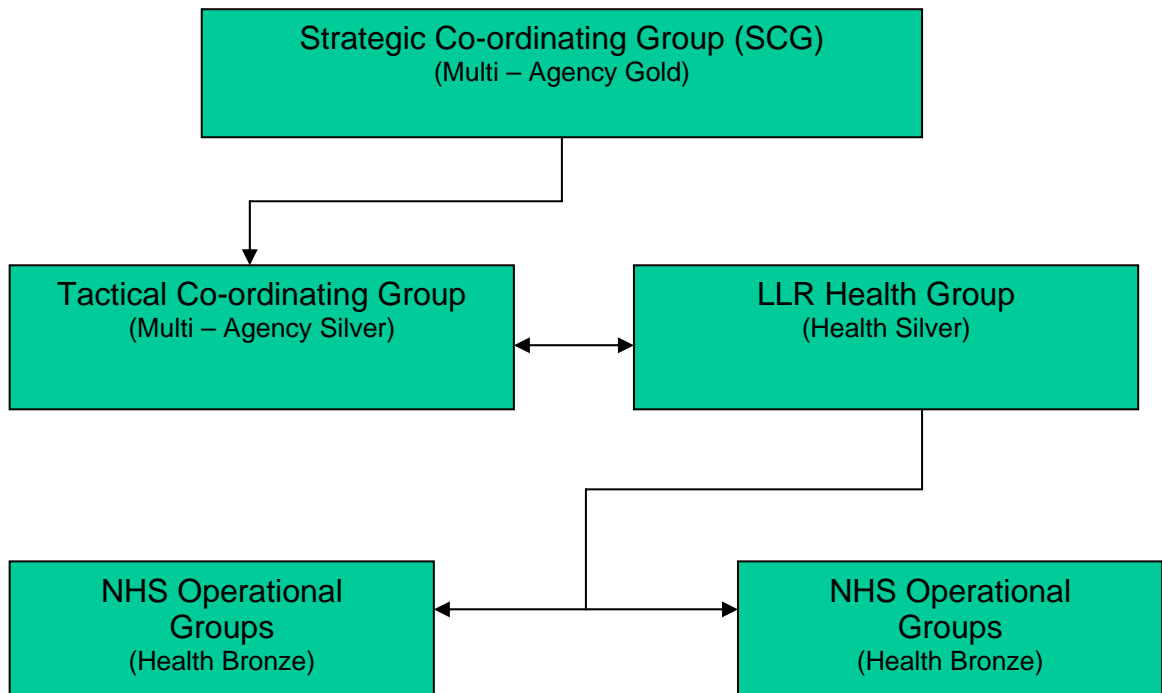
### **Tactical Co-ordinating Group (Multi-Agency Silver)**

The Multi Agency Silver will meet regularly as the main forum for multi-agency communication and co-operation. It will be based at Leicestershire Police HQ and chaired by Leicestershire Police in the first instance. Health will be represented by Public Health, an operational lead from Primary Care, UHL and EMAS. Its purpose is to ensure a co-ordinated and mutually supportive multi-agency response locally, and to interpret national and regional guidance into local action, and to support and inform the Gold group decision-making.

### **Trust Operational Groups**

Each organisation will have arrangements for their own local control rooms, which will remain in contact with the LLR Health Group. This communication channel will provide the health group with information on operational response, and the Health Group will provide information and guidance that comes from the local SCG. These groups will be responsible for continuity of business in their organisations throughout the pandemic. Membership will include operational managers

Reporting lines are as shown below.



## **Communications**

Internal communications in an incident are essential in enabling an organisation to respond effectively. Clear, pre-arranged communications channels should be identified as part of preparing for an emergency.

Good public communication is vital to the successful handling of any incident, and should be incorporated into all contingency planning. When the pandemic occurs, the key communications objective will be to deliver accurate, clear, timely information and advice to the public so they feel confident, safe and well informed.

### **Communications from Central Government**

During a pandemic, the Government (through the Civil Contingencies Committee (CCC), supported as necessary by Regional Civil Contingencies Committee (RCCC)) will issue firm advice on the full range of response policies that should be adopted to achieve the objectives set out above, based on its understanding (including through the use of scientific modelling) of the nature of the pandemic virus and its likely impacts. This advice will be communicated to the Leicester, Leicestershire and Rutland Strategic Co-ordinating Group (SCG) as local "Gold", and then on to all the LRF partner agencies. This process is described fully in the Concept of Operations.

The overall objectives of the communications strategy are to:

- Provide accurate, consistent and timely advice and balanced messages to instil confidence that the government and health services are responding effectively
- Develop and maintain strong local communications plans that are consistent with national messages and can be rapidly activated to disseminate timely and co-ordinated messages and current information to healthcare professionals, NHS organisations, local partners, the media and the public within the PCTs area.
- Deliver clear and consistent instructions to the public regarding the steps they should take to protect their health
- Provide specific advice, information and reassurance to those groups within the population that are contraindicated
- Offer timely, consistent and clear information, specialist advice from the CMO and the HPA also support to healthcare providers and other key stakeholders.

### **Communications across the area**

The Communications leads of the Strategic Health Authorities in the East Midlands have developed the communications strategy for managing communications with the public both before and during a pandemic.

## ***Surveillance***

### **Introduction**

Surveillance has been defined as "an ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practices", and not merely collection of data<sup>1</sup>. Thus, a timely, representative and efficient surveillance system is the cornerstone of control of epidemic-prone communicable diseases such as influenza

### **Management in commencement of pandemic**

The Health Protection Agency (HPA) will be responsible for the surveillance of the outbreak. This will consist of ensuring a heightened awareness of early cases, and monitoring the development of the epidemic curve. They will advise the agencies of data requirements. All agencies will develop data collection systems based upon existing winter pressure planning arrangements. Data on the progress of the pandemic will be collected via the QFLU system operated by the HPA and University of Nottingham.

Capacity and demand in the acute sector will be monitored by use of an expanded SITREP system

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<sup>1</sup> Flahault A, Dias-Ferrao V, Chaberty P, Esteves K, Valleron AJ, Lavanchy D. Flu Net as a tool for global monitoring of influenza on the Web. JAMA 1998; 280: 1330-2.

## ***Public Health response***

### **Introduction**

In achieving the national aim of reducing the impact of a pandemic, the existence of effective public health measures will need to be in place well in advance of a pandemic being declared

### **Infection Control**

Spread of the influenza virus can only be limited by the institution of effective infection control both before and during a pandemic. National guidance from the HPA has been provided<sup>2</sup>, which gives an overall picture of best practice. PCTs have worked with GP practices and other health care settings for which they are responsible to ensure adequate preparation for infection control practice in line with this guidance. The HPA have developed a range of guidance documents that identify infection control needs for a range of sectors, including Social Care and Police. As and when infection control advice becomes updated it will be circulated to all partner organisations for distribution

### **Vaccination**

PCTs recognise the importance of 'flu vaccination in at risk groups as a way of preventing the development of a novel virus.

Vaccines against the pandemic virus would not be available until at least 4-6 months after a pandemic had struck, which could be well after the first wave of illness in the UK. The Department of Health is intending to order sufficient vaccines for the whole population. But, even after vaccines start to become available, the total order is unlikely to be completed for several months. Final advice on prioritisation of vaccines will be issued during a pandemic when the characteristics and impacts of the pandemic virus are known. Whether to prioritise essential workers as the vaccines become available is under consideration, but decisions on prioritisation would need to take into account the practicalities of such a policy and the relative benefits provided. Further advice on policy in this area will be provided from the Cabinet Office. In the meantime, the action point for business continuity planning is that all sectors will need to plan to cope without vaccines in at least the first wave of the pandemic.

The vaccination of the public will be undertaken using the plans developed by the Mass Vaccinations and Treatment Group of the LRF

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<sup>2</sup> <http://www.dh.gov.uk/assetRoot/04/12/17/54/04121754.pdf> , published October 2005

## ***Health and Social Care response***

### **Introduction**

To ensure effective response to extraordinary circumstances, where an increased demand for health care is accompanied by reduced capacity in terms of workforce, the health system will need to be as de-centralised as possible. This will ensure that Primary Care services remain in operation as long as possible, and that Secondary Care services are used as effectively and appropriately as possible. This will take the form of managing demand by reducing non-essential work, and supporting Out-of-Hours services by working to extend the “in-hours” services to weekend daytime.

### **Antiviral drugs**

The main focus of the clinical management plan for patients with Influenza is that they receive antiviral drugs within 48 hours of the onset of symptoms. The Department of Health has ordered sufficient antiviral drugs to treat 25% of population, in line with the planning assumption that 25% of the population will become ill. These drugs will be the only major medical countermeasure available in the absence of a specific vaccine. Used for treatment only, they need to be taken as early as possible after symptoms first start, and within 48 hours of onset. Based on evidence from seasonal flu, treatment with antiviral drugs is expected *to shorten the duration of illness by one day*, and to reduce complications and hospitalisations. *They do not provide a cure*. Those taking them may still be ill for around one week or more, and consequently absent from work.

### **Resilience of Primary Care**

The organisation of Primary Care Services in a pandemic will be to where possible promote self-care for people in their own homes. Prior to a pandemic being declared, GPs and other primary care professionals are preparing by forming clusters of practices, developing between themselves plans of how services will be maintained throughout the pandemic phase. These plans include maintaining continuity of services when sickness and absence levels may cause the closure of smaller practices. The mechanisms and triggers for this are to be agreed across LLR, and will take the form of responding to the stage of the epidemic, rather than its impact.

Guidance has been developed for clinicians for preparing for pandemic at both the cluster level and practice level.

## **Clinical Guidelines**

The HPA, with the British Thoracic Society and the British Infection Society, have developed a set of clinical guidelines for the management of patients with influenza like illness during a pandemic.<sup>3</sup> These guidelines will form the basis of medical response to a pandemic, and will be circulated to health professionals as they become updated. The current version (Version 10.5) was distributed on the 29<sup>th</sup> March.

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<sup>3</sup> Department of Health 2005  
<http://www.dh.gov.uk/assetRoot/04/12/17/55/04121755.pdf>

## ***Business Continuity Planning***

Under the Civil Contingencies Act 2004, all Category 1 responders have a responsibility for

- Risk assessment
- Business Continuity Management
- Emergency Planning; and
- Maintaining public awareness and arrangements to warn, inform and advise the public

They also have a duty to co-operate in this process, and share information with partners. With Local Authorities, this extends to providing advice and assistance in business continuity planning to the local business community and voluntary agencies. These plans should support organisations in maintaining normal business in extraordinary circumstances.

Category 2 organisations are also expected to take part in civil protection at a local level, and should be engaged by Category 1 organisations when they have value to add to planning

## ***Recovery Planning***

Part of emergency preparedness is the capacity for recovery. Component parts of recovery are:

- Social impacts – disruption to daily life, utilities, public order
- Health impacts – deaths, physical and psychological impacts
- Economic impacts – businesses, infrastructure and local economy
- Environmental impacts – waste and pollution, built environment

Each organisation will have to participate in the overall recovery programme. It will be the responsibility of the LLR Health group to identify process for this (for the NHS) while the response is underway. Other sectors will undertake similar reviews.

There are two possible planning assumptions for after a pandemic phase; that there either will, or will not be a subsequent wave. In the case of the former, local plans will be revised to take into account lessons learned in the first phase, as well as revisions to national guidance and available countermeasures, including a specific vaccine.

In the event of no imminent threat of a further wave, the recovery phase will come into action. Specific plans will be required to deal with issues that have arisen. The objective will be to return services to a pre-pandemic level of function as soon as possible. The speed at which this can be achieved will be determined by a number of factors, including the residual impact of the pandemic, staff and organisational absence and fatigue and interruptions to supply chains.

Residual and dormant demand in Health and Social Care services will include the backlog of work postponed during a pandemic, and the specific health issues as a result of the pandemic, such as post-viral encephalitis. An assessment will need to be made of any impact on commissioned services.

Similar impacts will occur in all organisations, including both financial and non-financial loss.

NOT PROTECTIVELY MARKED

### ***Training and Exercising***

The plan will be exercised in total annually, with communications sections of the plan exercised six monthly.

### ***Audit and Review***

The plan will be available for audit by appropriate agencies. It will be reviewed annually, or more frequently as a result of changes to national guidance or planning arrangements. Appropriate sections of the plan will be amended following exercises. When the first phase of a pandemic has ended, the LLR 'Flu lead will lead a complete review of the plan.

## ***Appendix 1 – Meeting membership***

### **Strategic Co-ordinating Group**

- LC PCT Chief Executive (Chair)
- DPH LC PCT
- UHL
- CCDC HPA
- LRF co-ordinator
- Leicester City Council
- Leicestershire County Council
- Rutland County Council
- District Council Rep
- Leicestershire Police
- Leicestershire FRS
- EMAS
- Military
- Voluntary Sector (BRC)
- Prisons

### **Tactical Co-ordinating Group**

- Leicestershire Police
- Leicestershire Fire and Rescue Service
- EMAS
- NHS representation decided by County Health Group
- 7 District Council
- 3 Unitary Authorities
- Military Liaison
- Environment Agency
- Voluntary Sector (BRC)

### **County Health Group**

- LC PCT Exec level, nominated by Gold (Chair)
- PCT Emergency Planning co-ordinator
- Public Health LC PCT
- Public Health LCR PCT
- Provider arm LC PCT
- Provider arm LCR PCT
- University Hospitals of Leicester NHS Trust
- HPA CCDC
- EMAS
- Leicestershire Partnership Trust
- Leicestershire CC Social Services
- Leicester CC Social Services
- Rutland CC Social Services
- Prison Health

- BUPA / Nuffield Hospitals
- East Midlands Centre for Forensic Mental Health, Arnold Lodge
- Local Resilience Forum

***Appendices to be included***

Regional CONOPS (in final draft)

Communications Strategy for the NHS in the East Midlands

## ***Action Cards***

### **Chair of LLR Health Group (From lead PCT)**

- Convene meeting of Emergency Planning leads and Public Health from City and County PCTs, UHL, LPT, as well as representation from the HPA, EMAS, and Local Authority Social Services Departments
- Attend and feedback local NHS situation to LLR Multi-Agency Gold
- Identify individuals to perform roles described below:
  - Collate situation reports from these organisations to develop an overall picture for LLR, in terms of NHS capacity, sickness and absence levels and resource issues
  - Receive, where available, information and advice from the Regional Health Advice Team
  - Provide information as requested for the Regional NHS Co-ordinating Group
  - Attend and feedback Multi-Agency Silver meetings
- Set frequency of meetings of this group, dependant upon situation

## **Director of Public Health**

- Attend LLR Health Group as Public Health representation
- Attend Multi-Agency Gold as LLR Public Health advisor
- Participate in Teleconference for Regional HAT

## **Emergency Planning Co-ordinator**

- Confirm with other NHS organisations the setting up of incident rooms if required, confirming contact details with each organisation
- Maintain updated contact details across multi-agency groups
- Support PCT Chief Executive at Multi Agency Gold
- Provide support to chair of LLR Health Group, advising on multi-agency co-operation
- Attend Multi-Agency Silver with nominated representatives from LLR Health Group