

Pandemic Influenza Framework

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Version 7.0

London Resilience Partnership Pandemic Influenza Framework

Version 7.0 (May 2018)

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LONDON RESILIENCE GROUP

The London Resilience Group is jointly funded and governed by the Greater London Authority, London Local Authorities and the London Fire Commissioner. We are hosted by the London Fire Brigade. Our work, and that of the London Resilience Partnership, is overseen by the London Resilience Forum.

Version Control		
Version	Date	Change (owner)
1.0	May 2006	Approved by London Regional Resilience Forum
2.0	2007	Updated to reflect changes in command and control arrangements and updated guidance and planning assumptions
3.0	2007	Took into consideration further guidance issued by the Department of Health and Cabinet Office
4.0	March 2009	Incorporated recommendations following a national review of multi agency planning and was utilised in the 2009/10 pandemic
5.0	July 2012	Approved by London Resilience Forum
6.0	February 2014	Approved by London Resilience Forum following review.
7.0	May 2018	Amendments made by the Pandemic Flu Working Group, in part in response to Partnership consultation undertaken in May/June 2018 and review by the London Resilience Programme Board. This version was approved by the London Resilience Forum in June 2018.

Critical Information

Introduction	<p>This Framework has been designed for use by the London Resilience Partnership to enable a common understanding of the planning required to respond to an influenza pandemic in London. It aims to use existing plans and systems where possible and these have been duly signposted.</p> <p>Specific plans for Public Health England and the NHS are being developed to meet the health requirements of a pandemic response but all agencies should ensure that their business continuity plans can be scaled to meet the planning assumptions outlined in this Framework.</p>
Principles	<p>Given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles underpin pandemic preparedness and response activity:</p> <ol style="list-style-type: none"> 1. 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. 2. 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. 3. 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.
Further reading – key documents	<p>https://www.gov.uk/pandemic-flu https://www.gov.uk/pandemic-flu#workplacebusiness-guidance</p>

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1 Introduction

Aim of this document

- 1.1 The aim of this document is to provide the agencies that make up the London Resilience Partnership with a strategic framework to support their integrated preparedness and response to pandemic influenza. Planners should additionally read the further national guidance available at: <https://www.gov.uk/pandemic-flu>

Objectives of this document

- 1.2 To summarise and collate the key plans and procedures which would be activated in the event of an outbreak of pandemic influenza.
- 1.3 To ensure understanding within the London Resilience Partnership of a London-wide pandemic response.
- 1.4 To outline roles and responsibilities of partner agencies.

Security Classification

- 1.5 None. Public facing document.

Queries

- 1.6 For any comments or queries concerning this document, please contact the London Resilience Group (LRG): londonresilience@london-fire.gov.uk.

2 Background

- 2.1 Influenza is an acute infectious viral illness that spreads rapidly from person to person when in close contact
- 2.2 A future pandemic could occur at any time and originate anywhere in the world.
- 2.3 A pandemic may occur over one or more waves, each of around 15 weeks, some weeks or months apart. The second or a subsequent wave could be more severe than the first.
- 2.4 An influenza pandemic occurs when a novel influenza virus emerges against which the human population has little or no immunity; global spread is thus considered inevitable.
- 2.5 The incubation period ranges from one to four days (typically two to three).
- 2.6 Adults are typically 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.
- 2.7 All ages are likely to be affected, but those with certain underlying medical conditions, pregnant women, children and otherwise fit younger adults could be at relatively greater risk. The exact pattern will only become apparent as the pandemic progresses.
- 2.8 As most people will have no immunity to the pandemic virus, infection and illness rates may be higher than during seasonal influenza epidemics.
- 2.9 The national planning assumptions in the [UK Pandemic Influenza Preparedness Strategy](#) 2011 identify a reasonable worst case scenario (RWC) which indicates that there could be a cumulative clinical attack rate of 50% of the population, with the possibility of all cases occurring in a single wave. Up to 4% of those who are symptomatic may require hospital admission and up to 2.5% of those who are symptomatic may die.
- 2.10 The actual clinical attack rate of the virus will only become evident as person-to-person transmission develops however this number is likely to be higher in closed communities such as prisons, residential homes and boarding schools.
- 2.11 A range of pharmaceutical (antivirals, vaccines, other medicines) and non-pharmaceutical (personal protective equipment, hygiene measures, social distancing) interventions are available. Vaccines are unlikely to be available for the first four to six months of a pandemic, and therefore the other interventions are particularly key for the first wave.
- 2.12 In addition to their potential to cause serious harm to human health, pandemics can cause wider societal and economic damage and disruption. Social disruption may be greatest when rates of absenteeism impair essential services.

3 Planning Assumptions

- 3.1 [Preparing for Pandemic Influenza – Guidance for Local Planners \(2013\)](#) lays out key planning assumptions. There are a number of issues raised within the assumptions which planners should note.
- The use of common assumptions across the resilience partnership is important to avoid confusion and facilitate an integrated approach to preparation. However, one of the main challenges faced by those planning for an influenza pandemic is that the nature and impact of the virus cannot be known until it emerges and has affected a significant number of people
 - All impact predictions are therefore estimates – not forecasts – made to manage the risks of a pandemic. The actual impact may be very different.
 - Response arrangements must be flexible and able to deal with a range of possibilities and adaptable for a wide range of scenarios, not just the “reasonable worst case” detailed in the [UK Pandemic Influenza Preparedness Strategy](#) 2011 and National Resilience Planning Assumptions
- 3.2 Planners should not assume that the 2009/10 pandemic is representative of future influenza pandemics. A more virulent strain of influenza virus, and therefore more severe pandemic, could still occur at any time.
- Modelling suggests that regardless of where or when an influenza pandemic emerges, it is likely to reach the UK very quickly. From the time of arrival in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters of disease are occurring across the country¹.
- 3.3 As the 2009/10 pandemic showed, the demands of the pandemic are unlikely to be uniform, and different areas may be under differing degrees of pressure at different times, requiring flexibility of approach.
- 3.4 Local epidemics may be over faster and be more highly peaked than the national average.
- 3.5 Whilst there is likely to be local variability, local planners should plan to the peak of the wave; this assumes between 10-12% of the local population becoming ill each week during the peak of the local epidemic and that could be sustained over 2-3 weeks
- 3.6 Specific pandemic influenza guidance in respect of planning and response is available on Gov.UK for the following sectors
- [Telecommunications](#)
 - [Energy](#)
 - [Finance](#)
 - [Food](#)
 - [Transport](#)
 - [Water](#)
- 3.7 A recent cross-government group has reviewed the national planning assumptions in the [UK Pandemic Influenza Preparedness Strategy](#) 2011 and agreed that these remain appropriate and can be applied to all sectors with regards to potential absences rates and impacts.

¹ The Scientific Pandemic Influenza Advisory Committee’s Modelling Sub-Group Summary (Annex 1). Available at: http://www.dh.gov.uk/ab/SPI/DH_095904

4 Planning and Preparedness

Business Continuity and Resilience Planning

- 4.1 Pandemic influenza presents a unique scenario in terms of prolonged pressures through a reduced workforce and potentially increased workload for some responders. Organisations are therefore expected to have business continuity and contingency plans to ensure that critical services and outputs continue to be delivered throughout an influenza pandemic.
- 4.2 Planning should take place at three levels – Pan-London, Borough and within individual organisations. The [Guidance for Local Planners](#) states that pandemic plans should be 'based on existing systems and processes where possible, augmenting, adapting and complementing them as necessary to meet the unique challenges of a pandemic.'

Multi-agency Planning at Borough Level

- 4.5 A multi-agency group should be established to address pandemic influenza preparedness planning, testing and exercising at Borough Resilience Forum (BRF) level.
- 4.6 This can be done through the BRF or by another subcommittee under local determination, with appropriate terms of reference and governance.
- 4.7 Suggested representation for the group as follows:
- Clinical Commissioning Group
 - NHS England (London)
 - Primary care
 - Acute Trust(s)
 - Community Healthcare Provider(s)
 - Mental Health Trust(s)
 - Independent Health Sector
 - Public Health England
 - Local Authority (Director of Public Health, social services, children's services, emergency planning, environmental health)
 - Ambulance service
 - Police service
 - Fire service
 - Prisons (if applicable)
 - Voluntary sector
 - Faith sector
 - Local business hub / business improvement district
- 4.8 BRF planning activity and plans (multi-agency and single agency) should be aligned to the planning assumptions detailed in 'London Resilience Forum Pandemic Influenza Framework' and based on the planning guidance located on the [Pandemic Preparedness Section of GOV.UK](#).
- 4.9 Individual agency Business Continuity Plans should be aligned with the planning assumptions contained in the 'London Resilience Partnership Pandemic Influenza Framework' and based on the planning guidance located on the [Pandemic Preparedness Section of GOV.UK](#).
- 4.10 Depending on the severity of the pandemic, as well as pre-existing commitments, the Voluntary Sector may be able to provide additional support services and planners

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should give due consideration to the London Voluntary Sector Capabilities Document. The Voluntary Sector has capabilities across a wide range of functions such as:

- Welfare services e.g. staffing of emergency centres
- Psychosocial aftercare e.g. befriending and counselling
- Spiritual care & religious services e.g. advice and guidance on bereavement
- Medical support e.g. support to the ambulance service, first aid posts
- Transport & escort e.g. transport of patients / service users - more flu related
- Communications e.g. telephone / radio operators, interpreters
- Documentation / admin. e.g. coordinating convergent volunteers
- Equipment & resources e.g. bedding, catering, ambulances, shelter, communications.

- 4.11 Voluntary sector assistance should be sought as per the methods described in the Voluntary Sector Capabilities Document.
- 4.12 It is anticipated that the voluntary sector would experience increased demand for existing services in the event of a flu pandemic but would aim to accommodate additional requests for support where capacity allowed.
- 4.13 The following roles have been identified as areas where the voluntary sector, business sector or other organisations may be asked to provide support to health and social care services in the event of a flu pandemic. Some of these roles would require appropriate DBS clearance and/or first-aid training. The Chair of the London Resilience Business Sector Panel has confirmed that the business sector would in principle look to support these requests.
- Portering – in hospital settings
 - Catering – in hospital, care home and domestic settings
 - Collecting food / medicines – e.g. from pharmacies to homes / individual patients
 - Driving – patients / equipment
 - Domestic settings - helping people out of bed, cooking, cleaning, washing, changing dressings, shopping
 - Phone calls to check on patients / care users

BRF Communications

- 4.14 BRF should ensure that they hold contact details for locally delivered health and social care.
- 4.15 BRF should put in place a mechanism to share local situational awareness amongst partners to ensure an understanding of the impacts of a pandemic are understood within their locality.
- 4.16 Local arrangements to support central and regional Government in communicating advice to the local population and public messages should be established in line with the London Strategic Coordinating Group Public Communications Strategy.
- 4.17 Arrangements for communicating with vulnerable people (including deaf and disabled people) should be established (e.g. all communications are available and /or accessible in a variety of formats).
- 4.18 Local Authorities should ensure the following:

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- They hold collated contact details for school, early years and childcare settings.
- That robust plans are in place for communicating with parents to inform of closures and opening of schools are in place.
- That plans and arrangements are in place to support schools with remote learning.

Excess Deaths

- 4.19 The London [Excess Deaths Framework](#) provides information for planners preparing to manage excess deaths. There is also guidance on the management of death certification and cremation certification is available at: <https://www.gov.uk/pandemic-flu#guidance-for-local-planners>.

Training and Exercising

- 4.20 The London Resilience Partnership and the Sub-Regional Resilience Forums will undertake multi-agency exercises to prepare London for a possible future influenza pandemic as per the published London Resilience Training and Exercising Strategy and [London Prepared](#).
- 4.21 Partners should consider what training and exercising should be undertaken within their organisation as these are likely to differ according to the size, functions and likely impacts upon each partner. The responsibility for undertaking this training and exercising within each organisation lies with that organisation.
- 4.22 Guidance on which to base training is available on the [Pandemic Preparedness Section of GOV.UK](#). An off the shelf pandemic preparedness exercise (Exercise CORVUS) is available from PHE London Continuity and Resilience Team.

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Overview of Planning and Responsibilities

Activity	Regional	Borough	Organisation
Owner of plan shown in brackets			
Business Continuity Scalable business continuity plans should be in place at all levels and across all organisations to mitigate the impact of a pandemic	Signpost link for Small to Medium Enterprises and Voluntary Organisations	Through relevant local forums (e.g. Borough Resilience Forums, Health and Wellbeing Boards, work with local PHE, NHS and multi-agency partners to discuss, plan and share best practice, and address pandemic specific issues in respect of business continuity planning. (All)	Maintain effective business continuity plans to respond in a pandemic, identifying key issues, including which normal business functions are essential and which can be suspended or postponed. (All) Health and social care – extending and maintaining system wide health and social care flow.
Coordination and Information Sharing	Strategic Coordination Protocol (LRF)	Agencies will report individually between local level representatives /organisations and their SCG Representatives, supported by agreed mechanisms for sharing information across BRF partners	All partners, sectors and organisations within the LRPB arrangements contribute to information coordination and sharing arrangements (All)
	Local Authority Command and Control (LLACC and LLAG arrangements) (Local Authorities)	Local borough based coordination and information sharing arrangements in place. Feeds into the LLACC (when open) (LA & LRG.	
Communications with the Public	London Resilience Communication Group Emergency Plan	Local multi-agency Communications Plans and pathways to be agreed across all partners	Organisational Communications arrangements (All)
Multi-agency communications	Strategic Coordination Protocol (LRF)	Local inter-agency communications arrangements	Internal communications channels
Excess Deaths	London Excess	Local Borough level	Individual

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Activity	Regional	Borough	Organisation
Owner of plan shown in brackets			
	Deaths Framework (LRF)	Excess Deaths management Plans (LAs)	organisations to maintain effective operational and Business Continuity plans to maximise the capacity of death management process in line with existing duties. (All)
Training & Exercising	London Resilience Partnership Training & Exercising Group (LRF) SRRF Training and Exercising Programme (LRG & LA)	Local BRF Training and Exercising Programmes (BRFs)	Organisational Training and Exercising Programmes
Recovery	London Recovery Management Protocol (LRF)	Boroughs contribute to the LRF Recovery Protocol	Organisations to ensure recovery plans and processes are in place and preparations are made for subsequent waves.
Situational Awareness	For further Information see Section 8		

5 Response

- 5.1 The overall strategy to the management of an influenza pandemic is to minimise, where possible,
- the potential health impact of a future influenza pandemic
 - the potential impact of a pandemic on society and the economy, and
 - instil and maintain trust and confidence.

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- 5.2 The 2011 UK Strategy recognises the need to disassociate the UK response from the global WHO Phases and instead refers to five stages named in the table below. Key agencies at each stage are detailed.

Stage	Lead Organisation
Detection	Public Health England
Assessment	Public Health England
Treatment	NHS England
Escalation	NHS England
Recovery	See London Recovery Management Protocol

- 5.3 The stages 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 stages. Transition between stages will be determined at the time, considering regional variation and epidemiological evidence.

Detection

- 5.4 The focus in this stage would be intelligence gathering from countries already affected, enhanced surveillance within the UK, developing diagnostics specific to the new virus, and providing information and communications to the public and professionals. The indicator for moving to the next stage would be the identification of the new influenza virus in patients in the UK.

Assessment

- 5.5 The focus of this stage would be collection of detailed clinical and epidemiological information on early cases on which to base early estimates of impact and severity in the UK. Additionally it will focus on 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, treating cases/ suspected cases and potentially using targeted 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.

Detection and Assessment

- 5.6 These two stages together form the initial response. This may be relatively short and the stages 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

- 5.7 The focus of this stage would be treatment of individual cases and population treatment via the national pandemic flu service (NPFS) (if necessary), enhancement of the health response to deal with increasing numbers of cases, considering enhancing public health measures to disrupt local transmission of the virus. Depending on the development of the pandemic, this time should also be used to prepare for targeted vaccinations as the vaccine becomes available.
- 5.8 A range of pharmaceutical (antivirals, vaccines, other medicines) and non-pharmaceutical (personal protective equipment, hygiene measures, social distancing) interventions are available. Vaccines are unlikely to be available for the first four to six months of a pandemic, and therefore the other interventions are particularly key for the first wave.
- 5.9 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 pan London 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

- 5.10 The focus of this stage would be escalation of surge management arrangements in health and other sectors, prioritisation and triage of service delivery with the aim to maintain essential services, resiliency measures, encompassing robust contingency plans, and consideration of de-escalation of response if the situation is judged to have improved sufficiently.
- 5.11 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 stage at an early point in the Treatment stage, if not before.

Recovery

- 5.12 The indicator for this stage 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.
- 5.13 The focus of this stage would be normalisation of services, perhaps to a new definition of what constitutes normal service. This would include, but not be limited to:
- 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
 - post-incident review of response.
 - sharing information on what went well, what could be improved and lessons learnt.

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- taking steps to address staff exhaustion; planning and preparing for a resurgence of influenza, including activities carried out in the Detection stage
- continuing to consider targeted vaccination, when available; and preparing for post-pandemic seasonal influenza.

6 Pandemic specific response arrangements Health and Social Care

Antiviral Collection Points (ACPs) and Vaccination arrangements

- 6.1 NHS England is responsible for leading the delivery of antiviral collection points and public pandemic influenza vaccination campaigns in partnership with the wider NHS. It is planned that antiviral medication and pandemic specific vaccines will be delivered direct to point of patient access from the national stockpiles, rather than to local delivery hubs for onward distribution.

Negotiations are underway nationally regarding the most appropriate route for patients to access antivirals, with the intent that this is through NHS routes that are aligned to business as usual services as much as possible. It is not intended to require multi agency distribution centres in non-NHS premises as were established in 2009/10 in some London Boroughs. Specific information will be shared with resilience partners as it is developed and finalised.

Social Measurers

- 6.2 Local arrangements are in place to support the implementation of possible social measures or to reduce social impacts, including:
- Closure of schools and group early years and childcare settings
 - Voluntary isolation/quarantine
 - Support to prisoner handling and the judicial process, if there is a prison in your BRF.
 - Maintenance of public order
- 6.3 Plans are established to sustain patients in the community, including community care such as (list is not exhaustive – [section 4.11](#) details further potential support roles):
- Delivery of medicines
 - Meals on wheels
 - Community Nursing
 - Washing and feeding of patients
 - Portering

Infection Control

- 6.4 Advice on infection control in the workplace, in hospitals and healthcare facilities and laboratories is available on the Health and Safety Executive website at: <http://www.hse.gov.uk/biosafety/diseases/pandemic.htm>
- 6.5 HSE's general advice is to encourage each individual employee to adopt a common sense approach. If you are feeling unwell with flu-like symptoms and particularly if you are coughing and sneezing – then stay at home. This will help to prevent the disease being passed on to colleagues (and also fellow passengers on your way to and from work, if you travel by public transport). In the workplace, practice good personal hygiene measures – use a disposable tissue to control coughs/sneezes, dispose of it appropriately and wash your hands before eating, drinking etc.
- 6.6 Further advice is given regarding what employers should consider in respect of sending staff home, working with the public, whether masks should be worn and adopting alternative ways of working.
- 6.7 Specific infection control guidance is available for those [working in health and care settings](#).

Personal protective equipment for health and social care

- 6.8 The Department of Health and Social Care has stockpiles of appropriate personal protective equipment for health and social care providers to use when caring for patients and service users with pandemic flu. Distribution arrangements for these will be shared as they are developed and finalised. The intent is that these will be distributed direct from the stockpile to the NHS, or via local hubs for social care users.

NHS Surge Capacity Management

- 6.9 NHS surge capacity management is undertaken at the local level by Clinical Commissioning Groups and at the pan-London level by NHS England and NHS Improvement. During an influenza pandemic, a whole system approach to the surge would become even more important. NHS providers, LAS, primary care contractors and social care will need to ensure that all capacity is maximised. This planning should be undertaken at the local level to ensure that local health and social care services are aligned to support surge capacity.
- 6.10 Existing surge capacity plans would be scaled up to meet the expected demand and NHS England (London) would assume strategic control of London's NHS. The processes that will be used will be built on existing good practice used in periods of enhanced pressure – such as during winter or severe weather. The details of this are being agreed nationally and will be implemented in London when needed.

Support from other sectors, including social care, the voluntary and faith sectors, and the public themselves, may be sought in local areas if commissioned NHS services come under significant or extended pressures.

Processes exist for management of increased demand to 111 and LAS 999 services, including through dedicated algorithms and redirections of services users, should this be needed.

7 London Strategic Coordination arrangements

- 7.1 London's strategic coordination arrangements are set out in the Strategic Coordination Protocol available on the [London Prepared website](#). The Protocol details the arrangements for the coordinated strategic response and recovery to any emergency, as defined by the Civil Contingencies Act 2004, in London; including an influenza pandemic.
- 7.2 Responding to the health, social care and wider challenges of an influenza pandemic requires the combined and coordinated effort, experience and expertise of all levels of government, public authorities/agencies and a wide range of private and voluntary organisations.
- 7.3 To ensure an effective response, each organisation needs to understand its responsibilities and how its activities feed into and relate to the work being undertaken by other organisations contributing to the response.
- 7.4 A potential pandemic flu response will be triggered following a tripartite meeting or teleconference between London Resilience Group (LRG), NHS England (London) and PHE. This will allow for a coordinated assessment and informed judgement of the situation to be made. At this point, and at a time mutually agreed by the tripartite group, a Strategic Coordinating Group meeting will be convened.
- Typically an SCG² will be made up of representatives of the following agencies/organisations:
- NHS England
 - Public Health England
 - Local Authorities
 - London Resilience Group
 - Greater London Authority
 - Environment Agency
 - Police
 - Ambulance
 - Fire
 - Government Liaison Team
 - Transport Sector
 - Utilities Sector
 - Voluntary Sector
 - Faith Sector
 - Business Sector
 - Military
 - London Resilience Communication Group
- 7.5 A Strategic Coordinating Group (SCG) meeting for Pandemic Flu, would normally be chaired by PHE during the Detect and Assess elements the situation. NHS (England) or Local Authorities may chair the SCG during other phases depending on the circumstances. The London Resilience Group may also chair Partnership teleconferences if required.
- 7.6 The core functions of London's strategic coordination arrangements as set out in the

² Representation at a full SCG can be found in the London Resilience Partnership Strategic Coordination Protocol.

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Strategic Coordination Protocol:

1. Notification of Strategic Coordination Arrangements
 2. Coordination - ranging from monitoring the situation to a full Strategic Coordinating Group meeting
 3. Tactical Coordinating Group (pan-London) – a subordinate structure to the SCG
 4. On-scene Coordinating Group – a subordinate structure to the TCG
 5. Creating and Maintaining Shared Situational Awareness
 6. Determining Strategy, the Strategic Aim and Objectives
 7. Decision Making (multi-agency)
 8. Liaising with Central and Local Government
 9. Obtaining Local Authority, Scientific and Technical Advice Cell (STAC), Air Quality Cell (AQC) and Military advice
 10. Public, Business and Media Information
 11. Facilitating Coordinating Group Meetings
 12. Controlling and Capturing Financial Costs
 13. Oversight of Internal Resilience and Safety Issues
 14. Recovery Management
 15. Debriefing
- 7.7 When convened, the SCG will decide upon the issue(s) before them and how they wish to proceed. Should they decide that pan London monitoring and or strategic co-ordination is necessary they will agree how this is to be achieved.
- 7.8 The London Resilience Group in conjunction with the lead response organisation (usually the organisation of the SCG Chair) would arrange the meeting including inviting attendees. They would also be responsible for drawing up the agenda, circulating papers and other relevant information to group members as necessary and provide the formal record of discussions and decisions. Depending on the situation, further meetings may be convened.
- 7.9 Should the SCG consider it necessary to continue meeting, then the meeting/group should be designated with a title that reflects the issue(s) and purpose of the meetings/group (i.e. 'SCG Pandemic Flu Coordination Group'). This will ensure that should it become necessary to convene additional meetings of the partnership or to establish more than one Partnership meeting in relation to unrelated concurrent emergencies, the purpose of each can be clearly differentiated. In the longer term a representative of a Pandemic Flu SCG may be required to lead the partnership response throughout the pandemic.
- 7.10 The possible impact of the pandemic on critical staffing means that resilience measures such as nominated deputy committee members and the utilisation of remote meetings may be required.

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8 Situational Awareness

- 8.1 Information is crucial to the understanding and response to any major incident. For pandemic flu this is particularly important, as the inter-dependencies of agencies on each other's' continued resilience over potentially several months will become crucial.
- 8.2 During a pandemic, each organisation will be required to supply situation reports to their host Government Department which will be fed into COBR. Additionally, each organisation will provide reports to LRG, as secretariat to the London SCG or Partnership meeting, to produce an overall Common Operating Picture (COP). The London COP will provide key information and data on the present situation in London.
- 8.3 The London Situational Awareness Tool (LSAT) is the primary means by which a Common Operating Picture will be produced to support shared situational awareness. All partner organisations should upload their situational awareness information on LSAT. The London Resilience Group will oversee this process, set the reporting timeframes, and produce a COP to be shared with the partnership.
- 8.4 Examples of reportable intelligence are detailed below. Frequency (or battle rhythm) will be determined by the severity of the pandemic, the scale of the challenges arising, and available resources. In addition all will report on Public communications and media coverage.

Organisation	Examples of possible reporting lines
PHE	<ul style="list-style-type: none"> Enhanced surveillance and epidemiology Transmission and spread, e.g. circulating strain and severity
NHS	<ul style="list-style-type: none"> Surge, including primary care Impacts on elective work Critical care capacity Mortality and morbidity data Mortuary capacity – to Excess Death Steering Group
Local authorities	<ul style="list-style-type: none"> Impacts on local critical services Social care provision Impacts on cremation and burial services and mortuary capacity – to Excess Deaths Steering Group Local support to the health service/voluntary and community inputs and mutual aid issues and solutions Community concerns Business issues
London Resilience Group	<ul style="list-style-type: none"> Monitor and maintain a London wide overview of the situation and its impacts through a Common Operating Picture (using the London Situational Awareness Tool). Provide support to the Excess Death Steering Group by monitoring mortuary capacity.
Other organisations	<ul style="list-style-type: none"> Impacts on service delivery Staff absenteeism Requests for assistance

9 Recovery

- 9.1 The Recovery phase in the Department of Health and Social Care (DHSC) Strategy encompasses normalisation of services, restoration of business as usual services, evaluation of the pandemic, planning and preparation for a resurge in activity, and Targeted vaccination, when available. Recovery may occur between waves or at the end of the pandemic.
- 9.2 DHSC will issue information to inform plans following a review of the first wave and the availability of countermeasures.
- 9.3 Health and social care services may experience persistent secondary effects for some time, with increased demand for continuing physical and mental health care from:
 - Patients whose existing illnesses have been exacerbated by influenza.
 - Those who may continue to suffer potential medium or long term health complications.
 - A backlog of work resulting from the postponement of treatment for less urgent conditions.
- 9.4 The pace of recovery will depend on the residual impact of the pandemic, on-going demands, backlogs, staff and organisational fatigue and continuing supply difficulties in most organisations.
- 9.5 Plans will have to recognise the potential need to prioritise the restoration of services and to phase the return to 'new-normal' in a managed and sustained way.
- 9.6 The London Resilience Partnership will adopt the structures and strategies laid down in the [London Recovery Management Protocol](#).
- 9.7 A pan-London debrief will be undertaken in line with the London Resilience Partnership's Learning and Improvement Strategy. This will report to the LRF and to Central Government.

For information, please contact:

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LONDON RESILIENCE GROUP

The London Resilience Group is jointly funded and governed by the Greater London Authority, London Local Authorities and the London Fire Commissioner. We are hosted by the London Fire Brigade. Our work, and that of the London Resilience Partnership, is overseen by the London Resilience Forum.