

GUIDANCE

CONTINGENCY PLANNING FOR A POSSIBLE INFLUENZA PANDEMIC

Version 2
10 July 2006

Page	Contents	Relevant for planning by:		
		Category 1 responders	Category 2 responders	Wider community (businesses, public sector, voluntary sector, charities)
1	Contents table and relevance	✓	✓	✓
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(updated)	Staff absence from work	✓	✓	✓
10	Issues to Consider in Business Continuity Planning	✓	✓	✓
11	Evolving Policies for Managing a Pandemic			
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	Reducing the risk of infection	✓	✓	✓
	Social measures and travel restrictions	✓	To note and factor into planning as necessary	To note and factor into planning as necessary
Annex A	Additional advice available on the DH website	✓	✓	✓

✓ - to consider in further planning

This Guidance was produced by the Cabinet Office in consultation with the Health Departments and with other Government Departments. The Cabinet Office has issued it as part of our role in supporting the Department of Health, as Lead Department, in preparing and planning for a possible flu pandemic.

Changes from the Guidance issued in February 2006 are shown in yellow highlighted text

Summary Points

- In February 2006, the Cabinet Office issued guidance to assist local planning for a possible influenza pandemic. It was particularly addressed to Category 1 responders under the Civil Contingencies Act 2004 but relevant also to Category 2 responders under the Act, and to the wider community.
- This is an updated version: this section and part of Section 7 have been amended in the light of new guidance from the Department for Education and Skills (issued on 10 July 2006) which asks schools and child-care providers to plan for possible school closures.
- One of main challenges for planners is the uncertainty surrounding the nature of the pandemic virus when it emerges and its likely impact.
- The UK Health Departments' Influenza Pandemic Contingency Plan and the additional material in this Note therefore provide planning assumptions to aid consistent and coherent planning across the UK. But, at this stage, they can only be assumptions. Planning must be sufficiently flexible to cope with both the lower and the upper ends of the range of possible outcomes.
- Planning assumes that, once it has reached the UK, the infection will spread quickly and outbreaks are inevitable across the whole country.
- Medical countermeasures against pandemic influenza should not be regarded as a 'silver bullet' solution for business continuity. Vaccines will not be available in the first wave of a pandemic (possibly longer). And treating people with antiviral drugs lessens, but does not cure, illness. People who are ill will still need time off work.
- The material below provides advice to allow employers to calculate likely levels of staff absence that reflect their particular circumstances. As a rough working guide, organisations employing large numbers of people should ensure that their plans are capable of handling staff absence rates of up to 15% over the 2-3 week peak of a pandemic (in addition to usual absenteeism levels). Small businesses, or larger organisations with small critical teams, should plan for level of absence rising to 30% at peak, perhaps higher for very small businesses with only a handful of employees. To take into account possible parent-worker absences in the event of school closures, employers should also consider and plan for the impact on their businesses of possible school closures, taking into account the make-up of their workforces (eg, the proportion of staff with children under 16).
- Planning for the handling of excess deaths should be carried out against both the base case of some 54,000 excess deaths across the UK across the period of the pandemic and the prudent worst case that the number of excess deaths spread across more than one wave may give rise to the need to handle some 350,000 excess deaths in the UK in one wave.
- Key messages from the Government during a pandemic will be that people who are well should carry on with normal, essential activities as far as possible, at the same time taking personal responsibility for self-protection; and that those who are unwell, or think they are unwell should take social responsibility to lessen spread and thus help protect others.
- During a pandemic, the Government will issue specific advice on the full range of potential response policies, based on its understanding of the nature of the virus and its likely impact.

Introduction

1. Contingency planning for a range of risks is a key business activity for all organisations. It has received fresh impetus in the UK in recent years, especially following the passage of the Civil Contingencies Act 2004.
2. The Government judges that one of the highest current risks to the UK is the possible emergence of an influenza pandemic – that is, the rapid worldwide spread of influenza caused by a novel virus to which people would have no immunity, resulting in more serious illness than that caused by seasonal influenza.
3. This Guidance provides information and advice for Category 1 and 2 responders under the Act, and planners more broadly, engaged in contingency planning against the risk of an influenza pandemic.
4. 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.
5. 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.
6. 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. During a pandemic, the Government (through the Civil Contingencies Committee¹ (CCC), supported as necessary by Regional Civil Contingencies Committees² (RCCCs) and equivalent arrangements in the Devolved Administrations) 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.

¹ Often referred to as "COBR".

² RCCCs supported by Regional Resilience Teams in Government Offices in the Regions will be the focal points for information flows; for reporting local and regional impacts to CCC; and for issuing advice and guidance on response policies, and overseeing their implementation.

7. Until then, planning should be based on the assumptions³ set out in the UK Health Departments' Influenza Pandemic Contingency Plan (October 2005) – “The UK Flu Plan” - and on the additional advice contained in this Note, which builds on and develops in some areas Annex J to that Plan. Both documents draw on the best information currently available (again, especially through scientific modelling) on the potential impact of a pandemic virus and on the feasibility and merits of specific response options.
8. Uncertainty about the nature and impact of the pandemic virus means that planning across all sectors needs, for prudence, to be sufficiently flexible to cope with a range of possible impacts, including those arising from a pandemic virus with a clinical attack rate and case fatality rate in the upper ranges of the planning assumptions set out in the UK Flu Plan and this Note.
9. Further guidance will be issued over the coming months as the situation develops, as the results of scientific modelling become available and as policy work on response options is completed (in particular on schools and other educational establishments, on the use of face masks and on planning for excess deaths).

Purpose of Note

10. This Note is mainly addressed to Category 1 responders⁴ given their duties under the Civil Contingencies Act, in particular in regard to:
 - The preparation of emergency plans in relation to significant risks.
 - Business continuity planning.
 - For local authorities from May 2006, raising business continuity awareness among businesses in their communities.
11. It is also relevant to the warning and informing duty in the Act, which requires Category 1 responders to engage in pre-emergency awareness-raising work, and to warn and inform the public during emergencies.
12. In addition, the Note provides advice relevant to Category 2 responders⁵ under the Act and to planners in the wider community to assist them in their preparations for a possible influenza pandemic, especially in its coverage of

³ The specific planning assumptions for an influenza pandemic are consistent with the generic planning assumptions which underpin analysis in the current National Capabilities Survey for infectious diseases, which explores both generic preparedness for an infectious disease outbreak as well as specific preparations for a flu pandemic.

⁴ Category 1 responders – local authorities, police, fire and ambulance services, NHS bodies, Port Health Authorities, Environment Agency, Scottish Environment Protection Agency, Maritime and Coastguard Agency.

⁵ Category 2 responders – utilities, transport network, HSE.

business continuity, of the potential effect of medical countermeasures and on measures to reduce the risk of infection.

13. Many of the issues relevant to contingency planning for an influenza pandemic are common to other emergencies and will already have been addressed as part of normal contingency planning. Where this is the case, this Note should be seen as an invitation to relevant organisations to check that their generic arrangements will hold up well in an influenza pandemic.
14. This Note also invites relevant organisations to consider and feed back to the Civil Contingencies Secretariat in the Cabinet Office, either directly or via Regional Resilience Teams or Government Departments, their views on areas where they consider that additional specific information and advice would be valuable in improving their preparedness planning.

Sources of Guidance

15. In addition to the information and advice contained within this Note, other sources of advice currently comprise:
 - UK Health Departments' Influenza Contingency Plan (October 2005), plus further information for the public as well as information and operational guidance for the NHS. This is listed at Annex A. This material is available via the Department of Health's website - <http://www.dh.gov.uk/pandemicflu>.
 - Pandemic Influenza Checklist For Businesses (May 2006) – <http://www.ukresilience.info>.
 - HSE Guidance to employers, available via the HSE website - <http://www.hse.gov.uk/biosafety/diseases/influenza.htm>).
 - DfES Guidance to schools and child-care settings (July 2006) – <http://www.teachernet.gov.uk/wholeschool/healthandsafety/Influenza/>
 - Generic guidance to assist business continuity planning, at Chapter 6 of *Emergency Preparedness*, statutory guidance issued under the Civil Contingencies Act 2004. This material is available at the UK Resilience website - http://www.ukresilience.info/ccact/ep_chap_06.pdf.

Main Areas of Focus in Local Planning

16. The main areas on which Category 1 responders should focus are:
 - a. **Business continuity** planning, so that relevant organisations can continue delivering their essential services during a pandemic, taking into account the key planning assumption that medical countermeasures against pandemic influenza (antiviral drugs and vaccines) should not be regarded as a “silver bullet” solution for business continuity, particularly during the first wave of a pandemic.

- b. Co-ordinated multi-agency planning to support central Government in **communicating public messages** on hygiene measures to reduce the risk of infection and its spread.
- c. Co-ordinated multi-agency planning to implement where appropriate possible **social measures** which the Government may recommend on an advisory basis to reduce the risk to individuals of infection.
- d. Co-ordinated **multi-agency planning with the health service** (e.g. on the storage and distribution of antivirals; in due course, on planning mass vaccination programmes) consistent with any guidance from the Department of Health and devolved equivalents.
- e. Co-ordinated multi-agency planning in Local Resilience Forums to prepare for the **wider impacts** of a pandemic in their areas.
- f. Co-ordinated multi-agency planning for handling **excess deaths**, including surveying local capacity at relevant stages of the process from death to burial or cremation.

The Risk

17. The risk of a new human influenza pandemic is considered by the World Health Organisation (WHO) to have increased over the last two years, based largely on the risk posed by the H5N1 avian influenza virus, currently circulating in poultry in South East Asia and elsewhere.
18. 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 rate⁶, the severity of the illness it causes and the resulting case fatality rate⁷. These parameters will not be known until the pandemic virus emerges.
19. In order to assist planning, estimates of the impact of an influenza pandemic in today's circumstances have been developed drawing where appropriate on previous pandemics and by scientific modelling of a range of potential scenarios. The table below from the UK Flu Plan sets out, for clinical attack rate and case fatality rate, the range of possible outcomes during a pandemic in the UK which has one or more waves:

Overall case fatality rate	Clinical attack rate		
	10%	25%	50%
0.37%	21,500	53,700	107,500
1.00%	56,700	141,800	283,700
1.5%	85,100	212,800	425,500
2.5%	141,800	354,600	709,300

⁶ Clinical attack rate – percentage of the population who become ill.

⁷ Case fatality rate – percentage of those who become ill who subsequently die.

20. The WHO monitors influenza across the world. Once a new influenza virus has been identified and shown to have pandemic potential, the WHO will decide and inform national Governments of its view on the level of risk of an imminent pandemic, set against the phases of a pandemic listed at Chapter 3 of the UK Flu Plan. The UK Government will put into action its own plans relevant to each phase, including through activation and use of the CCC and sub-national crisis co-ordination structures as set out above.

Key Planning Assumptions

Public health effects

21. 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).

22. 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. (Detailed planning assumptions on hospitalisations and in other clinical areas are set out in the UK Flu Plan.)

23. 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).

24. 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.

25. Until the characteristics of the pandemic virus are known, **relevant planning should be carried out against the base case set out above of some 54,000 excess deaths across the period of the pandemic and the prudent worst case that the number of excess deaths spread across more than one wave may give rise to the need to handle some 350,000 excess deaths in the UK in one wave.**

26. It will be important to establish through this work what specific additional measures would need to be put in place were the pandemic virus to have a clinical attack rate and case fatality rate in the upper ranges of the planning assumptions set out above. A key point for local planning is likely to be the identification of potential sites for the location of facilities for the temporary

storage of bodies, prior to funerals taking place. This aspect of planning will be the subject of further, specific guidance, to follow shortly.

27. Antiviral drugs are expected to reduce the duration of the illness and the likelihood of complications. These drugs are now being stockpiled. A vaccine specifically to protect against the pandemic influenza virus cannot be made until the pandemic virus has emerged and will not start to be available until 4-6 months later. Even then, it will be a number of months before significant supplies become available. The current planning assumption is that vaccine will become available only after the first wave of the pandemic has passed.

Staff absence from work

28. The level of staff absence from work during a pandemic will depend significantly on the nature of the pandemic virus when it emerges. The planning assumptions set out below are based on current knowledge, analysis of past pandemics, published evidence and scientific modelling. Given the inevitable uncertainties, a range of figures is given in some areas. Organisations should ensure that their business continuity plans have the flexibility to accommodate these ranges.

29. During a pandemic, staff will be absent from work if:

a. They are **ill with flu**. Numbers in this category will depend on the clinical attack rate. If the attack rate is 25%, a quarter of staff in total will be sick (and hence absent from work for a period) over the whole course of the pandemic. If a pandemic occurs over one wave, this level of cumulative absence could be experienced by employers over a period of around 3-4 months. But there may well be more than one wave, with absence from work being spread across those waves.

b. They **need to care** for children or other family members who are ill with flu.

c. They **need to care** for (well) children because of local school closures in light of July 2006 guidance from the Department for Education and Skills which advises schools and child-care settings to plan for possible closure on a regional basis during a pandemic. Regardless of whether or not the Government advises schools to close, it is likely that some schools will in any case have to close because of shortages of staff, or because parents are not willing to send their children to school.

d. They have **non-flu medical problems**.

e. Their employers have advised them to **work from home**.

f. They decide to absent themselves for **other reasons**.

30. Business continuity planning against an influenza pandemic should have at its heart an estimate, through aggregation of data in each of the categories above, of the number of staff likely to be absent from work at the peak of the pandemic. Estimates of likely levels of absence from work caused by influenza or by the need to care for family members with influenza (that is, categories a).

and b). above) are set out in the table below against a range of assumptions on the clinical attack rate of the pandemic virus. The table also reflects the results of scientific modelling which suggests that small organisations, and small teams within larger organisations, may experience higher rates of staff absence at the peak of a pandemic than would large teams.

	Clinical attack rate		
	10%	25%	50%
Large Organisation			
% of people ill at peak	2%	5%	10%
% of people ill & carers taking time off at peak	3%	7%	15%
Small Organisation or unit			
% of people ill & carers taking time off at peak	6%	14%	30%
Total			
Cumulative % total of those ill over whole period of pandemic	10%	25%	50%

- These figures are estimates based on current knowledge and modelling
- All figures given are percentage of total workforce
- It is expected that ill people will on average be absent for 5-8 working days
- A small organisation or unit can be defined as a group of up to 15 people
- **In the event of local school closures, additional staff who are parent-workers may also be absent to care for (well) children.**
- These figures do not include 'normal' absenteeism levels; people taking time off due to family bereavement or psychosocial impact of pandemic; people self-absenting from work.

31. In order to derive estimates for the total number of staff likely to be absent from work at the peak of a pandemic, employers should add data appropriate to their circumstances on:

- a. The average number of staff 'normally' absent from work.
- b. The proportion of staff whom they will advise to work from home.
- c. Their judgement, based on the nature of their business and their employment practices, of the number of staff who might absent themselves from work for other reasons.

32. As a rough working guide, organisations employing large numbers of people, with flexibility of staff redeployment, should ensure that their plans are capable of handling staff absence rates of up to 15% over the 2-3 week peak of a pandemic (in addition to usual absenteeism levels). Small businesses, or larger organisations with small critical teams, should plan for level of absence rising to 30% at peak, perhaps higher for very small businesses with only a handful of employees. **To take into account possible parent-worker absences in the event of school closures, employers should also consider and plan for the impact on their businesses of possible school closures, taking into account the make-up of their workforces (eg, the proportion of staff with children under 16).**

33. Finally, employers should note that:

- a. Depending on the rate of spread of the virus within the UK, levels of staff absence from work are unlikely to be uniform across the country. Employers with sites spread across the UK may experience peak rates of absence at different times in different regions.
- b. Absentee rates could be higher than the estimates given here if the nature of the virus means that people take longer to recover from infection than the assumption shown above, or if some age groups of the population are affected more severely than others.

Issues to Consider in Business Continuity Planning

34. In carrying out business continuity planning, organisations will wish to consider how best to:

- a. Support the Government's efforts to reduce the impact of the pandemic by:
 - Taking all reasonable steps to ensure that employees who are ill or think they are ill during a pandemic are positively encouraged not to come into work. Personnel policies may need to be reviewed to achieve this aim.
 - Ensuring that employers and employees are made aware of Government advice on how to reduce the risk of infection during a pandemic. (Information for staff will be available on the Department of Health website and in printed form.)
 - Ensuring that adequate hygiene (e.g. hand-washing) facilities are routinely available.
- b. Put in place measures to maintain core business activities for several weeks at high levels of staff absenteeism, including options for remote working and expanding self-service and on-line options for customers and business partners.
- c. Identify those essential functions and posts, and perhaps individuals, whose absence would place business continuity at particular risk.
- d. Identify which services could be curtailed or closed down during all, or the most intense period, of the pandemic.
- e. Ensure that health and safety responsibilities to employees continue to be fully discharged.
- f. Identify inter-dependencies between organisations and ensure they are resilient, for example by ensuring that supplier organisations delivering services under contract have appropriate arrangements in place themselves to sustain their service provision.

g. As necessary, factor into their planning the need to support the health service.

h. Factor into their planning the presumption that assistance from the Armed Services will not be available⁸.

i. Factor into their planning that medical counter-measures will not solve business continuity requirements because antiviral drugs for treatment will only lessen the severity of the illness. They will neither cure it nor significantly reduce absenteeism.

35. In addition, organisations will need (as necessary) to be aware of, and plan for the consequences of measures that the Government may conclude are necessary to control or delay the spread of the disease, described below, which may result in additional staff absence from work (in addition to increased parent-worker absences arising from possible school closures).

Evolving Policies for Managing a Pandemic

36. This section sets out, on the basis of advice from UK Health Departments, information on:

- Access to medical countermeasures (antiviral drugs and vaccines).
- Reducing the risk of infection.
- Current thinking on social measures and travel restrictions.

Medical countermeasures

37. 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. The stockpile will be complete by September 2006. 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, preferably within 48 hours of onset. Their effectiveness will not, however, be known until the pandemic virus is circulating. 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.

38. If a pandemic were to emerge before the antiviral stockpile was complete, available supplies would be prioritised to treat health workers and the vulnerable (i.e. priority medical groups) first. As further drugs became

⁸ Military assistance might be available in exceptional circumstances, at the time of an emergency, if life and property are in immediate danger. But planning for an influenza pandemic should take into account that military support may not be available if local units are deployed on operations; nor should it be assumed that local units have personnel available with either the skill or equipment to undertake specialist tasks. And military personnel themselves will be vulnerable to the illness.

available, they would be offered to treat those who became ill. There is unlikely to be any further prioritisation of the stockpile by sector, not least because treatment only shortens the duration of illness by one day.

39. The **action point** for planners is thus that plans should be able to cope with rates of staff absence calculated on the basis of the advice above.
40. 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. We will provide further advice on policy in this area as it develops.
41. 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. When vaccines start to become available, essential and emergency services (other than the health service) and other sectors should not assume priority access to pandemic vaccine.

Reducing the risk of infection

42. Transmission of the pandemic virus from person-to-person will be through close contact. The balance of evidence suggests that the most important transmission routes will be through large droplets (e.g. from coughing and sneezing) and through direct and indirect contact with infected people. Airborne or fine droplet transmission may also occur.
43. These characteristics mean that the pandemic virus is expected to spread quickly through the population after it first arrives in the UK. Scientific modelling suggests that it may only take 2-3 weeks from the virus first entering the UK to its being widespread.
44. Early management of the pandemic will rely mainly on two elements. First, antiviral drugs for treating those ill with the pandemic. Second, robust public health messages encouraging sensible precautionary self-help measures to reduce the risk of an individual becoming infected. Alongside the key message to people to continue their everyday (essential) activities as normal will be messages encouraging personal responsibility for self-protection and social responsibility to lessen spread and thus protect others. The key public health messages will be:

If you do catch flu:

- Stay at home and rest
- Take medicines such as aspirin, ibuprofen or paracetamol to relieve the symptoms (following the instructions with the medicines). Children under 16 must not be given aspirin or ready made flu remedies containing aspirin.
- Drink plenty of fluids

You can reduce, but not eliminate the risk of catching or spreading influenza during a pandemic by:

- Covering your nose and mouth when coughing or sneezing, using a tissue when possible
- Disposing of dirty tissues promptly and carefully – bag and bin them
- Avoiding non-essential travel and large crowds wherever possible
- Maintaining good basic hygiene, for example washing your hands frequently with soap and water to reduce the spread of the virus from your hands to your face, or to other people.
- Cleaning hard surfaces (eg, kitchen worktops, door handles) frequently, using a normal cleaning product
- Making sure your children follow this advice.

These measures are for your own health and to avoid spreading the illness to others.

Social measures and travel restrictions

45. A third possible element of the response is the use of additional measures which would reduce social mixing and thereby aim to reduce exposure to the virus. The UK Flu Plan sets out a range of possible additional measures that would fall to be considered. These could include:

- a. Postponing large-scale public gatherings and events, particularly those with participants travelling from overseas. Even were event organisers to decide to proceed with events, they would need to consider the following factors which may increase the risk of further spread of infection:
 - Droplet spread in seated venues (usually three feet or less through the air).
 - The availability and adequacy of handwashing facilities.
 - The adequacy of, and standards set for, cleaning the venue before and after use.
 - The most appropriate management of areas of close human-to-human contact on entering or leaving the ground or venue.
 - Their own duty of care to their staff.
- b. Issuing advice to travel only if essential, encouraging remote working or the staggering of journeys to work using public transport.
- c. The introduction of additional port health measures or entry screening of passengers returning from those countries first affected by the pandemic virus. Even if implemented, such measures are likely to be discontinued once the virus has taken hold in the UK.

d. The introduction of exit screening at ports to protect other countries were the UK to be one of the first countries affected by the pandemic virus. As further countries became affected, the WHO would be likely to advise that this measure be discontinued.

e. The management of, or provision of advice on, the isolation of confirmed cases in closed communities such as care homes, boarding schools and prisons.

46. Scientific modelling has been used as far as possible to develop the evidence base to support Ministers' decisions on the feasibility and merits of such measures. Overall, the evidence so far suggests that there are significant uncertainties about whether public health benefits would in practice be achieved by the introduction of such measures.

47. Once the nature of the pandemic virus is known, further modelling will be undertaken as the basis for advice to Ministers on the pros and cons of introducing each measure. If it is assessed that the pandemic virus is likely to result in higher rates of sickness and death than suggested by modelling based on current planning assumptions, public health benefits may be more readily achieved.

48. In the event that Ministers decide that the merits of introducing any of these measures are likely to outweigh the disbenefits, local planners and other bodies will need to be ready to implement them. **Planning and associated exercising by Category 1 responders needs to continue on the basis that they might be asked to implement any or all of these measures.**

49. It is unlikely that Ministers would make implementation of such measures compulsory under available powers or under additional powers that could be secured under the Civil Contingencies Act, not least because of the difficulties of enforcement. But if the virus turned out to be more virulent than current planning assumptions, so that the balance of advantage changed, there might well be a case for requiring, rather than advising, such measures to be implemented. As well as decisions on which measures would on balance be helpful, Ministers would consider in the early stages of a pandemic the most appropriate implementation route (advisory or compulsory through regulation). **At this stage, however, planning should proceed on the basis that emergency powers will not be used. As a result, local responders will need to plan how best to promulgate the recommendations to their communities and to achieve compliance on a voluntary basis.**

Additional Advice Available on the DH Website

<http://www.dh.gov.uk/PolicyAndGuidance/EmergencyPlanning/PandemicFlu/fs/en>

General information

1. **Explaining pandemic flu** (October 2005)
A guide from the Chief Medical Officer (CMO) for healthcare professionals and the public.
2. **Key facts** (October 2005)
Key facts on pandemic influenza, its causes, and preparations for it.
3. **Important information for you and your family** (October 2005)
This leaflet describes pandemic flu, the risk of it occurring in this country, what makes it different from the 'ordinary' flu we get every winter, and what the UK is doing to prepare for a possible influenza pandemic.
4. **Frequently asked questions** (October 2005)
Answers to commonly asked questions about the likely impact on society.

Further advice and guidance on contingency planning

5. **Operational guidance for health service planners** (May 2005)
6. **UK operational framework for stockpiling, distributing and using antiviral medicines in the event of pandemic influenza** (September 2005)
7. **Clinical guidelines for patients with an influenza-like illness during an influenza pandemic** (October 2005)
8. **Guidance for pandemic influenza: infection control in hospitals and primary care settings** (October 2005)
9. **Wales Framework for Managing Major Infectious Disease Emergencies** (October 2005)

Via DfES website –

<http://www.teachernet.gov.uk/emergencies/planning/flupandemic/>

10. **Department for Education & Skills - Guidance for schools and other educational establishments** (July 2006)

Via UK Resilience website –

<http://www.ukresilience.info/publications/060516flubcpchecklist.pdf>

11. **Cabinet Office – Pandemic Influenza Checklist for Businesses** (May 2006)