LRF Pandemic Flu Preparedness

Executive Summary

The LRF pandemic flu questionnaire was developed and commissioned to support the work of the Pandemic Flu Readiness Board (PFRB) prior to Covid-19. This summary of LRF responses represent the situation at the point of collection in February 2020 and has been repurposed to support preparations for Covid-19. A range of actions are recommended in this report that fall to the local and national tiers to take forward (Appendices 1).

LRF pandemic Flu preparedness provides a good foundation for the Covid-19 Reasonable Worst-Case Scenario (RWCS) with the responses reassuringly indicating that all LRFs (38) have an overarching Pandemic Flu Plan with nearly all LRFs reporting 'significant' or at least 'some' partner engagement on Pandemic Flu planning. Areas of leading practice were highlighted with some regions working across LRF boundaries on planning and exercising.

However, in many cases assurance and exercising of these plans has not taken place in recent years, indicating that LRFs would benefit from support assuring their plans and the opportunity to look at some examples of leading practice put forward by other LRFs.

The greatest area of concern raised by LRFs and highlighted by the lower number of LRFs (28) with an Excess Deaths plan, was the local and national preparedness for the Excess Deaths RWCS; especially as local capacity struggles to cope with seasonal variations in mortality rates.

From the excess deaths plans reviewed, generally there was a lack of clarity about local capacity across the death management process and where steps could be taken to increase capacity and relieve pressure, whilst still maintaining existing processes. In this area LRFs would most benefit from additional support.

Signed by?

Contents

Introduction

MHCLGs Resilience and Emergencies Division (RED) asked each Local Resilience Forum (LRF) in England (38) to submit information on their Preparedness for Pandemic Flu as set out in the UK influenza pandemic preparedness strategy 2011 and NSRA 2019. Originally, the findings presented in this report, would inform plans for future exercises and national plans for responding to Pandemic Flu.

These findings will now also be used to support Covid-19 preparedness both nationally and locally, where areas have been identified as requiring additional support from government.

Both, the areas of concern and leading practice put forward by LRFs are recorded in this report and can be found in full in Appendices 2 and 3.

Methodology

All LRFs were asked to submit responses, between 3 - 14 February 2020, to questions regarding their Pandemic Flu preparedness. The questionnaire covered the following five areas:

1. LRF Risk Assessment – what is the local pandemic flu score and does this differ from the national assessment.
2. LRF Pandemic Flu Plan – when their plan was published and how they have assured the plan.
3. Partner engagement – how well engaged are LRF members in pandemic flu preparedness.
4. Working across LRF areas – which LRFs currently work together and any good practice to share.

5. Pandemic Flu related plans – what plans do the LRF have in place linked to pan flu and when were they assured, specifically regarding excess death.

No questions were asked regarding the resilience standard as this was just published in December 2019.

RED is reviewing all pandemic flu plans submitted against the new Pandemic Flu Resilience Standard (LINK) to determine if they contain all of the required elements and all Excess Deaths plans against the new Excess Deaths Guidance for Local Planners in England (LINK). It is understood that these have been issued since the plans were written but they may provide a useful steer on areas that might potentially be strengthened.

Risk assessment

All LRFs have Pan Flu in their risk register and whilst there is some variation in local risk assessments from the 2019 National Security Risk Assessment (NSRA), in the vast majority of cases these were set following the 2016 National Risk Assessment (NRA). LRFs with a different likelihood score noted that they will align to the 2019 NSRA likelihood rating when next reviewed.

Six LRFs had a lower impact score with one stating that this was due to a lower assessment of the impact on their local economy; this still meant that pandemic flu scored Very High on their risk register. The others were assessed against the 2016 NRA.

RECOMMENDATION 1 – LRFs should use the Covid-19 RWCS and the Pandemic Flu Resilience Standard to inform and direct their local preparedness activities, including development / review of plans and assurance processes.

LRF Plans

LRFs were asked about their pandemic flu, excess deaths and other associated plans, specifically when they were last published. All responding LRFs (38) reported having an overarching Pandemic Flu Plan (Table 4) with 36 having published their plans. 31 of those plans have been published since 2017 (see Table 7). All but one LRF indicated that partners are engaged to a 'significant extent' (24) or to 'some extent' (13).

LRF plans are based on individual agencies' pandemic response plans, as well as the business continuity plans that allow agencies to continue to provide their critical services throughout a disruptive incident.

RECOMMENDATION 2 – Individual agencies to review their own response and business continuity plans in line with the Covid-19 RWCS and the Pandemic Flu Resilience Standard.

Pandemic Flu Plans

To date RED has reviewed 24 LRF pandemic flu plans against the resilience standard. This has shown that most of the LRF plans covered the 'should have' outlined in the resilience standard. The areas that were less often covered were arrangements for multi-agency blue light services, inclusion of expectations of local institutions and stakeholders, links to the ethical framework, and recognition of the need for, and ability to deliver, a concurrent response during the duration of a pandemic.

The review was a limited desk audit and as such can only identify if the submitted plans cover areas highlighted within the Resilience Standard. Some of the areas may be covered in linked but separate plans. Such a review cannot provide assurance of capability, a responsibility that lies with the individual Category 1 responders who make up each LRF. Should external assurance of LRF

Pandemic preparedness be required, a more in-depth audit must be undertaken, including reference to governance, training, exercising, debriefing and review. Auditors should also seek to establish the level of qualification and experience of those charged with undertaking Pandemic preparedness.

RECOMMENDATION 3 – A 'Task Force' should provide support to LRFs in their assessment of local preparedness and provide national oversight of capability and readiness.

Just eight of the responding LRFs have a dedicated Pandemic Flu Group. These groups met with widely varying frequency, in three cases not at all in the last year. LRFs without a dedicated group highlighted that pandemic flu is covered by other groups within their LRF or the Local Health Resilience Partnership (LHRP) structures with strategic sponsorship on their executive groups.

RECOMMENDATION 4 – LRFs should form local Pandemic groups to coordinate local preparedness activities reporting into existing LRF structures.

LRFs are working together to develop their arrangements and sharing expertise with most LRFs (19) indicating that they have some joint working but independent plans with one in four (9 from 3 regions) having fully integrated plans. 10 LRFs have not worked with other LRFs at all in developing plans.

Of those that have a Pan Flu Plan, the majority (32) have exercised this Plan (Table 5) however just 13 have exercise since 2017, 8 did so as recently as 2019, and for the majority (19) it was before 2017 when the plan was last exercised.

RECOMMENDATION 5 – LRFs should undertake appropriate exercising to support LRFs assurance of their Covid-19 plans and promote joint working across LRF areas.

LRFs highlighted a variety of other approaches to assuring their arrangements, including:

- Consultation with the LRF / LHRP membership.
- LRF / LHRP Workshops.
- Peer challenge with senior leaders.
- Review against resilience standards.
- Review as part of annual EPRR Assurance process (1)

Exercising tended to focus on the Command, Control and Coordination (C3), consequence management and public messaging arrangements within the plans, with fewer LRFs exercising elements of regional or cross LRF response and recovery. LRFs noted that other plans that their pandemic flu plans rely upon are exercised more regularly.

Related plans

Twenty-nine LRFs have an Excess Deaths Plan, while eight have another flu related Plan. Of those that have an Excess Deaths Plan, the majority (22) have published this Plan and 15 exercised. Half (15) of those that have an Excess Deaths Plan have exercised this Plan (Table 14). Very few LRFs (9) have exercised their plan since 2017, with the remainder having last exercised before 2017. Other plans that LRFs highlighted included:

- Command and Control Plan
- NHS Mortuary Resilience Plan
- Joint Communicable Disease Incident/ Outbreak Management Plan
- Science and Technical Advice Cell (STAC) Plan
- Mass Treatment Major Incident Framework

- Mass Vaccination Plan
- Media and communications
- Novel Coronavirus Response Framework
- Pan [LRF] Strategic Emergency Response Framework
- Recovery Framework

Excess Deaths Plans

LRF Excess deaths plans focus on surging their existing systems to maximise capacity without additional infrastructure considerations. Based on RWCS for Covid-19 excess deaths plans suggest that local capacity calculations are now not sufficient to meet these requirements. Plans lack detail of how management of excess deaths would work in practice for a RWCS.

To date, RED has assessed 19 plans against the new *Excess Deaths Guidance for Local Planners in England;* all have consideration of the RWCS and have made calculations as to how many additional deaths they may need to manage and most LRFs have highlighted the need for additional costs although the majority have not been explicit about what those costs might be and where they may come from. Only two go further to measure the local capacity of the death management process to understand surge capacity and throughput of bodies.

RECOMMENDATION 6 – All LRFs to develop their excess deaths preparedness, including information on body storage and throughput capacity of their local death management system to support identification of the required capability to meet the Covid-19 RWCS.

Respondents made clear that the response is a reflection of collaboration between multiple agencies (e.g. LAs, Funeral Directors, Voluntary Agencies, LRF Partners, and Commercial Providers) and these need to have a joined-up approach, including with neighbouring areas.

As well as updated excess deaths guidance more information was requested covering Multi-faith aspects of excess deaths including what should/should not be done to ensure a nationally consistent approach.

RECOMMENDATION 7 – Government to release updated guidance covering excess deaths and faith considerations, to allow local areas to properly develop a robust capability for Covid-19.

Some areas have flagged existing capacity issues (locally and nationally) across the whole process during peak times while for others there are particular services/agencies which may not be able to service the demand in event of excess deaths.

Body Storage, other equipment and supplies

The issue of capacity for body storage in mortuaries and hospitals was raised most frequently. As one respondent explained, *"the most important aspect of managing an excess deaths event will be the availability of body storage, as this takes pressure off the entire death management process."*

Respondents flagged that such units would need to be able to freeze without drawing on national grid and that generators would be needed. Special considerations, such as storing contaminated/infected bodies also cause concerns. Respondents want guidance on any storage facilities e.g. HTA licensing of premises such as refrigerated warehousing used for longer term storage. They also asked whether Central Government could initiate discussions with such providers given they are often held by national companies.

As well as body storage capacity, respondents flagged concerns about current stock or access to supplies of body racking, chilling units, body bags, PPE etc. They noted that some larger items (e.g.

coffins) or short shelf life items cannot be stockpiled in advance and, when they may need them, there is likely to be demand drawing on the same resources possibly nationally and even internationally.

They also flagged that there's no National resources for supply and no national stockpile to draw on and questioned where responsibility lies for providing necessary equipment as well as for providing site management and security.

They noted that financial support could allow them to purchase items which have a long lead time and not held routinely by responders.

RECOMMENDATION 8 – government to identify resource and financial assistance for local areas to meet the Covid-19 excess deaths RWCS.

LRF concerns

LRFs were all asked what elements of the Pandemic Flu arrangements, if any, they are most concerned about with a full set of responses in Appendices 2.

Areas of concern were highlighted about excess deaths guidance, consistency of ethical decisions and multi-faith response as well as funding and legislative changes. Generally, concern is about a lack of timely national support to local areas including provision of supplies and guidance. They want to ensure the national response does not lag behind the local response and that intervention from government comes early enough to ensure a consistent, defensible, national approach that does not leave one area up for scrutiny compared to others.

RECOMMENDATION 9 – government to continue to share guidance on pandemic preparedness to allow LRFs to review their arrangements.

Concerns broadly covering one or more of the following, often interlinked, areas:

- Excess Deaths;
- Supply of Appropriate Equipment/Medicines;
- C3;
- Logistics;
- Information/guidance from Central Government;
- Health and Social Care sector capacity;
- Ethics/Complex Decisions;
- Skilled staff; Roles & Responsibilities;
- Critical Care;
- Testing/'First few hundred';
- Finance;
- Legislation;
- Essential Services;
- Business Continuity;
- Planning assumptions (incl. modelling tools);
- Scope of Plan;
- Communications;
- Recovery;
- Quarantine;
- Vulnerable people;

- Bereavement and Social Issues; and
- Discharge protocols.

RECOMMENDAITON 10 – Areas of concern highlighted by LRFs should be communicated to RED for the attention of the appropriate government departments.

RECOMMENDATION 11 – MHCLG to develop and share question and answer pack for LRFs that covers the areas of concern raised.

Leading practice

Thirteen LRFs reported having areas of good practice they were willing to share. This included: working with other LRFs in the region on plans, exercises and performance standards assessment; sharing information; building strong relationships; running several stages of an exercise prior to the table top part; modelling impact of national planning assumptions on local services; confidence and assurance of chairing arrangements; and joint LHRP Gold group and LRF SCG meetings where appropriate for resilience in command and control.

Several areas raised the following that could be beneficial for LRFs when reviewing planning for Covid-19:

- Reviewing the pan flu plans against the Resilience Standard relating to Pandemic Flu, this was found to be useful as a benchmark and highlighted additional considerations.
- Use of a daily mortuary capacity monitoring system to support both Excess Deaths and Mass Fatalities planning
- Held a series of webinars to raise awareness amongst resilience partners that proved effective at raising awareness and knowledge across the LRF.

RECOMMENDATION 12 – Share leading practice highlighted by LRFs.

Appendices 1. Recommendations

Please note that this is not a hieratical list of recommendations.

RECOMMENDATION 1 – LRFs should use the Covid-19 RWCS and the Pandemic Flu Resilience Standard to inform and direct their local preparedness activities, including development / review of plans and assurance processes.

RECOMMENDATION 2 – Individual agencies to review their own response and business continuity plans in line with the Covid-19 RWCS and the Pandemic Flu Resilience Standard.

RECOMMENDATION 3 – A 'Task Force' should provide support to LRFs in their assessment of local preparedness and provide national oversight of capability and readiness.

RECOMMENDATION 4 – LRFs should form local Pandemic groups to coordinate local preparedness activities reporting into existing LRF structures.

RECOMMENDATION 5 – LRFs should undertake appropriate exercising to support LRFs assurance of their Covid-19 plans and promote joint working across LRF areas.

RECOMMENDATION 6 – All LRFs to develop their excess deaths preparedness, including information on body storage and throughput capacity of their local death management system to support identification of the required capability to meet the Covid-19 RWCS.

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RECOMMENDATION 9 – government to continue to share guidance on pandemic preparedness to allow LRFs to review their arrangements.

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Appendices 2. LRF Concerns

Central Government

Respondents noted that national guidance needs updating, and concern raised about Government sharing information or providing advice. For example, the NHS national, regional and local response plans, including countermeasures and resource distribution should be made available to LRFs. Specific areas requested were the Cross-Government Pandemic Flu Bill, Excess Deaths guidance and the mechanisms for situation reporting centrally should be made clear.

Specialist resources

Concerns were raised about the availability and distribution of key medical equipment and supplies, in some cases to fill existing gaps. Respondents asked for clarity and guidance on process for supply chain management, coordination of limited supplies, and local area access to provisions.

Specific areas raised included the supply and distribution of PPE, including the process for local areas accessing national provisions of PPE, as well as for disposal of PPE, particularly for community-based staff. Similarly, LRFs requested clarity and guidance on arrangements for vaccine and antiviral provisions as it is understood these are commissioned nationally. The process for anti-viral collection points also needs to be confirmed.

As well as body storage capacity there are concerns about current stock or access to supplies of body racking, chilling units, body bags etc. It was noted that some larger items (e.g. coffins) or short shelf life items cannot be stockpiled in advance and, when they may need them, there is likely to be demand drawing on the same resources possibly nationally and even internationally. Financial support could allow them to purchase items which have a long lead time and not held routinely by responders.

They also flagged that there's no National resources for supply and no national stockpile to draw on and questioned where responsibility lies for providing necessary equipment as well as for providing site management and security.

Excess Deaths Capacity

Some LRFs have insufficient resource to hold an Excess Deaths Capability and so carry the risk, or cannot afford to hold third party contractual arrangements. They cannot all get additional resources or capabilities from Voluntary Sector Organisations.

The system nature of death management requires monitoring, identification and management of bottlenecks in individual agencies/steps. The system includes steps from pronouncing life extinct, collection of body, storage of body in temporary premises, potential viewing, disposal of body with the numerous administration challenges from coronial, registration of death, to release and disposal (including cremate/bury/memorial services).

There are concerns about resourcing excess deaths in anything other than a mass fatalities event. Some areas have flagged existing capacity issues (locally and nationally) across the whole process during peak times while for others there are particular services/agencies which may not be able to service the demand in event of excess deaths.

There are limited trained staff and, if there are any reductions such as absences for illness/care/bereavement, it may not be possible to train them to pivot to other roles. It isn't clear

what training staff have had for this in advance in each organisation. Additionally, the availability of sufficient capacity could be affected by:

- Blockages or delays in normal system.
- Pre-existing under capacity, possibly due to lack of investment for meeting demands e.g. of population growth.
- Annual winter pressure, especially during holiday period.
- Cost of multiple funerals within families/communities delaying funerals leads to increase storage time.
- Identifying suitable private provision.
- Securing private sector provision (e.g. shipping containers) e.g. with Memorandum of Understanding, needing legal advice for negotiating contracts, or waiting until the need arises and contact private sector supplies or rely on MACA.
- Supplier failure e.g. a key supplier not responding to communications, and lack of money to smooth the process and keep suppliers on retention.
- Multiple areas drawing on the same limited body storage nationally.
- Infrastructure limitations.
- Coronial boundary solutions.
- Agreeing responsibility for securing additional capacity if planned facilities are overwhelmed.
- Funding.

Roles & Responsibilities

Roles and responsibilities are unclear in some cases, including; what is expected of LAs in terms of responsibility for distribution of PPE to care providers and in terms of role in coordinating and influencing schools and private care facilities. The link between CCG, NHS and private sector and Social Care roles and responsibilities and integration with health responders may be unclear.

Clarity is needed on the role of the Scientific and Technical Advice Cell (STAC) and Scientific Advisory Group for Emergencies (SAGE) during a pandemic.

Testing/'First few hundred'

LRFs are concerned about the detection and assessment phases and 'First Few 100' as there are no commissioned services for community testing and prescribing. If sampling in a community setting is required, non-clinical staff may be asked to undertake this. Providers with clinical staff on site (e.g. registered nursing homes) may be able to undertake this however care homes may refuse to carry out their own testing due to lack of insurance cover.

C3

Some LRF partners cover larger geographical areas and will need to cover multiple LRF SCGs and TCGs, which can be difficult if battle rhythms overlap or there is insufficient staff. For these in particular, but for all agencies, it may be difficult to provide sufficient staffing for C3 and national reporting due to budgetary constraints and/or extended duration of response.

LRFs want clarity on which agency leads the SCG for Pandemic Flu (PHE, NHS, E&I, Local Authority Directors of Public Health) and links between health and social care in C3 structures.

Skilled staff and Recovery Recruitment

LRFs have identified existing shortages in appropriately trained staff across a number of agencies. With increased demand throughout a long incident response and potential staff absences, there will be even greater shortages of appropriately trained staff. Health staff may need to pivot to different roles (such as distribution of antivirals, use different PPE etc.) and, while some training can be conducted in advance, some will not be possible until a pandemic occurs and will need to be implemented rapidly.

Health and Social Care Sector Resilience

LRFs are concerned about the vulnerability and resilience of the health and social care sectors, and the ability of the NHS to cope with a large number of Pandemic Flu cases, and an extended incident response (even with practiced surge capacity). They questioned the ethics of responding with a lower level of choice/dignity in care and are concerned about what the impacts could be on the local public sector.

Business Continuity and Essential Services

Individual organisations need to be able to offer assurance of their own resilience, even in the context of high absenteeism or infection. They need robust business continuity plans to maintain workforce levels and prioritise continuation of services, especially for essential services, and their own incident management plans.

Guidance is needed on how disruption to essential supplies such as fuel, food and cash will be handled, and at what stage prioritisation would move from within a single organisation to across the public sector as a whole.

Critical Care, Quarantine, Bereavement and Social Issues, and Vulnerable people

LRFs are concerned about creating critical care capacity, and want clear clinical and ethical guidance for triaging critical care patients, support available for quarantine and support for those in quarantine. Another flagged concerns about helping with social and bereavement issues. One LRF was concerned about identifying vulnerable individuals.

Ethics/Complex Decisions

LRFs want clinical and ethical guidance on management of service changes, and triage and prioritisation of health resources. This should indicate how resources should be shared between patients with, for example, Flu, RTC Injury, or Cancer. It should also provide support resources for those making such decisions.

Planning assumptions (incl. modelling tools)

LRFs want to understand whether evidence (e.g. from the 2009 pandemic) supports current planning assumptions. They want to understand some of the detail in the planning assumptions e.g. whether expected absentee rates include bereavement absences. Ideally, they would like a modelling tool and to be able to obtain infection, excess death and absentee rates for different flu scenarios.

Scope of Plan

LRFs noted that as the plan is just focused on Influenza, some elements may not be relevant (e.g. antivirals) and it may be helpful to extend scope to an 'infections disease' plan including influenza.

Communications

Two LRFs noted they had concerns about communications strategy flagging possible issues with mixed messaging and lack of clarity as to which is the lead agency.

Discharge protocols

One respondent noted the need for robust testing within health and social care sectors of, and adherence to, rapid hospital discharge protocols. They noted there is a financial risk where rapid discharge is needed.

Appendices 3. Leading practice as assessed by LRFs

Responses are given in full below, with the exception of the three responses indicating that their Flu Plan could be shared (on request) as leading practice. In some cases, the same response was given by multiple LRFs in which case it is only presented once.

"[LRF] Pan Flu Framework (May 2018) and webinar approach to awareness raising. [LRF] Excess Deaths Framework (Feb 2020). [LRF] Novel Coronavirus Framework (Feb 2020). Good local exercising making use of Exercise Corvus. Generic strategic coordination arrangements, training and exercising are strong and help build good relationships."

London LRF

"Exercises - All on ResilienceDirect - Exercise starts 6 weeks prior to the actual 'table top'. Delegates are sent an initial Public Health England Briefing Note raising awareness of a new strain of flu in south east Asia (Scenario 1) and asks questions of organisational preparedness. 4 weeks out from the exercise delegates are sent an update in the form of a Common Operating Picture (COP) with first case in the UK, and similar questions relating to what organisations are now doing in preparedness; 2 weeks prior to exercise COP detailing local cases and asking further questions. At the actual exercise delegates already come with 'preparedness' and are set up in Tactical and Strategic Groups, working as if already at 'week 2' of Pan Flu Modelling. Framework - joint with [another South East LRF] as many organisations including NHSE/I, PHE and South Central ambulance Service are coterminous with both LRFs. Gives resilience in command and control with joint LHRP Gold group and LRF SCG meetings where appropriate."

Two South East LRFs

"Pandemic Flu modelling tool presented at PHE Conference to assess the real world impact of national planning assumptions on local services"

East Midlands LRF

"Information and plans have been shared across the South East by PHE and NHS England and NHS Improvement"

South East LRF

"Our pandemic flu plan is a NE LRFs (three LRFS) document. When it was exercised in 2016 this was done across the NE at SCG level with three SCGs sitting. We are planning to benchmark against the resilience standards jointly across the three NE LRFs."

Three North East LRFs

"LRF wide multi agency escalation notification (RMCI)"

Yorkshire and the Humber LRF

"There is confidence in setting up of strategic meeting, chairing arrangements and triggers for handover. There is assurance of chairing arrangements between the Police Commander and DPH at the onset of the pandemic. There is close working between health and social care partners and [LRF] at the strategic and tactical levels established via LHRP, [LRF] Strategic Board and the Health Protection Steering Group."

East of England LRF

Appendices 4. Tables

Table 1: LRFs Response Rate by Geographical Region

NHS Region	NSWW Region	LRF Responses	*Base*
North	North East England	3	***3***
	Yorkshire and the Humber	4	***4***
	North West England	5	***5***
Midlands	West Midlands	4	***4***
	East Midlands	5	***5***
	East of England	6	***6***
South	South East England	5	***5***
	South West England	5	***5***
London	London	1	***1***
England		**38**	***38***

Table 2: LRFs Local Assessment of Likelihood of Pandemic Flu, by Geographical Region

		LRFs by rating:						
NHS Region	**NSWW Region**	**1**	**2**	**3**	**4**	**5**	**Not assessed**	***Base***
North	North East England	0	0	0	3	0	0	***3***
	Yorkshire and the Humber	0	0	3	1	0	0	***4***
	North West England	0	0	2	3	0	0	***5***
Midlands	West Midlands	0	0	4	0	0	0	***4***
	East Midlands	0	0	1	4	0	0	***5***
	East of England	0	0	3	2	1	0	***6***
South	South East England	0	0	5	0	0	0	***5***
	South West England	0	0	0	5	0	0	***5***
London	London	0	0	0	1	0	0	***1***
England		**0**	**0**	**18**	**19**	**1**	**0**	***38***

Table 3: LRFs Local Assessment of Impact of Pandemic Flu, by Geographical Region

		LRFs by rating:						
NHS Region	**NSWW Region**	**1**	**2**	**3**	**4**	**5**	**Not assessed**	***Base***
North	North East England	0	0	0	0	3	0	***3***
	Yorkshire and the Humber	0	0	0	0	4	0	***4***
	North West England	0	0	0	0	5	0	***5***
Midlands	West Midlands	0	0	0	0	4	0	***4***
	East Midlands	0	0	0	0	5	0	***5***
	East of England	0	0	0	2	4	0	***6***
South	South East England	0	0	0	0	5	0	***5***
	South West England	0	0	0	4	1	0	***5***
London	London	0	0	0	0	1	0	***1***
England		**0**	**0**	**0**	**6**	**32**	**0**	***38***

Table 4: LRFs with Pandemic Flu Plan, by Geographical Region

NHS Region	NSWW Region	LRFs with a Flu Plan	*Base*
North	North East England	3	***3***
	Yorkshire and the Humber	4	***4***
	North West England	5	***5***
Midlands	West Midlands	4	***4***
	East Midlands	5	***5***
	East of England	6	***6***
South	South East England	5	***5***
	South West England	5	***5***
London	London	1	***1***
England		**38**	***38***

Table 5: LRFs with Flu Plan Assured, Published, and/or Exercised, by Geographical Region

NHS Region	NSWW Region	LRFs Flu Plan			*Base*
		Assured	Published	Exercised	
North	North East England	3	3	3	***3***
	Yorkshire and the Humber	3	4	4	***4***
	North West England	3	4	4	***5***
Midlands	West Midlands	3	4	2	***4***
	East Midlands	5	5	5	***5***
	East of England	6	5	5	***6***
South	South East England	3	5	4	***5***
	South West England	4	5	4	***5***
London	London	1	1	1	***1***
England		**31**	**36**	**32**	***38***

Table 6: LRFs by when Pandemic Flu Plan last Assured, by Geographical Region

NHS Region	NSWW Region	LRFs Flu Plan last Assured					*Base*
		2020	2019	2018	2017	Before 2017	
North	North East England	0	0	0	3	0	***3***
	Yorkshire and the Humber	2	0	1	0	0	***3***
	North West England	1	0	1	1	0	***3***
Midlands	West Midlands	1	2	0	0	0	***3***
	East Midlands	2	1	1	1	0	***5***
	East of England	0	3	1	0	2	***6***
South	South East England	0	2	0	1	0	***3***
	South West England	0	4	0	0	0	***4***
London	London	0	0	0	0	1	***1***
England		**6**	**12**	**4**	**6**	**3**	***31***

Table 7: LRFs by when Pandemic Flu Plan Published, by Geographical Region

NHS Region	NSWW Region	LRFs Flu Plan Published					Base
		2020	2019	2018	2017	Before 2017	
North	North East England	0	0	0	3	0	*3*
	Yorkshire and the Humber	0	0	1	3	0	*4*
	North West England	0	0	1	1	*2*	*4*
Midlands	West Midlands	2	2	0	0	0	*4*
	East Midlands	0	2	1	2	0	*5*
	East of England	1	3	0	1	0	*5*
South	South East England	1	2	0	1	1	*5*
	South West England	0	2	0	1	2	*5*
London	London	0	0	1	0	0	*1*
England		**4**	**11**	**4**	**12**	***5***	***36***

Table 8: LRFs by when Pandemic Flu Plan last Exercised, by Geographical Region

NHS Region	NSWW Region	LRFs Flu Plan last Exercised					Base
		2020	2019	2018	2017	Before 2017	
North	North East England	0	0	0	0	3	*3*
	Yorkshire and the Humber	0	1	0	0	3	*4*
	North West England	0	0	1	1	*2*	*4*
Midlands	West Midlands	1	1	0	0	0	*2*
	East Midlands	0	0	0	1	4	*5*
	East of England	0	1	1	0	3	*5*
South	South East England	0	2	0	0	2	*4*
	South West England	0	2	1	0	1	*4*
London	London	0	0	0	0	1	*1*
England		**1**	**7**	**3**	**2**	**19**	***32***

Table 9: LRFs by Extent of partner engagement, by Geographical Region

NHS Region	NSWW Region	LRFs Extent of partner engagement				Base
		Significant	Some	Low	None	
North	North East England	0	3	0	0	*3*
	Yorkshire and the Humber	3	1	0	0	*4*
	North West England	3	2	0	0	*5*
Midlands	West Midlands	3	1	0	0	*4*
	East Midlands	4	1	0	0	*5*
	East of England	4	2	0	0	*6*
South	South East England	3	2	0	0	*5*
	South West England	4	0	1	0	*5*
London	London	0	1	0	0	*1*
England		**24**	**13**	**1**	**0**	***38***

Table 10: LRFs with Dedicated Pandemic Flu Group, by Geographical Region

NHS Region	NSWW Region	LRFs with a Flu Group	Base
North	North East England	0	*3*
	Yorkshire and the Humber	0	*4*
	North West England	3	*5*
Midlands	West Midlands	1	*4*
	East Midlands	2	*5*
	East of England	0	*6*
South	South East England	1	*5*
	South West England	0	*5*
London	London	1	*1*
England		**8**	***38***

Table 11: LRFs by Pandemic Flu Group Frequency in last year, by Geographical Region

NHS Region	NSWW Region	LRFs Frequency of Flu Group Meetings last year					Base
		Never	Once or less	2-3 times	*4-6 times*	*> 6 times*	
North	North East England	0	0	0	0	0	***0***
	Yorkshire and the Humber	0	0	0	0	0	***0***
	North West England	1	1	1	0	0	***3***
Midlands	West Midlands	0	0	0	1	0	***1***
	East Midlands	1	0	0	1	0	***2***
	East of England	0	0	0	0	0	***0***
South	South East England	0	0	1	0	0	***1***
	South West England	0	0	0	0	0	***0***
London	London	1	0	0	0	0	***1***
England		**3**	**1**	**2**	**2**	**0**	***8***

Table 12: LRFs by Extent of working with other LRFs, by Geographical Region

NHS Region	NSWW Region	LRFs Extent of working with other LRFs			Base
		Fully	Some	*None*	
North	North East England	3	0	0	***3***
	Yorkshire and the Humber	4	0	0	***4***
	North West England	0	4	1	***5***
Midlands	West Midlands	0	2	2	***4***
	East Midlands	0	1	4	***5***
	East of England	0	4	2	***6***
South	South East England	2	2	1	***5***
	South West England	0	5	0	***5***
London	London	0	1	0	***1***
England		**9**	**19**	**10**	***38***

Table 13: LRFs with Excess Death Plan/Other Flu-related Plan, by Geographical Region

NHS Region	NSWW Region	LRFs with Excess Deaths Plan	LRFs with Other Flu-related Plan	Base
North	North East England	3	0	***3***
	Yorkshire and the Humber	2	0	***4***
	North West England	4	1	***5***
Midlands	West Midlands	2	0	***4***
	East Midlands	5	1	***5***
	East of England	4	1	***6***
South	South East England	4	3	***5***
	South West England	4	1	***5***
London	London	1	1	***1***
England		**29**	**8**	***38***

Table 14: LRFs with Excess Deaths Plan Published, and/or Exercised, by Geographical Region

NHS Region	NSWW Region	LRFs Excess Deaths Plan		
		Published	Exercised	*Base*
North	North East England	0	0	***3***
	Yorkshire and the Humber	2	0	***2***
	North West England	3	3	***4***
Midlands	West Midlands	1	2	***2***
	East Midlands	4	3	***5***
	East of England	3	2	***4***
South	South East England	4	3	***4***
	South West England	4	1	***4***
London	London	1	1	***1***
England		**22**	**15**	***29***

Table 15: LRFs by when Excess Deaths Plan Published, by Geographical Region

NHS Region	NSWW Region	LRFs Excess Deaths Plan Published					
		2020	2019	2018	2017	*Before 2017*	*Base*
North	North East England	0	0	0	0	0	***0***
	Yorkshire and the Humber	0	0	0	2	0	***2***
	North West England	0	0	1	0	2	***3***
Midlands	West Midlands	0	1	0	0	0	***1***
	East Midlands	0	1	2	1	0	***4***
	East of England	0	1	0	0	2	***3***
South	South East England	0	1	2	0	1	***4***
	South West England	0	1	0	0	3	***4***
London	London	1	0	0	0	0	***1***
England		**1**	**5**	**5**	**3**	**8**	***22***

Table 16: LRFs by when Excess Deaths Plan last Exercised, by Geographical Region

NHS Region	NSWW Region	LRFs Excess Deaths Plan last Exercised					
		2020	2019	2018	2017	*Before 2017*	*Base*
North	North East England	0	0	0	0	0	***0***
	Yorkshire and the Humber	0	0	0	0	0	***0***
	North West England	1	0	1	1	0	***3***
Midlands	West Midlands	0	1	0	0	1	***2***
	East Midlands	0	2	0	0	1	***3***
	East of England	0	0	1	0	1	***2***
South	South East England	0	2	0	0	1	***3***
	South West England	0	0	0	0	1	***1***
London	London	0	0	0	0	1	***1***
England		**1**	**5**	**2**	**1**	**6**	***15***

Table 17: LRFs by Number of other Flu related Plans, by Geographical Region

NHS Region	NSWW Region	LRFs Number of Flu Related Plans			
		1	2-3	4+	*Base*
North	North East England	0	0	0	***0***
	Yorkshire and the Humber	0	0	0	***0***
	North West England	1	0	0	***1***
Midlands	West Midlands	0	0	0	***0***
	East Midlands	1	0	0	***1***
	East of England	0	1	0	***1***
South	South East England	0	3	0	***3***
	South West England	1	0	0	***1***
London	London	1	0	0	***1***
England		**4**	**4**	**0**	***8***

Table 18: LRFs Other Flu related Plans, by Geographical Region

NHS Region	NSWW Region	No. other plans exercised	No. other plans exercised in 2019/20	*Total No. other plans*
North	North East England	0	0	***0***
	Yorkshire and the Humber	0	0	***0***
	North West England	0	0	***1***
Midlands	West Midlands	0	0	***0***
	East Midlands	1	0	***1***
	East of England	2	0	***3***
South	South East England	6	6	***8***
	South West England	1	0	***1***
London	London	0	0	***1***
England		10	6	***15***