MANAGEMENT PROCESS DESCRIPTION MPD617/4

NHSBT Pandemic Response Plan

This Management Process Description replaces MPD617/3	**Copy Number**
	Effective **06/02/2020**

Summary of Significant Changes

This MPD is a complete re-write of the previous version

Command and Control are aligned with NHSBT's Critical Incident Plan (MPD539)

The NHSBT response has been aligned with UK Pandemic DATER Phases

Policy

This document sits under POL137 and exists to ensure NHS Blood and Transplant (NHSBT) is ready to respond to disruption caused by the spread of a novel infectious agent resulting in a pandemic disease.

Purpose

This document describes how NHSBT will respond to the outbreak of a pandemic disease.

Responsibilities

All Staff

Respond to the declaration of a Pandemic Disease by following the principles outlined in this plan.

Director (Pandemic)

Assume overall strategic command of NHSBT's response to a Pandemic.

NHSBT Head of Business Continuity

Create and maintain a state of preparedness based upon this document and associated plans. Ensure NHSBT's approach aligns with the latest UK pandemic preparedness strategy.

NHSBT Business Continuity Manager

Ensure NHSBT's operational directorates are supported in using this document as a basis for implementing a proportionate departmental response.

Definitions

DHSC – Department of Health and Social Care

DATER – Phases of UK Pandemic Response:

Detection

Assessment

Treatment

Escalation

Recovery

LET – Local Emergency Team

NET – National Emergency Team

PHE – Public Health England

PHIC – Public Health Emergency of International Concern

PPE – Personal Protective Equipment

WHO – World Health Organisation

Applicable Documents

POL77 – Pandemic Flu Staffing Policy

POL137 – Business Continuity Policy

MPD340 – Pandemic Flu - Protecting and Managing Staff, Donors and Others

MPD539 – NHSBT Critical Incident Plan

MPD1095 – Emergency Planning Redeployment

MPD1379 – NHSBT Crisis Communication Plan

MPD1380 – Critical Incident Communication Plan – Blood Stock shortage

DAT3717 – Pandemic Disease - Operational Guidance for Service Managers

DAT3093 – National Emergency Team

This plan has been informed by national guidance issued by other World/UK Health Organisations, linked below:

Department of Health and Social Care / Public Health England

- Department of Health (2011) *The UK Influenza Preparedness Strategy (p.41)*
- Department of Health (2012) *Health and Social Care Influenza Pandemic Preparedness & Response*
- https://www.gov.uk/guidance/pandemic-flu

NHS England

- NHS England (2013) *Operating Framework for Managing the Response to Pandemic Influenza*
- https://www.england.nhs.uk/ourwork/eprr/pi/

World Health Organisation (Flu background)

- http://www.who.int/influenza/pandemic-influenza-an-evolving-challenge/en/
- http://www.who.int/influenza/preparedness/en/

Table of Contents

1 Introduction

NHSBT's overarching Pandemic Response Plan consists of two parts:

- This MPD provides a strategic summary of NHSBT's overall response
- DAT3717 provides operational guidance for service managers

In some cases, individual departments have maintained specific pandemic disease plans or included response options for a pandemic within their substantive departmental Business Continuity Plans.

Summary of NHSBT actions in response to UK DATER Phases

The actions outlined in the flowchart below have been mapped to UK DATER Phases and should be utilised by NHSBT's National Emergency Team (NET) as an aide-memoire to structure the response to a pandemic disease. In addition to these suggested actions, key agenda items for the Pandemic NET will include:

- **Staff Absence:** The NET should have up to date sickness/absence levels across the organisation to allow them to implement a staffing plan to ensure sufficient and safe staffing across all areas.
- **Blood Collection and Stock Levels**: The NET should have an overview of the impact on donation levels, current stock levels and changing demand for products.
- **Organ Donation, Transplantation and Tissues Capability:** The NET should have an overview of the impact on deceased and living organ donation, transplantation and tissue services on a UK wide basis
- **Manufacturing and Logistics Capability**: The NET should have a real-time overview of manufacturing and logistics capacity across the organisation, including impacts to air travel, distribution to island territories and the impact of staff absences in any specific area (laboratories, drivers, couriers etc).
- **Specialist Services Capability:** The NET should have up to date capacity information from Specialist Services.
- **Infection Control Measures:** The NET should have oversight of current Infection Control measures in place, to ensure they are sufficient and to enforce and escalate infection control measures (including PPE training).
- **Essential Supplies:** The NET should have up to date stock levels for essential supplies to ensure NHSBT has suitable supplies for the coming days, this includes masks and other items of PPE.
- **Communications**: During a Pandemic, communications should be considered for both internal and external audiences. Communication with hospitals, organ retrieval teams and donors will be of particular importance. MPD1380 sets this out.
- **External Stakeholders:** Communication with regulators, (for example, the MHRA and HTA) if there is a risk of patient safety. Communication with the UK and Irish Blood Services, DHSC, NHS England and devolved powers as required to share information and offer mutual aid.

DETECTION PHASE ACTIVATED
Appoint "Director (Pandemic)", declare a Critical Incident and implement Command & Control as per MPD539
Convene National Emergency Team (NET) to establish operational capabilities and NET meeting frequency
Determine any possible and proportionate action required in respect of donor selection criteria and donor testing in consultation with the Joint Professional Advisory Committee (JPAC)
Review Pandemic Staffing Policy and related Management Process (POL77 and MPD340)
Increase staff awareness of signs, symptoms and epidemiology of the pandemic disease as well as any infection control measures, reinforcing national guidance and material for the public issued by Public Health England, NHS England and/or DHSC
Communicate expectations for staff who have recently travelled to affected areas
Review infection control procedures and implement a Pandemic Infection Control Action Plan for staff focussed on respiratory/hand hygiene and use of additional personal protective equipment (PPE) where appropriate
Seek assurance around the preparedness of subcontractors, commissioned services and key suppliers
Consider communicating with Hospitals to understand their preparedness & expectations

The indicator for moving to the Assessment phase would be the identification of the novel pathogen in patients in the UK

ASSESSMENT PHASE ACTIVATED
NET meets at regular intervals and determines requirement for Local Emergency Team (LET) situation reporting
Director (Pandemic) to reassess incident level and consider “Operation Arizona” response
Commence multiagency engagement at the strategic level, considering the devolved administrations for Organ Donation and Transplantation activity and initiate reporting to DHSC on NHSBT status
Coordinate response activity with other UK Blood Services via UK Forum
Donor-facing departments begin to implement their respective Pandemic Plans where these exist
Continue coordinated release of Pandemic Medical/Self-Care messaging in line with national strategy
Convene a separate strategic Recovery Planning Group (RPG)
Consider building stock of blood products, tissues and critical consumables with an appropriate shelf-life
Assess how deceased and living organ donation and deceased tissue donation will be affected by increased demands on NHS resources and hospital capacity. Consider the impacts on organ and tissue retrieval and transplantation in the wider NHS.
Consider pausing projects at appropriate safe points

The indicator for moving to the Treatment phase would be evidence of sustained community transmission of the novel disease.

TREATMENT PHASE ACTIVATED
NET and LETs continue to meet - daily or as determined by the NET
Implement home-working arrangements for appropriate staff
Where required reallocate staff and redistribute equipment to maintain core functions
Consider establishing a Staff Welfare Team to agree and oversee any measures which may be introduced to assist staff i.e. frequently asked questions, provision of transport etc.
Increase capacity at static donor sites and consider an enhanced entry/screening protocol
Consider the restriction of mobile collection activity in badly affected areas

ESCALATION PHASE ACTIVATED
NET and LETs continue to meet – twice daily or as determined by the NET
Operation Arizona response to be stood up if not already invoked
Prioritise and triage service delivery concentrating on essential activity only
Fully implement departmental business continuity plans for handling staff shortage
Where staff absence increases to unsafe levels LETs are authorised to activate Emergency Planning Staff Redeployment Plan (MPD1095)
Implement any reduced-service policies agreed with subcontractors

RECOVERY PHASE ACTIVATED
Review availability of services, extent of loss and implement recovery strategy for return to 'New Normal'.
Downscale NET and LET meetings in accordance with recovery progress and possible further pandemic waves
Ensure business continuity plans are reviewed to capture any innovative response measures taken.
Take positive action to recognise and provide support for the mental health needs of staff

1.1 Objectives

During a Pandemic NHSBT's main objectives are to:

- Implement a flexible, precautionary and proportionate response
- Ensure the spread of disease is minimised
- Ensure that essential activities are maintained
- Manage a reduction of staff or donors due to illness
- Manage the incident through the National Emergency Team (NET) and Local Emergency Teams (LETs)
- Minimise morbidity and mortality from the pandemic disease among donors and staff
- Provide timely, authoritative and up-to-date information to service users, staff and partner agencies
- Return to normal working after a pandemic as rapidly and effectively as possible

1.2 Maintenance and Review

This plan is managed by NHSBT's Head of Business Continuity and reviewed annually by the Business Continuity Team and/or following lessons learned from incidents and exercises.

1.3 Exercises

NHSBT commits to exercising this Pandemic Response Plan at regular intervals as stipulated within NHSBT's Business Continuity exercise schedule (DAT3400).

1.4 Planning Approach

This plan recognises that Pandemics result from a novel (new) infectious agent (pathogen) or an infectious agent that is newly capable of spreading rapidly. Whilst pandemic planning focusses largely on the outbreak of a novel Influenza Virus (due to past events and the ease of airborne transmission via coughs and sneezes) it should be noted that this definition can apply to other infections subject to global spread such as Coronaviruses, Cholera and Dengue Fever. It is important to note that the availability of medical interventions will vary dependent on the type and nature of the disease.

Due to the random nature of pandemic events, NHSBT's planning places emphasis on a precautionary, proportional and flexible response.

- **Precautionary:** The response to any novel disease will take into account the risk that it could be severe in nature. Plans are therefore in place for a pandemic with the potential to cause severe symptoms or fatalities in individuals and widespread disruption to society.

- **Proportionality:** The organisation's response to a pandemic will be no more and no less than that necessary in relation to the known risks. The NHSBT plan in place provides for high impact pandemics, but also for milder scenarios, with the ability to adapt them as new evidence emerges.

- **Flexibility:** There is an in-built flexible approach to the response to any new pandemic but with departmental 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.

NHSBT's planning for a pandemic disease is informed by the UK Influenza Pandemic Preparedness Strategy (DHSC, 2011) and will continue to be:

- Evidence based
- Based on ethical principles
- Based on established practice and systems, as far as possible
- Across the whole of the organisation
- Coordinated at local Level with Partners and other local stakeholders.
- Coordinated at National Level with the appropriate section in the Department of Health and Social Care

1.5 Legal Framework

Under the Civil Contingencies Act (2004) a range of provisions could become available if the situation causes 'loss of human life, human illness or injury, disruption of services relating to health' (Section 19 (2) a, b, h). In the event of a severe pandemic disease affecting the UK, such powers allow the UK Government to implement emergency regulations where:

- An emergency has, is occurring, or is about to occur
- It is necessary to make provision for the purpose of preventing, controlling or mitigating an aspect or effect of the emergency, and
- The need for such provision is urgent

Amongst other things, those regulations may:

- require or prohibit movement to or from a specific place,
- require or prohibit assemblies of specified kinds, at specific places or at specific times,
- prohibit travel at specified times,
- prohibit other specified activities, and
- Create an offence of failing to comply with a provision of the regulations or obstructing a person in the performance of a function under these regulations.

N.B. For planning purposes, it is presumed that UK Government will rely on voluntary quarantine and other self-containment/control methods, invoking emergency powers only if they become necessary, in which case the least restrictive measures will be applied first.

1.6 Ethics

DHSC established the Committee on Ethical Aspects of Pandemic Influenza (CEAPI) in 2007. This group have been reviewed and recognised as a valid group. The CEAPI could be re-established as required in the future when needed. A copy of the ethical framework can be found here: https://www.gov.uk/guidance/pandemic-flu#ethical-framework

1.7 Organisational Arrangements

NHSBT's Chief Executive is ultimately responsible for all NHSBT resilience planning which includes planning arrangements for a Pandemic Disease. The organisation's response to a pandemic disease is led by a nominated Director who will manage the incident. They will be known as "Director (Pandemic)" and will initially chair the Pandemic NET with the support of the National Critical Incident Manager (NCIM).

1.8 Business Continuity

Departmental Business Continuity Plans provide guidance on maintaining reduced but acceptable pre-defined levels of service during periods of unusual pressures or interruptions to service supply. Departmental plans include considerations around how key products and services will be protected and maintained in the event of significant staff shortfall.

2 Background

Pandemics emerge as a result of a new pathogen or subtype that becomes easily transmissible between humans. Few - if any - people will have any immunity to the new disease thus allowing it to spread easily and to cause more serious illness. The conditions that allow a new pathogen to develop and spread continue to exist, and some features of modern society, such as air travel, could accelerate the rate of spread. Experts therefore agree that there is **a high probability** of a pandemic occurring, although the timing and impact are **impossible to predict**.

Past pandemics have varied in scale, severity and consequence, although in general their impact has been much greater than that of even the most severe winter 'epidemic'. Each pandemic is different and, until the novel pathogen starts circulating, it is impossible to predict its full effects. As such, it is impossible to forecast the precise characteristics, spread and impact of a new influenza virus strain, however, based on historical information and scientific evidence we are able to predict the possible impacts:

Many millions of people around the world will become infected, up to around 50% become ill with symptoms and a variable proportion die from the disease itself or from complications such as pneumonia.

In the absence of early or effective interventions, society is also likely to face social and economic disruption, significant threats to the continuity of essential services, lower production levels, shortages and distribution difficulties. Individual organisations may also suffer from the pandemic's impact on business and services. Large numbers of staff are likely to be absent from work at any one time."

3 Pandemic Risk

3.1 Risk Assessment

Pandemic disease remains the top risk on the UK Cabinet Office National Risk Register of Civil Emergencies (2017) due the high likelihood and potential impact of a pandemic (described broadly in the UK Planning Assumptions below).

NHSBT assesses the impact of a pandemic disease on blood, organ and tissue supply as severe with high likelihood. Key impact and response areas to be considered by NHSBT include:

- Reduced donor availability
- Reduced capacity within the NHS to facilitate organ and tissue donation, retrieval and transplantation
- Transmission of the pandemic disease through NHSBT activity
- Changing need for blood*
- Increased employee absence
- Supply chain disruption
- Potential for collection venues to conflict with facilities required for Antiviral Collection Points where applicable

*An adequate supply of blood is critical to the provision of acute healthcare during an influenza pandemic and will be vital for the emergency care of many patients including those requiring extracorporeal membrane oxygenation (ECMO) for respiratory failure associated with severe influenza pneumonia. Convalescent Whole Blood or Plasma therapy may also be appropriate in some cases.

During and after a severe pandemic the blood supply chain may take longer to recover and rebuild stocks than the rest of the NHS. Therefore, it is vitally important that resumption of business as usual activities requiring blood products is actioned in a coordinated way with NHSBT.

At peak, a severe pandemic will put great strain on the whole healthcare system. Demand for blood may fall because of a reduction in elective surgery and other blood-using treatments. Overall, however, it is anticipated that the available blood supply is likely to fall acutely due to a larger adverse impact on blood donation.

3.2 UK Planning Assumptions for Pandemic Influenza

"Reasonable worst case" planning assumptions are set out in DHSC's *UK Influenza Pandemic Strategy (2011)* and have been summarised below. The exact characteristics and impacts of a novel disease are impossible to predict accurately, and it should be noted that the assumptions below relate only to an outbreak of ***Influenza***.

- **Anytime, anywhere:** A pandemic could emerge at anytime, anywhere in the world, including in the UK. It could emerge at any time of the year. 'Pandemic Flu' differs from Seasonal Flu as it can occur at any time of the year, with little warning and the global population will have very little, if any, immunity to the virus
- **Impossible to stop:** It will not be possible to stop the spread of, or to eradicate, the pandemic infection, either in the country of origin or in the UK, as it will spread too rapidly and too widely.
- **3-5 Months:** From arrival in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters of disease are occurring across the country. Initially, pandemic influenza activity in the UK may last for three to five months, depending on the season. There may be subsequent substantial activity weeks or months apart, even after the WHO has declared the pandemic to be over.
- **Pandemic Waves:** The nature of pandemics is that there can be multiple waves of infection where the number of symptomatic cases increases and then falls over a number of weeks (a wave). A pandemic may have several waves or simply be made up of one wave.
- **50% of all people:** Previous studies suggest that roughly one half of all people may display symptoms of some kind (ranging from mild to severe). The transmissibility of the pandemic virus and the proportion of people in which severe symptoms are produced will not be known in advance.
- **Half of all staff affected:** Up to 50% of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic, affecting 35-50% of the population, this could be higher as some with caring responsibilities will need additional time off.
- **20% reduction in staff for 3 weeks:** In a widespread and severe pandemic, affecting 50 per cent of the population, between 15 per cent and 20 per cent of staff may be absent on any given day. These levels would be expected to remain similar for one to three weeks and then decline.
- **Additional absences:** Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, to look after children in the event of schools and nurseries closing, family bereavement etc.
- **Wide spectrum of illness:** Regardless of the nature of the virus, it is likely that members of the population will exhibit a wide spectrum of illness, ranging from minor symptoms to pneumonia and death. Most people will return to normal activity within 7 - 10 days.
- **Infectious for 5-7 days:** The incubation period for influenza will be in the range of 1 to 4 days (typically 2 to 3). Adults are infectious for up to five days from the onset of symptoms.

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.

- **30% of symptomatic cases require healthcare support:** Health services should prepare for up to 30% of symptomatic patients requiring assessment and treatment in usual pathways of primary care, assuming the majority of symptomatic cases do not require direct assistance from healthcare professionals.
- **1-4% of symptomatic cases require hospital care:** Between 1% and 4% of symptomatic patients will require hospital care, depending on how severe the illness caused by the virus is. There is likely to be increased demand for intensive care services.
- **2.5% of symptomatic cases may die as a result of influenza if no treatment proves effective:** These figures might be expected to be reduced by the impact of countermeasures, but the effectiveness of such mitigation is not certain. The combination of particularly high attack rates and a severe disease is also relatively (but unquantifiably) improbable.
- **Potential for 210,000 – 315,000 additional deaths over as little as a 15-week period**
- **Pre-pandemic vaccine:** The Government currently holds a limited supply of H5N1 vaccine. This could offer some protection in the event of an increased threat of a new pandemic arising from this highly pathogenic virus ("avian flu"). However, this vaccine would not necessarily be well-matched to the specific pandemic strain once it emerges and so the level of protection offered by the vaccine would not be known in advance.
- **Antiviral and antibiotic stockpiles:** The UK continues to maintain stockpiles and distribution arrangements for antiviral medicines and antibiotics sufficient for a widespread and severe pandemic.

4 Pandemic Phases

4.1 World Health Organisation (WHO) Pandemic Phases

WHO phases are based on the overall global situation and are used internationally for alerting purposes. It is important to note that following the 2009/10 Swine Flu (H1N1) Pandemic the indicators for action in the UK have been revised and decoupled from those used by the World Health Organisation (WHO). These UK indicators are described as phases named: Detection, Assessment, Treatment, Escalation and Recovery (DATER) and are intended to enable a more flexible and proportionate response based on a risk assessment of the current UK situation.

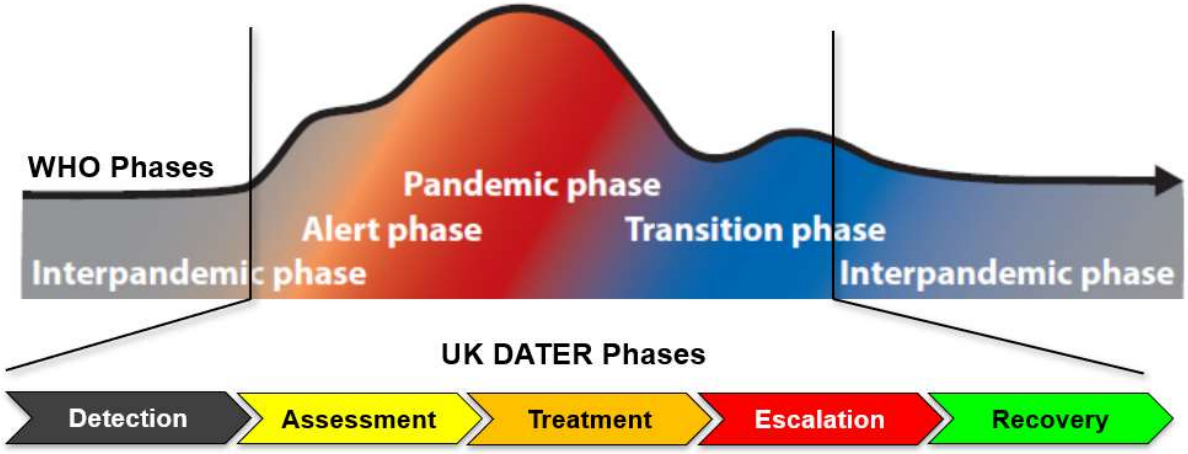
WHO Pandemic Phases:

- **Interpandemic phase:** This is the period between pandemics.
- **Alert phase:** This is the phase when a novel pathogen has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new pathogen is not

developing into a pandemic strain, a de-escalation of activities towards those in the Interpandemic phase may occur.

- **Pandemic phase:** This is the period of global spread of the pandemic disease caused by a new subtype. Movement between the Interpandemic, alert and pandemic phases may occur quickly or gradually as indicated by the global risk assessment, principally based on epidemiological and clinical data.

- **Transition phase:** As the assessed global risk reduces, de-escalation of global actions may occur, and reduction in response activities or movement towards recovery actions by countries may be appropriate, according to their own risk assessments.



4.2 UK Pandemic Phases (DATER)

UK pandemic planning is based on a five-phase model:

- **D**etection
- **A**ssessment
- **T**reatment
- **E**scalation
- **R**ecovery

The phases are not numbered as they are not necessarily linear, and it is possible to move back and forth or jump phases. It should also be recognised that there may not be a clear delineation between phases, particularly when considering regional variation and comparisons.

In a severe situation, it may be necessary to activate Detect and Assessment at the same time, then Treat and Escalate in short order, if not concurrently. The DATER phases will be used in flexible, precautionary and proportionate way in response to the level and severity of the pandemic. Further detail of how the wider health community will respond is contained within **Appendix A** of this plan.

5 Command and Control

5.1 Activation

The Detect phase of this plan will be activated either on the WHO declaration of a pandemic-related "Public Health Emergency of International Concern" (PHEIC) or on the basis of reliable intelligence suggesting a pandemic is imminent. The NHSBT Director (Pandemic) or Medical Director, can initiate activation of the NHSBT pandemic response in advance of the declaration of a pandemic by WHO, if it is considered sensible to commence preliminary actions before the pandemic has actually reached the UK. Upon activation of this plan:

- "Director (Pandemic)" will be appointed to lead NHSBT's response to the incident
- The National Emergency Team (NET) will meet to discuss initial actions required and establish a 'battle-rhythm', standing-agenda and reporting structure for subsequent meetings

The indicator for moving to the next phase (Assessment) would be the identification of the novel pathogen in patients in the UK.

5.2 Management of the Response

Refer to 'NHSBT Operational DATER Response Flow Chart' at the top of this document for a step-by-step summary of NHSBT actions in response to UK DATER phases as set out in the **UK Influenza Pandemic Preparedness Strategy (2011).**

In response to a declared Pandemic, the National Emergency Team will assess the impact of the pandemic on the organisation's operational capability and agree the appropriate response by modifying activity, re-directing resources internally and managing which services continue at normal levels, which services continue to operate but at reduced or modified levels and which services are temporarily discontinued.

During the Escalation phase all activity should be reduced to essential activity only, individual departmental Business Continuity plans should be fully implemented and NHSBT activity reduced to identified core activities only with non-critical staff allocated to supporting roles, where necessary. NHSBT's HR, Communications and Health and Safety teams will be required to activate their respective pandemic arrangements which are maintained separately to this overarching plan. In the event of staff absence exceeding tolerable levels, Local Emergency Teams are authorised to activate the organisation's Emergency Planning Redeployment Plan (MPD1095). These measures could also be implemented during the Treatment phase, if the organisation sees it fit.

Regular information will be passed between the National and Local Emergency Teams so that the national strategy is clear and local impacts and escalated. Local Emergency Teams will be responsible for liaison with local organisations where this is required (Local Resilience Fora, Emergency Services, Local Authority etc.) whilst he NET will provide regular status updates to the Department of Health and Social Care.

Appendix 1 – DATER levels and actions to be taken by the wider health service

DETECTION	This would commence either on the declaration of the 'Pandemic Alert' WHO Phase or earlier on the basis of reliable intelligence or if a Pandemic related "Public Health Emergency of International Concern" (a "PHEIC") is declared by the WHO. The focus in this stage would be: • Intelligence gathering from countries already affected • Enhanced surveillance within country • The development of diagnostics specific to the new pathogen • Information and communications to the public and professionals
ASSESSMENT	The indicator for moving into this phase would be the identification of the novel pathogen in patients in the UK The focus in this stage would be: The collection of detailed clinical and epidemiological information on early cases on which to base early estimates of impact and severity in the UK. Reducing the spread of the disease within the local community by: • Actively finding cases • Self-isolation of cases and suspected cases • Treatment of cases / suspected cases and use of antiviral prophylaxis for close / vulnerable contacts, based on a risk assessment of the possible impact of the disease
Detection and Assessment phases together form the initial response. This may be relatively short, and the phases may be combined depending on the speed with which the disease spreads, or the severity with which individuals and communities are affected. It will not be possible to halt the spread of a new pandemic pathogen, and it would be a waste of public health resources and capacity to attempt to do so.	
TREATMENT	The indicator for moving to this phase would be evidence of sustained community transmission of the novel disease. The focus in this stage would be: • Treatment of cases through routine NHS services and the National Pandemic Flu Service (NPFS) if required • Enhancement of the health response to deal with increasing numbers of cases • Consider enhancing public health measures to limit transmission of the disease as appropriate, such as localised school closures based on public health risk assessment.

	• Preparing for targeted vaccinations as the vaccine becomes available Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases and deaths. When demands for services start to exceed the available capacity available additional measures will need to be taken. This decision is likely to be made at a regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity.
ESCALATION	The focus in this stage would be: • Escalation of surge management arrangements in health and other sectors • Prioritisation and triage of service delivery • Resiliency measures
Treatment and Escalation phases form the overall treatment phase of the pandemic. Whilst escalation measures may not be needed in mild pandemics, it would be prudent to prepare for the implementation of the escalation phase in the early part of the treatment stage, if not before.	
RECOVERY	The indicator for moving to this phase would be when pandemic activity is either significantly reduced compared to the peak or when activity is considered to be within acceptable parameters. An overview of how services' capacities are able to meet demand will also inform this decision. The focus in this stage would be: • Normalisation of services • Restoration of business as usual services and catching up • Evaluation and post incident reporting • Taking steps to address staff exhaustion • Planning and preparation for a resurgence of activity • Continuing targeted vaccination, when available. • Preparing for post-pandemic seasonal influenza