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Date: 3 December 1997

Mr J Breen

NI CONTINGENCY ARRANGEMENTS FOR PANDEMIC INFLUENZA

1. You will remember the UK Health Department's Multiphase Contingency Plan for Pandemic Influenza (not attached) which we circulated to Boards and Trusts in March 1997.

2. I have drafted an NI plan based closely on the UK plan showing the respective roles of DH(L), and key players in GB, DHSS, Boards, Trusts and GP fundholders. I have tried to strike a balance between giving some of the background and rationale without going into the level of detail in the UK plan.

3. I would be grateful for your comments. I suggest that once you are content, we circulate it to colleagues within DHSS for comments before sending to to Boards, Trusts and GP fundholders.

DR ELIZABETH MITCHELL

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NORTHERN IRELAND CONTINGENCY ARRANGEMENTS FOR PANDEMIC INFLUENZA

INTRODUCTION

1. This plan outlines the Department of Health and Social Service's (DHSS) response to the occurrence of a world-wide influenza pandemic. It complements the UK Health Department's Multiphase Contingency Plan for Pandemic Influenza (Tab A). It provides a framework for the development of more detailed local plans by Health and Social Services Boards, Health and Social Services Trusts and fundholding practices.

2. A world-wide influenza epidemic will result from emergence of a new viral strain against which a high proportion of the population have no immunity. Typically such strains can appear at any time of the year and spread world-wide from their original source in approximately 6 months. Intervals between previous pandemics have varied from 11 to 42 years with no recognisable pattern. The last pandemic was in 1968/9. In most epidemics activity can be expected to last 6-8 weeks. The same applies to pandemic influenza activity in the UK, although in 1968/69 lower levels of activity continued for 3-4 months. Past experience suggests that between 8% and 25% of the community will suffer influenza illness during a pandemic.

3. If a new strain or sub-type of influenza virus is identified which has the potential to cause world-wide outbreaks, the World Health Organisation will call an emergency meeting of its Influenza Collaborators and will inform the Department of Health (DH), London. DH (2) will then inform DHSS.

4. This plan will be kept under review and revised as necessary in the light of new developments and experience.

AIMS AND OBJECTIVES

5. The purpose of the plan is to assist DHSS to prepare contingency arrangements in the event of a pandemic. The objectives of the contingency arrangements are:

- to reduce morbidity and mortality from influenza illness;
- to be able to cope with large numbers of persons ill, at home, in hospital and dying;
- to ensure essential services are maintained;
- to provide timely, accurate and up-to-date information for professionals, the public and the media at all stages.

REDUCING THE MORBIDITY AND MORTALITY FROM INFLUENZA

Prevention of influenza

Immunisation

6. Immunisation with appropriately formulated influenza vaccine can reduce the impact of influenza, particularly among those population groups most at risk of serious illness or death from influenza. An early priority of contingency arrangements will therefore be to secure supplies of vaccine against the new strain and to immunise as many people as possible. However, vaccine is likely to be in short supply and will have to be distributed equitably and administered to predetermined priority groups. The public will need to be educated about the reasons for vaccine not being generally available.

Priority groups for immunisation

7. The need to keep health and other essential services running will mean that, if vaccine supplies are limited, these groups may need to take precedence for vaccine over the risk groups recommended for vaccine in interpandemic years. The following list suggests priority groups for immunisation according to vaccine availability. The precise order of priority may be changed by the Influenza Advisory Committee in the light of

information on the emerging epidemiology of the pandemic, for instance among different age groups. Estimates of the numbers in each group are in Annex 1.

i. Healthcare staff with patient contact (including ambulance staff) and staff in residential care homes for elderly people;

ii. Those providing essential services which would be disrupted by excess absenteeism during an outbreak, eg fire, police, security, communications, utilities, undertakers, armed forces;

iii. Those with chronic respiratory or heart disease, renal failure, diabetes mellitus or immuno-suppression due to disease or treatment

(a) Age > 65 years

(b) Age < 65 years

iv. Women in the last trimester of pregnancy

v. Residents of nursing homes, residential homes & other long stay facilities

vi. All over 75 years of age (will include most elderly people living alone)

vii. All over 65 years of age

viii. Household contacts of individuals at risk

ix. Age groups likely to be particularly susceptible on the evidence of population screening tests for antibodies, or morbidity/mortality data, including that from countries already affected

x. Other selected industries

xi. Those aged 20 - 65 years

xii. Those aged 0 - 19 years old

xiii. On request

Organisation of immunisation

8. Vaccine distribution will be organised centrally in order to ensure equity. Local arrangements will need to be made for immunisation. It is suggested that in general immunisation will appropriately be carried out by doctors and nurses in the community

health services. Special clinics will be necessary for, for example, occupational groups or if vaccine becomes generally available. If it becomes available for younger age groups, immunisation in schools will be considered. Where general practitioners are required to provide immunisations which are not to be reimbursed along the lines of the normal annual immunisation programme, this would not be as part of General Medical Services. Health and Social Service Boards will need to contract separately with GPs to provide the service as necessary.

Antiviral drugs

9. The antiviral agents amantadine and rimantadine are active against influenza A, although rarely used for this purpose. They too are likely to be in short supply (rimantadine is not currently licensed in the UK). Doctors will be advised of national policy for their use as a supplement or alternative to vaccine for short term protection, as well as their role in treatment, in light of knowledge of the pandemic and the availability of the drugs.

Pneumococcal vaccine

10. Pneumococcal immunisation can be expected to reduce the incidence of pneumococcal pneumonia following influenza illness. Pneumococcal immunisation policy is contained in the Health Departments' memorandum *'Immunisation against Infectious Disease'* and should be followed. Attempts should be made during the interpandemic period to increase uptake in the recognised risk groups (for most patients, pneumococcal immunisation is a once off immunisation which should not be repeated). It is unlikely that manufacturers would be able to satisfy a sudden increase in demand at the time of a pandemic.

Slowing the spread of infection

11. In general, it is unlikely that the spread of influenza can be halted, but some slowing could possibly be achieved by reducing unnecessary, especially long distance, travel, and by encouraging people suffering from the disease to stay at home. Closing schools is likely to cause some problems, especially for working parents, but would be an option to be considered, particularly if teacher absenteeism reached levels at which schools could not function.

12. The risk of nosocomial spread may be reduced by isolation of cases, cancellation of cold admissions during the epidemic, particularly those with high risk medical conditions, and a policy of, as far as possible, admitting patients with influenza only if they have medical complications. (See also paras 18 and 19)

Treatment of cases

13. There is no evidence that antibiotics have a place in the management of uncomplicated influenza, but protocols for the treatment of complications such as pneumonia should help to give optimal care and reduce morbidity and mortality. The Northern Ireland Influenza Advisory Committee will issue guidance on prevalent organisms and their antimicrobial sensitivity patterns.

COPING WITH LARGE NUMBERS OF PEOPLE ILL AND DYING

Primary care

14. Support will be required for general practitioners and local arrangements will need to be made for mobilising, conserving and reinforcing manpower. Locum pools and recruiting retired doctors are options. In 1957, the loan of junior hospital medical staff

into the primary care setting in the evenings and weekends was said to be an effective measure. However, the requirements of hospitals and current insurance indemnity arrangements may now make this inappropriate.

15. Health visitors, community nurses and practice nurses may need to rearrange their work and be deployed to different duties. This will require liaison between Trusts, Boards and GPs in order to cover the required duties during a pandemic. Where local staffing 'banks' exist, these can be used to increase the availability of staff and produce flexibility of rotas. Where a 'bank' is set up to fulfil the needs of a Trust, it might be possible to use the staff registered on the bank in other settings such as primary care.

16. Increased demand for social services is likely at a time of increased staff absenteeism and Social Service Departments will need to consider whether, for example, to recruit additional home helps.

17. Community pharmacists will need to anticipate increased demand for home treatments such as simple linctus and antipyretics, and for a wider range of prescriptions, including antibiotics and oxygen. Reminders of the association of salicylates and influenza with Reye's syndrome in children under 12 years of age should be considered.

Secondary care

18. Non-urgent admissions, including serious but non-critical operations, will need to be reviewed and may need to be suspended to make beds available. Staff rotas will need to be reviewed. Trusts may be unable to meet the obligations of some of their predetermined contracts during the pandemic period.

Trusts? Emergency bed service.

19. **[DN. check who should issue Boards or Trusts]** should issue 'yellow' and 'red' alerts when the number of admissions is expected to rise to such an extent that all non-

critical admissions need to be restricted. This would particularly apply if there was a bed shortage over an area greater than that of a local Trust or Board

20. Supplies of relevant drugs (e.g. antibiotics) and equipment (e.g. ventilator equipment) will need to be secured.

21. Trusts plans must include mortuary arrangements in the event of a large number of deaths.

ARRANGEMENTS TO MAINTAIN ESSENTIAL SERVICES

22. Local arrangements will need to link in with contingency arrangements for other disasters and to address how essential services are to be maintained despite high absentee rates.

INFORMATION

23. Communication links will be essential at both national and local level, including telephone helplines. Regular information will be cascaded to doctors via CMO letters. Literature will be widely distributed to the public. Links with the media need to be well established in advance to encourage supportive reporting and to avoid unnecessary media scares.

MAIN ROLES OF THE ORGANISATIONS INVOLVED

DEPARTMENT OF HEALTH (LONDON) (DH/L)

DH

24. DH has national responsibility for planning, initiation, direction and central co-ordination of the response.

25. In order to promulgate these activities, on the DH being informed by WHO of the isolation of a new influenza virus with pandemic potential, the Secretary of State, advised by the Chief Medical Officer, will appoint an Influenza Advisory Committee (IAC). The composition of this committee and its role is at Annex 2. The IAC will be advised by an executive at working level of DH and other health department officials (Health Promotion, Nursing, Finance and Information Divisions, the National Health Service Executive (NHSE) and the Medicines Control Agency (MCA)) led by a Co-ordinator who will assume overall accountability for national arrangements.

26. The DH's roles include:

i. securing supplies of an effective influenza vaccine and anti-viral agents
ii. controlling the issue of vaccine and anti-viral agents
iii. monitoring adverse reactions to vaccines and drugs
iv. identifying categories of individuals who should be immunised or receive antiviral prophylaxis
v. issuing advice to doctors on the use of vaccines and anti-viral agents and the appropriate treatment of pneumonia
vi. issuing other appropriate advice to the health professions, managers, the public and the media
vi. liaising with DH Research and Development Division (RDD), PHLS, the Medical Research Council (MRC) and other organisations to agree research protocols which can be activated in the event of a pandemic

vii. liaising with international agencies such as WHO and EU, including over the world-wide distribution of vaccine

viii. collating and publishing (after the event) a formal report of data relating to the pandemic in the UK and its impact.

The Public Health Laboratory Service (PHLS)

27. The principal roles of the PHLS are to provide virological and epidemiological data upon which national decisions, such as the choice and deployment of vaccine or the use of antiviral agents, must be based, and to provide viral and other diagnostic services.

28. The ***Communicable Disease Surveillance Centre*** (CDSC), Colindale, obtains, analyses and distributes information on influenza activity, including laboratory data, mortality data from the Office of National Statistics (ONS), morbidity data from the Royal College of General Practitioners (RCGP) Research Unit, Birmingham and other sources in the UK as well as data from other European countries and the World Health Organisation (WHO).

The National Institute for Biological Standards and Control (NIBSC)

29. The NIBSC at South Mimms, NR Potters Bar, Herts:

i. assesses the serological response to immunisation and advises DH, WHO and EC on the need to update vaccine strains

ii. produces and distributes high growth reassortants and vaccine potency reagents for standardisation and for research.

iii. Batch releases influenza vaccines and liaises with vaccine manufacturers and other control laboratories.

The Medical Research Council (MRC)

30. The MRC has a co-ordinating role for research e.g. clinical trials of new vaccines/anti-virals, setting up collections of samples of clinical material/isolates for storage for later investigation.

DHSS

31. DHSS has responsibility for planning, initiation, direction and central co-ordination of the response in Northern Ireland.

32.. The DHSS's roles include:

i. liaising with DH and the national Influenza Advisory Committee
ii. securing supplies of an effective influenza vaccine and anti-viral agents
iii. controlling the issue of vaccine and anti-viral agents
iv. identifying categories of individuals who should be immunised or receive antiviral prophylaxis
vi issuing advice to doctors on the use of vaccines and anti-viral agents and the appropriate treatment of pneumonia
vi. issuing other appropriate advice to the health professions, managers, the public and the media
vii. collating data relating to the pandemic in Northern Ireland and its impact and preparing (after the event) a formal report.

Health and Social Services Boards

33. Boards are responsible for planning and implementation of local contingency arrangements. The following people may need to be involved in the development of local

plans: Director of Public Health, Director of Nursing, Director of Social Services, Director of Primary Care, Consultant in Communicable Disease Control, Public Relations Officer, Hospital & Community Trust Chief Executives, Director of the Registration and Inspection Unit, Chairman of Local Medical Committee, and Consultant Physician Infectious Diseases. Local Councils (for the work of handling dead bodies) and all other relevant groups

34. Local plans must clearly delegate responsibilities and include:

i. a named co-ordinator - normally the Director of Public Health

ii. membership of a pandemic co-ordinating committee consisting of key officials to be convened in the event of a possible pandemic

iii. an estimate of local vaccine needs for the nationally agreed priority groups in their population

iv. arrangements for ensuring vaccine is distributed and administered to priority groups

v. arrangements for issuing protocols and maintaining supplies of antibacterial and antiviral therapy

vi. contingency staffing arrangements for primary and secondary health care

vii. contingency arrangements for coping with the burden of illness

viii mortuary arrangements

ix. communication arrangements for the profession, the public and the media, including telephone helplines

x. arrangements for advising on management of local outbreaks and problems

xi. training

35 Local plans also need to consider the needs of ethnic minorities and faith groups.

Trusts and Fundholders

35. Trusts and fundholding practices are responsible for organisation of their own units to cope with the increased patient loads and staff absenteeism and for immunisation and provision of antiviral prophylaxis to essential staff according to nationally agreed guidelines.

Heading

36. The ***Regional Virus Laboratory*** investigates influenza-like illness and isolates strains of influenza virus. ***Hospital Microbiology Laboratories*** identify and assess antimicrobial sensitivities of bacteria giving rise to complications of influenza.

General Register Office (GRO)

37. GRO monitors weekly death rates.

PHASING THE RESPONSE

38. Six phases can be recognised in the emergence of a pandemic:

Phase 0	The interpandemic period
Phase 1	The emergence of an influenza virus with novel haemagglutinin ± neuraminidase ("new virus") outside the UK
Phase 2	Outbreaks of influenza caused by the new influenza virus outside the UK
Phase 3	New influenza virus isolated in the UK: pandemic imminent
Phase 4	Pandemic influenza in the UK
Phase 5	Return to background influenza activity

PHASE 0 - INTER-PANDEMIC PERIOD

39. **DH**(4)

i. maintain close links with PHLS/CDSC and the RCGP research unit

ii. advise on use of current vaccines and develop strategies to ensure compliance with recommendations on use

iii. monitor adverse reactions to vaccine

iv. support the development of improved vaccines and discuss needs of vaccine manufacturers in the event of a new pandemic strain

v. make plans for buying and supplying influenza vaccine in the event of a pandemic

vi. plan for the licensing and availability of antiviral drugs

vii. advise HA's and Trusts on the need for local contingency plans

viii. name a pandemic co-ordinator

ix. name an Influenza Advisory Committee

x. prepare provisional priority groups for influenza vaccine and anti-viral chemotherapy should these be limited

xi. estimate vaccine requirements and plan distribution network

xii. discuss research needs in the event of a pandemic with PHLS, MRC and other organisations

xiii. prepare contingency outline press briefings and advice to the health professions and the public for use in the event of phases 1-4

xiv. estimate costs of implementing contingency plans

40. **DHSS**

i. maintain close links with DH(4)

ii. advise on use of current vaccines and develop strategies to ensure compliance with recommendations on use

iii. make plans for buying and supplying influenza vaccine in the event of a pandemic

iv. plan for the availability of antiviral drugs

v. advise Boards and Trusts on the need for local contingency plans

vi. estimate vaccine requirements and plan distribution network

vii. prepare contingency outline press briefings and advice to the health professions and the public for use in the event of phases 1-4

viii. estimate costs of implementing contingency plans

ix. name a DHSS pandemic co-ordinator

x. name a Northern Ireland Influenza Advisory Committee which will include:

- Chief Medical Officer (Chair)
- Chief Nursing Officer
- Chief Pharmaceutical Officer
- Chief Inspector SSI
- Chief Executive HSSE
- Senior Medical Officer (Infectious Disease)
- Senior Information Officer
- Regional Information Branch (Gd 7)
- Assistant Director Capital and Emergency Planning
- Health Promotion Branch (PO)
- Chairman of GMSC (Gd 7)
- Chairman of HSSC
- Consultant Virologist
- Directors of Public Health

41. **Boards, Trusts and Fundholders**

i. prepare pandemic action plans

ii. identify a co-ordinator for their pandemic action plan

PHASE 2 - OUTBREAKS CAUSED BY NEW VIRUS OUTSIDE THE UK

45. **DH** (2)

i. requests manufacturers to develop and make vaccines incorporating the new virus and indicate quantity required

ii. continues to discuss ways of speeding vaccine production

iii. MCA processes licensing applications for new vaccines

iv. liaises with manufacturers and NIBSC over clinical studies of immunogenicity of vaccine

v. reviews available clinical data on age-specific attack rates and complications

vi. through NHS Supplies liaises with manufacturers to ensure supplies of antibiotics and other essential drugs

vii. warn HAs and Trusts of the possibility of a pandemic, reminding them that a plan should be in place and may need revising (depending on when it was written)

viii. issue further information to the professions

ix. finalise prepared press briefing and advice for the public

x. considers advice to the public about foreign travel to known affected areas

46. **DHSS**

i. liaises with DH (2) over quantities of vaccine required

ii. liaises with DH (2) and manufacturers to ensure supplies of antibiotics and other essential drugs

iii. warns Boards and Trusts of the possibility of a pandemic, reminding them that plan should be in place and may need revising (depending on when it was written)

iv. issues further information to the professions

v. finalises prepared press briefing and advice for the public

PHASE 3 - FIRST ISOLATES OF NEW VIRUS IN THE UK - PANDEMIC IMMINENT

47. **DH**

i. distribute information to HAs and Trusts, GPs, nurses and pharmacists/request HAs and Trusts to activate their influenza action plan

ii. advise regions to set up regional team

iii. reviews latest surveillance data

iv. finalises advice on the priority groups to be vaccinated

v. advises on use of vaccine/amantadine, including dose and number of doses and how to handle those who are not to be immunised

vi. monitors adverse reactions to vaccine/antiviral agents

vii. distributes package of advice to the general public, including explicit information about priority groups for vaccine to avoid a rush for vaccine

viii. liaises with manufacturers on availability of appropriate antibiotics

ix.. advise, after consultation with CDSC/LHI, on the most appropriate treatment of pneumonia

x. remind HAs and Trusts of the need for restriction of hospital admissions to meet the expected increased demand for hospital beds and that some contracts may need to be suspended

xi. sets up designated public enquiry and press lines

xii. considers daily updated recorded message.

48. **DHSS**

i. distributes information to Boards and Trusts, GPs, nurses and pharmacists

ii. requests Boards and Trusts to activate their influenza action plans

iii. NIIAC liaises with Board Pandemic Co-ordinating Committees

iv. reviews latest surveillance data

v. finalises advice on the priority groups to be vaccinated

vi. advises on use of vaccine/amantadine, including dose and number of doses and how to handle those who are not to be immunised

vii. distributes package of advice to the general public, including explicit information about priority groups for vaccine to avoid a rush for vaccine

viii. advises, after consultation with NIIAC, on the most appropriate treatment of pneumonia

ix. reminds Boards and Trusts of the need for restriction of hospital admissions to meet the expected increased demand for hospital beds and that some contracts may need to be suspended

x. set up designated public enquiry and press lines

xi. consider daily updated recorded message.

49. **Boards, Trusts and fundholders**

i. activate their Pandemic Influenza Plans

ii. arrange administration of vaccine if available

PHASE 4 - PANDEMIC INFLUENZA IN THE UK

50. **DH**

i. monitors the course of the outbreak to identify particular problems, e.g. disruption of essential services, availability of vaccine/antivirals

ii. monitors adverse reactions to vaccine and drugs

iii. holds regular press briefings and gives advice to professional groups

iv. continues telephone enquiry lines

v. considers if and when to advise that a national emergency be called

51. **DHSS**

i. continues to liaise with DH and IAC

ii. monitors the course of the outbreak to identify particular problems, e.g. disruption of essential services, availability of vaccine/antivirals

iii. continues to give advice to professional groups

iv. continues telephone enquiry lines

v. considers if and when to advise that a regional emergency be called

52. **Boards, Trusts and Fundholders**

i. in accordance with their local influenza action plan consider bed and staffing availability

ii. administer vaccine (if available)

iii. advise on amantadine use.

53. **GRO**

monitors weekly death rates

PHASE 5 - END OF PANDEMIC

54. A pandemic will be deemed to have ceased when the epidemiological indices have returned to background levels. The Northern Ireland Advisory Committee will prepare a report, reviewing the effectiveness of and lessons learned from the plan. The Chairman will then decide if the Advisory Committee should be stood down.

55. Board and Trust contingency plans should be reviewed in the light of experience during the pandemic.

ANNEX 1

ESTIMATES OF VACCINE NEEDS

See attached table. These are approximate numbers, based on the most up to date figures available in September 1996.

ESTIMATES OF VACCINE NEEDS: 1995 ESTIMATES

ANNEX 1

Population Group	England and Wales	Scotland	N.Ireland
1. Health care staff with patient contact			
GPs	30,585[1]	3,866	1,005
Practice nurses	16,500[1]	1,291	323
Hospital medical staff	52,320[1]	7,164	1,804
Hospital nursing staff	363,760[1]	55,545	15,047
Physiotherapists	13,260[1]	1,774	701
Ancillary staff	102,790[1]	19,192	9,061
District nursing staff	265,570	4,090	1,126
	33,430		
2. Essential services			
Fire	38,000	8,185	1,100
Ambulance	22,000	2,232	500
Police	152,000	14,479	7,300
Telephone	43,000	--	400
Electricity/gas	164,000	--	600
Undertakers	--	--	170

[1] Figures at 30.9.94

Population Group	England and Wales	Scotland	N.Ireland
3. Patients in current risk groups	5.33m	533,000	120,000
> 65 years)	2.01m	201,000	60,000
< 65 years) 5.33m	3.32m	332,000	90,000
4. Women in last trimester of pregnancy	165,000	15,509	8,000
5. Residents of long-stay facilities All communal estab (Residential/nursing homes = _ of this)	1.37m[2]	154,841[2]	37,583[2]
6. Health Care Assts	14,840	)	322
		) 17,945+	
7. Care Assts/Support Staff	29,030	)	731
	3,018		
	11,387		
8. Home Helps	56,960	20,818	10,163
	5,133		

[2] All temporary and permanent residents, residential and non-residential staff, visitors etc, present in residential homes for the elderly, children, psychiatric patients etc.; detention, defence and education establishments; hotels, hostels, ships etc on the night of the 1991 Census

Population Group	England and Wales	Scotland	N.Ireland
9. All over 75 years of age	3.6m	331,378	86,000
10. All over 65 years of age	8.1m	782,829	209,000
11. Household contacts of individuals at risk	--	--	--
12. Other selected industries	--	--	--
13. All aged 16-64 years	32.75m	3.38m	1.04m
14. All aged 0-15 years	10.3m	979,183	393,000
15. Whole population > 6 months of age	51.1m - those age$<^{6}/_{12}$	5.11m	1.63m

Do we need this.

National UK

ANNEX 2

COMPOSITION OF THE INFLUENZA ADVISORY COMMITTEE

Chair

Minister, Chief Medical Officer or senior DH official (4)

Members

Chief Medical Officer (or alternate) if not chair

Medical Director, NHS Ex

Representatives from the other UK Health Departments

Chairman of the Joint Committee on Vaccination and Immunisation and/or chairman of the JCVI Respiratory Panel

Director of PHLS (or alternate)

Director of CDSC (or alternate)

Director of CPHL (or alternative) - normally a virologist

Director of NIBSC (or alternate)

Director of WHO Collaborating Centre

Representative from Medicines Control Agency (MCA1B)

Head of Health Promotion Division and/or DH co-ordinator*

Representatives from:

- Finance Division
- NHS Supplies
- Nursing Division
- Information Division
- NHS Executive
- Welsh Office

Head of the Emergency Planning Co-ordination Unit

A Regional Director of Public Health

NHS representatives (HAs, Trusts, GPs)

A Regional Epidemiologist

A Consultant in Communicable Disease Control

Secretariat: provided by HPA3

For consideration for co-option/observers as required or as members of subgroups:

Representatives of:

- RCGP Research Unit
- Vaccine manufacturers
- Royal College of Physicians
- British Medical Association
- Royal College of Nursing
- Royal Pharmaceutical Society
- The Health Education Authority
- The Association for Influenza Monitoring and Surveillance (**aims**)
- Relevant charities/patient organisations

Other Government Departments:

- Home Office
- Department of Social Security
- Department of the Environment
- Department of Trade and Industry
- Department of Transport
- Department for Education and Employment
- Ministry of Defence

A general, respiratory and/or infectious disease physician, geriatrician, occupational physician and/or paediatrician

DH:
- HEF
- RDD

International:

- CDC Atlanta
- WHO

A Mathematical Modeller

Other media representatives

(4)

*** The DH Co-ordinator (normally Grade 3) will be supported by an executive group of working level officers:**

HP3A Branch head

HP3A Senior Medical Officer

HP3A Grade 7

Nursing Division

Finance Division

Pharmacy Division

Information Division

NHS Executive

MCA