directors of adass
adult social services

Ensuring DASS and their partner decision makers have the critical and most up to date information and data on needs and capacity to plan for and make timely and rational decisions about the reprioritisation of services in response to a future flu pandemic

and

Identifying People who are Vulnerable in a Flu Pandemic Crisis

March 2018

The most up to date source of Government guidance documentation is the Gov.UK Pandemic Flu Webpage:

www.gov.uk/guidance/pandemic-flu

The Government flu pandemic website was updated in November 2017. Although links are provided in this report to national guidance documents for ease of reference, readers should use the website to check they are reading the most up-to-date version.

It is recommended that this document is read in conjunction with the Introduction to the ADASS Pandemic Flu Planning Reports.

In Summary, this report refers to:

a) Information from government to LRFs and from LRFs to local health and social care planners for example trigger points, statutory changes in recognition of the emergency.
b) Information about who the people are in local areas who are potentially vulnerable in a pandemic using the definition in the Civil Contingencies Act 2004.
c) The role of local level statistical analysis of the potential impact of flu pandemic on local populations and on resources to meet prioritised needs.
d) Dynamic monitoring arrangements of care capacity – physical, human, paid/trained and volunteers trained and untrained. Anticipating the financial costs of increasing staff capacity in direct care provision and in augmented back office functions for example call centres and liaison posts.
e) Monitoring of demand and capacity and its financial impact on commissioners and providers to ensure sustainability of provision during the pandemic and afterwards.
f) Information about decisions made nationally and locally about who will pay for the cost of care of people who have not been assessed for eligibility and

charging. This should include decisions about the prompt routing of payments to providers to protect their financial viability.

g) Information to increase paid and volunteer workforce capacity by using light touch recruitment and training processes.
h) Dynamic monitoring information about continuity of local supply of essential services, including energy, fuel, medicines and public transport.
i) Local arrangements to manage demand in terms of calls from health and social care staff, volunteers, family carers and the public about vulnerable individuals.
j) Using volunteers to provide care in the community and facilitating villages and neighbourhoods to build local resilience.
k) Information about school, and college closures and the impact of those closures on care staff. The opportunities to ask school staff to volunteer and to use school kitchens to provide meals to those who need them.

1. Government expectations of preparedness in local areas

In this report the term vulnerable people has a much broader meaning than that normally understood in adult social care. The Civil Contingencies Secretariat of the Cabinet Office produced guidance on Identifying People who become Vulnerable in a Crisis' in 2008 [1], to be applied as appropriate to different kinds of emergencies.

In the context of an emergency such as pandemic flu, vulnerable people are defined as those:

> *"(who) are less able to help themselves in the circumstances of an emergency".*

In the event of a pandemic, these may include: children (the situation may be exacerbated by school closures), older people, mobility impaired, mental/cognitive function impaired, sensory impaired, individuals supported within the community, immuno-compromised children and adults, those with underlying health conditions, individuals cared for by relatives, homeless, pregnant women, and those in need of bereavement support.

When information is supplied by Government about which age groups in the population are most affected by the particular strain of flu, planners can take targeted action for those most at risk groups.

Whilst all the government documents in the introduction are pertinent and should be read in the light of the overarching UK Flu Pandemic Strategy updated in Nov 17, for this specific report the reader is directed to:

> "Gov.uk pandemic flu website" [2] for links to the most up to date versions of the following documents:

[1] www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders
[2] https://www.gov.uk/guidance/pandemic-flu

- *Preparing for Pandemic Influenza – Guidance for Local Planners/LRFs (Jul 13)*[3]
- *Identifying People who are Vulnerable in a Flu Pandemic Crisis – Guidance for Emergency Planners and Responders published by the Civil Contingencies Secretariat in the Cabinet Office (Feb 08)*[4]
- *Health and Social Care Influenza Pandemic Preparedness and Response published by the Department of Health in April 2012.* [5]

2. The role of the Local Resilience Forum (LRF)

Section 4 of the Guidance for Local Planners/LRFs (Link above) lists its Government expectations of operational response arrangements:

> *"In England and Wales, the primary responsibility for planning for and responding to any major emergency rests with local organisations, acting individually and collectively through Local Resilience Fora (LRF) and Strategic Coordinating Groups (SCGs). The purpose of the SCG is to take overall responsibility for the multi-agency management of an outbreak at local level".*
>
> *"Local Health Resilience Partnerships (LHRPs) are not statutory organisations and accountability for emergency preparedness and response remains with individual organisations, in line with their respective statutory duties. Local authorities will also contribute more widely…given their range of responsibilities…and their community leadership role."*

The above are quotes from Section 4 of the Local Planners/LRF Guidance.

It is vital that DASSs, their Local Authorities and other partners make decisions on prioritisation and reprioritisation of services within the formal decision-making arrangements of the LRF. DASSs may benefit from requesting their LRF convenes to review its flu pandemic plans and test this aspect.

In Dec17 ADASS surveyed DASSs' in England to obtain a picture of the level of preparedness for flu pandemic and received a response from approximately 50% of councils responsible for social services. Free text responses revealed that whilst areas were able to respond in a definite manner about their own business continuity plans and civil contingency planning arrangements for emergencies, many such plans were five years old or more with little indication of these plans having been recently tested. Most respondents did not distinguish between local operational plans and LRF Strategic Plans in their answers.

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[3] www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders

[4] www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders

[5] *www.gov.uk/government/uploads/system/uploads/attachment_data/file/213696/dh_133656.pdf*

Many respondents were not confident that they had agreed and tested mechanisms in place to identify their local population of vulnerable people as defined by the Civil Contingencies Act.

Existing strategic and operational plans for flu pandemic not revisited and tested and lack of confidence in how people who become vulnerable in a pandemic will be planned for are **the most significant information gap and risks** identified in the survey in terms of planning to meet Local Authority and Adult Social Care statutory responsibilities in a pandemic.

Two published strategic plans are listed in the introduction to this report:

- Derbyshire Local Resilience Forum (LRF):[6]
- Southampton Public Health Pandemic Influenza Plan:[7]

These were sourced from the web and included because they demonstrate a strong planning approach for emergencies in general and flu pandemic in particular at strategic level. It is not clear, in these and other plans sampled through our web-based research, how local operational plans and planners will go about creating their Lists of Lists of people who are/likely to be vulnerable.

The guidance on identifying people who are vulnerable in a crisis was published in 2008. Since then GP Registers of patients with long term conditions and disabilities have grown in sophistication and reliability. It may be that GP Registers and lists of their vulnerable patients using risk scoring may have overtaken some of the approaches recommended in the 2008 guidance. This needs clarification at national level, including the agreements and protocols necessary for GPs to release patient data during a pandemic.

Further enquiries of DASSs about their operational plans may provide some good examples of methodologies already in place.

Whilst this report is not about planning for Education, Annex C of the LRF Planners Guidance refers to Education and the implications of schools closing or remaining open on infection spread and on the workforce. Decisions about Education services will impact on capacity and demand during a pandemic. If a pandemic is having a significant effect on young people and children, there may be a national decision to close schools and colleges or more local decisions taken at LRF level with Education Authorities.

[66] www.derbyshireprepared.org.uk/files/uploads/Derbyshire_Strategic_Plan_for_Pandemic_Influenza.pdf

[7] www.publichealth.southampton.gov.uk/images/scc-pandemic-influenza-plan-v3.2-january-2016.pdf

3. Creating Lists of Lists

The *Cabinet Office Guidance on Identifying People who are vulnerable in a crisis* refers to lists of lists (Page 24-29 at the attached link).[8]

It is one of the oldest published guidance documents, is still relevant to flu pandemic and other emergencies and recommends specific detailed lists and analyses of vulnerability to assist planners. It should be read alongside *Annex D - Social Measures – Vulnerable People (page 27) of the Pandemic Influenza Guidance for local planners/LRFs)* [9]

The preparedness phase includes knowing who will provide the DASS and/or local health and social care emergency coordination team with information about the numbers of people who will be potentially vulnerable under the definition, the types of vulnerability and their geographical clustering. This can then be modelled through expertise in the LRF group into a dataset that can be updated dynamically during the phases of a pandemic.

Early joint agreement is required at LRF and local level about who - the council/public health department/the local NHS commissioners is responsible for taking the lead on identifying vulnerable adults, and how the resources of these several organisations are used to best effect to analyse and maintain the data received.

One example of a data base of vulnerable people is that held by **Utilities/Energy suppliers** who, we understand, work to a national standard regarding prioritising maintenance and restoration of supply to specific vulnerable people/groups. In any one neighbourhood there could be up to 10 different companies involved. Consideration should be given to how lists of vulnerable people are obtained from Utility Companies.

In this report references to vulnerability are mainly about elderly people because of the current high level of demand on health and social care within that age group already, but the guidance makes it very clear that there are many types of vulnerability and responses appropriate for each type – whilst avoiding stereotyping individuals it does support population level planning. A further reason to not think just about elderly people is that until the pandemic numbers start to rise nationally it will not be clear which age groups are most affected. Clearly people with compromising health conditions may be at greater risk of infection and complications, but age groups not previously exposed to this pandemic strain of the virus and therefore with no built-up immunity may be at greater risk.

[8] www.gov.uk/government/uploads/system/uploads/attachment_data/file/61228/vulnerable_guidance.pdf
[9] www.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf

In the ADASS Survey of Directors about flu pandemic preparedness Dec 17 the identification of people who become vulnerable in a flu pandemic, beyond those the council contracts care for or allocates personal budgets to, appeared to be the weakest area in terms of planning done and confidence in how to go about it effectively.

Establishing the lists of sources of information about vulnerable people and information flows, gaining agreement and cooperation and testing them will take some time in each LRF and local health and social care emergency co-ordination area. **Engagement with providers and the local voluntary sector and service user advocacy groups for a wide range of age groups** is a positive means of communicating the implications of a flu pandemic in a context of **working together to plan to minimise harm and maximise mutual support**.

Early estimation of numbers, types and locations of people with vulnerabilities will enable planners to estimate required resources and care capacity. Local planners should ensure they include **planning for additional supplies of community equipment** such as Personal Protective Equipment (PPE) for care staff and volunteers, commodes, continence supplies, walking frames, turning sheets, disposable sheets/laundry services etc for use in the community in the same way health are planning for additional supplies of medicines, clinical waste and anti-viral medication to meet demand.

Early national communication about the appropriate use of PPE will be necessary because otherwise the demand for PPE could rapidly outstrip supply if it is over used. Advice on controlling cross infection will be required, with information especially aimed at front line health and social care workers.

Early planning for increased numbers of people who become highly vulnerable during a pandemic will also support **financial planning** at local and national level.

When national and LRF trigger points occur, specific local plans will be activated. This will include identification of potentially vulnerable people and their locations. This will be complemented by the identification of individual needs and the type of care required. Once a phase of pandemic flu activity has passed, it will be necessary to consolidate information during what could be a short period of recovery before preparation for a further wave. The cycle of pandemic flu can be difficult to predict but eventually there will be a need to recover to normal working.

Prioritisation and reprioritisation of public services and care and support: Tasking of Public Services will fluctuate during phases of the pandemic. Decisions should be based on accurate local (LRF area) assessment and national or LRF trigger decisions based on the changing demands. Demand levels will fluctuate within and between local areas. **Planners should not focus solely on a 'reasonable worst case' response – this is learning from the 2009 pandemic in UK.**

An influenza pandemic can occur either in one wave or in a series of waves. Each wave can last 12 – 15 weeks and occur weeks or months apart. Second or subsequent waves could be more serious than the first. A local epidemic may be

more highly peaked and over faster than the national average. *(sect 3.1 of Guidance for Local Planners/LRFs, link below)*. [10]

Identifying potentially vulnerable people and monitoring care capacity at local area level is expected to be a dynamic process over several weeks or months, with potentially daily situation reporting to the LRF and from the LRF up to government.

Managing fluctuating demand and supply at local area level will be supported through mutual aid within ADASS regions. The benefits of this means of mutual support and regional/sub regional activity should not be underestimated.
LRFs and Local Health and Social Care Resilience Partnerships should consider the demand for different communication channels for professionals and the public to notify them of vulnerable people becoming ill with flu. These should include ample telephone call handling capacity; email messages and smart phone apps may be another route. All require prompt triaging and appropriately prioritised response.

If a telephone isn't answered, the caller knows no one has heard about the problem and will take other actions instead. If an email or text message is sent then the sender considers that message sent and received, which is not the same as read and action taken.

There will be formal arrangements between NHS111 and any other contact centres which have been set up to manage the flu pandemic demand in the community. It is expected that national decisions will be made about call numbers and handling capacity but responding to request for social care will be at local level.

Note: People who may need additional care and support in the event of a pandemic flu may not have flu themselves.

They may become acutely ill with another condition and highly vulnerable because the level of treatment and care they might normally expect is not available.
Decisions need to be made about who receives what level of response to any health or care need, dependent on the local situation. The same would apply in a severe fuel shortage or other emergency such as extreme weather, both of which could occur at the same time as a pandemic wave in an area.

4. Ethical Framework for decision making about treatment and care priorities:

The Ethical Framework sets out the importance of minimising harm, recognising that some harm is likely to be unavoidable.

> *"Decision makers will need to use the best information that is available to them at the time (for example the likely effects of a particular decision). Whether or not a decision was ethically appropriate has to be judged in*

[10] *www.gov.uk/government/uploads/system/uploads/attachment_data/file/225869/Pandemic_Influenza_LRF_Guidance.pdf*

relation to the situation that existed at the time it was made, rather than by reference to facts that only became apparent at a later stage."-"Harm is a broad concept and is intended to cover the physical, psychological, social and economic harm that a pandemic might cause." [11]

The Ethical Framework is intended to guide strategic policy makers and local planners consider the ethical aspects of their decisions in an emergency.

It will help professionals and decision makers, guided by their own professional codes, to develop policies on clinical issues for use during a pandemic. It is of no help to front line staff in a practical way. Without further detailed guidance staff may be unable to decide between priorities in difficult situations.

The ethical framework and any local prioritisation framework must be understandable and usable by care workers and health and social care professionals making decisions about relative priorities within their workload. Without this, decision making will be slow and cumbersome and a greater harm to individuals may result than if an informed decision was made (and recorded and reported) by the worker on the spot.

Conversations with DASSs have included reference to care service prioritisation strategies and solutions used during extreme weather and during the Tour de France Yorkshire leg. At the time of writing, however, no written records of these have been identified – the response has been that it is intuitive, common sense and that mutual aid between providers played a major part.

We recommend that national planners engage with care providers and others to design for practical guidance for commissioners and for front line staff.

5. Linking Ethical Decision making to securing additional care and support capacity

An example of the type of decision that can be planned for:

- When considering using volunteers to make visits and provide basic care, decisions should be made at local level about, for example:
- volunteers provide a second pair of care hands or act as driver to a paid and trained worker but do not enter the house
- Volunteers undertake visits alone within specific parameters. Volunteers may include adults with learning disabilities or physical disabilities or children who become carers of their relatives and may require support.

The decision should be made in the context of avoiding a greater harm in an escalation period/a peak – is a greater harm to have no one go into that 'too sick to get out of bed' person that day because the available person, perhaps their neighbour who has phoned in expressing concern, is not known to the decision

[11] www.gov.uk/guidance/pandemic-flu#ethical-framework

maker, does not have their neighbours key or key box code and is not DBS checked for another volunteering or paid role?

Flu Friends has an established definition and is part of the existing national communication strategy. However actual care giving is not currently in the definition. Whilst adding it in may cause people to step back from being a flu friend, some flu friends may start to add physical care into their support of isolated individuals with flu.

Facilitating resilience in villages and neighbourhoods is a vital step but needs time to be planned for. In Derbyshire the Emergency Planning Teams are working with local communities on building local resilience and recruiting flu friend.

The Ethical Framework guidance states that **records should be kept of decision taken and the justification for them.** This matters for accountability and to review decisions at the end of short, specified periods. Such records can also help people learn from experience in order to respond to further pandemic waves, or to a different pandemic in the future.

The importance of up to date, but perhaps never entirely accurate, local capacity and demand information on a daily basis becomes evident when applying the ethical framework to decision making.

6. Forward planning for dynamic monitoring of health and care service capacity and demand – the available care capacity may be greater than the actual service capacity (in terms of beds) that is safe to use.

Whilst health and care capacity and demand are of course taken to mean both beds and staff, this section focuses on capacity for beds in Care Homes and house visits by community health staff/domiciliary/care workers.

Local health and care resilience partnerships and their equivalents will already be monitoring care capacity in hospital, in care homes and in the community at least weekly to manage care capacity pressures now.

ADASS Executive recently adopted an internal report *'Provider Failure – A check list for Regional Response. ADASS 2017.* It gives guidance to DASSs on managing the consequences when for whatever reason care quality is compromised to the point that it is not appropriate to refer or place service users with that provider. Part of the management of the care capacity pressures caused by provider failure is ADASS regions or sub regions identifying appropriate vacancies quickly - often within less than a week, facilitated by a lead officer.

In a flu pandemic there may be extreme pressure exerted by local and national politicians, relatives of sick people, managers and clinicians in the local NHS to utilise any vacant care capacity. It is probable that individual politicians/councillors, clinicians, hospital bed managers and certainly the public will be unaware of care quality issues within some providers, probably because the CQC judgement is not yet through all the legal processes and published. **The apparently available care service capacity is always greater than the actual care service capacity** that is safe to use. Some care providers, under financial pressure due to vacancies, will be

tempted to contact the NHS direct offering care capacity despite being judged not competent, at that time, to deliver safe care to their current residents/clients, let alone an additional number of very ill people.

A care provider normally providing good or excellent quality of care may have bed/visit vacancies but also a number of sick care staff which means they are at full capacity and unable, without risking care quality and client safety, to take additional patients/clients safely. There are ample examples of excellent providers being pressed to take additional clients/residents in an emergency and then not being able to cope

Commissioners in health and social care should give providers the confidence to say 'no' to more when they reach a safe limit. It is for this reason that normal contractual requirements may need amendments to be appropriate for pandemic conditions.

Social Care and NHS Commissioners will look to their local Council Leaders and NHS Commissioners for support in this matter when faced with pressure to use every available care bed or care provider. They need support to hold their nerve when hospitals are under enormous pressure to free beds by discharging to community care.

Care capacity will be affected by financial pressures on care providers. DASSs and the NHS should make joint agreements ahead of a pandemic how providers will be paid for activity under a range of circumstances in the pandemic. Small providers will have cash flow difficulties at a lower threshold than Commissioners may realise.

Monitoring of care staff sickness levels: In researching this report there has been discussion about the methodologies to do this, the barriers to gathering accurate information, and the benefits of collecting and monitoring it beyond local commissioner/operations level.

Where social care commissioners already have these arrangements in place, contracted for and working well, they should continue and there may be a useful sample for national collection to monitor trends of sickness in care staff for example length of illness, whether they return from sick leave in a pandemic etc.

Where such collection and analysis are not already well established it could be considered that the barriers to accurate and timely collection are large and the benefits too few.

It is considered that the real indicator of supply pressures is Care Service Supply and local population flu sickness levels in the workforce and child age groups which may lead to care staff taking sick leave or carers leave.

There would be value in adult social care and health tracking sickness levels in social work and community health staff who have assessment roles. Beyond that, the organisational change in health and local authorities means that the essential support functions for social care and community health care are often dispersed and no longer managed in one directorate, such as council contact centres. Some essential functions may be contracted out. So beyond monitoring of assessors, it is

recommended whole council staff sickness rates are monitored using normal reporting systems and forwarded to LRFs and beyond.

Vacancy rates are also relevant, and a flu pandemic may cause more migrant workers to return home – affecting care supply. Political (Brexit), financial (value of sterling) and cultural factors may cause staff to withdraw from the care workforce and either take other employment or return to their homes in UK and abroad.

Care at Home provider advice from the UKHCA is that it takes a minimum of 13 weeks to recruit and train a care worker, with significant expense and effort from the employer. If these staff are not going to be required after the pandemic there is no motivation for employers to do this.

In the longer term, a proper workforce strategy for recruiting young people into the health and care workforce at apprenticeship level is required so that they see it as a reputable career, with opportunities for progression.

7. Forward planning for active coordination of capacity of paid workforce, volunteer workforce and unpaid carers

This is a huge subject, and local areas will wish to make their own arrangements to reflect the population and geographical characteristics of their council/STP area and neighbourhoods. Different areas will have different kinds of paid and voluntary capacity that can be called on.

Forward assessment of workforce capacity and dynamic monitoring of care staff supply in the community should include:

- NHS staff
- Staff in registered care providers in whom there is confidence about care quality
- Family/informal carers
- Paid/contracted staff in different roles but whose
    - DBS certificates and safeguarding training are in date
    - Remit in their normal roles mean they have useful transferable skills, for example:
        - School staff of all types
        - Foster Carers

One suggestion made is that Adult Social Care Team Leaders liaise with Head Teachers of local schools to get early warning of intention to close, and to identify opportunities for the school – open or closed – to offer services to the local community during the pandemic – for example extra school lunches that can be delivered to those who need them.

Volunteers within specific **national voluntary organisations** including for example:

- British Red Cross
- St Johns Ambulance
- Khalsa Aid
- Age UK

- Street Pastors

All these volunteers are DBS checked and well trained to a standard set by their national organisation. The volunteers are well supervised at local level, generally accustomed to assessing risks and reporting up appropriately and used to dealing with distress and challenging behaviour.

The Red Cross and St Johns Ambulance have training capabilities and capacity that can train other volunteers in basic bedside nursing, basic life support and hygiene.

Local voluntary organisations that already apply Safeguarding policies and procedures. Examples of these include local faith organisation pastoral care teams - their volunteers are accustomed to visiting frail/needy people at home, local councillors, school governors etc. Local volunteers know their neighbourhoods well, can call on the resources with them, and have a local infrastructure to work within.

The capacity of national and voluntary organisations will vary from one area to another, and arrangements to involve them in care and social support may best be made at local operational level.

8. Information about capacity pressures in other essential services:

Troubles never come alone, for example:

- If a pandemic flu has peaks in November and December, care staff supply is further depleted by staff who are on low contract hours taking retail jobs to boost their income. If it occurs during school holidays care workers cannot be compelled to cancel their holidays.
- The UK and Europe functions on a ‘just in time’ supply system.
- The Overview to the Pandemic Flu Strategy states that social infrastructure can be expected to be damaged, for example fuel supplies, prescription supplies (often from Holland), community call line services, ambulance services, public transport, energy suppliers, maintenance engineers.
- Illness levels amongst the workforce in essential infrastructure organisations should also be monitored and the reporting arrangements determined nationally. Workers in obscure jobs often find that their essential skills and role are only noticed when they are not there to provide them.
- The impact of extreme weather for example floods, storms, snow or a heat wave on an already fragile social infrastructure cannot be overly stressed.

The recommendations in this report are listed in Annex A.

Annex A Recommendations
as at 25/1/18

Recommendations

1. Government departments should simplify and unify guidance with more clarity about specific actions and protocols. This would be of great assistance to DASSs and others responsible for implementation.

2. Government guidance should include a simple explanation of the various local planning groups. This would enable DASSs and their teams to ensure they understand the different groups that require their involvement at strategic and local levels and to be familiar with their place in the associated Gold, Silver and Bronze functions in each.

3. DHSC should provide information and guidance to enable planning for care capacity during a flu pandemic as an augmented winter planning process, in order to reach local joint health and social care agreements and to negotiate changes to contracts to be applied at trigger points. This should include guidance on risk assessment, ensuring an understanding of all LRF members of the clinical decision making required before bringing a service back into use after being closed due to flu and should identify contract terms and strategic care partnership approaches that have been the most successful in maintaining care supply and quality in periods of stress, such as periods of severe weather and periods of excessively high demand. This would strengthen confidence, cooperation and competence in health and social care providers in the different ways of working and support learning from previous pandemics or crises.

4. DHSC should liaise with the Association of Directors of Public Health (ADPH) and Public Health England (PHE) on the role of Directors of Public Health in contributing clinical decision-making to the risk assessments required before bringing an adult social care service back into use after being closed due to flu.

5. Government should update aspects of the 2008 Guidance on Identifying People who are Vulnerable in a Crisis in the light of the development of GP patient registers, providing information on long term conditions, learning disability and patient risk scores relating to hospital admissions, to support DASSs with collating required information. These registers are far more sophisticated and accurate than in 2008 and should form part of the information available to DASSs. Protocols about GPs sharing patient information and recovering the confidential information at the end of the pandemic will be required.

6. LRFs should ensure that Health and Social Care resilience partnerships have early joint agreements at local level about which organisation will take the lead on identifying vulnerable adults, analysing the data and maintaining an up to date data base throughout the pandemic. This should include joint agreements on information sharing.

7. The Government should consider how to make available to DASSs information on vulnerable adults and their locations within the criteria used by Energy Suppliers and other Utility Companies.

8. Government departments and national representative bodies should encourage the sharing of updated flu pandemic plans, from strategic to local operational level, to enable learning from each other.

9. Government should provide guidance to DASSs about the importance of early information, both quantitative and qualitative, from early engagement with Care Providers, voluntary organisations and advocacy groups for a wide range of age groups and needs should be made available to DASSs to inform planning and should be refreshed, as appropriate, at suitable points leading up to, during and after a flu pandemic.

10. LRFs should share information on local facilities such as closed schools and colleges and the availability and capacity of such facilities if available for use, to inform planning, in liaison with Directors of Children's Services.

11. DHSC should ensure that guidance includes the importance of information about stocks of, access to and appropriate use of increased provision of:

    - personal protective equipment (PPE), such as masks and gloves
    - community equipment, such as commodes, bed rails, grab rails and incontinence pads.

12. Government Departments should consider providing guidance on live data on staff sickness/availability throughout a pandemic.

13. Government Departments should provide support with systems to collate data on suitable volunteers from families, the third sector or the community is required, as this was an area of weakness identified by the survey.

14. DHSC should give full consideration to the information needs associated with coordinating the use of volunteers in expanded roles that may include personal care as well as social support.