City of London and London Borough of Hackney

Pandemic Preparedness, Response and Recovery Plan

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Contents

1. Definitions

- **Business Continuity Plan (BCP):** A plan to help ensure that business operations continue during disruptions such as a pandemic.

- **Emerging disease:** Diseases that appear in a population for the first time, or that may have existed previously but are rapidly increasing in incidence or geographic range.

- **Epidemic:** The widespread occurrence of an infectious disease in a community at a particular time.

- **Infection Prevention and Control (IPC):** Measures and procedures implemented to prevent the spread of infections

- **Morbidity:** The rate of disease in a population.

- **Mortality:** The rate of death in a population.

- **Mutual aid:** The voluntary reciprocal exchange of resources and services for mutual benefit.

- **Non-pharmaceutical interventions (NPIs):** Actions, other than those involving pharmaceuticals (such as vaccines or medications), that people and communities can take to help slow the spread of a disease. Examples include hand hygiene, social distancing, and mask-wearing.

- **Outbreak:** An observed number of cases greater than that expected for a defined place and time period, or two or more cases with a common exposure.

- **Pandemic:** An epidemic occurring worldwide, or over a very wide area, crossing international boundaries, and usually affecting a large number of people.

- **Pathogen:** Organism that can cause disease in humans and other hosts.

- **Personal Protective Equipment (PPE):** Equipment worn to minimise exposure to hazards that cause serious workplace injuries and illnesses.

- **Therapeutics:** Treatments and medications used to manage and treat a disease.

- **Zoonotic disease:** An infectious disease that has jumped from a non-human animal to humans. The pathogens involved may be bacterial, viral or parasitic.

2. Introduction

Aim and Objectives

2.1. The aim of this plan is to strengthen our preparedness and enable the coordination of an effective response and recovery to a pandemic in the London Borough of Hackney and the City of London.

2.2. The objectives of this plan are to:

- Establish a framework to strengthen local systems to prepare for, respond to, and recover from pandemics.
- Detail the activation procedures and mechanisms for transitioning between pandemic phases: preparedness, response and recovery.
- Provide a vulnerability assessment for the City of London and London Borough of Hackney.
- Outline the roles, responsibilities, and governance structures for pandemic preparedness, response and recovery for Hackney Council and the City of London Corporation.

Background

2.3. Pandemics often result from novel pathogens (such as viruses or bacteria) that spread across a large region (multiple continents or worldwide), affecting a substantial number of individuals due to a lack of population immunity.

2.4. Pandemics are classified as high-risk in the National and London Risk Registers, with high likelihood and catastrophic impact ratings.

2.5. There are five key transmission routes (respiratory, blood-borne, faecal-oral, vector-borne and direct contact transmission routes) with respiratory pathogens considered the most likely cause of a future pandemic.

2.6. Pandemics can generate unprecedented demand and disruption to health and care services, overwhelm death management services, and create profound challenges across morbidity, mental health, social support, community cohesion, and psychological wellbeing.

2.7. Wide-ranging secondary impacts may also include economic impacts, food security implications, supply chain disruptions (such as medical and fuel) and exacerbation of existing health inequalities.

2.8. The ongoing risk of pandemics is driving significant investment in national preparedness across the five key transmission routes (see paragraph 2.3).

2.9. Furthermore, due to the profound and far-reaching impacts, there are legislative requirements for pandemic preparedness and response planning for local authorities. This planning is guided by several legislative and regulatory frameworks, including the Civil Contingencies Act 2004.

3. Scope

3.1. This plan applies to the London Borough of Hackney and the City of London. It focuses on the actions and responsibilities of Hackney Council, and the City of London Corporation, setting out specific measures to protect public health, maintain essential services, and coordinate with local-system partners.

3.2. It is expected that other Category 1 responders, such as the NHS (guided by the NHS England Framework for Managing the Response to Pandemic Diseases), and the UK Health Security Agency, will have separate pandemic preparedness and response plans specific to their functions and responsibilities.

3.3. This plan sets out:

- Pandemic vulnerability assessments for the City of London and London Borough of Hackney.
- The Council and Corporation's strategic approach to pandemic preparedness, response, and recovery.
- Pre-activation and phase transition protocols as well as underpinning governance arrangements.
- General guidance for all Council and Corporation services and service-specific action plans.

3.4. The plan does not detail specific business continuity arrangements for contributing directorates or services.

3.5. The plan is hazard-agnostic (i.e., it is independent of the pathogen and mode of transmission).

3.6. This plan is intended to be a live document and will be reviewed regularly to address changing evidence, guidance and contextual factors.

3.7. There is inherent uncertainty about what a future pandemic agent may be and how it may behave. Therefore, some response elements will need to be developed reactively or adapted once more information is known. However, this plan builds on existing systems and incorporates learning from the COVID-19 pandemic.

4. Planning Assumptions

4.1. Each pandemic is unique and it is impossible to predict when one will occur. Impacts will depend on many different factors including transmission routes, disease severity, global travel and the distribution of morbidity and mortality.

Infectivity and Spread

4.2. While it will not be possible to stop the spread of a new pandemic, early containment efforts will aim to slow transmission to better understand the disease and inform recommendations for policy and intervention.

4.3. A pandemic's impact cannot be predicted until it has affected a significant number of people; therefore early projections should be treated as assumptions rather than forecasts.

4.4. A pandemic may lead to behaviour changes in the population that will depend on the nature of the disease and the government's response.

4.5. Depending on the mode of transmission and location of initial cases, an infective pathogen could reach the UK very quickly, with localised clusters of the disease occurring nationwide as quickly as within one or two weeks.

4.6. While all ages may be affected, certain population groups, such as those that are vulnerable and/or those with underlying health conditions, are likely to be at higher risk of poorer outcomes.

Health and Care Surge Demand

4.7. Effective treatments are unlikely to be available at the start of the pandemic. Similarly, an effective vaccine will take a substantial amount of time to develop.

4.8. The emergency state of the pandemic in the UK will last at least 9 months, and potentially substantially longer. Response mechanisms are therefore likely to be required beyond 9 months to manage the risk and recovery.

4.9. A potential pandemic scenario (e.g., an unmitigated respiratory pandemic) assumes up to 50% of the UK's population could fall ill during the course of the pandemic. An estimated 1.34 million people (~2%) may require hospitalisation, with deaths potentially leading up to 840,000 (~1.2%).

4.10. Locally, healthcare and mortuary services for City and Hackney should prepare for at least 5,420 cases requiring hospitalisation and 3,252 deaths.

4.11. A pandemic scenario will necessitate that the local response is integrated with regional or national response efforts.

Staff Absence

4.12. Up to 50% of the workforce may require time off at some stage. Close-contact teams may experience even higher levels of absenteeism.

Wider Sector and Community Impacts

4.13. Impact assumptions include, but are not limited to:

- Fatality management processes becoming overwhelmed
- Rates of domestic violence increasing
- Mental health and wellbeing impacts
- Disrupted access to support services
- Public behavioural changes and community disorder
- Disruption to transport, ports and broader services
- Severe economic impacts, with disruption to essential services, utilities and food chain supplies
- Exacerbation of health inequalities
- Greater need for community support and reliance on the voluntary and community sector
- Concurrent incidents during the sustained pandemic response and recovery
- Impacts on small and medium-sized businesses, with front-facing workers at highest risk (e.g., cab drivers and small restaurants)

5. Policy Context

National

5.1. The Department for Health and Social Care (DHSC) is the lead government department for pandemic planning. As of March 2025, the department is developing five pandemic transmission-specific plans (respiratory, blood-borne, faecal-oral, vector-borne and direct contact transmission routes), with an initial focus on respiratory-borne pandemics. Note: **the UK Influenza Preparedness Strategy 2011 has been discontinued**.

5.2. The UKHSA National Communicable Disease Outbreak Management Guidance outlines the principles to support local health protection system responses to outbreaks of infectious disease.

Pan-London

5.3. The London Resilience Interim Pandemic Response Framework (2023) supersedes the previous frameworks for pandemic influenza (2018) and coronavirus (2020). The updated framework adopts a disease-agnostic approach. It outlines organisational responsibilities in areas including food supply and distribution, health and care services, support for vulnerable individuals, and excess deaths planning.

5.4. As of March 2025, a London Health Resilience Partnership Pandemic Framework is in development. This framework will define roles, responsibilities and escalation protocols specific to London's health and care systems.

5.5. A draft pan-London Memorandum of Understanding (2024) for managing complex infectious disease outbreaks (defined as those requiring a multi-agency response) is also under development.

Local

5.6. Directors of Public Health have overall responsibility for assuring local systems are in place to respond to health protection incidents and outbreaks, ensuring identified risks are mitigated and controlled.

5.7. This pandemic plan and response activities are interdependent with, or supported by, other local emergency plans and response protocols including:

- Hackney Identification of Vulnerable Persons Plan
- Hackney Incident Plan
- Hackney Mass Fatalities Arrangements
- Hackney Recovery Plan
- Hackney Multi Faith Emergency Response Plan
- Hackney Excess Deaths Plan

5.8. The principles underpinning this plan align with existing regional and national resilience arrangements. The plan, including key contacts, will be reviewed annually to reflect the latest expert advice and national planning guidance.

6. Preparedness

6.1. Hackney Council and the City of London Corporation are committed to assessing and strengthening readiness to respond effectively to a potential pandemic. The following preparedness measures outline the approach to developing, testing and operationalising the plan.

Pandemic Preparedness Activities

6.2. To ensure readiness, the following activities are being or are committed to be undertaken:

- This plan has been developed in consultation with key stakeholders and services. The plan will be reviewed annually in line with national planning guidance and the situational context.
- An exercise will be conducted to test the operationalisation of the plan, once every three years.
- Relevant service leads have received a handover of the plan and will consider its implications for their service operations and responsibilities.

Health Protection Capability and Training

6.3. The City and Hackney Public Health Team has a dedicated resource focused on protecting the population from infectious diseases threats. The resource also includes management of an established Health Protection Forum.

6.4. The Forum, supported by the Health Protection Risk Register, works with local partners to monitor and address infectious disease risks, such as sub-optimal vaccine coverage and inequalities in uptake.

6.5. While Consultants in Public Health provide health protection leadership, regular training is planned to equip wider teams with basic outbreak and emergency response competencies.

Coordinated Response

6.6. Locally commissioned services (e.g., sexual health and drug and alcohol services) will be engaged to ensure that service partners are clear on their roles and obligations for pandemic response and can be mobilised accordingly.

Community Engagement

6.7. Community engagement work is underway, including the development of partnerships through Volunteer Centre Hackney and Community Health Champions, to build trust and social capital with groups at greater risk of poorer health outcomes.

6.8. Information sharing channels will be reviewed to ensure that culturally sensitive communications are accessible during a pandemic.

7. Vulnerability Assessment: London Borough of Hackney

7.1. The London Borough of Hackney is particularly vulnerable to the impacts of a pandemic due to a combination of health, socioeconomic, and environmental factors. While the overall risk of a pandemic may be comparable to other areas in London or England, the consequences in Hackney are likely to be more severe due to these underlying vulnerabilities.

7.2. Appendix 2 details specific vulnerabilities within Hackney and the City of London using an Equity and Health Impact Assessment (EqHIA) framework. It summarises both local and national impacts observed during the COVID-19 pandemic, and identifies population groups at heightened risk in the event of an unmitigated or similar pandemic scenario.

7.3. To ensure an equitable response during a pandemic, this assessment is underpinned by the **protected characteristics** defined under the Equality Act 2010, and is further informed by the **Core20PLUS approach**. The Core20PLUS approach considers the most deprived 20% of the population, as well as additional groups beyond deprivation that may experience broader health inequalities.

7.4. This assessment should be used alongside existing emergency planning processes for identifying and supporting vulnerable residents during an emergency.

7.5. This assessment does not outline specific mitigation measures, as these are addressed within the broader pandemic plan and detailed service-specific action plans.

Summary of the Pandemic Vulnerability Assessment

7.6. All population groups were negatively impacted by the COVID-19 pandemic, though the type and severity of harm varied. All have been identified as being at risk of adverse outcomes, though the extent of impact will depend on the nature of the pathogen and the response measures in place.

7.7. Overall, identified vulnerability relates to five key themes:

- exposure risk
- infection risk
- exclusion from support and services
- increased mortality and morbidity
- wider impacts on health, wellbeing, and on frontline services.

7.8. **Exposure Risk:** In Hackney, structural disadvantage is likely to increase exposure to frontline workers, people in informal or insecure employment,

working age men, migrants with No Recourse to Public Funds, individuals from Black, Asian and Minority Ethnic background and non-English speakers.

7.9. High-risk settings, such as overcrowded homes, hostels, care homes, and asylum seeker accommodation, particularly in more deprived areas (e.g., parts of southern Hackney), face increased risk of transmission.

7.10. **Infection Risk:** Hackney has high levels of deprivation and prevalence of long-term health conditions both of which contribute to increased infection risk. Older adults, disabled residents, people with drug and alcohol dependence, and people who are rough sleeping or homeless are especially vulnerable due to existing health and structural inequalities.

7.11. **Exclusion from Support and Services:** Hackney's diverse population includes groups who face systemic barriers to accessing health information, services, and support. Around 12% of households lack internet access; this especially affects older adults, low-income families, and communities such as the Charedi Jewish population, who also experience lower digital engagement and limited interaction with mainstream services.

7.12. Over 10% of residents do not speak English as a main language, with significant Turkish, African diaspora, and Charedi communities affected. Migrants with No Recourse to Public Funds (NRPF) were excluded from COVID-19 financial protections such as furlough. These barriers place these groups at even greater risk of reduced access to services, public health interventions and support.

7.13. **Mortality and Morbidity:** Higher rates of severe illness and death are likely to be seen among older adults, those with pre-existing conditions, residents in care homes, and racial groups, particularly Black African, Black Caribbean, and Bangladeshi communities. Vulnerabilities are likely to persist without targeted and equitable interventions.

7.14. **Wider Impacts on Health and Wellbeing, and Frontline Services:** Children and young people are likely to face disrupted education, digital exclusion, food insecurity, and safeguarding risks, especially those in care, temporary accommodation and from higher deprivation backgrounds.

7.15. Women in cohabiting arrangements and migrants are at increased risk of experiencing increased domestic violence and/or financial hardship.

7.16. LGBTQ+ residents, homeless individuals, people with drug and alcohol dependencies, and people with mental health needs may experience greater isolation, exclusion from services, and declining mental health. These impacts may place sustained pressure on frontline health, care and support services.

8. Vulnerability Assessment: City of London Corporation

8.1. Appendix 2 details specific pandemic vulnerabilities within Hackney and the City of London.

8.2. The City of London, often referred to as the Square Mile, is a unique area with a diverse population and workforce.

8.3. Approximately 8,600 residents live in the City of London. 1 in 52 workers in the UK are employed in the City, with a total workforce of around 614,000. 70% of workers in the City are employed in high-skill jobs.

8.4. During the COVID-19 pandemic, the City was less affected by furlough measures compared to the rest of the UK, reflecting a higher degree of economic resilience.

8.5. Population vulnerabilities are likely to exist for City of London residents, but at a far reduced scale compared to Hackney.

8.6. A pandemic is likely to result in reduced office occupancy rates in the Square Mile, as professionals shift towards remote working. However, vulnerabilities will remain for those in front-facing roles and supporting businesses (particularly small and medium-sized enterprises), such as retail and hospitality.

8.7. Additional at-risk groups and factors include:

- The **essential workforce**, such as cleaners, construction workers, and staff in retail, hospitality, and other front-facing roles that cannot be performed remotely, who are at heightened risk of exposure during a pandemic.
- **Areas of higher deprivation**, particularly Golden Lane and Portsoken Ward, where residents may face compounded social and economic challenges.
- A **high number of rough sleepers**, placing pressure on health and outreach services and increasing transmission risk.
- A notable population of **unaccompanied asylum-seeking children**, who may face barriers to accessing health and social support.
- Residents reporting a **disability**, who may experience disrupted care or difficulty accessing essential services during health emergencies.
- Elevated transmission risk in **close-contact environments** including education settings (14) and nurseries (13). There are no care settings in the City of London.

9. Pandemic Phases and National Coordination

9.1. This pandemic plan focuses on three phases:

- **Emergence:** Reliable international evidence or UK intelligence reports the emergence of a known or unknown pathogen with human-to-human transmission, and minimal population immunity to the pathogen or strain.

- **Delay and Mitigate:** The pathogen spreads to the wider population and there is evidence of sustained and then widespread community transmission. Demands for services may start to exceed the capacity available. Pressures on wider society resulting in contingency measures being implemented.

- **Recovery, Prevent and Prepare:** There are high levels of population immunity, and sustained levels of low transmission or reduced disease severity. There may be normalisation and restoration of services, and planning for possible pandemic resurgence.

9.2. Key actions for the Government and local system partners for each phase of a pandemic are detailed in the table below (Table 1).

Table 1: Key Actions for Government and Local Partners During a Pandemic	
Emergence	The initial pandemic response will focus on stopping further transmission and reducing cases to zero. The Government will: ● Implement border measures, with a focus on isolation capabilities, disease surveillance and early detection. ● Provide surveillance and intelligence, including information regarding transmission dynamics of the pandemic agent, and groups more susceptible to infection or poor outcomes. ● Provide advice and implement public health measures to contain the spread of infection. ● Develop and provide countermeasures including diagnostics, therapeutics, vaccines and PPE. ● Lead communications with the public and key partners. Local authorities are likely to focus on: ● Conducting preparedness assessments, including the review of local pandemic response plans. ● Delivering local communications, guidance and information to internal teams and key stakeholders. ● Reviewing business continuity plans (BCPs) and updating emergency and vulnerable contact lists.
Delay and Mitigate	During this phase, the Government (and regional bodies) will: ● Continue disease surveillance and provide situational and international updates. ● Scale up testing capacity. ● Implement or adapt interventions. ● Roll out available therapeutics and vaccines, by priority. ● Coordinate planning and delivery of health services. Local authorities will likely focus on: ● Strengthening local disease surveillance, and assessing vulnerabilities and population and service impacts. ● Coordination of response activities, in collaboration with the local system, and community and voluntary sector partners. ● Implementing public health measures, in line with the developing evidence and national directives. ● Ensuring continued provision of health and social care services, community support and mutual aid. ● Responding to negative public behavior, misinformation and disinformation that may circulate locally.
Recovery, Prevent and Prepare	During this phase, local/national pandemic response structures will shift towards recovery and future preparedness: ● Response structures will be stood down. ● Supporting services will return to BAU / or a new normal. ● Pandemic-specific functions will be integrated into routine practice, scaled down or ceased as required. ● Preparation for future waves will continue. ● Debriefing and evaluation of the response will be facilitated and learning captured.

10. Plan Activation and Early Response Actions

Early Response Actions Before Plan Activation

10.1. Hackney Council and the City of London Corporation have independent corporate command structures (Gold, Silver, and Bronze) for handling emergencies and assessing the impact of incidents on public services and the local population.

10.2. The response to an emerging pandemic escalation should begin before a pandemic is formally declared. The initial response should be led by the Director of Public Health (DPH), to initiate local actions relevant to the 'emergence phase' of the pandemic, and establish coordination of any response strategy.

10.3. Situational awareness may be informed by technical briefings, risk assessments, notifications, and intelligence from the UKHSA and partners.

10.4. If the local impact of the pandemic escalates, or national direction triggers a formal response, then the Council/Corporation's Gold Command (Strategic) should convene to lead the overarching corporate response. Membership includes:

- The Chief Executive or Gold Lead
- Director of Public Health (DPH)
- Directors for Legal and Governance
- Strategic Directors (e.g., Adults, Children and Families, Housing, Human Resources and Finance)
- Director for Communications
- Corporate Emergency Planning

10.5. The initial meeting should cover:

- Suggested membership of the Group
- Current situational overview
- Potential public health impact or worst case scenario based on the situational context and information available at the time
- Council/Cooperation operational impact
- Internal preparedness and business continuity readiness
- External roles, responsibilities, response actions and cross-agency coordination
- Internal roles, responsibilities, response strategies, communication and coordination

10.6. A proportionate escalation approach is recommended, with response strategies reviewed as more information becomes available.

10.7. All meeting notes, actions and associated documents should be stored in a central repository, accessible to all representatives. The Public Health team will serve as the secretariat.

Activating the Pandemic Response

10.8. The Director of Public Health holds responsibility for activating the pandemic response. Activation may also be triggered by the respective gold command groups for City and Hackney, even before a national or regional pandemic plan is formally enacted.

10.9. The response plan can be activated following:

- Declaration of a Public Health Emergency of International Concern
- Declaration of a Pandemic Alert Phase or 'Enhanced Incident'
- An escalated pandemic risk
- An increase in hospitalisations, outbreaks or mortality, necessitating a formal emergency response
- An advisory or directive issued by the UKHSA or relevant authority

10.10. Once activated, governance structures will be mobilised accordingly.

11. Pandemic Response Governance

11.1. The local pandemic response and governance structure is organised across three tiers: **Strategic**, **Tactical**, and **Operational** (Fig. 1). This framework is intended to ensure coordinated leadership across services and groups, effective information flow, and clear escalation routes when required.

11.2. Regional and national structures (e.g., COBR and the Strategic Coordination Group) are expected to provide overarching strategic direction and oversight, but are outside the scope of this plan.

Strategic Level

11.3. **City and Hackney Health Protection Board:** The Board will lead development of the pandemic strategy, coordinate response efforts across the system, and maintain oversight of local impacts. The membership of the Health Protection Board may need to be reviewed to ensure appropriate representation form across the Council/Corporation for a pandemic response context.

11.4. **Council/Corporation Gold:** The Gold Group will provide corporate strategic leadership for the Council/Corporation. It is expected to set priorities, oversee the organisation's strategic response, oversee the pandemic governance, align directorate actions, and engage political leadership (e.g., the Mayor and Cabinet).

Tactical Level

11.5. Hackney Council / City of London Corporation Silver Groups: Five groups will manage tactical coordination:

- **Corporate Resilience Group**: Responsible for internal services, workforce, ICT, and facilities.
- **Borough Impacts**: Responsible for community facing services and addressing inequalities.
- **Multi-Agency Local Coordination Groups**
  - ❖ Excess Deaths
  - ❖ Community Resilience
  - ❖ Resilience Local Coordination

11.6. These groups will be expected to translate strategic direction into action, support operational delivery, and maintain situational awareness across service areas.

Operational Level

11.7. **City and Hackney Pandemic Operational Groups:** These groups will coordinate the day-to-day response and pandemic-related actions for their respective local authority.

11.8. **Task and Finish Groups:** Will be established as needed to address specific issues or support time limited programmes (e.g., contact tracing, vaccine delivery, PPE distribution).

11.9. **Health Incident Management Team:** The Group will manage acute incidents and outbreaks with partners, and provide public health advice and oversight.

Supporting Groups

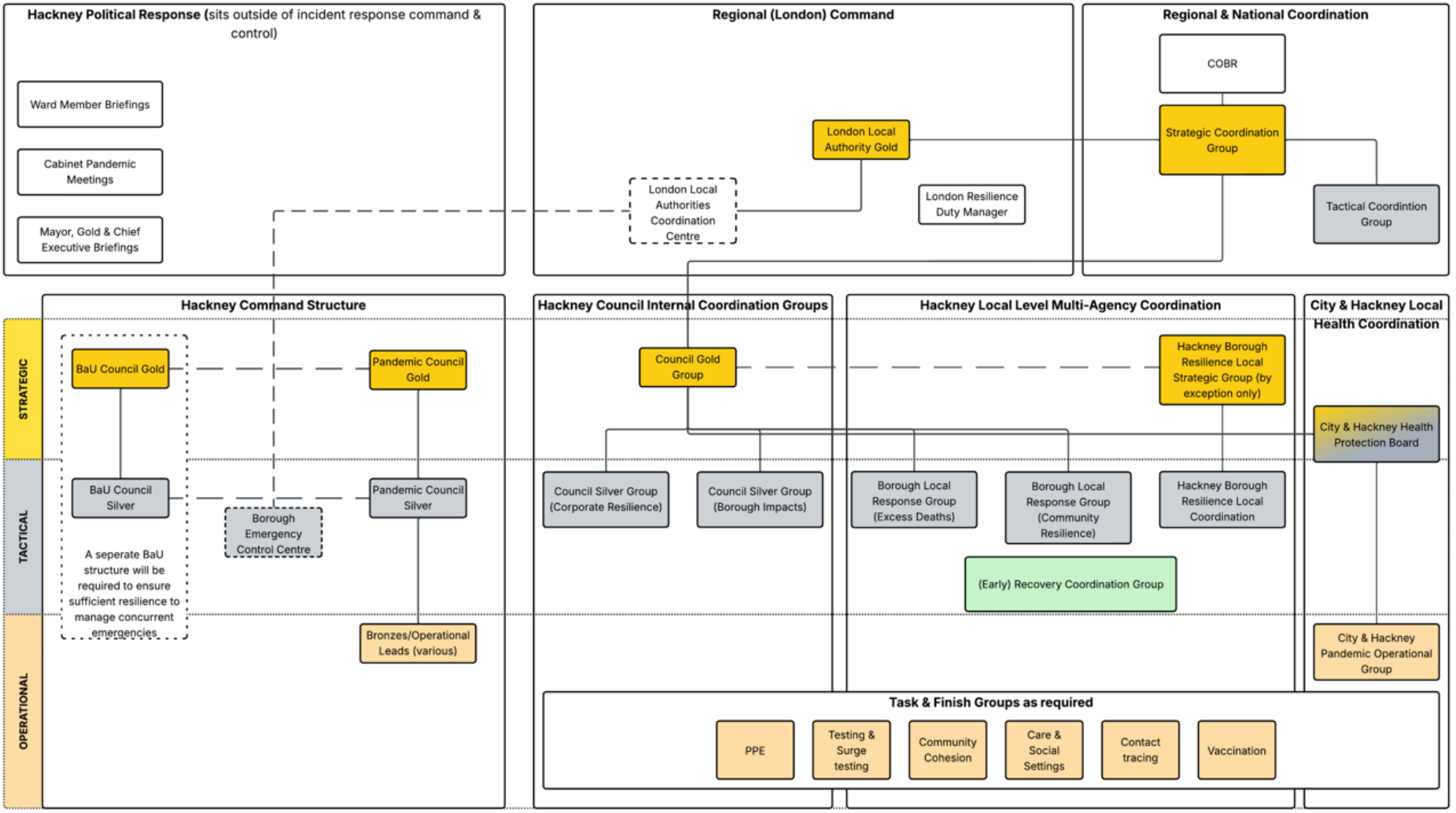
11.10. **(Early) Recovery Coordination Group (RGC):** The Group will plan for transition and long-term recovery. It should identify early issues and support strategic decision making.

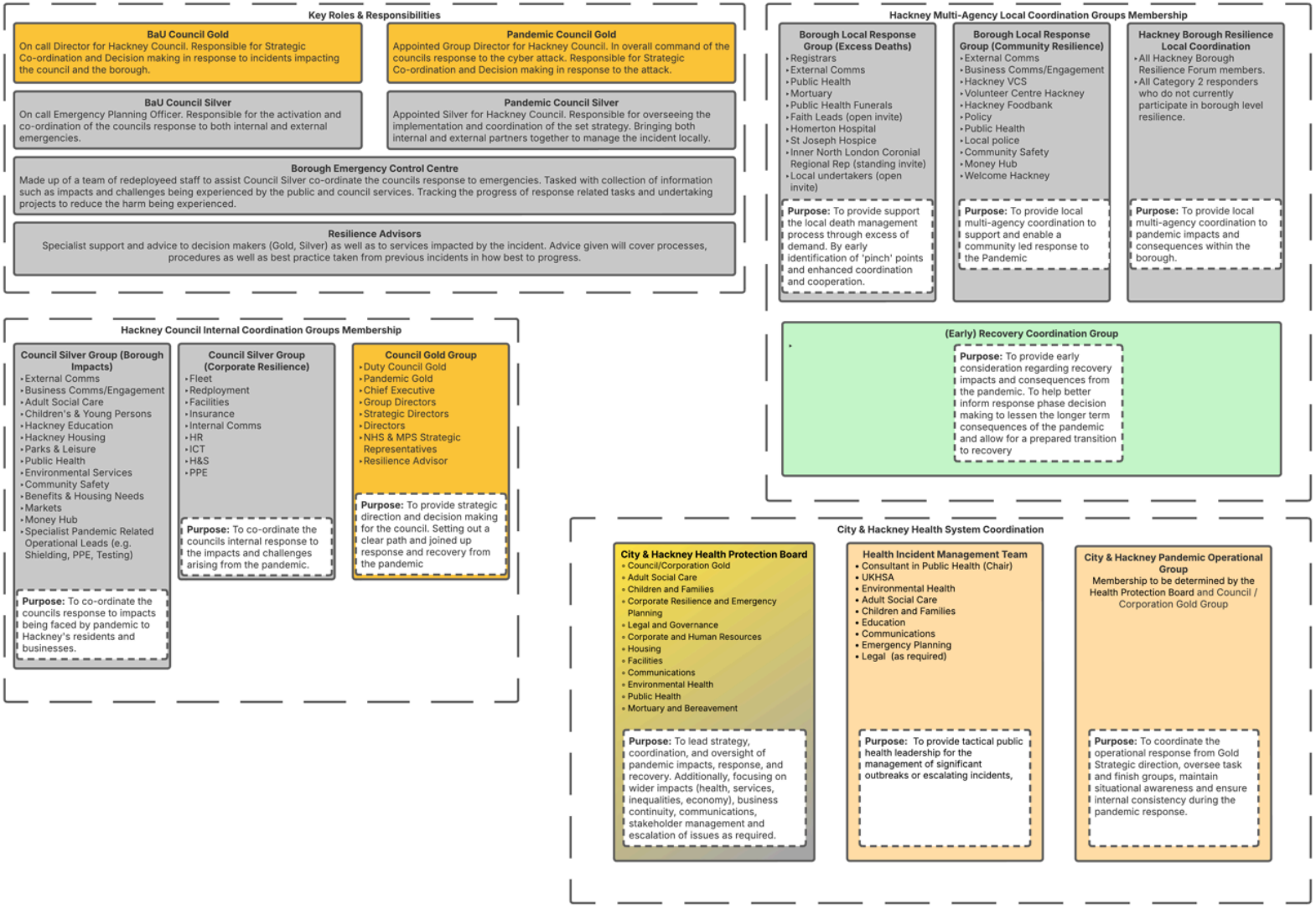
Multi-Agency Involvement

11.11. Although this plan focuses on internal governance structures, a full response may involve external partners and agencies, including but not limited to:

- North East London Integrated Care Board (NEL ICB)
- East London Foundation Trust (ELFT)
- Homerton University Hospital Foundation Trust (HUHFT)
- Emergency Services (Metropolitan Police, London Fire Brigade and London Ambulance Service)
- City and Hackney Integrated Primary Care (previously the GP Confederation)
- Hackney Voluntary and Community Services

Figure 1: Hackney Pandemic Plan Governance Structure and Reporting




Key Roles & Responsibilities
BaU Council Gold
On call Director for Hackney Council. Responsible for Strategic Co-ordination and Decision making in response to incidents impacting the council and the borough.
Pandemic Council Gold
Appointed Group Director for Hackney Council. In overall command of the councils response to the cyber attack. Responsible for Strategic Co-ordination and Decision making in response to the attack.
BaU Council Silver
On call Emergency Planning Officer. Responsible for the activation and co-ordination of the councils response to both internal and external emergencies.
Pandemic Council Silver
Appointed Silver for Hackney Council. Responsible for overseeing the implementation and coordination of the set strategy. Bringing both internal and external partners together to manage the incident locally.
Borough Emergency Control Centre
Made up of a team of redeployeed staff to assist Council Silver co-ordinate the councils response to emergencies. Tasked with collection of information such as impacts and challenges being experienced by the public and council services. Tracking the progress of response related tasks and undertaking projects to reduce the harm being experienced.
Resilience Advisors
Specialist support and advice to decision makers (Gold, Silver) as well as to services impacted by the incident. Advice given will cover processes, procedures as well as best practice taken from previous incidents in how best to progress.
Hackney Multi-Agency Local Coordination Groups Membership
Borough Local Response Group (Excess Deaths)
Registrars
External Comms
Public Health
Mortuary
Public Health Funerals
Faith Leads (open invite)
Homerton Hospital
St Joseph Hospice
Inner North London Coronial Regional Rep (standing invite)
Local undertakers (open invite)
Purpose: To provide support the local death management process through excess of demand. By early identification of 'pinch' points and enhanced coordination and cooperation.
Borough Local Response Group (Community Resilience)
External Comms
Business Comms/Engagement
Hackney VCS
Volunteer Centre Hackney
Hackney Foodbank
Policy
Public Health
Local police
Community Safety
Money Hub
Welcome Hackney
Purpose: To provide local multi-agency coordination to support and enable a community led response to the Pandemic
Hackney Borough Resilience Local Coordination
All Hackney Borough Resilience Forum members.
All Category 2 responders who do not currently participate in borough level resilience.
Purpose: To provide local multi-agency coordination to pandemic impacts and consequences within the borough.
(Early) Recovery Coordination Group
Purpose: To provide early consideration regarding recovery impacts and consequences from the pandemic. To help better inform response phase decision making to lessen the longer term consequences of the pandemic and allow for a prepared transition to recovery
Hackney Council Internal Coordination Groups Membership
Council Silver Group (Borough Impacts)
External Comms
Business Comms/Engagement
Adult Social Care
Children's & Young Persons
Hackney Education
Hackney Housing
Parks & Leisure
Public Health
Environmental Services
Community Safety
Benefits & Housing Needs
Markets
Money Hub
Specialist Pandemic Related Operational Leads (e.g. Shielding, PPE, Testing)
Purpose: To co-ordinate the councils response to impacts being faced by pandemic to Hackney's residents and businesses.
Council Silver Group (Corporate Resilience)
Fleet
Redployment
Facilities
Insurance
Internal Comms
HR
ICT
H&S
PPE
Purpose: To co-ordinate the councils internal response to the impacts and challenges arising from the pandemic.
Council Gold Group
Duty Council Gold
Pandemic Gold
Chief Executive
Group Directors
Strategic Directors
Directors
NHS & MPS Strategic Representatives
Resilience Advisor
Purpose: To provide strategic direction and decision making for the council. Setting out a clear path and joined up response and recovery from the pandemic
City & Hackney Health System Coordination
City & Hackney Health Protection Board
Council/Corporation Gold
Adult Social Care
Children and Families
Corporate Resilience and Emergency Planning
Legal and Governance
Corporate and Human Resources
Housing
Facilities
Communications
Environmental Health
Public Health
Mortuary and Bereavement
Purpose: To lead strategy, coordination, and oversight of pandemic impacts, response, and recovery. Additionally, focusing on wider impacts (health, services, inequalities, economy), business continuity, communications, stakeholder management and escalation of issues as required.
Health Incident Management Team
Consultant in Public Health (Chair)
UKHSA
Environmental Health
Adult Social Care
Children and Families
Education
Communications
Emergency Planning
Legal (as required)
Purpose: To provide tactical public health leadership for the management of significant outbreaks or escalating incidents,
City & Hackney Pandemic Operational Group
Membership to be determined by the Health Protection Board and Council / Corporation Gold Group
Purpose: To coordinate the operational response from Gold Strategic direction, oversee task and finish groups, maintain situational awareness and ensure internal consistency during the pandemic response.

12. Council/Corporation Actions After Plan Activation

12.1. The table below outlines the key actions and considerations for the Council/Corporation following activation of this plan. Detailed service-specific actions and recommendations are outlined in Section 16.

12.2. All meeting notes, actions and associated documents should be stored in a central repository, accessible to all representatives. The Public Health team will oversee the secretariat arrangements.

Table 2: Actions and Considerations for the Council/Corporation following Response Plan Activation		
Theme	Actions and Considerations	Responsible Lead(s)
Emergence: The emergence phase will set out the arrangements for a structured and coordinated response.		
Assessment and Initial Actions	Convene meeting of the Health Protection Board: ● Review the response plan, interdependent emergency plans and procedures to identify vulnerable residents. ● Conduct Council/Corporation risk assessment and pandemic vulnerability assessment. ● Implement initial actions based on the public health risks and operational impacts. ● Review key contacts and service area leads. ● Ensure data sharing agreements are in place. ● Coordinate with system response efforts. ● Consider activating the Borough Emergency Control Centre if necessary.	Health Protection Board Borough Resilience Forum
Business Continuity	● Assess critical services. ● Seek assurance regarding the readiness and robustness of business continuity plans (BCPs) for service areas. ● Evaluate threshold for mutual aid support. ● Assess whether other local authorities would be in a position to provide mutual aid if requested.	Corporate Leadership Emergency Planning
Communication	● Establish communication needs and channels for both workforce and key stakeholders. ● Provide situational updates, IPC guidelines and protocols. ● Coordinate public facing communications in partnership with other responding organisations. ● Co-design with the community, voluntary and faith sectors to ensure that resident facing communications are culturally acceptable and effective. ● Ensure information is accessible to stakeholders (including residents and	Communications Human Resources

	communities), groups not directly affiliated with voluntary and community sector organisations, and those without digital access. ● Develop / maintain communication channels with key population groups through voluntary and community sector organisations. ● Review distribution lists for information sharing, including with the VCS.	
Delay and Mitigate: This phase of the pandemic will focus on slowing transmission and minimising harm and disruptions to critical services, while implementing public health measures and providing support to vulnerable population groups.		
Financial Model for Pandemic Response	● Develop a scoped financial model to support the pandemic response, including predefined spending arrangements and sign-off processes.	Finance and Corporate Resources
System Coordination	● Coordinate system-wide activity to increase uptake of public health interventions, especially among underserved groups, by working with health partners, key settings, voluntary and community organisations and groups (including community health champions).	Public Health
Data and Intelligence	● Collaborate with relevant stakeholders to ensure access to critical data (e.g., case identification (testing), hospital admissions, deaths) for strategic response planning.	Public Health
Equalities and Inclusion	● Ensure all pandemic-related policies and service changes are compliant with the Equality Act 2010 and have considered the specific vulnerabilities detailed in the assessment. ● Establish system wide frameworks to assess the pandemic impact on public health, operational decisions and programmes of work - on groups at higher risk of ill health or adverse outcomes.	Emergency Planning Corporate Resources Legal and Governance
Community Wellbeing and Cohesion	● Work with community safety partners and trusted messengers (e.g. faith settings and community health champions) to monitor tensions, support vulnerable groups, maintain trust, and promote public health measures. Ensure	Emergency Planning / Public Protection Communities Team

	intelligence, engagement and responses are joined up with any community-focused task and finish groups/response teams.	
Welfare and Support to Vulnerable Residents	● Identify and address gaps in emergency support. ● Assess the disproportionate impacts on vulnerable residents / populations and target support to mitigate these. ● Coordinate with partners to reach those at higher welfare risk. ● Review referral pathways to local advice and support (e.g. housing). ● Partner with trusted agencies (e.g. the VCS) to deliver welfare outreach (e.g., via local settings such as schools or care settings).	Emergency Planning All Services
Staff Absence, Safety and Wellbeing	● Review and update the staff absence and sickness policy. ● Communicate recruitment, hiring and retention policies. ● Review compassionate leave policy. ● Establish absence/sickness reporting procedures. ● Ensure protocols for workforce safety and welfare.	Corporate and Human Resources
Legislation and Governance	● Monitor legislative changes and emergency authorisations. ● Use Director of Public Health and local authority powers as needed to implement local health protection measures. ● Confirm emergency response funding (e.g., for contact tracing).	Legal and Governance Corporate Leadership
Excess Deaths and Bereavement	● Track death rates and mortuary capacity. ● Update critical contacts and review excess death plans with the General Register Office. ● Confirm staffing, facilities, and equipment needs. ● Communicate process changes to stakeholders. ● Monitor legal changes and support staff wellbeing.	Mortuary and Bereavement
Incident and Outbreak Management	● Convene the Health Incident Management Team for significant outbreaks. ● Create a communications plan and on-call rota to manage queries and materials, and prevent staff burn-out. ● Follow national guidance (e.g. from UKHSA) as the primary source for outbreak	Public Health

	and incident response. Develop local SOPs only where essential to operationalise or adapt national guidance to specific local settings or service delivery needs. ● Enable local delivery of national response functions if requested. ● Support isolation through financial and practical assistance. ● Support community level enforcement of outbreak measures.	
Communication (Staff and Public)	● Keep staff informed on operational changes, infection control, and relevant policies. ● Communicate clearly with the public and partners (through a wide range of communication channels including services, settings, partners and VCS) on: ○ Situational updates and guidance ○ Health messaging (culturally appropriate, translated, trusted channels) ○ Access to support and service changes	Communications Human Resources
Supporting Care and Support Settings	● Connect with providers and partners to review business continuity and IPC. ● Identify and support vulnerable individuals. ● Address financial pressures from operational disruptions. ● Maintain communication across Public Health, IPC, ASC, and frontline services to monitor risks and service continuity.	Adults Social Care Public Health
Infection Prevention and Control	● Apply current IPC guidance. ● Support schools, care homes, and key settings with IPC and outbreak management. ● Coordinate PPE supply and support infection secure practices, and hygiene measures, in all relevant settings and Council/Corporation buildings. ● Conduct exposure mapping and management as needed.	Facilities Human Resources Public Health
Targeted Interventions	● Support actions to reduce or disrupt transmission, aligned with public health guidance and local needs, and coordinated with national and regional efforts.	Public Health
Establish sustainable resourcing	● Reactivate the redeployment pool to release staff to assist in pressured teams ● Fund and recruit into ‘ghost posts’ for Pandemic Response ○ Emergency Planning & Response Officer (39822) ○ PPE Provisions Manager (40130)	Human Resources Emergency Planning

	○ BECC Lead Officer (40554)	
Establish sustainable resourcing	In preparation for a pandemic, establish training for public health staff to upskill and align with emerging national policy and guidance.	Public Health
Recovery, Prevent and Prepare: This phase of the pandemic will focus on supporting services to return to 'business as usual' or the new normal as quickly as possible, while recognising that there will be a legacy of impacts that will take time to recover from. Community impacts and inequalities will be reviewed, to inform support on those that have been most impacted.		
Transition to Recovery	● Stand down response structures and lead the transition to recovery.	Corporate Leadership
Business as Usual	● Integrate pandemic-specific interventions into routine business as usual, or scale down if no longer required.	All Services
Preparedness for Resurgence	● Maintain readiness for potential future waves and surge capacity, including a review of existing response arrangements, and contingency plans.	Public Health Emergency Planning
Evaluation and Lessons Learned	● Facilitate and participate in internal and multi-agency debriefs and structured evaluation exercises. Document lessons learned, and incorporate lessons into pandemic preparedness plans and other relevant emergency plans.	Emergency Planning
Staff Welfare	● Support staff recovery, ensure adequate rest, and recognise contributions.	Corporate Leadership

13. De-escalation and Transition to Recovery

13.1. The Health Protection Board, with the agreement from the Council/Corporate's leadership, will determine when the use of this plan may be stood down.

13.2. Conditions under which the plan may be stood down include:

- Following receipt of notification from national authorities that the significant impacts of the pandemic are over and regional and national structures, and pandemic measures, are being stood down.
- The risk to the public's health has reduced to a level that no longer necessitates action above and beyond business as usual.
- Key services have stabilised and can operate under routine arrangements, or responses can be absorbed into 'business as usual'.
- The Recovery Coordination Group (RCG) has been firmly established and engaged.

13.3. A formal transition from the pandemic response governance to the RCG should take place. This event must be to be formally communicated and documented.

13.4. Part of the stand down process should include:

- Undertaking an initial impact assessment to inform recovery priorities.
- Evaluation of the response to inform future pandemic planning.
- Ensuring that copies of notes, actions logs and decisions are saved securely, and can be made available when requested.

13.5. The end of emergency measures and beginning of recovery efforts should be communicated to partners, stakeholders and the public.

14. Recovery Phase Activation

14.1. The recovery process will focus on rehabilitating the community and restoring services following a pandemic.

14.2. Communities may face livelihood disruptions, trauma, mental health issues, shifting of social norms, increased domestic violence, and escalating health needs due to challenges in accessing care and support during a pandemic. The impacts of a pandemic are likely to be disproportionately distributed throughout society as was during the COVID-19 pandemic.

14.3. The following recovery principles will apply:

- **Effective coordination:** clear plans to manage and end the response.
- **Community participation**: actively involving communities to understand how they have been impacted and how to support them to recover.
- **Reducing inequalities:** targeted support to groups most impacted by the pandemic.
- **Monitoring and responsiveness:** systems to maintain situational awareness, track needs and reinstate support if necessary.

14.4. Once activated, the objectives and key actions of the Recovery Coordination Group (RCG) will be to:

1. Establish recovery governance structures, with clear roles, responsibilities and escalation processes.
2. Conduct an impact assessment to inform recovery efforts.
3. Maintain engagement with partners and communities throughout to ensure a wide and representative range of impacts are collected and addressed.
4. Develop a recovery action plan, based on the outcomes of the impact assessment and community engagement.

14.5. Additional priorities should include:

- Prioritising the return of essential Council or Corporation services and communicating the status of services (normal, disrupted, or closed).
- Focus on supporting the economic and business sector to recover.
- Targeting support to those most in need and reducing inequalities.
- Monitoring and supporting workforce welfare.

14.6. The RCG will be stood down once its key objectives have been met and the community has reached a stable post pandemic state. The Chair of the RCG, in consultation with key stakeholders including the Council's/Corporation's leadership and partner agencies involved in the recovery response, will be responsible for standing down the RCG.

14.7. The decision to stand down the RCG should be formally recorded, and a transition plan should be in place for any ongoing services that may be needed after the Group has been stood down.

15. Pandemic Response: General Guidance for Services

15.1. This section outlines the general procedures and considerations for responding to a pandemic, to be followed by all services in addition to the service-specific action plans detailed in Appendix 1.

15.2. In preparation for emergencies, including pandemics, services should develop **business continuity plans** considering:

- Identification of critical functions.
- Assessment of the impact of the reduction in staffing levels, and the resourcing needed to maintain critical services (for example, diverting staff from non-critical areas).
- Identification of vulnerable staff and staff that would be able to work from home.
- Service provision and reliability due to supply chain and external system disruptions.

15.3. Services should adhere to **public health and evolving guidance**. Key infection prevention and control principles include:

- Routine hygiene practices
- Use of personal protective equipment (PPE)
- Adherence to non-pharmaceutical interventions (NPIs)

15.4. Services should prioritise the needs of **vulnerable populations**, as identified in the vulnerability assessments for City and Hackney, and ensure alignment with the principles set out in the Equality Act 2010.

15.5. Decision making, policy development and response activities should evaluate their potential to either reduce, create or exacerbate **health inequalities**.

15.6. Steps should be taken to ensure that negative impacts are mitigated for, and that opportunities to improve broader health outcomes are maximised, particularly for those who are most vulnerable.

15.7. Services should ensure **clear communication** and communicate service adjustments to staff and the public.

15.8. Services should engage with **stakeholders and local partners** to ensure an effective and coordinated response.

15.9. **Community engagement** will be essential to providing reassurance, community cohesion and compliance with the pandemic response.

16. Appendix 1: Service-Specific Action Plans

16.1. Some service areas - and the population groups they support - may be disproportionately affected during a pandemic, and are likely to require tailored mitigation strategies to address specific challenges.

16.2. Therefore, in addition to the general guidance, service-specific action plans are provided in Appendix 1, which includes guidance for:

- Education Services
- Children and Families Services
- Adult Social Care
- Public Health
- Housing
- Human Resources, Communications and Corporate
- Mortuary and Bereavement Services
- Emergency Planning

16.3. Each action plan includes:

- Worst-case scenario assumptions, alongside those illustrated in the planning assumptions section, to inform targeted action plans
- Goal specific actions to address key risks.

Education

Assumptions:

1. **Disruption to Education:** School closures will be introduced to curb community transmission. School inaccessibility, digital exclusion, and varying levels of parental support may impact children, especially those from disadvantaged backgrounds, and with special education needs.
2. **Safeguarding Risks:** Reduced contact with settings may increase risk for children known to safeguarding teams, and for vulnerable children.
3. **Workforce Challenges:** Staff availability could be disrupted, requiring flexible staffing arrangements and additional workforce support.

Goals	Actions
Ensure school operations and continuity	1. Identify and support vulnerable staff to maintain school functionality. 2. Assess and strengthen technological infrastructure to facilitate a (rapid) shift to remote learning if necessary. 3. Adapt service systems to provide appropriate support to schools and settings, remain accessible to all children, and implement reasonable adjustments for SEND students. 4. Ensure education, health and care plans continue to function. 5. Confirm contingency staffing and support measures, ensuring that school operations remain sustainable during staff shortages.
Safeguard vulnerable children	1. Identify children for whom schools are a protective factor, and collaborate with Children's Social Care to address needs where disruptions to school are anticipated. Implement protocols to monitor and support at-risk children, including in-person visits. 2. Establish systems to provide regular pastoral and welfare checks on vulnerable pupils not attending structured discussions, covering both learning and wellbeing. Partner with Children' s Social Care to support the screening of pupils for whom contact cannot be made. 3. Maintain a directory of services and establish referral pathways for families that meet thresholds or may be in need of additional support services (e.g. mental health services, bereavement services). 4. Ensure continuity of free school meals or alternative schemes.
Mitigate education disadvantage	1. Supply digital devices to children without access and provide alternative resources for families with limited internet access. 2. Support remote engagement for SEND and other vulnerable children. 3. Implement tracking processes to monitor engagement with alternative learning. 4. Address language and cultural barriers to support families.

Children and Families Services

Assumptions:

1. **Safeguarding and Service Access:** Non-pharmaceutical interventions, including possible restrictions, are likely to disrupt usual routines, creating barriers to accessing Council support and advice. Children's safety may be compromised. Families may experience increased hardship.

Goals	Actions
Safeguard children	1. Prepare for increased demand. 2. Develop a database of vulnerable children (i.e. under a Child Protection Plan). 3. Implement protocols to monitor and support at-risk children. Engage other services (i.e. schools) and community sector partners to monitor and report safeguarding concerns. 4. Establish outreach programmes to support parents and families in accessing the right support, adapting communications as required. 5. Develop a directory of services and support, and refer families to appropriate resources (i.e. pre-paid supermarket cards where food security is an issue, digital devices to enable remote learning for children, and mental health services for families in distress).

Adult Social Care (with Support from Public Health)

Assumptions:

1. **Increased Demand:** Increased demand for state-funded and self-funded provision, including community and residential care. Decreased provision for informal carers. Individuals previously not known to services may experience changes in their health and social care needs. Care settings are likely to have an increased role in supporting rapid discharge from hospital to maximise hospital capacity. A higher number of individuals may receive care at home (when they would normally have been hospitalised). There may be increased hospital discharge to care settings.
2. **Staffing Challenges:** Staffing shortages due to illness, and initial training and support gaps for staff and unpaid carers.
3. **Transmission:** Enhanced transmission in community settings, requiring robust infection prevention and control.

Goals	Actions
Prevent infection spread in social care settings	1. Implement a capacity tracker (e.g. workforce, outbreaks, PPE). 2. Share data with relevant stakeholders to build a comprehensive understanding of needs. Ensure robust risk assessments are in place across community settings. 3. Share and apply national and public health guidance. 4. Provide infection prevention control (IPC) training to staff. 5. Share public health guidance with social care providers. 6. Identify and prepare capacity to store significant demand for appropriate PPE. 7. Support care settings with implementation and regular review of public health guidance, including SOPs for: ● Use of personal protective equipment (PPE) ● Infection prevention and control (IPC) ● Shielding and self-isolation protocols ● Testing (routine, outbreak and whole-setting approaches) ● Outbreak management
Support workforce	1. Support contingency plan development with social care providers to address staffing shortages (e.g. mutual aid, re-deployment and enabling extended shifts), and encourage providers to access additional funding (where available). 2. Review capacity tracker to identify and address emerging concerns. 3. Ensure that business continuity plans reflect continued care provision during high periods of staff absence or enduring transmission/outbreaks. 4. Review capacity for mutual aid arrangements and ensure readiness for surge staffing, including redeployment and agency support. 5. Promote measures to limit staff movement between settings and cross-deployment. 6. Ensure arrangements are in place to ensure staff can take time off if they need to (for example, sick pay in order for staff to self-isolate).

	7. Ensure processes are in place to monitor the health and wellbeing of front line staff, and ensure access to mental health and support. 8. Establish and maintain safeguarding pathways where providers cannot maintain safe care levels.
Promote care at home	1. Support providers in encouraging care in a person's home wherever possible. 2. Ensure provision for additional domiciliary services, and consider mutual aid. 3. Establish risk assessment to be conducted prior to home visits. 4. Collaborate with voluntary and community sector (VCS) organisations to fill service gaps.
Discharge and transfer policies	1. Establish and communicate hospital discharge protocols, including designated care homes for discharged patients. 2. Agree arrangements for the transfer or admission to care homes from the community and from other care facilities. 3. Ensure provision for self-isolation and cohorting within care settings.
Surveillance and risk monitoring	1. Monitor and report case fatality rates and risk indicators (as social care recording systems allow), including where possible age, dementia, physical frailty, co-morbidities and learning disabilities. 2. Develop a tracker for care home staffing, outbreaks, PPE levels, and access to pharmaceutical interventions. 3. Ensure effective data-sharing mechanisms between relevant stakeholders such as public health, care providers, commissioning and IPC team.
Managing ingress and cross-transmission risks in settings	1. Establish and maintain protocols to reduce nosocomial (those originating in hospital) transmission related to: ○ New admissions from the hospital or community ○ Returning residents ○ Visiting professionals ○ Residents attending off-site appointments 2. Review and update visiting protocols, especially in care settings experiencing enhanced transmission or outbreaks. Ensure a balanced approach to help reduce loneliness, isolation and distress for residents and families. 3. Ensure provision for self-isolation and cohorting within care settings as part of discharge and transfer. 4. Support settings in adapting safe visiting practices (e.g., designated visitor, testing-based protocols).
Community cohesion and wellbeing: support access	1. Establish and promote safe access points for domestic abuse support in partnership with DAIS (e.g., helplines, online reporting etc)

to safeguarding and domestic violence support	2. Review, reinforce and promote referral pathways to services and support. Promote innovative approaches to encourage access to specialist support, for example, by providing discrete signposting in pharmacy settings.
Accessing interventions	1. Support access to testing for staff and settings, including rapid response to suspected outbreaks.

Public Health

Assumptions:

1. **Workforce Challenges:** High demand for health protection expertise resulting in the need for rapid upskilling of staff and deployment to new roles. Redeployment and response to national policy may impact service delivery.
2. **Governance and Coordination:** Increased responsibility for public health leadership in coordinating multi-agency responses.
3. **Health Protection and IPC:** Increased demand for IPC advice in high-risk settings, additional resources required to support critical health protection functions (e.g. outbreak management and contact tracing).
4. **Community Engagement and Communication:** Greater demand for accessible messaging and engagement with marginalised and vulnerable communities.

Goals	Actions
Strengthened Public Health workforce	1. Establish training for public health staff to upskill and align with emerging national policy and guidance. 2. Develop flexible staffing framework to enable rapid redeployment of public health officers where needed. Identify and secure funding proportionate to the scale of the hazard as appropriate. 3. Undertake roles and responsibilities as required by the command structure. 4. Maintain a RAID log (Risks, Actions, Issues and Decisions) to document critical actions, decisions and lessons learned. 5. Develop standard templates for situation reporting (SITREPs) to ensure clear communication across public health teams and relevant stakeholders/services, and inform response escalation as necessary.
System Coordination	Ensure pandemic specific needs and response activities are coordinated through established pandemic governance structures, including oversight by the Health Protection Board.
Guidance and Information	1. Lead development of localised outbreak management plans. 2. Provide guidance to local partners, providers, settings communities, businesses and the VCS to minimise spread and impact on vulnerable populations. 3. Communications to encourage compliance and participation with non pharmaceutical and pharmaceutical interventions. 4. Advise and support the Council in responding to changing national government advice. 5. Integrate with local services to ensure a comprehensive and effective place-based response.
Enhanced surveillance, monitoring and	1. Regularly review local epidemiology and share with relevant partners. 2. Implement surveillance and monitoring system to track case-level

intelligence	data and support enhanced health protection response e.g. contact tracing, and in collaboration with relevant agencies e.g. UKHSA. 3. Conduct population-wide risk assessment to identify vulnerable groups and settings for cohesive responses.
Support for local communities and preventing health inequalities	1. Partner with the voluntary, community and faith sector to mobilise community assets (e.g. Volunteer Centre Hackney, community health champions) in communicating public health messaging and promoting uptake of interventions. 2. Develop culturally tailored communications to improve accessibility and compliance of public health and social measures. 3. Collaborate with community leaders to serve as trusted links for underserved community groups.

Housing

Assumptions:

1. **Housing Insecurity:** Housing remains an important social determinant of health. A pandemic is likely to result in economic hardship for many, resulting in housing insecurity. It is anticipated that evictions and homelessness will increase. Vulnerable households are likely to include families with dependent children, disabled individuals, families receiving means tested benefits, adults aged 65 years and above, recent migrants, and those on low income and not on benefits.
2. **Support Needs:** Without temporary reforms to renting law and the welfare systems, as during the COVID-19 pandemic, evidence emphasises debt advice and legal assistance as the most effective secondary measures to prevent evictions.

Goals	Actions
Enhanced support for tenants at risk of eviction	1. Use predictive analytics to monitor factors identified in previous homelessness cases to detect changes in risk profiles. This may involve analysing data held on universal credit applications or requests for additional rent funding from the Council. 2. Identify at-risk individuals and families (for example, through partner agencies such as community and faith groups) and provide debt advice to help tenants tackle financial challenges independently. 3. Refer at-risk individuals and families to channels that offer legal assistance where possible. 4. Explore opportunities to provide financial aid for tenants facing homelessness due to the sudden financial crisis. 5. Where available, encourage uptake of government housing and financial support initiatives.
Expansion of temporary housing options	1. Prepare for mass scale temporary housing solutions by partnering with local businesses, such as hotels, and leveraging public facilities to provide emergency accommodations. 2. Engage with rough-sleeping teams to assess needs and identify suitable move on accommodation for rough-sleepers. 3. Collaborate with health partners to provide wraparound services, such as mental health support, in hostels and emergency accommodations.

Human Resources, Communications and Corporate

Assumptions:

1. **Workforce Challenges:** Health protection, communication, and home-office organisation may be the primary focus of human resources. As the pandemic progresses, securing and retaining staff may become more critical. Workforce impacts including absenteeism, reduced capacity, and stress are likely to affect ways of working, resulting in routine business disruptions.
2. **Additional Considerations:** These include financial costs, frontline service continuity, political pressures and public expectation management.

Goals	Actions
Staff health and safety, and retention	1. Develop guidance covering: ● risk assessments ● default position and working protocols for roles that do not require on-site presence ● approval process for adjustments to working arrangements ● protocols for staff working in alternative locations ● logistical changes 2. Ensure provisions to safeguard workforce health and safety by: ● proving personal protection equipment (PPE) where required, and enforcing compliance with safety measures. ● offering relevant training, including infection, prevention and control. ● identifying vulnerable employees, issuing individual risk assessments and determining necessary workplace adjustments. 3. Explore options to promote staff retention. 4. Prioritise critical functions if staff redeployment is necessitated. 5. Monitor staff absences by service. 6. Create channels for reporting of overall staff wellbeing.
Public management, communications and engagement	1. Ensure compliance with national guidance and communicate the Council's position. 2. Review and ensure safe operations for frontline and public facing services. 3. Communicate service changes and closures to the public. 4. Develop communication plans and campaigns to complement and support all aspects of the response. 5. Ensure that the Council/Corporation website is updated with information and signposting for local residents and stakeholders, including updates on national guidance and local support. 6. Facilitate arrangements for volunteers interested in supporting aspects of the local response where appropriate.
Financial management	1. Assess and address the financial implications of the response, including staffing and service adjustments costs.

Mortuary and Bereavement

Assumptions:

1. **Excess Deaths:** Excess deaths will place significant strain on mortuary and bereavement services, accompanied by potential disruptions to burial and cremation protocols.
2. **Workforce Challenges:** Overstretched capacity may necessitate reliance on mutual aid.
3. **Legislative Changes:** Legislative changes will impact registration, burial and cremation processes.

Goals	Actions
Capacity Tracking	1. Maintain stock of certification forms, burial and cremation equipment. 2. Ensure body storage containers and standby generators are operational. 3. Review availability of casual registrators or additional staff and prepare for deployment if demand escalates beyond existing capacity.
Multi-agency partnership and coordination	1. Liaise with acute trusts and local health agencies to monitor death rates. Regularly review mortuary capacity and assess whether adjustments or scaling up are necessary. 2. Be prepared to make space adjustments for temporary mortuary facilities if required. 3. Coordinate with emergency planning teams and partner organisations for logistical support. 4. Develop mutual aid agreements with nearby authorities or private providers to manage excess demand.
Dignified burials and cremations	1. React promptly to any changes in legislation affecting mourning/funeral protocols. As much as possible, respect cultural norms and procedures around burials and cremations. 2. Prepare to update communication channels for families about changes in services and protocols. 3. Review potential risks or disruptions that could impact the ability to perform cremations and burials. 4. Develop contingency plans to ensure dignity in burials and cremation services. 5. Maintain compassionate communication with families about changes to services.

Emergency Planning

Assumptions:

1. **Capacity:** The service may experience workforce stretch. There will be a need for an effective command and control to manage the response and coordinate actions.
2. **Legislative Changes:** Continuous changes may affect operational priorities and resource allocation.
3. **Multi-Agency Coordination:** There may be greater reliance on multi-agency coordination for an effective response.

Goals	Actions
Effective governance	1. Participate in and contribute to the relevant command and control leadership structure. 2. Ensure pandemic governance is established as per the plan, is regularly reviewed, is fit for purpose and is effective. 3. Ensure consistent decision-making flow between emergency planning and public health teams. 4. Ensure coordination with regional and national governance structures, as well as those of other key local system partners.
Ongoing review of legislation and guidance	Regularly monitor changes to national legislation or guidelines. ● Communicate any updates or implications to affected stakeholders and services. ● Ensure managers and teams are trained on any policy changes where relevant. ● Adjust emergency plans in line with new requirements.
Multi-agency coordination and humanitarian support	1. Collaborate and coordinate with multi-agency partners, such as local resilience forums, the NHS and voluntary and community sector partners to deliver a coordinated response. 2. Provide humanitarian support to affected individuals and communities in line with emergency plans. 3. Maintenance of public order (in partnership with Community Safety)
Logistics support	Transport and distribute emergency centre equipment and other emergency planning resources.
Community cohesion surveillance and monitoring	1. Establish frameworks to identify and monitor emerging community tensions, hate incidents or misinformation that may arise from the pandemic. 2. Maintain active links with the community and faith sectors to: ● Understand pandemic impacts on specific communities (e.g., collective grief, mental health, social cohesion etc). ● Build trust and share timely and culturally appropriate guidance. ● Facilitate two-way communication between communities and the Council/Corporation.

	3. Monitor compliance with legislative measure, and the incidence of antisocial behavior, and develop proportionate enforcement strategies that reflect the local community context. Consider the influence of: ● Perceived constraints on civil liberties ● Misinformation and public trust ● Neighborhood-specific behaviours and levels of engagement
Community cohesion and wellbeing: business compliance and enforcement	Engage with businesses and licensed premises to reinforce public health regulations and safeguarding responsibilities.
Community cohesion and wellbeing: communications and public messaging	1. Develop localised and accessible public health and safety messaging, considering underserved groups and digitally excluded groups. 2. Counter misinformation and disinformation in partnership with the community and voluntary sector, faith networks and neighbourhood teams. 3. Use trusted individuals and community champions to promote compliance with public health and social measures.
Community cohesion and wellbeing: equalities and inclusion	1. Monitor and document pandemic impacts across protected characteristics and vulnerable communities. 2. Provide regular feedback to the pandemic response governance to ensure that lived experiences are reflected in key decision making policy.
Community cohesion and wellbeing: partnership working	1. Ensure that information-sharing and feedback protocols are in place with relevant system partners. 2. Ensure local response plans are aligned with the activities of local resilience partners and system-partners (for example, policing and health).

17. Appendix 2: Vulnerability Assessment for City and Hackney

Vulnerability Assessment for the City of London and Borough of Hackney			
Group	**Learnings from the COVID-19 Pandemic**	**Hackney Specific Context**	**City of London Specific Context**
Children and Young People	Children and young people were affected by disrupted education, loss of in-school support (especially for SEND), and reduced access to free school meals. Many experienced mental health decline due to remote learning and isolation, bereavement, and family stress. Disruption to routine health services, including vaccinations, also impacted wellbeing. Children from deprived backgrounds faced deepened inequalities; digital exclusion, lack of equipment, caring responsibilities, and limited access to tuition or quiet study space. Young carers were particularly affected. Many vulnerable children became less visible to services, raising safeguarding concerns. Those in care or temporary accommodation (e.g. hostels, asylum hotels) faced increased risk of transmission, isolation, and reduced support.	Around 23% of residents in Hackney are aged 0-18. There are high levels of child poverty (43%) and overcrowding (33%), particularly south of the borough. Key settings at risk include: Hostels (at-least 5), Primary schools (87), Secondary schools (34), Special schools (3), Nurseries (80) and Children's Centres (21). A future pandemic risks compounding long-term inequalities in health, wellbeing, and education for vulnerable and disadvantaged children and young people, highlighting the need for targeted investment and equitable decision-making in pandemic response and recovery.	54% of residents in the City of London are aged 40 and under. This is higher than London (57%) and England (49%).
Older Adults	Older residents were hardest hit by COVID-19 - facing higher mortality,	7% of residents in Hackney are 65 years and over. 18% of adults aged 55 and	54% of residents in the City of London are aged 40 and under. This is higher

Vulnerability Assessment for the City of London and Borough of Hackney			
Group	**Learnings from the COVID-19 Pandemic**	**Hackney Specific Context**	**City of London Specific Context**
	illness, isolation, and disrupted care. The pandemic created unprecedented demand for both formal and informal care. High-contact settings like residential care homes increased transmission risk. Most severe cases and deaths involved pre-existing conditions; dementia, Alzheimer's, diabetes, cardiovascular and chronic respiratory or kidney disease. Some, like dementia, relate to age. Others, like diabetes, were clear risk factors. Many of these conditions stem from poor social determinants of health.	above have one or more long-term health conditions. High risk settings in Hackney include care homes (13), hostels (at-least 5) and supported living settings currently supported by the IPC team. Response measures should prioritise shielding, access to services and support, and social connection for this age group.	than London (57%) and England (49%).
Disability	The pandemic led to increased isolation, disruptions to specialist-support and routine care, and placed additional reliance on external or social support.	19% of residents in Hackney identify as being disabled. This may intersect with other vulnerabilities (i.e., poverty and safeguarding). An estimated 1,200 people in Hackney have a learning disability, with around 450 known to Adult Social Care.	11.8% of residents reported having a disability according to the 2021 Census.
Marriage	During the pandemic, married (and cohabiting) couples faced vulnerability due to shared financial pressures, emotional stress and changes in	There are 15% cohabiting couples with no dependent children in Hackney, and 15% without. Frontline services should be aware of the unique vulnerabilities of	Data is limited.

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	interpersonal dynamics, increased caregiving responsibilities and isolation from social networks and support.	cohabiting couples and families.	
Pregnancy and Maternity	Hospital restrictions during labour may have led to increased feelings of isolation. Pregnancy can increase susceptibility to infection and severe illness.	There are approximately 4,000 live births at Homerton every year highlighting the importance of maintaining accessible services and support for expectant mothers.	Births to City of London residents are registered with the Islington Registrar. The number of births to City of London residents is likely to be very low given the City itself is small.
Religion and Belief	Reduced access to in-person worship and mourning practices during the pandemic increased social isolation for many faith communities. There was also a reported rise in religiously motivated hate crime. Some ethnic and religious groups experienced disproportionately high COVID-19 infection, under-vaccination, and mortality rates, particularly for individuals from Bangladeshi backgrounds, and Black African and Black Caribbean communities.	Hackney's Multi-Faith Emergency Response Plan provides a systematic framework for working with local faith groups, including considerations around religious practice, diet, language, and customs. Hackney's population includes Christians (31%), Muslims (13%), and Jewish residents (7%), though the Jewish population, particularly the Charedi community, is likely undercounted. Notably, 36% of residents do not identify with any religion. The Charedi Jewish community has a distinct public health profile and pandemic vulnerability, shaped by large households, limited digital access, and lower engagement with mainstream public services. Without targeted and co-produced approaches, this	The religion breakdown in the City of London is as follows: ● No religion (44%) ● Christian (35%) ● Muslim (6%) ● No Answer (9%)

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		community is at risk of being excluded from public health messaging and interventions.	
Race	Risks of mortality were cumulative; being male, older and BAME with an underlying health condition, working in a higher risk occupation, and living in a deprived area in overcrowded housing. BAME groups are disproportionately represented in more deprived areas and high-risk occupations, and these risks are the result of longstanding inequalities and structural racism. Migrants with No Recourse to Public Funds (NRPF) were excluded from key support. Digital exclusion and language barriers further limited access.	The following groups in Hackney are among the most likely to be vulnerable during a pandemic, including individuals from White British (36%), Black/Black British (23%), Asian/Asian British (11%) and Mixed Ethnic (6%) background. Other inclusion health groups, such as the Turkish, Gypsy, Roma and Traveller (GRT), Charedi Jewish Community and NRPF are also likely to experience compounded risk.	The City of London has a predominantly White population (69%) with non-white minorities including communities of Asian (17%), Mixed (6%) and Black (3%) background, which may signify digital exclusion and information access challenges. The City of London is also home to one of the most international workforces in the UK; 49% of workers come from outside the UK, with 678, 000 workers estimated in the City in 2023.
Sex (Female)	Women faced greater income loss, increased unpaid care burdens, and heightened risk of domestic and sexual violence during the pandemic. Frequent drinking increased during lockdown.	52% of Hackney's population are female. Gender responsive planning is required to ensure that wellbeing and safety needs are addressed during a future pandemic.	45% of City of London residents are women.
Sex (Male)	Men of working age were impacted by the COVID-19 due to economic pressures, mental health strain and	48% of Hackney's population are male. This group will require targeted outreach to ensure they are not under supported	A higher proportion of residents from the City of London are male (55%).

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	lower engagement with health services.	by mainstream services and social contexts.	
Sexual Orientation	Individuals undergoing gender reassignment were at higher risk of experiencing higher mental health needs, reduced social contact and advocacy, and experienced disruptions to gender affirming services and care.	Around 8% of Hackney's population identify as Lesbian, Gay, Bisexual, or another non-heterosexual orientation. The 2021 Census indicates that just over 1% of Hackney's population identifies as transgender.	Data is limited.
20% Most Deprived	Overcrowded living conditions and poor-quality housing were associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and experienced by people with lower incomes. Being a key worker role (including those in health and social care, and elementary skills such as security guards, and bus and taxi drivers), unable to work from home and being in close proximity to others put people at higher risk.	Deprived communities are less resilient to shocks. Hackney is the third most densely populated borough in England. Areas of high deprivation include Upper Clapton, Stamford Hill, Hackney Marshes and Homerton. Delivery of services and interventions will need to consider equity to avoid worsening disadvantage.	The City of London is among the top 25% most densely populated boroughs in England. Areas of high deprivation include Golden Lane and Portsoken Ward. Additionally, the City of London is working to support the hidden workforce; the workforce are those essential support staff in routine, manual and service occupations such as cleaners, maintenance workers, construction workers and security staff without whom businesses could not function. These groups face heightened risk due to frontline exposure and many roles that cannot be done remotely, highlighting the importance of additional protection and recognition during a pandemic.

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People Experiencing Homelessness	Homeless individuals experienced higher infection risk, complex health needs and limited access to services, particularly for those with overlapping substance use or mental health issues.	Hackney has at least 3 dedicated temporary accommodations and over 4,000 households in temporary accommodation. Hackney has higher rates of homelessness (21 per 1,000 households) compared to London (18) and England (13). Over 400 people were reportedly rough sleeping or at risk in 2022. Low barrier, integrated services and outreach are required to maintain engagement with care during a pandemic.	The City of London is the 5th largest rough sleeping population in London; 656 people were seen sleeping rough by outreach workers in 2024.
Non-English Speakers	Non-English speakers were more likely to experience reduced access to public health information, increased risk of misinformation, and lower uptake of key health measures such as COVID-19 vaccination.	More than 10% of Hackney residents do not speak English as their main language, with large Turkish, Charedi, and African diaspora communities. At least 89 languages are spoken in Hackney, with 1 in 3 residents born outside the UK. Communities will require tailored awareness and outreach to ensure equitable access to public health interventions.	At-least 67 languages are spoken in the City of London; 1 in 2 residents are born outside of the UK.
Digitally Excluded Individuals	During the pandemic, digital exclusion led to reduced access to services and health information, and increased isolation and disconnection from support.	Around 12% of Hackney households lack internet access, with digital exclusion most affecting older adults, low-income families, and some ethnic minority groups, including the Charedi community. Offline and community	Digital exclusion is a major issue for many Londoners.

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		outreach options will be required to ensure that all population groups have access to essential services.	
Asylum Seekers and Refugees and Undocumented Migrants	Asylum seekers and undocumented migrants often face overcrowded housing and were excluded from some pandemic support (e.g., furlough). They had greater exposure to COVID-19 through frontline or informal work. These groups were therefore excluded from critical public health safety nets.	Hackney has a notable population of asylum seekers and undocumented migrants, supported by local organisations such as the Hackney Migrant Centre. They will require trusted, accessible services and tailored support to mitigate structural disadvantage that increases risk for adverse outcomes.	The City of London Corporation has a significant number of unaccompanied asylum seeking children compared to its overall child population, responsible for 23 in 2019.
People with drug and alcohol dependence	People with drug and alcohol dependence experienced significant and layered impacts during the pandemic due to disruptions to harm reduction and support services, higher risk of infection and transmission and stigma in accessing services and support.	Hackney has higher-than-average rates of drug and alcohol-related admissions/deaths. This group often has underlying health conditions, compounded vulnerability, may engage in risky behaviours, and face reduced service access. This group will require integrated and structural support to limit exposure risk and adverse outcomes.	Data is limited.