Government Response to the House of Lords Science and Technology Committee Report on Pandemic Influenza – 3rd Report of Session 2008–09

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
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Introduction

The House of Lords Science and Technology Committee published its follow-up Report on Pandemic Influenza on 28 July 2009. This Command Paper sets out the Government's response to the conclusions and recommendations in that report.

The Department of Health has co-ordinated the response, consulting with the Devolved Administrations, the Civil Contingencies Secretariat, the Department for Environment, Food and Rural Affairs, the Department for International Development, the Health Protection Agency (HPA), the Royal College of General Practitioners, and the British Medical Association (BMA).

The Government is grateful to the Committee for the timely contribution to our work on pandemic planning generally and the response to the swine flu pandemic in particular. Having now carefully considered the report and consulted various stakeholders, we are pleased to provide this response to the report.

The Government's response to the Committee's conclusions and recommendations

1. We commend these steps that the Government has taken to prepare for the pandemic. (paragraph 16)

The Government welcomes the recognition in the report of the extent of our pre-pandemic plans, including the steps we have taken to prepare the NHS, stock antivirals, pre-order vaccine and ensure that the public has quick access to treatment where clinically indicated. These efforts meant that when the swine flu virus emerged we were in a strong position.

The Government is proud of the work done over the past five years and feels that the UK can take a great deal of credit for its role as a global leader in pandemic planning. The Government would like to thank all those engaged in planning at a local level, across the Devolved Administrations, in the NHS, the HPA, local government and elsewhere for their hard work and commitment.

Testaments to UK preparedness have come from many sources, for example from the World Health Organization (WHO), who said in November 2007, "the UK is still in the vanguard of countries worldwide in preparing for a pandemic, and is also one of the leading global players in addressing the cross-sectoral issues in their planning". In addition, Dr Neil Ferguson of the Medical Research Council Centre for Outbreak Analysis and Modelling stated in July 2008 that "the UK is one of the few countries in the world to have based policy rigorously on the best available scientific knowledge in a largely open and transparent manner".

2. The Committee has long recognised the importance of advanced whole-systems (end-to-end) testing and welcomes the Government's plan. We would however invite the Government to explain why it was not undertaken sooner. (paragraph 20)

and

3. Whilst we understand the need to divert attention to the immediate challenges of the current pandemic, we are disappointed that the assessment and testing processes and other activities connected with UK pandemic preparedness were not sufficiently well-advanced so as to mitigate this need more significantly. (paragraph 21)

As part of the Government's approach to developing plans for dealing with pandemic influenza, a series of assessment, testing and assurance processes have been used.

NHS planning has been informed by the UK-wide Exercise Winter Willow, the biggest-ever peacetime exercise on how to prepare for an influenza pandemic, undertaken in 2007. All NHS organisations completed self-assessments of their pandemic plans in December 2007 and again in December 2008, with many subsequently strengthening their plans as a result. Furthermore, all NHS organisations have been encouraged to test their plans as set out in the 2009/10 NHS Operating Framework.

NHS organisations have also participated in exercises to test the multi-agency response to a pandemic. In March 2009, Local Resilience Fora (LRFs) completed an exercise programme sponsored by the Cabinet Office. This programme tested a selection of eight multi-agency LRF plans across England, with participation from non-health and health organisations, and tested planning for pandemic-specific issues, including interaction with and support for the health response. Lessons from this exercise programme have now informed swine flu preparedness work.

The latest round of self-assessments was interrupted by the outbreak of the current swine flu pandemic in April 2009, just before these were due to be validated and ahead of the planned programme of whole-systems testing. While clearly it would have been preferable for this programme to have been completed in advance of the emergence of the virus, it was appropriate to finish putting robust plans in place before shifting towards testing them.

Exercise Peak Practice was delivered in September 2009 to help the NHS in England prepare for a possible second wave of swine flu in winter 2009. It consisted of ten strategic, 'tabletop' exercises, one led by each strategic health authority (SHA) in England. The objectives of the exercise were to assess:

- the regional healthcare command and control system;
- the logistic resilience and support to NHS organisations;
- NHS communication strategies, including keeping staff and the public informed;
- within the defined health and social care economy, known areas of risk including: NHS staffing resilience, critical care capacity, women's and children's services, ambulance and mental health services and social care;
- the level of preparedness for the recovery phase; and
- using local knowledge, local risks as determined by the SHA chief executive officer in collaboration with local commissioners.

A summary of the results of these exercises will be placed in the House of Lords library shortly.

In preparation for Peak Practice, the Department of Health has provided off-the-shelf exercises and in many areas there have been region-wide exercises.

Further details of past exercises undertaken are provided at Annex 1.

4. The Committee has significant concerns about the delay in the operation of what the Department of Health describes as the enhanced National Pandemic Flu Service (NPFS) and invites the Government to provide a more detailed explanation of the reason. We also seek reassurance that the enhanced service will be able to meet anticipated demand and that it will be fully operational in the autumn, in good time to meet the challenges of the anticipated second wave of influenza. (paragraph 26)

There would always have been elements of the Government's plan that were not ready if a pandemic came immediately. The enhanced version of the National Pandemic Flu Service (NPFS) was one of them. The elements of the NPFS led by NHS Direct were on programme to be delivered by the due date when the first swine flu outbreak occurred. This needs to be seen against a backdrop of three things: antiviral stockpiles were in place, as were sleeping contracts for vaccine, and an interim NPFS could be created (and indeed has been).

The Government recognises that it is very important to ensure that the IT systems are tested sufficiently before they are used. The interim solution was tested before its launch and a full programme of testing has been built into the delivery timeline for the enhanced solution by the autumn.

This programme of testing for the interim solution included specific testing for security, performance, usability, accessibility, clinical safety and functional flow. A similar approach is being taken for the enhanced solution before it becomes operational.

The enhanced NPFS will be ready in the autumn, if it is needed. This version offers a more flexible IT platform, but user experience will be similar to that for the interim solution. The enhanced version is also being designed to offer NPFS Professional, a channel to allow healthcare professionals to authorise an antiviral to a patient directly, without completing the full assessment process. The Government is satisfied that the enhanced service will have the capacity to meet demand even at peak times during a reasonable worst-case scenario pandemic.

In its report the Committee noted:

The evidence about the total call capacity of the centres is not entirely clear. The Government, in their written evidence, told us that this would be 45,000 per hour (p 34); in oral evidence Bruce Taylor, Deputy Director for Pandemic Influenza at the DoH, said that "at any one time we would be expecting at least 20,000 people to be able to access … [the] Flu Line"

To clarify this point, written evidence provided to the Committee in December stated, "We aim to have around 7,500 call centre seats—and so these agents will be able to deal with up to 45,000 calls an hour". This is based on an average call time of ten minutes and is a maximum requirement of the non-automated telephony channel. The oral evidence that the Government's aim would be for 20,000 people to be able to access the system at any one time included the automated and web-based channels of the service as well, and so gave a greater capacity.

5. On 16 July, the Secretary of State for Health announced that the National Pandemic Flu Service in England would be activated from the end of the following week. We welcome this announcement. However, bearing in mind the Government's assertion that "at [WHO] Phase 6 [announced on 11 June] the National Pandemic Flu Line Service will come into operation" (p 34) and given the move to the mitigation (or treatment) phase and the phasing out of the Flu Response Centres in early July, we would invite the Government to explain why mobilisation of (what we assume to be) the interim service was delayed. (paragraph 28)

We welcome the report's endorsement of the decision to activate the NPFS, in England. Given that it was a major undertaking for the NHS to mobilise a national network of distribution points, it was felt that it would only be justified when there were widespread levels of influenza-like illness across the country. Because this was not the situation on the declaration of WHO Phase 6 in June 2009, the mobilisation of the NPFS was not justified, although, as the Committee notes, it was advised in December 2008 of the planning assumption that at Phase 6 mobilisation would be necessary. While the increase in the number of cases meant that the containment strategy was no longer considered appropriate, the pressures on local healthcare services had not reached the point where the service was required.

In the week from 8 to 15 July 2009, the number of primary care trusts (PCTs) under pressure increased from six to 110 – that is why the immediate decision was taken to launch the service. It then required seven days to mobilise the service, which was launched on 23 July. There was no delay in making this decision because the service was not ready to be implemented.

The service is now working well, with more than 1,000 antiviral collection points up and running. As of 8 October, 1,603,935 assessments have been undertaken, which have generated 1,033,746 unique reference numbers for individuals to receive antiviral and 651,147 have subsequently accessed their course of antiviral treatment. About 45% of all contacts have been made using the online system. GPs have been able to focus on those people with underlying health conditions who think they may have swine flu as well as continuing to treat people with other illnesses and undertaking normal preventive work.

Throughout this outbreak of swine flu, we have worked closely with health professionals and delivered a proportionate response to the developing situation.

6. We invite the Government also to provide further clarification about the design, scope and terms of reference of the interim service, and about whether the Flu Line Service, interim or enhanced, is separate from NHS Direct, a service which is already familiar to the public, or supplementary to it. If separate, we invite the Government to set out the cost-benefit analysis underpinning that decision. (paragraph 29)

The objectives of the interim NPFS are to:

- provide antiviral treatment to all those who clinically need it within the desired timeframe;
- reduce the burden on frontline primary care services as far as possible by providing a separate route for those with uncomplicated cases of influenza-like illness to access and collect antivirals; and

- gather surveillance information to provide a current assessment of the situation and inform future strategy.

The interim service comprises the following elements for accessing antivirals:

- the assessment of a patient's symptoms and their need for antivirals;
- the web and telephony infrastructure to support the assessment process; and
- ACPs and the associated staffing and operational and system arrangements for the issue of antivirals.

The NPFS is augmented by the Swine Flu Information Line, which was launched at the start of the swine flu outbreak.

The standard patient pathway for the interim service can be summarised as follows:

- Symptomatic individuals or their flu friend use the website or the dedicated telephone line, where they are taken through a clinical algorithm to determine whether antivirals are clinically appropriate.
- If so, a unique reference number is generated. The flu friend takes this number, together with an identification document for the symptomatic individual, to an ACP. They will also need to take proof of their own identity.
- At the ACP, the authorisation number and identification information are checked to ensure that they match the information provided when the assessment of symptoms was completed (assuming use of the web or telephone service).
- The ACP will reconfirm certain details with the flu friend to ensure that the correct antiviral is provided – for example if it is for a child or a pregnant woman. The flu friend is also given a leaflet for the symptomatic individual. This includes current Medicines and Healthcare products Regulatory Agency (MHRA) advice on what to do if there is an adverse reaction.

The NPFS is separate from the core services provided by NHS Direct. It is accessed through a separate telephone number and is supported by a separate infrastructure and call centres. Under the direction of the Department of Health and the Devolved Administrations, NHS Direct has led the development of the NPFS, and has contracted with British Telecom for the system development of the web application to support internet and telephone services.

Given the likely volume of calls, it was agreed that the NPFS should be built as a stand-alone system so as not to affect existing services. This included NHS Direct as well as the central NHS database and associated applications. Given the uniqueness of the service and the fact that it was anticipated that it would need to lie dormant for long periods of time, the 'managed service' approach was taken in order to achieve low management costs when the service was not operational. This service could be ramped up in the event of a pandemic.

7. A pandemic could place extraordinary pressure on critical care capacity. We invite the Department of Health to provide more detailed information about the current basis on which critical care contingency arrangements for a pandemic have been made and, in due course, to explain any changes in the Department's assessment following the whole-system "stress tests" in September or following lessons learnt from actual experience. We would, in particular, welcome more detailed information about how it would be possible to "double" critical care facilities. (paragraph 34)

The Department of Health published a critical care strategy on 10 September 2009 that describes the approach to managing critical care in an H1N1 flu pandemic.

The NHS has been preparing for an influenza pandemic for around five years, and is acknowledged to be one of the best prepared health systems in the world. Since April 2009, there has been a sharpened focus on preparing specifically for the demands of swine flu.

Guidance published on 1 May 2009 entitled *Pandemic flu: Managing demand and capacity in health care organisations* reinforced to the NHS the recommended planning requirement of a 100% increase (a doubling) in the availability of critical care beds from normal levels.

The National Director for NHS Flu Resilience wrote on 2 July 2009 to all NHS chief executives to make clear the expectation that preparedness plans need to be reviewed and subjected to further testing. Alongside this, each NHS board made a statement regarding the readiness of its organisation in September 2009.

The Department of Health has also collaborated with professional bodies to help local organisations test the resilience of their critical care services. SHAs have been working with local chief executives and critical care network colleagues to ensure that critical care resilience informed the formal updates that NHS boards made in September. This will also include the resilience of bed management and transport arrangements, so that areas less affected by swine flu at any one time can help those areas that are more affected.

SHAs have been leading regional planning, working with PCTs and individual hospitals to ensure that there are plans in place to deal with an increase in demand for critical care as a result of swine flu.

Each of the ten SHAs in England has now confirmed to the Department of Health that it has robust plans in place to be able to double the capacity of critical care, in response to swine flu.

Critical care services operate as part of the whole health and social care system, and so cannot be viewed in isolation. Our approach recognises these inter-dependencies and seeks to maximise the contributions that other parts of the system can make. This means trying to prevent as many patients as possible becoming infected with swine flu, providing appropriate treatment with antivirals and in primary care trying to prevent serious illness developing, as well as ensuring that patients who need it are rapidly admitted to hospital, with those most likely to benefit from critical care being able to access it when needed.

The NHS is planning a phased approach, aimed at matching the level of response to the pressure being felt by local services. The priority is to enable as many people as possible to benefit from critical care and potentially life-saving treatment.

During the winter months of every year, more people become seriously ill and require hospital care than at other times of the year. Services in all NHS hospitals are used to dealing with this increase in demand, and there are tried-and-tested strategies in place to respond.

Often during winter, services enter a phase one response, which involves increasing the capacity of critical care by opening additional critical care beds and expanding the numbers of nurses, for example by using bank staff. To help reduce demand from non-emergencies, there may be some corresponding reduction in elective activity.

Should a surge in swine flu cases occur, it is expected that critical care services will experience a significantly greater increase in demand this winter. All SHAs have confirmed that, in response, their services will be able to enter phase two, doubling the available bed capacity.

If required, SHAs have confirmed that it would take three days on average to double the number of critical care beds, and hospitals have plans in place to sustain this increase for the maximum expected duration of the peak in demand (between eight and ten weeks). Some organisations and critical care networks have indicated that they could sustain this surge longer and the Department of Health is currently working with SHAs to follow up the issues involved in sustaining a doubling of capacity.

This doubling of capacity will enable those patients who might benefit from critical care to be cared for, in these extraordinary circumstances during the peak of the pandemic, in numbers much greater than would normally be possible.

The extra numbers of beds can be created by the upgrading of level 2 critical care and post-operative surgical beds to level 3 critical care beds. In some cases, however, this means that level 2 care will need to be provided on general acute wards to patients who are recovering and do not require level 3 beds. This is necessary to maintain the flow of patients through the hospital, and free up level 3 facilities for other, sicker, patients.

In order to create additional level 3 capacity, hospitals may need to redeploy ventilators and other essential equipment that are normally used elsewhere. Similar decisions would need to be taken in relation to medicines and consumables. SHA plans to support the increase in capacity also include the purchasing of additional ventilators, the preparation of plans to ensure that consumables are available and contingency plans to ensure their supply. Work is under way within the Department of Health to ensure that the supply chains that exist for these products are robust.

Such a significant increase in critical care capacity will necessarily have an impact on the level of specialist critical care support that can be provided to each patient. Some of the therapeutic strategies used in critical care are very labour intensive or require highly specialised equipment, and not all of these are likely to be available during the peak level of demand. NHS staff are used to increasing bed capacity and treatments during seasonal winter pressures, but a doubling of capacity for a period of eight to ten weeks would require changes to the ways that treatments could be provided.

In this case, critical care services will be seeking to strike a clinically appropriate balance between providing high-quality care available at normal levels of activity and enabling as many patients as possible to benefit from this potentially life-saving treatment.

To help inform this work and advise on best practice, the Swine Flu Critical Care Clinical Group has been established. It is chaired by Dr Judith Hulf, immediate past President of the Royal College of Anaesthetists, and has a broad range of clinical and logistical expertise. The group will offer advice to the Department of Health on how the NHS should best increase adult and paediatric critical care capacity in response to an increased demand for services caused by swine flu. It will also consider and advise on management, staffing and logistics issues, working with a wide range of clinicians to develop credible clinical advice and strategies to support staff. The group is working and communicating with the appropriate authorities in Scotland, Wales and Northern Ireland on the provision of comprehensive critical care services across the UK.

Depending on how many extra beds are required, it may be necessary to change the normal staffing ratios, with fewer highly specialist staff, supported by non-specialist nurses, looking after more patients. Existing critical care staff may be asked to work longer hours, with reserve staff deployed to critical care facilities.

Staff with previous critical care experience are currently being identified, and training programmes are being implemented on a regional basis. In addition, some staff, such as anaesthetists and those who normally work in recovery areas or on specialist respiratory wards, have skills that can be used to manage patients in critical care. These staff will need to be deployed to critical care in order to boost the numbers of staff who are able to manage critically ill patients under supervision, supplementing the cohort of staff who usually work in critical care.

Elsewhere in the hospital, changes will be needed to keep as many critical care beds as possible free for swine flu and emergency patients, and to allow staff to be redeployed in order to support expanded critical care units.

For example, the majority of inpatient elective surgery could be postponed and outpatient activity would need to be reduced during peak weeks of demand. The postponement of elective operations will be on clinical grounds, linked to the likelihood of the patient requiring critical care following their operation.

We recognise the impact that this will have on people who are waiting for operations or other treatment. While we are confident that people will understand the need to prioritise critically ill swine flu and other emergency patients during a peak, we need to make sure that other patients who are waiting for treatment are not unduly disadvantaged, and that their care continues to be managed appropriately.

People who have their operations postponed because of swine flu will be prioritised for treatment as the NHS recovers from the peak phase, in line with clinical need and the length of time they have been waiting.

Work is ongoing to provide support and advice to frontline staff on how to maximise the benefits for patients that can be achieved through a doubling of critical care capacity, to explore the potential for critical care services to go even further should this be necessary and to develop a clear national framework for how decisions to escalate the phased response should be taken.

Learning from the Australian experience, we recently convened a sub-group of the Swine Flu Critical Care Clinical Group to consider current ECMO[1] capacity and whether we should look to extend it for the current influenza pandemic.

The group looked closely at all the available evidence on the clinical effectiveness and cost-effectiveness of ECMO, combined with modelling on the likely demand for ECMO in the UK. As a result, the Chief Medical Officer announced on 1 October that we would double the number of beds providing adult respiratory ECMO at Glenfield hospital in Leicester from five to ten.

8. We invite the Department of Health to say whether they are aware of this risk [of healthcare workers refusing to come to work] and, if so, what steps they are taking to avoid this happening in the UK. We also ask whether the Department is satisfied that clinicians feel confident about the effectiveness of, support from, and clarity for decision-making provided by the current legal and ethical clinical framework. (paragraph 36)

It is natural for staff to be concerned about the risk of catching any infectious disease. Therefore, the NHS as an employer takes very seriously its responsibility to ensure that staff are appropriately protected. The Department of Health has worked closely with a number of stakeholders, including the RCGP, the BMA and the Royal College of Nursing, over a number of years to develop detailed guidance to the NHS on a wide variety of issues, such as ensuring that staff feel safe and supported at work during a pandemic. We are currently developing further guidance for healthcare workers who are pregnant or at higher risk from swine flu.

We have also taken steps to protect healthcare workers from infection. There are stockpiles of facemasks and respirators available to protect healthcare workers who come in close contact with infectious patients. In addition, the vaccination of frontline health and social care workers will begin at the same time as the first at-risk group.

We consulted the NHS Litigation Authority (NHSLA) on human resource issues prior to issuing the guidance document *Pandemic influenza: Human resources guidance for the NHS* in August 2008. This sets out a clear framework and should provide the reassurance that clinicians need. Further guidance in *Pandemic flu: Managing demand and capacity in health care organisations* (issued in May 2009) specifically addresses issues affecting critical care.

However, we agree with the conclusions of the Committee on Ethical Aspects of Pandemic Influenza (CEAPI), an independent advisory group to the Government, at its meeting on 21 May 2009 that central guidance is unlikely to fully address these concerns and that they will have to be discussed at a local level. The Committee concluded that it is not possible, or desirable, to offer healthcare workers guarantees, in advance, that they would never be challenged over a decision they made. However, there has been a good deal of guidance on how to take such decisions.

As long as staff act in accordance with the managing demand and capacity guidance alongside the ethical framework, issued by the Department of Health and the Cabinet Office based on advice from CEAPI in November 2007, their behaviour is likely to be considered reasonable. The reassurance provided by the NHSLA-agreed wording, taken

1 Extra-corporeal membrane oxygenation (ECMO) – a highly specialised critical care technique that can oxygenate blood outside the body

alongside the General Medical Council guidance, is already substantial. We do not imagine that further exploration of these issues would produce a different result. However, it may well be that people are insufficiently aware of the extent of existing guidance and we are looking at ways to increase publicity of the information that is already available.

9. We recommend that the Government should put in place a national reference point, for use by general practitioners, from which they can request advice on the treatment of high-risk groups. We would expect that advice to be based on knowledge gained from activity within the UK and also from knowledge acquired by treatment centres abroad. (paragraph 37)

We already work closely with the RCGP and the BMA General Practitioners Committee (GPC) and provide advice on policy and context issues to GPs, drawing on local, national and international experience. We have established a clinical group to review queries from GPs and to ensure the widespread dissemination of advice on frequently raised issues.

Both the RCGP and the GPC have very important roles in disseminating information for GPs. The RCGP has developed a reference table on its website, which compiles previous advice on the H1N1 virus so that GPs can look up information on a range of common issues. This can be found at: www.rcgp.org.uk/clinical_and_research/pandemic_planning/h1n1_guidance_reference_table.aspx

The Royal College of Obstetricians and Gynaecologists is developing plans to facilitate discussion of best practice based on experience so far in caring for pregnant women.

The Department of Health is currently collating a library of frequently asked questions, which can be used as a resource for doctors and other healthcare workers. The answers to these are usually based on expert advice, accrued and collated by the Department to provide responses to a wide range of questions. Questions include requests for information about appropriate protection for patients with long-term tracheostomies, advice about interactions between antiviral medicines and other drugs, requests for evidence on the efficacy or safety of antiviral treatments, and questions about the nature of vaccines.

In addition, plans are now being put into operation to provide a service through which clinical information can be exchanged, with appropriate data protection safeguards. As cases increase, an accumulation of information may help to inform decisions on the incidence of particular presentations and complications.

Periodic teleconferences have proved very useful for intensivists to share information about methods of supporting patients with respiratory failure, but the range of concerns in intensive care is more circumscribed than the many and varied issues dealt with by GPs. Many GPs have their own local networks, such as paediatricians, clinical infectious diseases centres and clinical virologists, to whom they turn for advice about unusual or challenging cases. The Continuing Professional Development programme has also provided opportunities for local-level discussion of clinical best practice. These could be extended to provide local support, or to facilitate telephone discussions between GPs from other PCTs, especially in influenza 'hotspots'.

10. We welcome the advice of the Chief Medical Officer against "flu parties" and support the Government in maintaining their efforts to ensure that this message is communicated effectively. (paragraph 38)

We welcome the Committee's endorsement of the Government's advice on 'flu parties'. The Chief Medical Officer for England has said:

We would never recommend intentionally exposing anyone to swine flu.

It is seriously flawed thinking to allow the virus to spread unabated through 'swine flu parties'. We don't yet know enough about the risk profile of the virus, and whilst it has generally been mild in the UK, in some parts of the world young previously healthy adults have died. Parents would never forgive themselves if they exposed a vulnerable child (perhaps a contact of a child at a party) to serious illness.

We need to be mindful of any future development of the virus and we remain vigilant in monitoring the disease.

The Government is aware that we need to be mindful of any future development of the virus and we continue to monitor the progression of the disease carefully.

The Government's response to other outstanding issues identified by the Committee

In its report the Committee stated:

A number of issues emerged during this short inquiry which relate to more general pandemic influenza preparedness and which we have not been able to address thoroughly but are important to note for the purposes of future assessment of UK preparedness in present circumstances.

We have provided information on the issues identified below.

i. The operational aspects of ensuring a fair and sensible distribution of antivirals and the implications of a shift to a targeted antivirals approach

and

ii. The need for a consistent and clear strategy on how and to whom antivirals should be distributed

The NPFS was launched in response to significant pressure being placed on GP practices, out-of-hours services and NHS Direct by the number of people seeking advice and treatment for influenza-like illness. As the service is available both online and over the telephone, and is supported by an extensive network of ACPs, the Government believes it provides the basis for a fair and sensible approach to distribution, allocating appropriate treatment to all those who need it.

While we feel this is an appropriate response to the current situation, it should be noted that the NPFS would not have been appropriate during the first weeks after the virus had spread to the UK, when the numbers of cases of swine flu were low and we were operating a containment strategy. We entirely agree that there is a need for clarity and consistency wherever possible, but equally there is a need to respond appropriately to changing circumstances, for example should antiviral resistance begin to emerge or new evidence appear about side-effects. We continue to keep our strategy of antiviral distribution under review during this current pandemic in light of scientific advice. We will also ensure that the strategy for any future pandemic reflects the specific situation to which we are responding.

iii. The importance of a robust communications strategy so that the public at large are aware of the pandemic and of what to do (both to prevent infection or in the event of infection) but, at the same time, are not unduly alarmed

The Government entirely agrees that clear and transparent communication is at the heart of any pandemic response. We have endeavoured to provide the public with useful information and a balanced view of the situation whenever necessary.

The mobilisation of the NPFS in England has been accompanied by a major public information campaign. A total of £1.7 million has been committed to significant press insertions and radio advertising in England to promote the new service.

We set out the new arrangements for the treatment phase of the response in a short guide that was e-mailed to NHS staff and made available online for the public.

A leaflet entitled *Important information about swine flu* was sent out to the vast majority of UK households between 5 and 19 May. It contained information about the outbreak and everyday measures people can take to protect themselves and reduce the spread of infection. Some 31.6 million leaflets were printed: one for every UK household, plus a stock for people to order if they need another copy (leaflets are also available though GP surgeries and pharmacists).

To keep the public informed, a mass public health campaign was also undertaken in May with print, TV and radio advertisements. The advertisements warned the public about swine flu and reminded people to cover their noses and mouths with tissues when they cough and sneeze and then throw the tissue away and wash their hands. The message is simple: 'Catch It. Bin It. Kill It.'

'Ambient' advertising (for example public transport posters, shopping trolley inserts, or ATM screens) to support good respiratory and hand hygiene continued throughout the summer and we are currently looking at extending this into the autumn.

A survey conducted by the Department of Health from 2-4 October showed that only 9% of people in the UK were dissatisfied with the amount of information available on swine flu. In addition, around 20% of people said they were washing their hands and disinfecting their homes and workplaces more often as a result of swine flu, reflecting the success of the 'Catch It. Bin It. Kill It' campaign. Surveys following a communications campaign around the launch of the National Pandemic Flu Service showed that only about 20% of people would go to their doctor directly to obtain Tamiflu if they suspected that they had swine flu, down from a high of 58%.

A communications campaign is being planned to raise awareness and understanding of the swine flu immunisation programme and explain who should be among the first groups to get the vaccine when it becomes available.

Materials for health professionals, including a new Immunisation Green Book chapter, fact sheet, Q&A, consent template, Patient Group Directive template and patient vaccine invitation letters, are in preparation. Plans for informing the public are still under development, but will include a leaflet, surgery poster and vaccine record card.

iv. The vital importance of streamlined and consistent communication to frontline healthcare workers on clinical guidelines and organisational arrangements

We have systems in place to ensure that guidance reaches frontline healthcare workers. For example, when we changed our strategy for the West Midlands and London, NHS flu leads received a letter setting out outbreak management considerations, which was cascaded to GPs and other staff.

A range of other communications from the Chief Medical Officer, the National Director for Pandemic Influenza Preparedness, the National Director for NHS Flu Resilience, the Director of Immunisation and others have been disseminated to the NHS, advising on issues including best practice and other changes of strategy. In addition, we have recently created a new easily accessible section on the Department of Health's website for clinical information and guidance for professionals.

Further details of the support and communications provided for healthcare workers are set out in the response to point nine above.

v. Frontline support mechanisms, including the steps that should be taken to identify frontline healthcare workers and whether they should be given a course of antivirals in advance, so that they could start to take them at the first sign of infection

Both members of the public and frontline staff who become symptomatic with suspected swine flu can access antiviral medication rapidly through the NPFS. We have also recognised the need to protect frontline health and social care staff from infection because of the increased risk at which their job places them, which is why they have been prioritised for vaccination. Vaccination of frontline health and social care workers (approximately 2 million people) will begin at the same time as the first at-risk group, and will continue for as long as necessary. This group is at increased risk of infection and of transmitting that infection to susceptible patients. Protecting these people will help the workforce remain resilient and able to treat sick patients.

The Government has also ordered 226 million additional facemasks and 34 million additional respirators for health and social care workers during a widespread outbreak, and some of these have already been delivered. We have said from the start that Tamiflu would be provided to all NHS frontline workers for them to take when symptomatic.

Leaders across the NHS also have a critical role to play in supporting our crucial workforce throughout the pandemic in every respect. We are engaging with a full range of stakeholders to achieve this.

vi. The need to prepare for the uncertainty of antiviral resistance, including decisions about stockpiling a strategic reserve of antivirals, and the implications of a prophylaxis strategy on the development of resistance

The H1N1 virus currently circulating is sensitive to both Tamiflu and Relenza. However, genetic mutations of the virus leading to reduced susceptibility or resistance are a concern with any antiviral treatment, and all countries have to make decisions based on their own assessment of the disease and situation locally.

The Government has stockpiled both Tamiflu (23 million courses) and a strategic reserve of Relenza (10.5 million courses). Because initial treatment is mainly with Tamiflu, it is probable that if the virus does develop resistance it will be to Tamiflu. In this situation, we could switch to treating mainly with Relenza.

An established network of HPA and NHS laboratories across the UK closely monitors changes in the nature of the influenza virus (including subtype, strain and susceptibility to antivirals) and any associated trends in bacterial infections. This will continue to be reported weekly to the Department of Health through the central databases of the HPA Centre for Infections.

We recognise arguments that antiviral treatment should be restricted to certain at-risk groups, on the grounds that using the drugs to treat all cases increases the chances of antiviral resistance and exposes too many people to the risk of side-effects from the medicine. Despite the tragic deaths of people with swine flu, it remains the case that the disease has so far proved mild for most people, and the majority of people make a good recovery without antivirals.

However, in previous pandemics mortality has moved from the seasonal flu pattern, which hits the very young and very old hardest, to a situation where young adults are worst hit. In the current pandemic, previously healthy adults are among those who have been hospitalised or have died from swine flu.

In light of this, we do not feel that science is yet in a position to lead to a clear and unequivocal decision on treatment policy and have therefore decided on a precautionary approach, whereby everyone who is diagnosed with swine flu should be offered antivirals. We will of course keep this policy under continuous review as the situation evolves.

vii. provision for the prompt development of a pandemic-specific vaccine, factoring in time for the appropriate clinical trials to take place to ensure its safety and effectiveness and, once proven, decisions about its fair and sensible distribution, including decisions over the upper and lower age limits, given the risk from infection in infants and children

In preparing for a pandemic, appropriate clinical trials to assess safety and the immune responses were carried out on vaccines very similar to the swine flu vaccine. Those vaccines were shown to have a good safety profile.

Furthermore, 14 projects costing £2.25 million have been fast tracked by the National Institute for Health Research (NIHR) on behalf of the Department of Health for urgent national swine flu research. The priority studies will provide vital clinical and scientific evidence that will inform the Government's response to the virus in the coming months.

Results are expected by the end of the year, and will bolster the body of evidence available to experts who advise the Government on how to protect British people. More details on this research and the teams involved can be found at: www.netscc.ac.uk

The European Commission has granted marketing authorisation to the swine flu vaccines from GSK and Baxter.

As Secretary of State for Health Andy Burnham announced on 13 August 2009, the following groups will be the initial priority groups for vaccination, in order of priority (numbers given are approximate and are for England only):

1. People aged over six months and under 65 years in the current seasonal flu vaccine clinical at-risk groups (about 5 million people)
2. All pregnant women, subject to licensing conditions on trimesters (about 500,000 people)
3. Household contacts of people with compromised immune systems, e.g. people in regular close contact with patients on treatment for cancer (about 500,000 people)
4. People aged 65 and over in the current seasonal flu vaccine clinical at-risk groups (about 3.5 million people). This does not include otherwise healthy over-65s, since they appear to have some natural immunity to the virus.

Vaccination of frontline health and social care workers (approximately 2 million people) will begin at the same time as the first at-risk group, and will continue for as long as necessary.

The Joint Committee on Vaccination and Immunisation (JCVI) reviewed the evidence and advised the Department of Health on these priority groups. This advice was also scrutinised and endorsed by the Scientific Advisory Group for Emergencies.

We will continue to take the best independent scientific advice to inform our decisions on vaccination issues.

The JCVI has advised that use of the vaccine in the wider healthy population should depend on the evolution of the pandemic as well as new and emerging clinical data on the use of the vaccine.

Annex 1: Details of exercises undertaken since 2005

Since 2005, across the UK, there have been a significant number of exercises at national, regional and local levels, in health and non-health sectors, which have helped drive forward planning for an influenza pandemic.

National and international

Exercise Winter Willow took place over three days in January and February 2007 and was a full-scale, Tier 1 exercise testing all levels of the planned UK response to an influenza pandemic. Over 5,000 people from a wide variety of UK organisations representing national and regional government, industry and the voluntary sector participated. This followed on from Exercise Shared Goal in June 2006, an exercise led by the Department of Health that involved a COBR simulation and which aimed to practise and validate response policies and the decision-making process at WHO Phase 5.

Both Scotland and Northern Ireland have conducted their own pandemic exercises to date. In Scotland, Exercise Big Chill involved NHS Lothian, Fife, Borders, NHS24 and other partners. In Northern Ireland, Exercise Delilah tested the ability of the Department of Health, Social Services and Public Safety, the wider Health and Personal Social Services family and other government departments to respond to an influenza pandemic.

On an international level, the UK has also participated in Exercise Common Ground in 2005, the only major EU exercise to date. This was a two-day command-post exercise across all 25 EU Member States, and included Commission and Ministerial involvement, with the aim of testing Member States' national pandemic plans. It tested all Member States' emergency operations centres and included representatives from European vaccine and antiviral manufacturers.

United Endeavour exercises held in 2005 and 2008 were used to test the process for providing the health surveillance data to inform the operation of COBR.

Regional and local

Exercise Cold Play, developed by the HPA, has been used on over 50 different occasions, including in every region across England, and has been distributed to the Devolved Administrations and to the Channel Islands. It has been run in various forms by SHAs, PCTs, acute trusts, mental health trusts, individual hospitals, health protection units, the National Blood Service, local police forces, universities, the voluntary sector, emergency services, prisons, local councils and airports.

Exercise Cold Play has also been widely used on a multi-agency basis, and LRFs have benefited greatly from it. The National Capability Survey results for 2008 show that 69% of LRFs have had their pandemic influenza plan validated by a multi-agency exercise within the last two years.

Local and regional exercises to date

Date	Exercise name	Region	Purpose and participants	Type
Nov 2008 to Mar 2009	Various	Across England	A Cabinet Office-sponsored LRF exercise programme to test both the multi-agency command and control mechanisms within the LRF and planning for pandemic-specific issues, including schools closure, provision of care for vulnerable people, management of excess deaths, and linkages between the NHS and local responders. Participants included representatives from the local authorities, children's and adult social care services, police, fire and rescue services, ambulance trusts, the NHS, the HPA, plus local coroners and 'category 2' responders.	Tabletop
Dec 2007	New Day 5	West Midlands	An exercise for multi-agency professionals from both health and non-health sectors. This aimed to explore the challenges around the wider health community response to, and management of, business continuity issues arising from a pandemic, with a particular focus on food and transport issues at the peak.	Tabletop
Nov 2007	Phoenix	London	An exercise for health professionals and partner agencies in both private and public sectors to explore the challenges that are likely to arise for the health service immediately following a pandemic.	Tabletop
Jan 2007	Athena	London	A one-day, multi-agency exercise held by the HPA and NHS London. The aim was to explore the response to, and management of, an influenza pandemic in London by the health service and partner organisations (including emergency services, voluntary sector, transport providers and others).	Tabletop
Nov 2006	Cold Play	London	A local exercise which aimed to explore links with the Influenza Pandemic Committee and all participating agencies prior to and during a pandemic and to explore business continuity issues that will arise.	Workshop style

Date	Exercise name	Region	Purpose and participants	Type
Oct 2005	New Day 1 and 2	West Midlands	An exercise aimed at the Regional Civil Contingencies Committee with health and multi-agency partners. The main issues revolved around business and service continuity and warning and informing the public.	Tabletop
Sep 2005	Aurora	Yorkshire and the Humber	A multi-agency exercise exploring issues around the health response and business continuity issues both within the health service and the wider business community during a protracted 'rising tide' incident.	Tabletop
Jun 2005	Arctic Sea	East Midlands	A multi-agency exercise involving the NHS, local authorities and the police. It provided an opportunity to test the health response itself and business continuity issues within the health service and the wider community during a protracted 'rising tide' incident.	Tabletop
Nov 2004	Icarus	London	The first pandemic influenza exercise that tested the multi-agency planning and preparedness in London.	Tabletop
Mar 06 to present day	Cold Play	Across England	An 'off the shelf' pandemic influenza exercise package providing a generic format for use by local health organisations (and adaptable to organisations in other sectors). It has been used over 50 times. Details above.	Workshop style
September 2009	Peak Practice	One event in each region	Strategic exercise to test regional command and control, resilience and support and communications strategies.	Table top

Sector exercises

In October and November 2006, the financial sector organised a market-wide exercise to improve its preparedness by providing each of the participants with an opportunity to review, test and update their plans for managing a pandemic threat.

Exercise Chain Reaction, held at the beginning of 2008, was used to test the reliability of the medicines and healthcare consumables supply chain for primary and community care, in the simulated event of an influenza pandemic, in order to understand any vulnerabilities. Participants included representatives from pharmaceutical manufacturers, distributors, wholesalers and retailers – as well as players from the Department of Health, the NHS and relevant agencies.

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