Faculty of Public Health
of the Royal Colleges of Physicians of the United Kingdom
Working to improve the public's health

UK Faculty of Public Health response to the consultation on the UK Influenza Pandemic Preparedness Strategy 2011

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health and wellbeing of the population through three key areas of work: health improvement, health protection and health services. In addition to maintaining professional and educational standards for specialists in public health and providing practical information and guidance for public health professionals, FPH advocates on key public health issues, influencing policy change at the highest level, and working closely with policymakers, professionals and the public to make a positive difference to people's health and wellbeing.

This response has been prepared by FPH's Health Protection Committee which is formed of experts in the field of public health and health protection.

5. We intend the strategy to reflect a pragmatic yet effective approach, reflecting clinical and operational realities. Do you think the proposed characterisation of low, moderate and high impact is the right approach?

Yes. It is very important to retain maximum flexibility.

- Consistency is more difficult to achieve (and may not be appropriate) since the intensity of the pandemic may vary both between and within the UK countries.

4 St Andrews Place • London • NW1 4LB • Tel: I&S Fax: 020 7224 6973 • Email: enquiries@fph.org.uk
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- A uniform approach within Scotland, Wales or Northern Ireland makes sense given the smaller population size, but different approaches may also be necessary in different regions of England, particularly early in the pandemic.
- To impose the same response (at the same time) in areas experiencing very different intensity of flu activity will put considerable strain on public health and other services.
- The Strategy should make explicit that the phases may not follow in strict order and that different parts of the country may be in different phases.
- It may also take several weeks before the impact can be properly assessed so the initial response may have to assume high impact even if it later turns out to be a low impact pandemic.

Detailed comments follow:

Initial phase

- Contact tracing should be kept to a minimum as it is very labour intensive. Data about secondary attack rates is probably best obtained from investigation of school or institutional outbreaks rather than from community cases.
- Clinical data collection about hospitalised cases (as in FluCIN) should also be activated during this phase.

Low Impact

- The NPFS is unlikely to be required during this phase.

Moderate impact

- Information on how to support family members and neighbours should be given at this stage or even for Low Impact (and not be confined to a High Impact response).

6 We have described the revised response phases and indicators for transition between them. How helpful do you find this?

- This is helpful, though the relationship to the impact parameters described in Table 1 is not entirely clear.

- Public health services are likely to be under greatest pressure during the EVALUATE phase.

- We are pleased to see an unequivocal statement that attempting to halt the spread of a pandemic is a waste of public health resources.
- The role of mass contact tracing in slowing down the pandemic is unclear and needs more research and evaluation.

- The indicator for moving from the EVALUATE to the TREAT phase is critical, since managing the EVALUATE phase over a prolonged period would pose a huge challenge to public health services. This requires a clear, unequivocal definition of what is meant by 'sustained community transmission'.

7. The language used to describe the response phases is important. How well do the names describe the phases and focus of activity?

- The terms are better than those used for the phases of the Australian pandemic plan (alert, delay, contain, sustain, control, recover) since they do not imply that the pandemic can be controlled or modified.

- The terms 'EVALUATE' and 'TREAT' are not ideal, since both of these are processes that should be going on throughout the pandemic. 'ASSESS' would be preferable to 'EVALUATE'. 'TREAT' has the dual meaning of 'act' and 'medicate': possible alternatives might be 'RESPOND' or 'MANAGE' or 'MAINTAIN'.

8. Do you agree with the broad approach adopted for the strategy, organised around the three principles - precautionary action, proportionality, and flexibility?

- Yes. This seems very sensible.

GENERAL COMMENTS

3.1 Sharing scientific information between countries is vital. The arrangements for doing this during the 2009 pandemic were very ad hoc and need further refinement. The UK

was the first country to be severely affected in Europe and made a very positive contribution to EU data requirements, but if the initial focus were elsewhere it would be vital to have rapid access to good epidemiological data across the EU.

3.27 In addition to scientific advice from SAGE, it is important that DH receives independent public health advice from the HPA and that they are separately represented at COBR. Similarly, the DAs should receive independent advice from their corresponding health protection or public health organisations.

4.8 Detailed data gathering on the first cases became a huge burden on public health services during 2009 pandemic. The initial target was to gather data on the 'first few 100' cases (FF100) but this was extended to several 1000 cases. There should be careful consideration of the minimum data set that is required from each case and the number of cases on whom data will be required.

Detailed data gathering on hospitalised cases is also important, but took considerable time to set up during the 2009 flu pandemic. A system to do this should ideally be established in advance of any pandemic, perhaps in the form of a sentinel hospital surveillance network that operates every flu season.

4.27 Prompt initiation of antiviral treatment is critical to efficacy. They should be started within 48h - 'within two days' is ambiguous. Since antivirals are the mainstay of treatment, and since time to initiation of treatment is critical to their efficacy, this parameter should be closely monitored throughout the pandemic. It is one of the key parameters of the effectiveness of clinical measures. Pre-distribution of antivirals to households or prescription of a 'standby' course of antivirals to people in special risk groups could reduce the delay in starting treatment.

4.28 More extensive use of antivirals during seasonal influenza could assist in promoting greater professional and public awareness of their role and of the importance of reporting symptoms early and starting treatment rapidly.

4.32 Use of antiviral prophylaxis is unlikely to have a major role at any stage of a pandemic and is very resource intensive to administer.

6.10 It is local public health services, rather than primary care services, which bear the brunt of the pressure during the initial phase of the pandemic.

6.11 Local public health services also bear the brunt when flu hotspots emerge. Specialist laboratory services will also be busy but are usually located at regional or national level.

6.20 Normal primary care services should be used as far as possible and the NPFS only activated as a last resort. If the NPFS is activated it remains vital to continue collecting virological surveillance data in order to track the course of the pandemic and data on time to initiation of antiviral treatment in order to monitor the effectiveness of clinical measures.