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T Irrelevant & Sensitive
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17 June 2011

Dear Sir/Madam

BMA response to DH consultation on UK Influenza Pandemic Preparedness Strategy 2011

The British Medical Association (BMA) welcomes the opportunity to respond to the 'UK Influenza Pandemic Preparedness Strategy 2011'.

The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 140,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare

For any queries regarding this submission, please contact NR as per the details above.

Yours sincerely

Personal Data

NR

Head
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BMA

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Introduction

The BMA supports a UK-wide strategic approach to planning for and responding to the demands of an influenza pandemic. We support the dual national and local focus of the strategy but believe that more work needs to be done to ensure integration between both spheres. The current reorganisation of the NHS and the public health system (due partly to their application to England only) jeopardises a coordinated and integrated UK approach. The BMA would ask that the government consider the knock on effects of these reforms on the strategy. Moreover, it is important to note that in future years, new health and social care organisations may be in place and it will take time for them to develop knowledge and organisational memory.

The BMA commends the evidenced based approach outlined in the document. We would like clarification about the composition of the scientific advisory group. We would also suggest that the Chief Medical Officers of England and the devolved nations be members of this group. This will facilitate synergy, joint working and flows of information.

Comments not covered by the consultation questions

The speed with which the pandemic can develop

Paragraph 2.12 highlights the need and importance for arrangements to deal with a pandemic to be in place before it occurs. During the 2009/10 swine flu pandemic the BMA General Practitioner Committee (GPC) engaged in discussions with NHS Employers and the Department of Health (DH) to develop such guidance and we would urge that a "sleeping strategy" is put in place before the arrival of another pandemic.

There is evidence to suggest that the containment phase of the 2009 pandemic delayed the onset of mass illness by a few weeks and this enabled the NHS as a whole to prepare more fully than would otherwise have been the case.

Potential economic impact of an influenza pandemic

Although commercial organisations may be able to mitigate losses by Business Continuity Management (BCM), it is unreasonable to expect proportionate mitigation from the NHS by BCM because of:

- the nature of our business in meeting the demands of a flu pandemic
- our greater exposure to infectious disease
- the high proportion of female workforce with other caring responsibilities
- the fact that our executive work cannot be undertaken by remote working.

Lessons from the H1N1 (2009) influenza pandemic

The BMA is concerned that some of the key lessons from 2009 have not been learnt. Particularly, the issue of how 'hot spots' are handled and how this locally impacts on primary care, secondary care and public health services. A system that is used to running at close to capacity can be quickly over-run by even a moderate increase in cases, particularly as there is need for service continuity.

We are disappointed to see that the consultation lacks detail about support for isolated areas of high activity. Further thought also needs to be given to issues including: how locum doctors could be engaged by the service; the use of personal protective equipment; the reimbursement for services rendered by public health trainees; the redeployment of non-essential staff, and; the prioritisation of scarce resources such as Intensive Care and High Dependency Units.

Some hospital services can be suspended during a high priority pandemic but a redeployment policy needs to be established in advance so these staff can report to their local primary care centre and be redeployed where necessary. To start doing this during a pandemic is unwise, as the experience of 2009 indicated.

In terms of surveillance, it took some weeks to be able to conclude categorically that the 2009 pandemic was mild. Initial indications from its course in Mexico were that it was severe. We therefore believe that the gathering of surveillance data should continue for as long as is required to distinguish the nature and impact of the pandemic – a process which may take several weeks. During this time some form of containment should also take place as a natural experiment, as this will help inform the overall knowledge of the threat. More basic surveillance should continue throughout the pandemic rather than just stop.

Planning assumptions for a future influenza pandemic

Planning assumptions for a future influenza pandemic, need to include the possibility of the virus acquiring new virulence factors during the pandemic, either increasing or decreasing its impact.

Communications for health and other professionals

The BMA supports the sentiments outlined in paragraphs 17 and 18 of chapter 5. This withstanding, effective communication amongst the healthcare workforce requires medical leaders to be taken into the Department of Health's (DH) confidence at an early stage and for the DH to understand the differences between the various medical organisations and their remits. Often times, the DH seems to confuse the roles of the Royal Colleges (science and standards) and, for example, the BMA, which has operational roles (including negotiating terms and conditions of work) with regard to branches of practice, including but not exclusively, General Practitioners.

International travel, border restrictions and screening

The BMA strongly agrees that there is no need or benefit to be gained from health professionals meeting arriving planes or ships. There may be some benefit from requiring carriers to keep passenger manifests and to share these with public health services on request.

Maintaining essential services and normal life

Whilst a 'Business as usual' philosophy is desirable, we believe it is necessary to be realistic and manage expectations as to the extent that this will be possible.

Businesses with their own stocks of antivirals/vaccines should be required to take account of national policy and local public health advice before distributing these as to do so in an inconsistent way would undermine the national response and trust in the plan.

Consultation questions

1. **We intend the strategy for responding to low, moderate and high impact influenza pandemics to reflect a pragmatic yet effective approach, taking clinical and operational realities into account. Do you think this is the right approach? Please describe why (or why not). See Chapter 3 page 25.**

The BMA supports the low, moderate and high typologies of pandemics and their responses. This withstanding, it is important to recognise that pandemic outbreaks may not fit neatly into either of these categories. Nor may it become apparent for some time into the pandemic, which is the most appropriate category. Moreover, there needs to be greater appreciation of the fact that whilst certain areas may be facing a moderate influenza pandemic others may be facing a high influenza pandemic.

In addition to regional and national variation, it is important to recognise that even within well demarcated geographical areas there can be significant differences in number of cases and workload. The BMA is also concerned about NHS services which straddle administrative boundaries, and believes that more thought needs to be given to coordination in such circumstances.

The issue of variation highlights the potential for local decisions to impact negatively on other localities. We would like further clarification of how such situations would be dealt with. This highlights the need for national coordination whilst maintaining local flexibility.

We support the three principles underpinning all pandemic preparedness. In terms of proportionality, emergency planning theory and practice suggests initial response is proportionate to the worst case scenario based on the available data. The response is then down-tuned to suit new information. It is very difficult to upgrade a response once started.

The consultation seems to be that the medical services are only disrupted in times of high outbreak. This assumption is misplaced. A long period of low impact increased activity in ether primary, secondary or community care, will take its toll on those trying to deliver both routine services and cope with an influenza pandemic. Whether the pandemic is judged mild, moderate or high impact, the pressure on medical services could therefore be very similar. This is particularly the case where GP Practices are concerned. In this setting, patients with mild disease are just as likely to seek a consultation with their practice as someone with more severe disease. It is therefore the numbers of patients affected rather than the severity per se that has the most impact on medical services. Therefore because of the way GP practices are resourced they may need special arrangements activating well before (and discontinuing well after) those for other organisations. Likewise, intensive care capacity may well be overwhelmed even in low impact flu pandemics.

In reference to the risk of critical and intensive care services being overwhelmed in a short severe pandemic, and the need for appropriate planning of staff numbers, COBRA/SAGE may wish to take a view on redeployment of staff. Having a pre-arranged national agreement on giving the pandemic flu vaccine should also be considered.

We believe that a targeted vaccination is key in response to high impact influenza pandemics and are disappointed to see that the DH continues not to have a sleeping strategy for swiftly activating targeted vaccination.

The BMA strongly supports the sentiments of chapter 3 that decisions about the nature of the response to the pandemic must be made on the basis of expert scientific evidence. Further detail is needed about how this would be operationalised, both at national and local level. We recognise that this would involve a range of specialists, but strongly believe that the involvement of public health doctors, with specialisms in health protection, is key and should be enshrined into the response system.

2. **We have described the response phases and indicators from transition between them. How helpful do you find this? How can we improve upon what we have described? See chapter 3 page 28.**

The BMA largely agrees with the definitions used and finds them helpful. We support the recognition that these phases could occur simultaneously, for example in the case of evaluate and treat. This is likely to put additional strain on services responding to the pandemic.

The detect phase needs to account for the possibility that the pandemic strain may first arise in the UK. In terms of the evaluate phase, while the spread cannot be halted it may be delayed, buying valuable time for the NHS and society to mount the treat, escalate and recover phases. Adequate plans must be put in place well in advance to facilitate this.

We are pleased to note the DH's acknowledgement of the critical role of professional leaders in a pandemic response and would ask that this leadership be established at all levels of any pandemic response, including both locally and nationally.

3. **The language used to describe these response phases is important. How well do the names describe the phases and focus of activity? See Chapter 2 page 28.**

The language used is fit for purpose and correctly describes the phases and activity outlined. It is also clear and understandable.