The UK Pandemic Preparedness Strategy 2011: Analysis of Impact on Equality

1. Statement of duties

The Equality Act 2010 mandates a duty within the public sector to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and those who do not share it.

The protected characteristics are Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or belief, Sex, Sexual Orientation. The Department of Health's (DH) Analysis of Impact on Equality (AIE) process is a key element of demonstrating how it is meeting the duty. It also considers other groups that may experience disadvantage and barriers to accessing services as well as poorer experience and outcomes.

The aim of the UK Pandemic Preparedness Strategy 2011 is to support integrated planning and preparations for pandemic influenza across government, in health and social care and in public and private sector organisations. The purpose of analysing the impact on equality of the Strategy is to consider the impact it could have on different groups and take steps to mitigate any potential negative or adverse impacts.

This AIE has been developed with input from policy leads in the Department of Health and other Government Departments, as well as drawing on experience from the 2009 H1N1 pandemic.

2. The purpose of the UK Pandemic Preparedness Strategy 2011

The *UK Pandemic Preparedness Strategy* sets out proposals for a UK-wide strategic approach to planning for and responding to the demands of an influenza pandemic. In planning and preparing for an influenza pandemic, the Government's strategic objectives are to:

- protect citizens and visitors against the adverse health consequences as far as possible;
- prepare proportionately in relation to the risk;
- support international efforts to prevent and detect its emergence and prevent, slow or limit its spread;
- minimise the potential health, social and economic impact;
- organise and adapt the health and social care systems to provide treatment and support for the large numbers likely to suffer from influenza or its complications whilst maintaining other essential care;
- cope with the possibility of significant numbers of additional deaths;
- support the continuity of essential services and protect critical national infrastructure as far as possible;
- support the continuation of everyday activities as far as practicable;
- uphold the rule of law and the democratic process;
- instil and maintain trust and confidence by ensuring that the public and the media are engaged and well informed in advance of and throughout the pandemic period; and
- promote a return to normality and the restoration of disrupted services at the earliest opportunity.

The *UK Pandemic Preparedness Strategy 2011* builds on the approach set out in the 2007 *National Framework for responding to an influenza pandemic,* taking account of the experience and lessons learnt in the H1N1 (2009) pandemic and the latest scientific evidence. In particular, the strategy aims to:

- develop better plans for the initial response to a new pandemic, when the focus should be on rapid and accurate assessment of the nature of the pandemic virus;
- put in place plans to ensure a proportionate response to a range of scenarios to meet the differing demands of milder and more severe pandemic viruses, rather than focusing just on the "worst case" planning assumptions;
- take greater account of differences in the rate of spread of the disease across the country and internationally;

- take more account of the learning from behavioural scientists about how people are likely to feel and behave during a pandemic;
- develop better plans for managing the end of a pandemic – the recovery phase and preparation for subsequent seasonal flu outbreaks.

The proposals set out in the *UK Pandemic Preparedness Strategy 2011* have been developed jointly across government, with professional, NHS, social care and public health organisations, and based on advice from clinical, scientific and other experts.

The strategy has embedded in its principles that access to care and treatment will be fair for people from any background. In particular, the strategy continues to be based on the ethical principles set out in responding to pandemic influenza - the ethical framework for policy and planning, developed by the Committee on Ethical Aspects of Pandemic Influenza (CEAPI). These principles state that:

- everyone matters;
- everyone matters equally (this does not mean that everyone is treated the same, but according to their needs);
- the interests of each person are the concern of all of us, and of society; and
- the harm that might be experience by each person matters, and so minimising the harm that disasters and major incidents cause if of central concern.

Further details are at: www.dh.gov.uk/pandemicflu.

3. Legislation

Certain regulatory changes were enacted to support the response to the 2009 H1N1 pandemic and will continue to provide a legislative framework for future pandemic responses. These are:

- *SI No. 1164: The Medicines for Human Use (Miscellaneous Amendments) Regulations 2009*

  Regulation 4 of these Regulations amends regulation 8 of the Medicines for Human Use (Manufacturing, Wholesale Dealing and Miscellaneous Amendments) Regulations 2005 to enable the wholesale distribution of unauthorised medicinal products in response to the suspected or confirmed spread of pathogenic agents, toxins, chemical agents or nuclear radiation which could cause harm.

- *SI No. 1165: The Medicines for Human Use (Prescribing)(Miscellaneous Amendments) Order 2009*

  Articles 4 and 5 of this order amend the Prescription Only Medicines (Human Use) Order 1997 and Medicines (Pharmacy and General Sale—Exemption) Order 1980 respectively to provide for the supply of a medicinal product during a pandemic in accordance with a protocol approved by the Secretary of State and Minister for Health, Social Services and Public Safety, or by an NHS body for the purpose of treating a pandemic disease which is a serious risk to human health or potentially a serious risk to human health.

- *SI No. 2205: The National Health Service (Miscellaneous Amendments Relating to Community Pharmaceutical Services and Optometrist Prescribing) Regulations 2009*

  Regulations 3(b), 4, 14, 15, 16, 19, 23, 25, 31, 33 and 34(3) contain measures enabling temporary emergency changes to the arrangements for the provision of pharmaceutical services and local pharmaceutical services in England in the event of an emergency arising out of a threat to human welfare which is caused or which may be caused by human illness (for example, pandemic influenza). In the case of such an emergency, arrangements are put in place to enable retail pharmacies and dispensing doctors to relocate temporarily or take on additional premises without needing to go through the normal applications process – and to enable dispensing doctors to provide pharmaceutical services to patients who are not on their normal patient list. Retail pharmacies included in a pharmaceutical list, whose opening hours are subject to detailed provisions in the PS Regulations, are given additional flexibilities to allow them to make emergency changes to their opening hours and to close premises, where it is reasonable to do so. Retail pharmacies and dispensing doctors will revert to their normal arrangements with their Primary Care Trust after the emergency, unless these have been changed in the mean time via the normal applications process.

Impact Assessments in respect of SI 1164 and 1165 are available from the Medicines and Healthcare products Regulatory Agency, Market Towers, 1 Nine Elms Lane, London SW8 5NQ. SI 2205 was assessed as not requiring an Impact Assessment.

4. Analysis of Impact on Equality for the UK Pandemic Preparedness Strategy 2011

The experience of the general public of services during a pandemic flu outbreak fall into three main categories:

- Access to information (about symptoms, services and treatment)
- Access to treatment (where required)
- Impact of wider strategic pandemic planning

As the strategy primarily relates to public service delivery, this document analyses the equality impact of the policy within these key areas. However, consideration is also be given to any equality impact the policy may have on staff.

4.1 Access to information

4.1.1 Communications

The main aims of the Government's pandemic flu communications and public engagement strategy are to:

- establish confidence in the ability of the Government and health services to manage an effective response;
- communicate what pandemic flu is and why it is different from seasonal or other types of flu;
- help people to recognise the symptoms;
- advise and help people to understand what to do to minimise the risk of infection to themselves and others including:
    - what to do if they get infected (i.e. how to access the National Pandemic Flu Service (NPFS) and use medication);
    - how best to look after themselves and others; and
    - encouraging compliance with key policies (e.g. stay at home if ill, avoiding mass gatherings if needed, hand and respiratory hygiene, accessing the NPFS appropriately).
- communicating the role of vaccines and antiviral medications;
- help the general public understand, accept and support the actions of the Government and public health services;
- ensure that health and care staff have the right information to perform their role; and
- identify the most efficient and reliable ways of delivering information in a range of scenarios to a variety of audiences so to maximise understanding and drive appropriate behaviour without causing panic or appearing disproportionate.

During a pandemic, mass media communications are used, with some targeted elements as appropriate, to ensure appropriate messages reach the whole population. The latest scientific research (4.3.6) and surveillance data (4.3.7) is utilised to inform communications.

An example of good practice in targeted communications during the 2009 H1N1 pandemic was the way in which the Department worked with third sector organisations.

The Department had 70 partners. Amongst others, these included: Age Concern, Carers Uk, Red Cross, St Mungos, Shelter, Scope, RNID, RNIB, Turning Point, National Heart Forum, National Kidney Federation, Kidney Research UK, The Stroke Association, British Liver Trust, British Lung Foundation, Parkinsons Disease Society, Diabetes UK, Asthma UK, Cancer Research UK, MS Society, Alzheimers Society, Refugee Support, Citizens Advice Bureau, Friends Family and Travellers and Rethink.

Examples of the work produced with these partners included:

- bespoke swine flu articles in Diabetes UK and British Lung Foundation magazines, and
- Diabetes UK disseminating key messages through various channels with a reach in excess of 180,000 members and partners.

We did not target organisations to reach specific groups based on ethnic minority at the planning stage as there was no reason to suspect that this group would be at any greater degree of vulnerability than the rest of the population. However, at a later stage when it became apparent from the tracker that BME groups were showing more concern about swine flu, the Department commissioned research to determine the reason for this. By the time the results were known, it was deemed disproportionate to the size of the risk to take further action as the worst part of the pandemic was over.

At the same time, the Department contacted a range of faith groups to see if they had adequate information and this was confirmed. When there were specific messages to get to the Muslim community regarding the Hajj[1], this was led by the Foreign and Commonwealth Office with Department of Health input.

The Department held two face to face briefings with Third Sector organisations during the H1N1 pandemic, as well as issuing regular email bulletins to Third Sector contacts for dissemination in their channels. We also put all our collateral (ads, leaflets, posters) on a shared website so they could download them.

In preparing the public communications material, the Department targeted the general public as a whole. However, it was recognised that:

- certain groups may find it more difficult than other to access treatment routs (non English speakers, refugees, asylum seekers, homeless, those with cognitive disorders or sensory impairment);
- those with existing health conditions, or who were pregnant, may be more concerned about any health emergency;
- certain groups may not be able to easily access mainstream communication channels (homeless, refugees, travellers); and
- there was a need to address the usual accessibility issues in any literature (languages, easy read, braille, tape, British Sign Language).

[1] The Saudi government advised that those in the at risk groups should postpone their pilgrimages due to the pandemic and that they should have a seasonal flu jab as a precaution before applying for a visa.

Pandemic preplanning therefore identified the stakeholders (third sector groups) who could reach these groups as it would be impractical for the Department to produce a wide range of customised information that might need to change rapidly in an emergency.

Lessons learned from 2009 H1N1 pandemic: Users of the National Pandemic Flu Service were most likely to have first heard about it from television news / programmes (34%), or were made aware of the service by their GP (12%). Over the course of the pandemic, 79% of saw information about the NPFS on television and 21% received information from their GP.

Lessons learned from 2009 H1N1 pandemic: Most users were aware that the remit of the NPFS was to assess symptoms and provide access to antiviral medication if necessary, and most users contacted the service to this end. However, a fifth (20%) felt that the NPFS would provide information about swine flu symptoms and a similar proportion (18%) felt that the service would give general information about swine flu. This suggests some misconception about the remit of the service, which could be lessened in the future with specific communication in terms of exactly what the NPFS is designed to provide.

During the inter-pandemic period the main objectives are to provide accurate advice and information about flu, engage with stakeholders, encourage the adoption of high standards of personal hygiene and prepare the population for the emergence of an influenza pandemic and its potential impacts. This activity supports the Department's strategic role in protecting public health.

Because of the differing ways in which people access and interpret information, communications policy within the strategy may impact differently on various groups.

Best practice from 2009 H1N1 pandemic: Advice about swine flu was set out in a leaflet that was sent to all households in Britain during the 2009 H1N1 pandemic. Further information can be found at: http://www.direct.gov.uk/en/Swineflu/News/DG_177995

Age: Over-65s can be at greater risk of life-threatening complications from flu. The strategy would recognise this with targeted advertising and communications in appropriate media.

Lessons learned from 2009 H1N1 pandemic: Those aged 55 or over were more likely to have heard about the NPFS through newspapers and 16-34s more likely to have found out about the NPFS online.

Disability: Those with certain conditions such as diabetes or asthma or people undergoing cancer treatment can be at greater risk of life-threatening complications from flu. The strategy would recognise this with targeted advertising and communications in appropriate media as happened during the 2009 H1N1 pandemic. It is the policy to produce material in a range of different formats including large print, braille and audio. Communications would also be disseminated via NHS and Social Care frontline staff and charities such as the Diabetes and Asthma UK.

Best practice from 2009 H1N1 pandemic: The swine flu information leaflet was available in large print, easy read, audio and British Sign Language versions. Further information can be found at: http://www.direct.gov.uk/en/Swineflu/News/DG_177995

Ethnicity: From May 2009 to March 2010, the department undertook a weekly tracker of public perceptions and attitudes to the H1N1 pandemic. During August 2009, the tracker highlighted the fact that ethnic minority individuals were notably more concerned than the general population about the pandemic. The communications team evaluated the evidence available at this point but were unable to determine whether this was due to the impact of communications materials; the impact of a demographic factor (such as the regionality of the pandemic); or a combination of the two.

Communications leads decided not to try to develop segmented materials for BME communities at that stage, without sufficient knowledge on which to base their development (although advertising material was placed in a range of minority ethnic press publications). Research was commissioned to inform segmented communication in any future pandemic. This was conducted between September and November 2009 and comprised qualitative interviews with people from minority ethnic communities and also with frontline health professionals working in areas with high ethnic populations.

The Department recognised the need for research amongst people from these communities to understand the factors that could lie behind these differences in perceptions and attitudes. The study was also required to identify the relevance and effectiveness of the Department's swine flu communications in the context of specific communication needs amongst the BME communities.

The research revealed four types of "attitudinal cluster" across those interviewed. These types were:

- the "in controls", mainly parents from a variety of ethnic backgrounds but aged 25 to 45;
- the "followers", generally men and women aged 46 and over from the Bangladeshi, Pakistani, Chinese and Indian communities, and Black Caribbean and Black African women over 46;
- the "disconnected passives", mainly people over 46 from Somali, Bangladeshi and Pakistani communities and some younger people born and brought up abroad;
- the "disconnected cynics", mainly black African or Caribbean men over 46.

They showed distinctly different attitudes to health issues, government information, and treatment/vaccinations and had different levels of awareness of swine flu information and this information can help future planning.

Analysis of their information needs suggests a range of measures that can be implemented during a future pandemic – and indeed when communicating information on seasonal flu – to provide greater reassurance and, where appropriate, behaviour change for each "cluster".

The impact of the mainstream campaign on BMEs was analysed in another piece of research *(tns bmrb "RHH and Swine Flu Vaccination Campaign" Evaluation Qualitative Tracking Research, October 2009 to February 2010).* This found that BMEs had the lowest spontaneous awareness of advertising or media coverage during most of the pandemic and that the overall reach of materials was lowest among this group. In terms of behaviour, they were less likely than other groups to wash hands and use anti-bacterial gels.

The specific research on BME communications on swine flu is available to inform planning of all future campaigns. However, it is worth noting that mainstream communications were seen as completely appropriate for two of the four "clusters".

As mentioned above, information from the RHH and vaccination campaign evaluations does show that ethnic minorities were less likely to wash hands and use anti-bacterial gels and this, again, is information that can help in formulation of seasonal flu and pandemic communications planning.

A future strategy would seek to address issues arising from this by considering targeted advertising in ethnic media or via stakeholder communications from trusted community voices where this was indicated.

It is our standard policy to produce material in a range of differerent languages, which are chosen under advice from the Central Office of Information.

Best practice from 2009 H1N1 pandemic: The swine flu information leaflet was available in Welsh, Arabic, Bengali, Chinese, Farsi, French, Gujerati, Polish, Portuguese, Punjabi, Somali, Spanish, Tamil, Turkish and Urdu. Further information can be found at: http://www.direct.gov.uk/en/Swineflu/News/DG_177995

Lessons learned from 2009 H1N1 pandemic: Those in BME groups were significantly less likely to have heard about the NPFS through TV or newspapers and more likely to have heard about it from family and friends or online.

Gender reassignment (including transgender): The communications element of the strategy will not impact differently on the basis of gender reassignment.

Marriage and civil partnership: The communications element of the strategy will not impact differently on the basis of gender.

Pregnancy and maternity: Pregnant women can be at greater risk of life-threatening complications from flu. The strategy would recognise this with targeted advertising and communications in appropriate media.

Religion or belief: The communications element of the strategy will not impact differently on the basis of religion. However, there may be some cross-over with the policy of targeting specific ethnic groups where appropriate.

Gender: The communications element of the strategy will not impact differently on the basis of gender, other than in the case of pregnant women.

Sexual orientation: The communications element of the strategy will not impact differently on the basis of sexual orientation.

Socio-economic disadvantage: The communications element of the strategy will not impact differently solely on the basis of socio-economic disadvantage. However, there are crossovers with social care and charities which will be supported by targeted communications material developed for and aimed specifically at specific groups.

Carers: The communications element of the strategy will not impact differently on the basis of caring responsibiltiies.

4.2 Access to treatment

4.2.1 Antiviral treatment during early phase

Rapid antiviral provision is specified as an important planning aim in the National Strategy for responding to an influenza pandemic. In the early stages of a pandemic, before there is sustainable community transmission, symptomatic individuals will access healthcare services in the normal way, usually via their GP. Antiviral medicines and consumables will be distributed to primary care providers according to need. As it utilises existing patient treatment pathways, this phase of the strategy has no equality impact in respect of access to treatment.

4.2.2 National Pandemic Flu Service (NPFS)

The NPFS is the primary route to treatment during a pandemic, the deployment of which is essential to relieve the pressure on healthcare services in the event of a pandemic. Its aim is to enable large numbers of people to be assessed rapidly by either web or telephony, the remainder being able to access GP services. The NPFS is composed of a number of routes which include:

- The public web route - used by the public or their flu friend[2] over the internet
- The call centre route - used by call centre operators who act as proxies for the public or their flu friend over voice
- The National Pandemic Flu Service Professional (NPFS Pro) - used by health care professionals to view a patient's antiviral issuance and to issue an authorisation number or direct antiviral if they deem it clinically appropriate.

The process is:

- A symptomatic individual will contact the NPFS and an assessment using a clinical algorithm will be undertaken.

[2] A "flu friend" is a non-symptomatic individual who collects antiviral medicine on behalf of a symptomatic individual. Flu friends may also assist individuals with the online or telephony assessment process. Flu friends may be persons known to the symptomatic individual or can be persons nominated by primary care providers to act for those who do not have anyone they can ask to be a flu friend.

- If required, the individual will be authorised to receive an antiviral medicine. The individual will then need to note down an authorisation number. A Flu Friend can do this on behalf of a symptomatic individual.

- The Flu Friend (with their own identification and the symptomatic individual's) will then attend an Antiviral Collection Point, provide the authorisation number and collect the antiviral medicines. The NPFS will also direct patients to a GP or other NHS service should they require any additional advice or treatment.

Lessons learned from 2009 H1N1 pandemic: The 2009 Influenza Pandemic: An independent review of the UK response to the 2009 influenza pandemic - Dame Deirdre Hine, stated that: "I have heard from a range of English interviewees that the NPFS sufficiently reduced primary care pressure at a time when it was most required. Evidence also suggests that patients were able to access antiviral treatment rapidly, with 97% of those who collected antiviral medicines authorised by the NPFS doing so within 48 hours."

Lessons learned from 2009 H1N1 pandemic: Most users (86%) were satisfied with the service, and three in five (60%) were very satisfied. Online users were more likely to be satisfied overall (88%) than telephone users (85%). Those told to contact a GP (of whom 91% were satisfied) or who collected their antiviral medication (90% satisfied) more likely to be satisfied with the service than those not issued an authorisation number for an antiviral medicine (82%).

Age: The NPFS may impact differently on older people due to the likelihood of this group to use the channels of access available. Research suggests that there is a reluctance amongst older people to access healthcare through telephone services - mainly because of a belief that their health needs will be best served by seeing their GP. Research also suggests that take up of the internet, although increasing, is still not high among this group. Since antiviral medicines will be distributed primarily following the issuing of authorisation numbers by the telephone and internet based NPFS, older people may be less likely to use it. In addition, older people may be more likely to live in social isolation and therefore not have someone available to act as a Flu Friend. Appropriately targeted national and local communications, informing the public how to access the NPFS and trusted individuals allocated to act as Flu Friends by the local primary care consortium will help mitigate these factors.

Lessons learned from 2009 H1N1 pandemic: People over 65 make up 15.89% of the population of England and Wales yet accounted for just 3.14% of NPFS assessments. Conversely, under 5s represent 5.93% of the population but accounted for 9.51% of NPFS assessments. However, this is in line with epidemiological studies of the pandemic, which show that children were most affected while adults aged over 50 years had evidence of some pre-existing immunity, with much lower clinical attack rates.

Lessons learned from 2009 H1N1 pandemic: Younger users were more likely than older users to recommend the service: 95% of 16-34s compared to 85% 35-54s and 84% 55 or over (note however that younger users are highly correlated with those using the online service, which itself is related to higher levels of advocacy). Those aged 55+ were more likely to be dissatisfied with the formulaic nature of the questions asked (60% compared to 29% overall). Future communications highlighting the medical expertise behind the assessment 'script' may reduce dissatisfaction with the formulaic nature of the assessment. For the telephony service, those aged over 55 (33%) were more likely to say they could not understand the individual call handler (overall 12%).

Disability: Some disabled groups may have difficulty accessing the service via the channels available. Research has shown that accessing services by telephone can pose problems for disabled people. This can be due to a number of different factors such as: specialist technology required to access services; poor design of automated systems; and a lack of understanding of disability issues amongst staff in call centres.

Steps have been taken to address these difficulties. To support users with hearing difficulties the NPFS telephony service is designed to provide minicom services. The web based service will also provide an alternative for hearing impaired consumers with fewer barriers than with audio-based services.

Users of NPFS who have visual impairment may find the web based service difficult to access. This difficulty is mitigated by ensuring that the design of the web service is compliant with the W3C Web Accessibility Initiative (WAI) Web Content Accessibility Guidelines (WCAG). However, it is expected that the people who have visual impairment will find NPFS telephony service more accessible or will choose to access flu related service through their existing route of healthcare.

The design of NPFS (and supporting local GP consortia arrangements) will continuously include due consideration of accessibility to groups with wider communication difficulties.

Ethnicity: The NPFS will not impact differently on members of black and minority ethnic (BME) groups compared to the general population. Research suggests that the levels of fixed telephone and internet usage are similar across these groups and use of mobile telephony is slightly higher amongst BME groups.

However, there may be a differential impact of NPFS on non-English speakers that will be negative. For that reason, the NPFS translation service has been and will be available on the web-based access channel in the following languages: Welsh, Polish, Turkish, Russian and Portuguese[3].

The National Audit Office (NAO) review of NHS Direct highlighted that people whose first language is not English are disadvantaged in discussing medical

[3] These languages were identified as the most common languages in which information was requested from NHS Direct. However, language selection was also driven by technical limitations of presenting information in certain forms of script.

problems. The telephone option for NPFS may present communication difficulties for users whose first language is not English. Thus, for groups who find spoken English more difficult, the web based NPFS will provide a more accessible service.

For groups who have limited, or no written and spoken English language skills (and do not understand any of the languages for which a translated service will be provided) access to NPFS will be restrictive. However, alternative arrangements have been planned to mitigate this. Local GP consortia will be required to ensure that non-English speakers have accesses to antiviral medicines if required. This may be by engaging with local community groups to ensure that sufficient support is available to use the NPFS service, or enabling these groups to use their normal routes to medical care for assessment and authorisation of antiviral. Additionally, Flu Friends can assist non-English speakers by accessing the service on their behalf. These measures will ensure that non-English speakers will have sufficient access to assessment and authorisation in the event of a pandemic.

Lessons learned from 2009 H1N1 pandemic: BME users/patients were slightly less likely to recommend the NPFS service (85% would recommend) than white users (88% would recommend). BME groups were more likely to *disagree* that the information given was easy to understand (16% BME dissatisfied compared to 3% white) and that they found it easy to answer the questions asked (7% BME dissatisfied compared to 3% white). For the telephony service, those in BME groups (34%) were also more likely to say they could not understand the individual call handler (overall 12%) and to say that they felt rushed (50% compared to 12% overall).

Socio-economic groups: The NPFS will not have a negative impact on the basis of socio-economic group. The use of a free to call telephone number will ensure that members of the public are not deterred from using the NPFS service because of financial reasons.

Gender reassignment (including transgendered people): The NPFS will not impact differently on these groups.

Religion or belief: The NPFS will not impact differently on the basis of religion or belief.

Marriage and civil partnership: The NPFS will not impact differently on the basis of marital/civil partnership status.

Carers: The NPFS will not impact differently on carers.

Pregnancy and maternity: The NPFS will not impact differently on the basis of pregnancy or maternity.

Gender: The NPFS will not impact differently on the basis of gender.

Lessons learned from 2009 H1N1 pandemic: Slightly more female patients were both assessed for (55%) and authorised (54%) antiviral medicines.

Epidemiological studies during the pandemic showed no statistical difference in infection rates between genders.

Sexual orientation: The NPFS will not impact differently on the basis of sexual orientation.

4.2.3 The use of antiviral medicines for prophylaxis

Antiviral medicines can also be used for the prophylaxis (or prevention) of pandemic influenza, as a way of limiting the spread of the disease from person to person. Targeted prophylaxis on clinical grounds (i.e. for those in at risk groups) can be an effective way of protecting at risk individuals in a household where there is illness. This type of prophylaxis, used successfully in the H1N1 2009 pandemic and is likely to be used in future pandemics.

Lessons learned from 2009 H1N1 pandemic: Modelling data from cases identified during the containment phase suggest that treatment of cases in association with prophylaxis of their close contacts reduced the reproduction number by an estimated 16% in those who received the intervention.

As antiviral medicines for prophylaxis would be issued to groups assessed as being particularly at risk, this policy could impact differently on different groups; in particular on the grounds of age (children and older people), disability (people with underlying health conditions) and gender (pregnant women). However, this would be on the basis of clinical need and there is no evidence from the 2009 H1N1 pandemic to suggest that at risk individuals were not offered appropriate antiviral medicines.

4.2.4 Immunisation

There are two key types of pandemic vaccine, which are:

Pandemic specific vaccines: These are developed specifically to protect against the pandemic strain, once this is isolated. The process of developing and manufacturing the vaccine takes four to six months.

Pre-pandemic vaccines: These have been stockpiled as a contingency measure for the Influenza A H5N1 strain. The vaccine does not necessarily provide specific protection for the pandemic strain but could provide limited but useful protection.

The Committee on Ethical Aspects of Pandemic Influenza (CEAPI) considered the use and prioritisation of vaccine in 2006. They concluded that the most appropriate course of action would depend on the particular circumstances, including what could be achieved with the amount of vaccine available at the time. This is in line with the view of the Joint Committee on Vaccination and Immunisation.

Given this advice, the presumption should be that prioritisation of vaccine will depend on the emerging profile of at-risk groups for the virus, with priority given to clinical risk groups and health and front-line social care workers. There are no plans to prioritise vaccine for any other specific groups or sectors for business continuity reasons. Throughout the pandemic, the case for vaccinating other groups will remain under review taking vaccine availability and the specific characteristics of the virus into account.

As vaccination would be targeted at groups assessed as being particularly at risk, this policy could impact differently on different groups; in particular on the

grounds of age (children and older people), disability (people with underlying health conditions), and pregnancy. In addition, carers are a priority case for vaccination in the strategy. Those in at risk groups will be known to local healthcare professionals who will ensure that appropriate treatment is received. The NPFS online and telephony assessment systems are also designed to identify anyone in an at risk group and refer them to their GP for treatment.

4.2.5 Antibiotics

The main role of antibiotics is to reduce the severe illness and deaths which could arise from secondary infection[4]. To ensure antibiotics are available in a pandemic the Government will maintain a stockpile of antibiotics which it would make available if there was clear evidence of shortages in the supply chain in primary or secondary care.

Antibiotics would be prescribed on the basis of clinical need and this policy would not impact differently on different groups.

4.3 Impact of wider strategic pandemic planning

4.3.1 NHS and Social Care

NHS and social care services will play a leading role in reducing overall morbidity and mortality in a pandemic are likely to come under intense pressure, even in a relatively mild pandemic.

Whilst the key elements and measures to be taken will be determined at national level, the practical arrangements for the implementation of the initial response requirements will be for local decision based on the pressures being faced at the time.

Health and social care organisations will need co-ordinated plans to manage the consequences of increased demand and to allow the response to be delivered effectively across agencies. This includes mobilising the available capacity and skills of all health and social care staff (including, where appropriate and possible, recently retired staff) and ensuring that all partners understand what health and social care will and will not be delivered and by whom.

NHS

After the initial phase of a pandemic, the implementation of a mass assessment and authorisation service in the form of the NPFS (4.2.2) should relieve pressures on frontline NHS services. However, the NHS may face particular challenges in both delivery of pandemic services and maintenance of normal healthcare services that include:

- establishing and operating antiviral collection points to dispense antiviral medicines to symptomatic individuals assessed and authorised via the NPFS;
- assessing and treating symptomatic individuals referred to primary care by the NPFS because of underlying health conditions;

[4] Secondary infections are non-pandemic flu infections which may have increased severity in patients weakened by pandemic flu infection.

- assessing and treating symptomatic individuals who elect to attend primary care rather than use the NPFS;
- meeting additional burdens on services due to extra pressures on acute hospital beds;
- providing local communication on pandemic flu symptoms and services; and
- maintaining "business as usual" healthcare care services in the face of pandemic pressures and potential staff shortages from infection.

These challenges mean that those groups particularly reliant on healthcare services may be impacted by policy measures taken to mediate a pandemic. The policy could therefore potentially impact differently on the basis of age and disability but local NHS services should use their knowledge of local needs to plan to mitigate any impact by ensuring that essential services are protected. Guidance to support the strategy, together with existing guidance will support primary care providers in this task, encouraging a multi-agency, integrated approach to maintaining services.

The Department of Health published *A Framework for Local Action* in October 2008. Its purpose to assist NHS organisations to develop and use human rights based approaches to support their core business of planning and delivering high quality and accessible health services for all. As such, it is a starting point for NHS organisations seeking to:

- put NHS values such as dignity, respect and equality into practice;
- shape services and procedures that put the human at the heart of healthcare;
- effectively support their staff and commissioned providers to fulfil their specific duties under the Human Rights Act 1998, as well as progressing the Care Quality Commission standards on human rights and patient treatment; and
- support and add value to their work on related duties and priorities such as:
    - commissioning a Patient-Led NHS;
    - ensuring equality;
    - dignity in care;
    - delivering patient choice;
    - providing more personalised services and ensuring that people have a stronger voice; and
    - safeguarding the most vulnerable people.

In addition, from April 2011, policy decisions taken by local authorities fall under the Equality Act 2010 which imposes an equality duty on public sector bodies to take account of gender, race, disability, age, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity and marriage and civil partnership, in making policy decisions and delivering services.

Social care

The majority of influenza patients will be treated using an approach based on care in the home. There may therefore be particular challenges in maintaining social care services during a pandemic that include:

- maintaining communication on essential messages to a range of social care services across all sectors;

- reliving pressures on time to support care home residents and people cared for in their own homes when they have influenza;
- sustaining people with complex needs who are currently supported with intensive care packages in the community;
- providing emergency care for vulnerable people looked after at home by informal carers if their carer is ill;
- maintaining "business as usual" care services to vulnerable individuals in the face of pandemic pressures and potential staff shortages from infection, and
- sustaining indirect care services for example meals on wheels, community equipment and community alarm services.

These challenges mean that those groups particularly reliant on social care services may be impacted by policy measures taken to mediate a pandemic. The policy could therefore impact differently on the basis of age, disability and socio economic group (which, in some areas, could include BME groups) but local authorities should use their knowledge of local needs to plan to mitigate any impact by ensuring that essential services are protected. Guidance to support the strategy, together with existing guidance will support local authorities in this task, encouraging a multi-agency, integrated approach to maintaining services.

However, from April 2011, policy decisions taken by local authorities fall under the Equality Act 2010 which imposes an equality duty on public sector bodies to take into account of gender, race, disability, age, religion and belief, sexual orientation, gender reassignment, pregnancy and maternity and marriage and civil partnership when making policy decisions and delivering services.

4.3.2 Mobilisation

A Mobilisation Guide has been designed within the context of wider pan-government planning, including the Strategy, to enable the Department of Health to prepare for, mobilise and sustain the health response in the event of a major health incident such as an influenza pandemic. It provides an overview of the key decisions and processes that central health and social care management will need to undertake in setting up and managing a pandemic response. Lessons learned from swine flu have been incorporated into both the design of this guide and formulation of the mobilisation processes. The guide:

- sets out mobilisation arrangements in the context of a central departmental health planning and response;
- outlines an 'end-to-end' mobilisation process, dividing the response into five distinct phases to reflect when specific guidance and actions are appropriate for particular segments in the disease cycle;
- is aimed at guiding and supporting integrated contingency planning and preparations for pandemic influenza in health and social care organizations, and more widely across government, public and private sector organizations; and
- provides an overview of public health and social care management, highlighting roles and responsibilities.

The Mobilisation Guide will not impact differently on the grounds of age, disability, ethnicity, gender, sexual orientation or socio-economic group. However, it provides a framework for the mobilisation of the various pandemic response systems (such as the NPFS) which may, individually impact differently on certain groups.

4.3.3 Antiviral Distribution

The purpose of the antiviral distribution policy within the strategy is to contribute to the achievement of an effective UK response to an influenza pandemic by:

- designing and maintaining the NPFS to provide mass assessment and authorisation of antiviral medicines in England during a pandemic;
- designing and maintaining a robust system to distribute antiviral medicines locally; and
- designing and maintaining a robust system to effectively manage, store and transport antiviral stock during a pandemic.

The antiviral distribution policy supports the NPFS assessment and authorisation service to ensure that access to antiviral medicines is provided to affected persons in the event of a pandemic within 7 days or less of the onset of symptoms.

Antiviral distribution policy within the strategy will not directly impact differently on the grounds of age, disability, ethnicity, gender, pregnancy and maternity, religion or belief, sexual orientation or socio-economic group as scientific evidence is based purely on research published in the scientific and medical literature. However, it supports the frontline NPFS service which itself may impact differently on certain groups (see 4.2.1).

4.3.4 Clinical Countermeasures

Clinical countermeasures policy within the strategy supports the treatment policies through the sourcing and purchasing of stocks of vaccines, antiviral medicines and equipment used in treatment and infection control. The type and quantity of stocks ordered and held is based on the latest scientific evidence. As such, clinical countermeasures policy does not impact differently on different groups.

4.3.5 Infection control

Infection control, including respiratory and hand hygiene, is an important tool in tackling the spread of the influenza virus during a pandemic. Existing guidance on infection control for healthcare workers includes sections on patient management, infection control precautions, use of personal protective equipment (PPE) and environmental infection control as well as occupational health. PPE should be worn to protect staff from contamination with body fluids and thus reduce the risk of transmission of pandemic influenza between patients and staff and from one patient to another.

The Department of Health's policy on healthcare workers who are at high risk for complications of pandemic influenza (e.g. pregnant women, immunocompromised workers) is that they should be considered for an alternative work assignment, away from direct patient care for the duration of the pandemic or until vaccinated.

Infection control measures, as taken by healthcare professionals, are applied as appropriate to the situation. As such, infection control policy would not generally impact differently on different groups. There is a minor gender issue in that certain types of respirator cannot be used safely by men with facial hair (this could also affect certain BME and faith groups) but alternative respirators

are available and guidance states that employers should provide these where necessary.

Further information for healthcare professionals is contained in *Pandemic Flu-Infection control guidelines for use in hospitals and primary care settings*, which is available on the Department of health website at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080771.

Advice to the public on infection control will be issued along with other pandemic information using the communications policies outlined at 4.1.1. These include providing communications in alternative formats and languages for those who need them.

4.3.6 Science

The aim of the science strand within the strategy is to ensure that pandemic preparedness and response activities are informed by the best available clinical and scientific advice. This includes providing assurance that the Government's assessment of scientific evidence is comprehensive, accurate and impartial through the use of independent scientific advisory committees. In addition, ensuring that a research agenda is in place, that results are used to inform policy, and that a programme of research is in place for future pandemics. The main objectives are to:

- provide the secretariat to Scientific Pandemic Influenza Advisory Committee (SPI) and Pandemic Influenza Clinical Advisory Committee (PICO) and their sub-groups;
- remain abreast of the global and UK literature on science and clinical aspects of pandemic flu and provide briefing on developments as appropriate;
- liaise effectively with other parts of the programme and other Scientific Advisory Committees (SACs) to ensure that activities, including planning for future pandemics, are appropriately informed by scientific evidence;
- act as a liaison point with the medical Royal Colleges and the HPA for the collation and dissemination of advice and information; to maintain good relations with them and with professional colleagues to ensure the timely and appropriate identification and sharing of relevant information as well as consideration by PICO;
- reassess the research agenda for pandemic influenza ensuring that research is commissioned to address priority gaps, results are used to inform policy, and that a programme of research is in place for future pandemics; and
- maintain collaborative working with appropriate funding bodies.

Science policy within the strategy follows the Code of Practice for Scientific Advisory Committees issued by the Government Office for Science which states that *The basic principles which government departments should follow in assembling and using scientific advice…are that departments should:*

- *think ahead and identify early the issues on which they need scientific advice and early public engagement, and where the current evidence base is weak and should be strengthened;*
- *get a wide range of advice from the best sources, particularly when there is uncertainty; and*

- *publish the evidence and analysis and all relevant.*

Science policy within the strategy will not directly impact differently on the grounds of age, disability, ethnicity, gender, marriage and civil partnership, pregnancy and maternity, religion or belief, sexual orientation, socio-economic group as scientific evidence is based purely on research published in the scientific and medical literature. However, since data is collected across all groups, certain aspects of this evidence base may highlight differences between different groups and this could inform future policy decisions to target services accordingly.

Lessons learned from 2009 H1N1 pandemic: The 2009 Influenza Pandemic: An independent review of the UK response to the 2009 influenza pandemic - Dame Deirdre Hine, stated that: "Scientific advice received by officials and ministers was exceptionally important in this response. There were high levels of uncertainty regarding the nature of the virus, which meant that ministers were heavily reliant on scientific advice for an understanding of the potential threat of the pandemic."

4.3.7 Surveillance

Surveillance is essential to ensure that accurate, timely, and reliable information is provided to all partners involved in a response to a pandemic. It is also of significant benefit in informing the press and public during a pandemic. The aim of the surveillance policy within the strategy is to ensure that the necessary information will be available in a timely manner to:

- allow early detection of pandemic influenza in the UK;
- determine the characteristics of the pandemic strain so as to inform national and local level decisions about the management of clinical and public health measures necessary to mitigate and manage the effects of the pandemic;
- provide accurate and timely assessment of the spread and clinical impact of the virus to inform the national co-ordination of the overall UK response to the pandemic;
- identify service pressures within the NHS and social care arising from the pandemic;
- provide accurate and timely information to the public, interested professionals, and the media about the progress and health impact of the pandemic;
- enable clinical audit and research programmes to be undertaken to increase understanding of the nature of the pandemic and to inform plans for future ones by supplying data on the virus, including whether it any particular groups are affected; and
- communicate relevant information needed in other countries and at a European and global level (ECDC and WHO).

Where possible pandemic influenza surveillance will be built on existing central data collection mechanisms, which include all protected groups, that are already in place to monitor the onset, magnitude and duration of seasonal influenza activity.

Routine virological, clinical, and epidemiological data on seasonal influenza are currently collated by the HPA, on a UK basis and published weekly during the normal influenza season.

In addition, the NHS has a well-established system in place for monitoring pressures on the health service, particularly in winter and when influenza is circulating. This data is collated centrally by the Department of Health.

Surveillance policy within the strategy will not impact differently on the grounds of age, disability, ethnicity, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, sexual orientation or socio-economic group. Data is collected on patients who fall ill and seek healthcare and therefore do not distriminate against any subset of the population. The only groups that would be seperately identified are those which might react differently to a particular flu strain because of genetic reasons (race, gender) acquired/lack of aquired immunity (age) or highteded risk (pregnant women and people with certain underlying health conditions). If any of these subsets of the population are more affected by pandemic influenza than other subsets, this will be reflected in an imbalance of data collected across the population.

Lessons learned from 2009 H1N1 pandemic: The Pandemic influenza preparedness programme: Statistical Legacy Group - a report for the Chief Medical Officer, stated that "surveillance of the pandemic in the UK had been among the most comprehensive in the world. For example, the UK appears to be the only country that implemented WHO's recommendation to include the first few hundred cases in a formal epidemiological study."

"all data streams actually collected during the H1N1 (2009) pandemic were useful to the response."

4.3.8 Utilities, services and infrastructure

A severe pandemic could impact on the UK's utilities, services and infrastructure if large-scale infection results in a high number of people being unable to attend work.

Failures in certain services could impact disproportionately heavily on certain groups. For example, older people may be particularly vulnerable to disruption in energy supply while those in certain social-economic groups, may be particularly reliant on public transport and services provided by agencies of the Department for Work and Pensions.

The strategy outlines the cross-Government and industry measures in place to mitigate such impact. All key Government and private sector service provides have emergency plans to maintain services as much as possible in the event of staff shortages, focussing on agreed regulatory priorities where appropriate.

4.3.9 Public gatherings, travel and schools

There is limited evidence that restrictions on mass gatherings or travel will have any significant effect on influenza virus transmission. In addition, the cancellation or postponement of events and travel could have major social and economic consequences. For these reasons the working presumption will be that Government will not impose any such restrictions.

There is some scientific evidence of the potential benefit of school closures in certain circumstances, both in terms of protecting individual children from infection and in reducing overall transmission of illness. However, the conclusions are complex, stressing the need for strict separation of children outside school. The economic and social consequences of prolonged school closures would also be considerable. Proactive closure of schools and similar settings (ie widespread closure as a preventative measure) will therefore only be recommended if the disease is particularly severe, and as one of a range of social distancing measures.

School closures would impact differently on parents and, potentially, on grounds of gender if the burden of caring for the children outside of school falls primarily on women.

5. Engagement and Involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation? **Yes**
How have you engaged stakeholders in gathering evidence or testing the evidence available? Stakeholders have been engaged in the provision of evidence - scientific data, research, up-to-date policy lines (where the document covers areas within another Department's remit) and analysis of the response to the 2009 H1N1 pandemic (both domestically and worldwide) - that were used to inform the proposals.
How have you engaged stakeholders in testing the policy or programme proposals? Stakeholders have been engaged at each drafting stage, providing feedback and comment on the policy. Stakeholders will be further engaged during the formal consultation process.
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs: **The Scientific Pandemic Influenza (SPI) Committee** – gathered and assessed the latest data **Government Office for Science** – gathered and assessed the latest data **The Pandemic Influenza Operational Group (PICO)** – discussed the issues and agreed the overall policy direction **NHS** – reviewed draft and revisions **The Royal Colleges** – reviewed draft and revisions **Devolved Administrations** – reviewed draft and revisions **Cabinet Office** – reviewed draft and revisions **DEFRA** – provided policy lines, reviewed draft and revisions **BiS** – provided policy lines, reviewed draft and revisions **DfE** – provided policy lines, reviewed draft and revisions **DfT** – provided policy lines, reviewed draft and revisions **MoJ** – provided policy lines, reviewed draft and revisions **DWP** – provided policy lines, reviewed draft and revisions **MHRA** – provided scientific evidence, provided policy lines, reviewed draft and revisions **HPA** – provided scientific evidence, lessons learned from 2009 H1N1 pandemic, reviewed draft and revisions **DH policy leads** – reviewed draft and revisions

6. Summary

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

The UK Pandemic Preparedness Strategy 2010 should not impact differently on protected groups in any significant way. The strategy's primary focus is on identifying **all** symptomatic individuals and providing a route to treatment that eases pressure on primary care and other services. Steps have been taken to mitigate potential differential impact by ensuring that communications will be available in a range of languages and formats and that access to treatment is available via more than one route and is available in different languages (online).

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The UK Pandemic Preparedness Strategy 2010 is designed to provide information, assessment and treatment in the event of a pandemic flu outbreak with a view to relieving pressures on primary care services and mitigating the impact of a pandemic on the UK as a whole. As such, it does not have a role in eliminating discrimination, harassment and victimisation.

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The UK Pandemic Preparedness Strategy 2010 is designed to provide information, assessment and treatment in the event of a pandemic flu outbreak with a view to relieving pressures on primary care services and mitigating the impact of a pandemic on the UK as a whole. As such, it does not have a role in advancing equality of opportunity.

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

The UK Pandemic Preparedness Strategy 2010 is designed to provide information, assessment and treatment in the event of a pandemic flu outbreak with a view to relieving pressures on primary care services and mitigating the impact of a pandemic on the UK as a whole. As such, it does not have a role in promoting good relations between groups.

7. Research and Sources

Ethnic Dimension "BME Communities and Swine Flu" Qualitative Research, January 2010

"RHH and Swine Flu Vaccination Campaign" Evaluation Qualitative Tracking Research, October 2009 to February 2010

Ethnic minority groups and communications services - Ofcom

NHS Direct in England - National Audit Office

Blind and partially sighted pensioners at risk March'04 - Royal National Institute for the Blind

www.rnid.org.uk - Royal National Institute for the Deaf

The Consumer Experience – Ofcom

Telephones – what features do disabled people need? - John Gill and Tony Shipley;

The Web: Access and Inclusion for Disabled People - Disability Rights Commission

A qualitative study of older people's views of out-of-hours services - Judy Foster, Jeremy Dale and Lynda Jessopp

Internet Access 2007: Households and Individuals - Office of National Statistics

National Pandemic Flu Service Evaluation 2010 – IFF Research

The 2009 Influenza Pandemic: An independent review of the UK response to the 2009 influenza pandemic - Dame Deirdre Hine

National Pandemic Flu Service Data Summary Report – Department of Health

2001 Census – Office for National Statistics

HPA Weekly National Influenza Reports - Summary of UK surveillance of influenza and other seasonal respiratory illnesses

Pandemic influenza preparedness programme: Statistical Legacy Group - a report for the Chief Medical Officer

Epidemiological report of pandemic (H1N1) 2009 in the UK; April 2009 – May 2010 - HPA