Is the United Kingdom Prepared For The Next Pandemic Flu Threat?

by Dr Miriam Armstrong of CICM
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Introduction

On April 1st 2013 new arrangements for the planning and delivery of English health policy and service provision came into force. The new arrangements apply across the breadth of the entire healthcare system, from the Department of Health and new Government Advisory Bodies, such as Public Health England, down to the frontline via hospitals, local authorities and Clinical Commissioning Groups.

To say there is plenty of trepidation about whether the new arrangements are fit for purpose and can deliver the Coalition Government’s aspirations for the NHS is a minor understatement! The seismic nature of the changes could easily be underestimated by those less familiar with the politics and workings of our much loved national institution, but is obviously not lost on those who have spent their working lives in service of its aims.¹

Not an April Fool’s ploy, as of that date some 160 NHS organisations, including all Primary Care Trusts and Strategic HealthAuthorities (previously at the hub of service commissioning and delivery) were abolished and over 200 Clinical Commissioning Groups took over. Sadly, their closure was accompanied by the departure of many very senior personnel which begs the question of what will be lost from the health service during the transition period, and perhaps not replaced?²

On top of the reforms, the NHS is also struggling to find a meaningful response to the bitter pill of criticism it was forced to swallow as a result of the degrading conditions and treatment of patients at the Mid-Staffordshire NHS Foundation Trust. Horrific failures in basic care laid bare by the Francis Inquiry³ were attributed to ‘system failures’ that prioritised business principles and goals above the quality of patient care, in particular the hospital’s obsession with becoming an NHS Foundation Trust.

One might have thought that the truly shocking findings of Francis would have prompted a rethink about whether the NHS was ready for major structural reform at a time when patient care was clearly being compromised, but no let up was forthcoming, other than organisations being encouraged to conduct a ‘listening exercise’ with staff whilst the Department of Health (DH) formulated its longer-term response.

It is against this backdrop that the potential for the new healthcare system to react to the threat of a new pandemic must be assessed.

New arrangements for pandemic emergency response

From April 1st, the Department of Health will continue as the lead for healthcare emergencies, in conjunction with the Cabinet Office, and is tasked with the following:⁴

- ensuring plans are in place to deal with the threats listed on the National Risk Register and that the entire health system is ready to deal with emergencies;
- supporting Ministers, the Cabinet Office, and other Government departments during emergencies;
- working with the Devolved Administrations (DAs) and international organisations (especially the World Health Organisation, WHO) to ensure that an effective and co-ordinated response occurs during a crisis.

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¹ http://www.guardian.co.uk/society/2013/apr/01/nhs-risk-reforms-healthcare-chief
² http://www.nuffieldtrust.org.uk/blog/preparing-new-nhs-lessons-departing-leaders
³ http://www.midstaffspublicinquiry.com/
⁴ http://www.gov.uk/government/policies/planning-for-health-emergencies
In addition NHS England (previously known as the NHS Commissioning Board) newly created on the 1st April to take over certain functions of the DH, will also assume specific emergency duties, including responsibility for health emergencies and to co-ordinate the NHS response alongside Local Authorities, who acquired public health functions from the 1st April and are required to work with health organisations, police and other emergency services to deliver the local response.

Pandemic flu has been identified as an ongoing threat to the UK and since the experience of the 2009 swine flu (H1N1 virus) epidemic, a substantial investment of taxpayers money has been made to evaluate the UK response and translate that experience into practice. The question is whether the structures and personnel taking up that role within the new arrangements can maintain that learning / preparedness?

The current UK approach to minimise the threat of an influenza pandemic

The Department of Health (DH), England, together with the Health Departments of the Devolved Administrations of Scotland, Wales and Northern Ireland, published a communications strategy to accompany the UK Influenza Pandemic Preparedness Strategy 2011 and subsequent guidance for the health and social care community.

The strategy addresses health-related communication across the usual three stages of a crisis response: preparatory; acute phase of the pandemic; recovery. It was written with the benefit of an evaluation of the national response to the 2009 swine flu (H1N1 virus) pandemic and evidence reviews of the effectiveness of population communication during a pandemic.

The principal lesson learned from the evaluation was the need to plan flexibly and proportionately for a range of possible scenarios (particularly dependent on the virulence of the infection and its distribution) recognising that outbreaks will occur in different locations at different times and with differing intensities. It is especially important to be able to take rapid stock of the situation, as some characteristics of the virus will only become known once a pandemic is fully underway.

Audiences for the pandemic communications strategy

Overarching engagement strategy:

The communications strategy had been written to accompany the main UK Influenza Pandemic Preparedness Strategy and is intended to cover the majority of the UK population, with special arrangements for certain sub-groups. Therefore communications focus on the mainstream channels, with targeted elements for specific audiences. In line with current policy on paid-for communications, the emphasis is on first maximising the use of Government-owned channels and partnership channels, before supplementing communications with paid-for routes where appropriate.

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Central co-ordination of all activities, and national direction of public information, comes from the Department of Health (DH), who informs the Cabinet Office and the Departments of Health in the Devolved Administrations (DAs) if either an outbreak involving a new influenza virus occurs, or when the World Health Organisation (WHO) declares a pandemic.

The Cabinet Office is responsible for alerting other government departments and for working with the DH to develop, update and circulate top-line briefings via the DH Media Centre. If a prolonged or severe event looks likely, then the Cabinet Office might activate the Government News Co-ordination Centre (NCC).

The Government News Co-ordination Centre is part of the Cabinet Office Briefing Room (COBR) emergency management model and is designed to manage the communications aspects of a crisis, emergency or other major disruption. In a period of increased alert, such as during a pandemic, the NCC will become operational to support the DH and will work to COBR policy direction. The DAs have their own emergency management response arrangements.

Preparing for, responding to and recovering from an influenza pandemic also depends significantly on the co-operation and co-ordination of efforts between central government and DAs, public authorities (central and local), businesses, non-governmental organisations, the voluntary sector and the public.

**Communications via Health & Social Care Organisations**

The DH will alert health and social care organisations through existing networks in place at the time of the pandemic. From April 2013, the information cascade will be via NHS England to Clinical Commissioning Groups (CCGs). Similar arrangements will operate throughout the UK. National messages will be consistent throughout, but may be tailored to more specifically reflect the experience of certain areas through regional and local networks.

Advice to the UK Government will be available from all CMOs and their departments, public health organisations, professional bodies, expert groups and individuals. In addition, there is a specific requirement under the Code of Practice for Official Statistics, to publish weekly epidemiological reports on an appropriately accessible website, such as that of Public Health England (PHE) and the equivalent organisations of the DAs.

**Communications for health and other professionals**

Health and social care professionals need access to timely and accurate clinical information and advice to enable them to take effective action and treat patients appropriately. The UK Government is working with professional bodies, such as the Medical Royal Colleges, to give and receive advice during a pandemic. Health professional websites will also be an important source of information. The DH will agree approved content and the right process for syndication of information to multiple sites to ensure all information is fully updated during a pandemic. This is likely to occur via a daily conference with web leads of all the main sites.

**Communications to the public**

The UK Government and DAs will use a wide range of media to communicate effectively to the public during the time of a pandemic. The Department of Health will be the primary source of health-related messages, working closely with the Cabinet Office and DAs.
Public communications aim to convey messages, engage in discussion and to identify areas of concern. Chief Medical Officers, and other trusted personnel who are effective media spokespeople, will be relied upon to issue regular press briefings. Other information channels, such as key websites (for example, PHE, NHS Choices, the appropriate Medical Royal Colleges) and social media channels (via a social media strategy) will be used in order to reach as broad an audience as possible.

Direct communications will be made available in a variety of forms, such as Braille, audio and Easy Read versions, to those with disabilities and will be translated into other languages.

National advertising campaigns will also consider how to target all sectors of the population using specific channels and tailored to local experience where possible.

National telephone help-lines may also be deployed, such as the National Pandemic Flu Service (previously operated by NHS Direct) a system of call centres that provide an authorisation number for people to pick up antivirals on behalf of patients.

**Communications objectives and principles during a pandemic**

These are the essential aims of the pandemic communications strategy to the public:

1. To explain and provide information on the outbreak;
2. To establish and maintain public confidence in official communications;
3. To impart information to minimise the risk of infection and associated harm.
4. Be proportionate to the threat and relatively easy to implement.

1. **To explain and provide information on the outbreak**

   • Government and NHS organisations are responsible for providing accurate and timely information throughout the course of a pandemic. In particular, that health and social care staff should have the right information available to perform their role and respond to enquiries from the public.
   • Explain the difference between seasonal flu and pandemic flu. Also that the pandemic virus is likely to continue to exist and circulate as seasonal flu once the outbreak is over.

2. **To establish and maintain public confidence in official communications.**

   • Communications should first and foremost reassure the public.
   • Communications should establish and maintain public confidence in the ability of the Government and healthcare system to prepare for, and manage, an outbreak so that society can continue with normal business as far as possible.

3. **To impart information to minimise the risk of infection and associated harm.**

   • Communications will advise the public how to protect themselves and others during the outbreak.
   • Communications will encourage the public to adopt the following behaviours:
     - Adopt good hygiene practices;
     - Recognise the symptoms of pandemic flu;
     - Understand what they need to do if infection occurs;
     - Understand the role of vaccines and antiviral medicines.
Any public information campaigns about seasonal influenza should be, as far as possible, compatible with the core objectives and messages of pandemic flu, such as the importance of good respiratory and hand hygiene and vaccination uptake.

4. Be proportionate to the threat and relatively easy to implement.

Communications should be measured to:

- manage public expectations;
- engage the media to give timely and accurate information;
- ensure technical explanations or expertise is available to support responsible, informed reporting;
- provide open access to a variety of direct information sources, such as telephone help-lines and websites;
- conduct research and pre-testing to identify communication priorities, and to ensure that messages are clear and effective;
- deliver public information campaigns directly and/or through other media channels; provide specialist advice for particular settings and sectors;
- encourage ongoing debate about the ethical, professional and practical implications of an influenza pandemic.

During a pandemic, the Government will track public awareness, attitudes and behaviour through social media monitoring, market research and other research (such as Tracking Surveys) to find out how effective messages are, the extent of their population reach and to measure public engagement.

Preparation and planning (inter-pandemic phase)

The purpose of the planning phase is to make sure response arrangements are in place and are both proportionate and properly tested. In particular:

- Communication planning arrangements are kept under review to ensure they remain fit for purpose, for example, in the case of NHS restructuring.
- The emergency communications team (specified in Annex D of the Communications Strategy) can be stood up at activation.
- NHS, public health and social care staff, marketing partnerships and the media will be briefed on the severity of the flu virus and the measures the public will need to take in preparation for a pandemic.
- Protocols are up-to-date regarding communications with the Cabinet Office.
- The most up-to-date evidence has been reviewed with the Scientific Pandemic Influenza Advisory Committee sub-group on Behaviour & Communication.
- A media engagement strategy is in place (including social media).
- A cross-government digital plan is in place.
- Any specific arrangements for particular groups have been reviewed and agreed.
- Contact lists for stakeholders, especially NHS communications people, are kept up to date.
- Where practicable, the channels to deliver key communications have been tested.

Any public information campaigns about seasonal influenza in the interim period should be, as far as possible, compatible with the core objectives and messages of pandemic flu (such as the importance of good respiratory and hand hygiene and vaccination uptake) and allow testing of proposed pandemic communication channels.
Suggested public messages:

• A flu pandemic can strike at any time. You need to be prepared to look after yourself and members of your family.
• The following are likely to be at higher-risk: e.g. very young, very old, immuno-compromised, healthcare workers.
• If you are in a high-risk group it is important to protect yourself against all influenza by getting vaccinated when it is offered / available.

Impact level and phases (pandemic begins)

Lessons learned from the evaluation of the 2009 H1N1 influenza pandemic include devising plans that will support a proportionate response to a variety of pandemic scenarios (such as a relatively mild outbreak) rather than just focusing on the ‘worst case scenario’. A new UK approach to taking action in response to the indicators of a pandemic was outlined in the UK Influenza Pandemic Preparedness Strategy 2011. The response is divided into separate phases, which are unnumbered as they may not occur linearly - indeed it is possible to move back and forth between phases or jump phases. In a severe scenario it may be necessary to activate all phases concurrently.

The phases are:

• Detection
• Assessment
• Treatment
• Escalation
• Recovery

Monitoring is essential to inform the right response as the pandemic develops and shifting trends, such as increase use in social media by the population (reflecting information needs) will help determine the appropriate response.

Public messages will begin with the Core Messages (the importance of good respiratory and hand hygiene to help limit the outbreak) with additional messages being adopted depending on the Phase and/or Severity of the outbreak.

Detection and Assessment

The Detection phase commences either when a public health emergency is declared by the WHO or on the basis of other reliable intelligence on an influenza outbreak. The Assessment phase commences when the identification of the specific viral strain becomes known.

Whilst health professionals focus on identifying possible cases, isolating and treating them together with their close contacts, communications professionals should assist with managing pressure on primary cares services by advising the public on self-care options and giving clear guidance on when to seek medical help.

The DH and DAs have responsibility for maintaining a rapid response communications team to be activated on declaration of a pandemic emergency. A virtual Emergency Preparedness team was established in the UK in advance of the 2012 London Olympics and remains on standby. The team has a designated two hour turnaround period in which to write and post message content onto principal websites, for example, NHS Choices, the DH and emergency staff bulletin sites.
The main aim of communications during this period is to promote and reinforce those individual and collective actions that will help reduce the rate of spread of the virus.

**Suggested public messages:**

- Follow public health advice from the Government and health professionals;
- Consider how you and your family might prepare for disruption to school or childcare facilities due to staff shortages;
- Lower the spread of infection by practising good hand hygiene – use a tissue if you cough or sneeze, wash your hands regularly with soap and water or use a sanitising gel;
- Know your local healthcare services – such as where to find a GP or pharmacy and NHS telephone help-line numbers or websites;
- Support friends and family who are ill – they may need you to pick up medicines or food for them;
- If you develop flu, then stay at home, keep warm and drink plenty of fluids;
- If you have a long-term medical condition, or think you are more susceptible to flu, then contact your GP or tell another health professional.

The two stages Detection and Assessment form the initial response. This phase might be relatively short, depending on how fast the virus spreads or how severely communities are affected. It is not possible to halt the spread of a pandemic flu – merely to try to limit its impact. The trigger for the Treatment phase to be activated is sustained community transmission of the virus, i.e. transmission beyond those in close contact with previously identified cases.

**Treatment and Escalation**

These two phases focus on large-scale treatment arrangements, depending on the severity of the virus and how far and fast it spreads.

Escalation of the response begins when demand for services begins to exceed available capacity (not normally required for mild pandemics). The decision to escalate will be determined by local information and rely on continued detailed surveillance activity.

The Treatment phase involves the NHS moving into full response mode. It lasted for eight months during the 2009 H1N1 pandemic:

- Treatment of individual cases and population treatment via the National Pandemic Flu Service if necessary;
- Enhance the health services response to deal with increasing numbers of cases;
- Consider adopting certain public health measures to disrupt spread of the virus, for example closing local schools;
- Prioritise vaccinations;

The Escalation phase will also include:

- further prioritisation of treatment, such as reducing non-urgent services and introducing triage to maintain essential services;
- other community resilience measures, for example advice to specific occupations, such as the police, undertakers, paramedics, funeral directors, registrars, cemetery and crematorium managers.
As the pandemic escalates, it will be important to maintain confidence in the Government’s response by helping people understand how to access medical treatment quickly if they need it. The national news and DH corporate channels will be utilised to explain the progression of the outbreak and practical public health messages, including:

- incorporating local intelligence into communications to reflect the likely variety of impact felt in different parts of the UK;
- tailor messaging to help manage pressures on local services;
- encourage alternative means of accessing treatment and advice, for example, the telephone National Pandemic Flu Service (NPFS);
- developing and launching a vaccination campaign to prioritise frontline staff and specified ‘at risk’ groups first.

Credible clinician voices, e.g. Chief Medical Officer, will be used wherever possible, including in social media, and a number of data sources (e.g. social media / network / buzz monitoring) will be used to track public response and opinion.

The availability of a pandemic strain-specific vaccine is likely to become available within 4-6 months of the pandemic being declared.

Depending on the severity of the outbreak, the availability of the vaccine and scientific advice, then prioritisation may need to be directed at frontline staff and higher risks groups at the outset. Any public information campaign will need to be mindful of the supplementary messages required for those who are not first-line priorities, but who may be concerned for themselves or others.

**Recovery**

This phase is defined by surveillance indicating that the peak of infections has passed and demand for services is reducing. However it may take several months for the system to return to the pre-pandemic state. During this time communications should remain active and responsive to change, whilst gradually reducing pandemic-specific activities (for example the national telephone help-line). This phase could take several months.

During this phase communications to the public will:

- continue to keep them informed about the progression of the epidemic;
- continue to encourage good respiratory and hand hygiene;
- review messages needed for the public and specifically higher-risk groups.

An evaluation of all pandemic communications activities should commence during this phase.

**Discussion**

Many lessons learned from the experience of the 2009 H1N1 pandemic have been incorporated into the most recent UK strategies (see Table 1) however, it is clear that Government cannot act alone in limiting the impact of a pandemic and close co-operation is required between all aspects of society to achieve this.
Table 1 – Key messages from A Strategic Review of the Department of Health’s Swine Flu Communications During the 2009 Pandemic.

<table>
<thead>
<tr>
<th>ENCOURAGING FINDINGS</th>
<th>REMAINING CHALLENGES</th>
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<tbody>
<tr>
<td><strong>Public attitudes, beliefs &amp; opinions:</strong></td>
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<tr>
<td>Public approval for overall Government response, who regarded it as calm, sensible and in their interest.</td>
<td>Significant misunderstanding of the differences between the various types of influenza and the differential risks.</td>
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<tr>
<td>Public respiratory and hand hygiene campaigns achieved very high levels of awareness.</td>
<td>Confusion between the purpose of vaccines versus antiviral medicines, their safety and side-effects.</td>
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<tr>
<td>Similar success was obtained for public swine flu vaccination campaigns.</td>
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<tr>
<td><strong>Behavioural change:</strong></td>
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</tr>
<tr>
<td>Some evidence of positive changes to respiratory and hand hygiene by the public, which may have helped limit viral transmission rates.</td>
<td>No negative effects reported.</td>
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<tr>
<td>Uptake in vaccination amongst NHS staff was considerably higher for swine flu (57%) than achieved in other seasonal flu campaigns (e.g. 13%);</td>
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Communications effectiveness:
Vaccination campaigns were clear and effective in delivering their messages on vaccine availability and priority groups.

The level of ‘positive, on-message media coverage’ was 43% overall; a significant achievement, especially around Government preparedness.

Overall Government communications were perceived to be competent and transparent.

The use of senior clinicians (rather than Ministers) as the primary public face for the Government response was well-received.

The (then) CMO was regarded as an authoritative and credible spokesperson. This was also true for the DAs.

Campaign visuals (e.g. the ‘sneeze man’ and ‘see germs’ images) were very well recalled and liked by the public. Similarly the ‘Catch it, Bin it, Kill it’ slogan was well-received.

The development of strong partnerships with the Third Sector and commercial organisations significantly extended the reach of key messages and materials.

Digital communications coped well with an unprecedented demand for online information, with 93% of people surveyed reporting they would have used either the DH, NHS, NPFS or other Government sites if they experienced flu symptoms.

Communications effectiveness:
The was some lack of clarity about the role of the National Pandemic Flu Service – despite its apparent success (accessed by 2.7 million people during the pandemic) in diverting significant demand for treatment away from the NHS.

There was some confusion in the media regarding the use of certain terms and phrases, especially ‘reasonable worst case scenario’ which was interpreted as a prediction, rather than as a planning concept.

In addition the term ‘containment’ was used by the DH as a strategy to reduce the rate of transmission, not to describe the segregation of cases.

The terms ‘pandemic’, ‘virulent’ and ‘contagious’ were not easily understood by the public. ‘Pandemic’ was often considered to refer to the severity of the disease, rather than its geographical spread.

A secure internet site might assist the rapid conveyance of information from the centre to key field personnel, including locums and other mobile health workers.

“Clear, consistent and co-ordinated messaging across the full range of communication channels, tailored to the needs of specific audiences, is crucial to maintaining the public trust, compliance and support essential to the effective management of a pandemic. Adoption of hand and respiratory hygiene advice, social distancing measures, effective and responsible use of antivirals, and uptake of vaccination, are all predicated on successful communication.”

*The 2009 Influenza Pandemic independent review, Chapter 8 Communications, Paragraph 8.1*

Despite there being some major communication achievements with public information campaigns, overall the public response to the 2009 pandemic appears to be one of semi-apathe with the view, evidenced by media and tracking feedback, that perhaps the threat was over-estimated. This view was likely to be assisted by the relatively mild symptoms experienced by most sufferers and some media criticism of the Government’s handling of the crisis, for example the expenditure on stock-piled vaccines (which were unused) and how effective they might be...
even if administered. However, the independent review chaired by Dame Deirdre Hine found the overall Government response to be proportionate and effective.

A summary of the main communication recommendations is provided in Table 2:

Table 2 – Key recommendations from The 2009 Influenza Pandemic Independent Review and The UK Pandemic Influenza Communications Strategy 2012.

<table>
<thead>
<tr>
<th>Central government co-ordination:</th>
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<tr>
<td>The Cabinet Office should ensure that the communications approach (weekly briefings, Q&amp;A sessions) adopted by the DH &amp; DAs is used, where appropriate, as a model of best practice for emergency situations. Closer collaboration between the two departments and at the lower levels should be embedded into this response.</td>
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<th>Public attitudes, beliefs and opinions:</th>
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<tr>
<td>Future communications regarding seasonal and pandemic flu should prioritise greater public understanding of the various types of flu and differential risks.</td>
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<tr>
<td>More public education is needed on vaccines and antiviral treatments.</td>
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<th>Communications effectiveness:</th>
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<td>Use of jargon and scientific language should be avoided in public communications.</td>
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<td>Rigorous pre-testing of future telephone and web-based NPFS activities should occur with the public.</td>
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<td>A media campaign promoting use of the NPFS should occur before a pandemic.</td>
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Communications effectiveness: (contd)

Use of jargon and scientific language should be avoided in public communications.

The considered research conducted on the visual imagery used in the 2009 pandemic should be revisited for future campaigns.

The provision of telephone help-lines should be reviewed, particularly whether a single point of contact is preferable for the public.

Rigorous pre-testing of future telephone and web-based NPFS activities should occur with the public.

A media campaign promoting use of the NPFS should occur before a pandemic.

A Government communications strategy should also be devised for the social care sector, but co-ordinated with the health sector strategy.

Conclusion

There is no doubt that the 2009 experience has helped shape and refine a more tailored and efficient approach in the new strategy, however the core challenges will inevitably remain the same, for example, how to motivate an appropriate public response whilst avoiding panic or generating unnecessary anxiety or behaviour.

One approach entailed the adoption of behavioural science insights into determining communications strategy (the findings of which are presented in a second article) however, the effectiveness of messages in limiting the spread of the virus will ultimately depend on the co-operation of individuals and their willingness to take responsibility for their own and others’ health.

The principal concern of this article lies in whether the organisational ‘know how’ gained from the valuable experience of the (thankfully relatively mild) 2009 swine flu pandemic has been captured in the legacy of reports and strategies produced pre the new DH / NHS arrangements from April 2013 – or whether, like so many previous NHS reorganisations, the collective experience is lost within the transition to alternative arrangements as new organisations set out to make their independent mark.

Concern has been expressed at the vast amounts of public money spent on vaccines for the pandemic in 2009 (which totalled £239 million up to April 2010) but the independent review by Dame Deirdre Hine concluded that the accusation of poor-value-for-money was only valid in hindsight (due to the low virulence of the influenza strain) whereas at the time of the negotiations the severity of the virus was not known. Perhaps it should also be noted that, in the context of the vast amount of public monies being used to rescue certain financial services institutions at the time, the decision of the Department of Health to resource a national vaccination programme should not be regarded as overly profligate? However, as part of her review of vaccination policies, Deirdre Hine did recommend that ‘sleeping contracts’ with GPs and other willing providers, such as community pharmacists, to assist with the administration of large-scale vaccinations programmes should be negotiated in advance of, not during, a pandemic to secure better value agreements. Similarly, that the DH should negotiate advance-purchase agreements with potential suppliers that allow more flexibility over the eventual quantities of vaccines purchased, as during the 2009 epidemic when the virus was

14 Interestingly, although the 2009 Strategic Review praised the Department of Health for its openness in providing information to journalists on the pandemic itself, that same approach was not extended to journalists requesting financial information about the supply of vaccines.
acknowledged as less virulent than anticipated, a ‘break clause’ in the order for vaccine supplies was accepted by Baxter Healthcare, but not by GlaxoSmithKline. It should also be stressed, that the most recent UK pandemic strategy (2011) has planned for a range of responses, so that the resources employed to limit the impact of a future outbreak are proportional to its severity.

In summary, certainly the UK had developed a sophisticated level of preparedness to cope with a pandemic flu epidemic pre-2013 NHS restructuring, and had reviewed and adapted its response proportionately. It is hoped that political aspirations have not overriden the system’s ability to do just that, either operationally or financially, in the next influenza crisis.

Dr Miriam Armstrong