Chapter 8
Health Protection & Emergency Planning

The responsibility for the protection of the health of the local population falls to the PCT. In line with the national approach, this role is shared in conjunction with the local Health Protection Unit. For Kingston, this partnership is with South West London Health Protection Unit (SWLHPU), based in Wandsworth. The PCT has a link Consultant in Communicable Disease Control and a link nurse.

SWLHPU produce their own Annual Report summarising key data for the previous year. The most recent was published in September 2006. This highlights 11 key areas in health protection, and presents a summary of validated data for 2005 for South West London on:

- Vaccine preventable diseases
- Legionella
- Influenza
- Tuberculosis
- Gastrointestinal infections
- Sexually transmitted infections
- Bloodborne viruses
- Infection control in the community
- Healthcare associated infections
- Malaria
- Training
- Clinical Governance

A full copy of this comprehensive report can be accessed via:
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947399461

There have been some key areas of interest for Kingston in terms of health protection in 2006-07 and it is useful to highlight these in this report. These are:

- Childhood immunisation
- Sexual health (this topic is placed here given the importance of dealing with sexually transmitted infections although it should be noted that sexual health is wider than just protection from infection)
- Emergency planning

Childhood immunisation

Uptake of primary immunisations in SW London

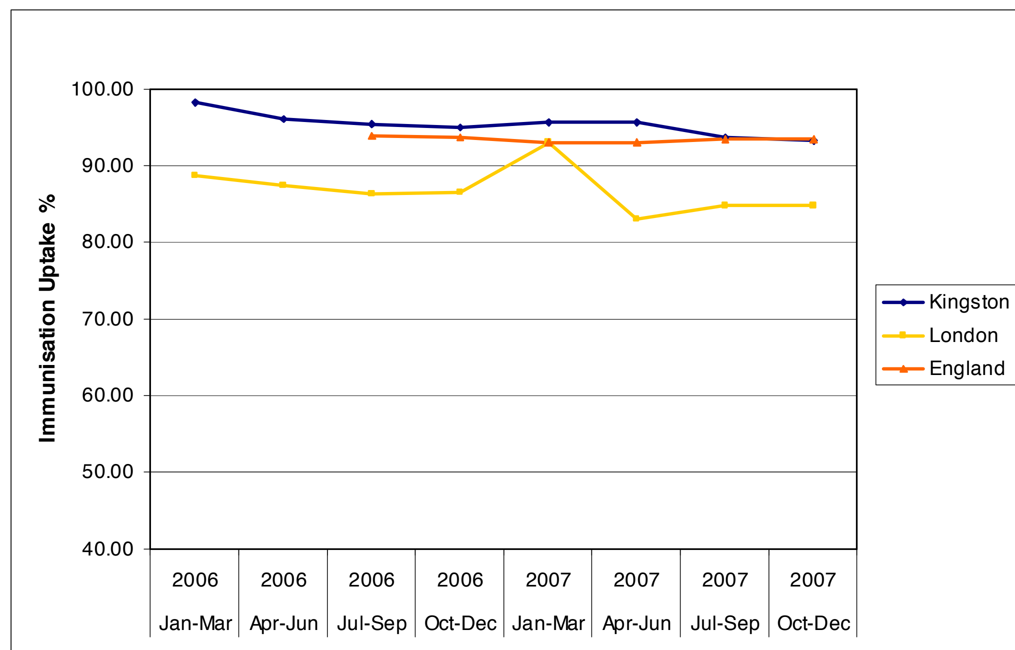
In 2006 the recorded uptake of primary immunisation in South West London was good relative to London but poor when compared to the national uptake. Kingston PCT had the highest recorded uptake in all primary immunisations compared to the other SW London PCTs in both 2006 and 2007.

DTaP/IPV/Hib

Kingston PCT has continued to achieve high uptake of DTaP/IPV/Hib (also known as the '5 in 1' vaccine, which immunises against diphtheria, tetanus, pertussis (whooping cough), polio, and *Haemophilus influenzae* type b) and recorded data have been consistently above the London average (Figure 14).

Figure 14

Recorded uptake (%) of DTapPol at 24 months in Kingston, London and England



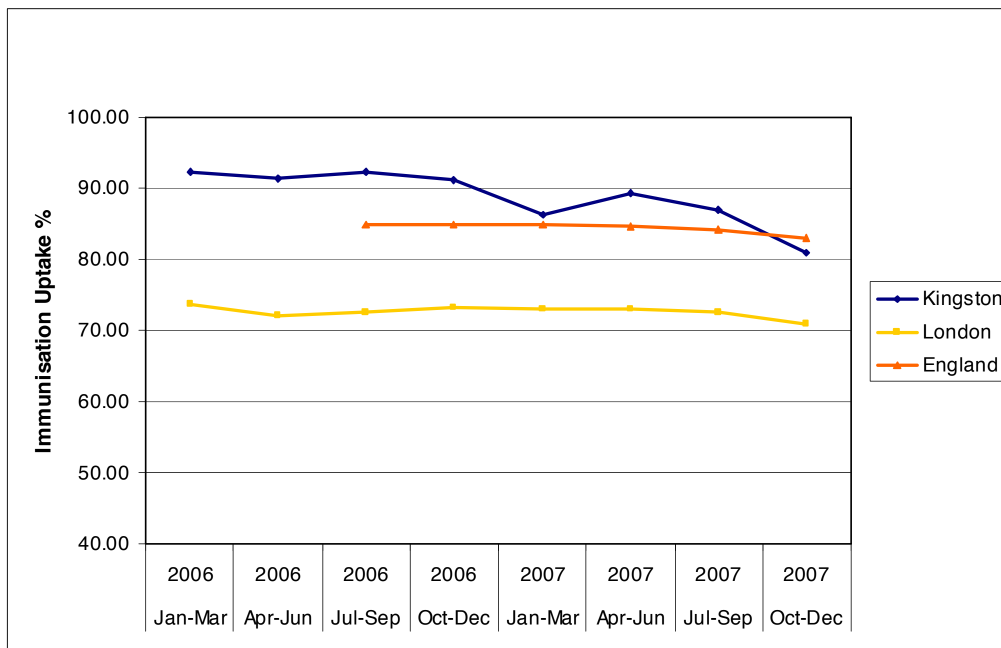
Source: Health Protection Agency. COVER data, 2008[45]

In September 2007 the PCT implemented the Hib (*Haemophilus influenzae* type b) catch-up campaign in accordance with Department of Health policy and provided training for Practice Nurses in conjunction with the SW London Health Protection Unit. This campaign ensures that children who have not previously been offered a Hib booster had the opportunity to receive this dose.

45 Health Protection Agency. COVER (Cover of Vaccination Evaluated Rapidly) data, 2008 (accesed at http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1207035524818 on 15 July 2008)

Measles, Mumps and Rubella (MMR) uptake
London's MMR uptake rates are well below the coverage level required to prevent outbreaks of measles, mumps and rubella from occurring and as a result of this there have been outbreaks of measles during the past year in North and East London. Recorded uptake of MMR in Kingston has fallen over the course of 2007 and is currently below the national target of 92-95% needed to achieve population immunity coverage levels, and also below the national average, although higher than coverage in London as a whole (Figure 15).

Figure 15
Recorded uptake (%) of MMR at 24 months in Kingston, London and England



Source: Health Protection Agency. COVER data, 2008[45]

Future Immunisation Priorities
Improving the uptake of childhood immunisations, particularly the MMR vaccine, has been identified as a priority for London. Kingston PCT recognises that continued investment is needed in this area in order to meet national targets and local trajectories over the coming years. More work needs to take place locally to identify and reduce inequalities in vaccine coverage and ensure that all children in Kingston are protected against vaccine preventable diseases. It is planned that the PCT's child health system will begin its move over to the RiO system at the end of 2008 / beginning of 2009 and it is anticipated that this will bring improvements to Kingston's immunisation recall and reporting system.

The introduction by the Department of Health of the Human Papilloma Virus (HPV) vaccine programme for 12 to 13 year old girls which will commence in September 2008, followed by the catch-up for girls up to the age of 18 to begin in Autumn 2009, requires the PCT to establish an effective and efficient programme for the targeted cohort in Kingston. Planning for this is currently underway within Kingston PCT in conjunction with neighbouring PCTs, to ensure that a consistent approach is taken across the sector.

Sexual Health

Julia Waters, Sexual Health Programme Lead (julia.waters@kpct.nhs.uk)

Introduction

Sexual Health is an important part of physical and mental health. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease[46]. Sexual health is thus a wide topic, and this chapter limits its focus to teenage conceptions, sexually transmitted infections (STIs) and their impact on health, abortions, contraception, school education, and sexual knowledge, attitudes and behaviour.

Why this is an important public health issue

Improving sexual health is prioritised in *Choosing Health*[47] because risk-taking sexual behaviour is increasing across the population; because diagnoses of HIV, Chlamydia, genital warts and syphilis have increased in recent years; because sexually transmitted infections can lead to cancer, infertility and death; and because delay in diagnoses and treatment can lead to more people being infected.

The National Strategy for Sexual Health and HIV[46] highlights significant inequalities in sexual health. Sexual ill health disproportionately affects women, teenagers and young adults, gay men, and Black and minority ethnic groups. There is also a strong link between social deprivation and STIs, abortions, and teenage conceptions.

Local issues

Four priorities were agreed for improving sexual health in Kingston, and it was agreed that these were the top priorities for action given high rates of Sexually Transmitted Infections in South West London.

1) Improvement in access to GUM services

Genito-urinary medicine (GUM) services provide specialist advice and management of STIs and HIV.

Sexual health service improvement is now a government priority. PCTs are expected to ensure that 100% of patients seeking GUM services are offered an appointment within 48 hours with at least 95% being seen within 48 hours. The aim of the target is to reduce the levels of STIs and support communicable disease control by increasing access to GUM services. This target is included within the top six priorities for the 2007 - 2008 Operating Framework for the NHS.

46 Department of Health. The National Strategy for Sexual Health and HIV. London: Department of Health; 2001.
47 Department of Health. Choosing Health: making healthy choices easier. London: Department of Health; 2004.

STIs are on the rise nationally and, although there has been a reduction in gonorrhoea rates, Chlamydia, HIV and syphilis are increasing with little significant reduction in other STI rates. Easy access to GUM services with shorter waiting times is essential to reverse these trends.

In February 2007 in Kingston PCT, the Health Protection Agency reported that 67% of attendees at GUM were seen within 48 hours and 87% were offered an appointment within 48 hours. By August 2007, Kingston PCT had improved performance with 78% of attendees being seen within 48 hours and 86% offered an appointment within 48 hours. April 2008 data showed that 97% of patients were offered an appointment in 48 hours and in May 2008 this had reached 100%.

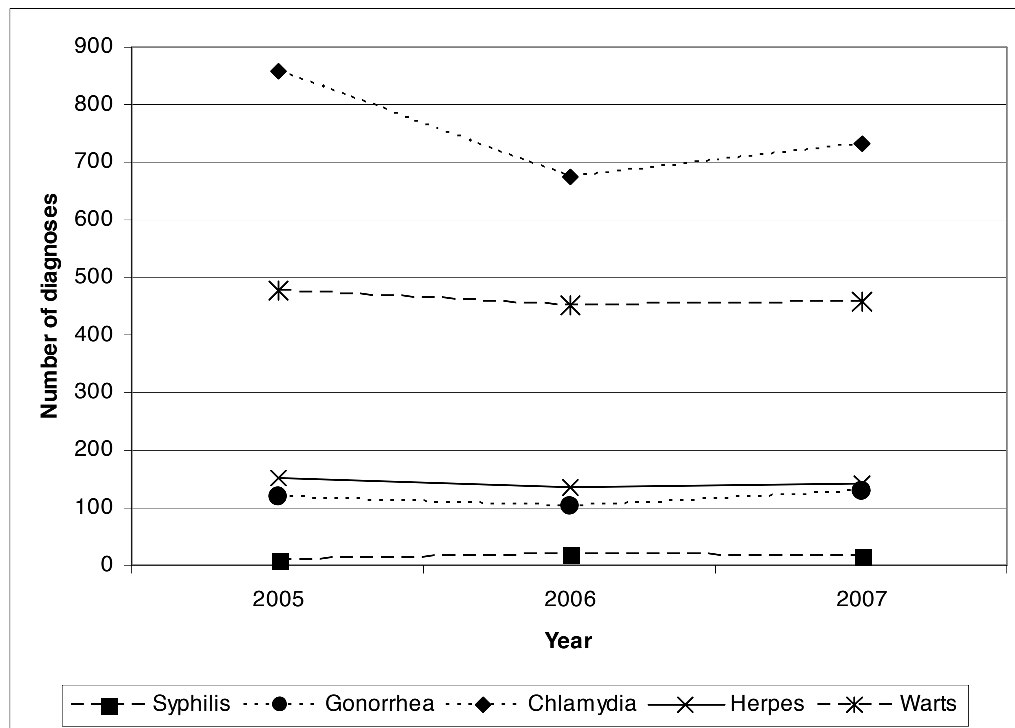
Work to understand blocks to the service in Kingston has been done, and some problems identified, for example telephone facilities have now been improved to facilitate access to the clinic.

Total number of new STI cases diagnosed

This section concerns the five major STIs reported in KC60 data: syphilis, gonorrhoea, chlamydia, genital herpes and genital warts, with Figure 16 showing the trends in new diagnoses for these infections at Kingston hospital in 2005 to 2007[48]. About half of these attendees are Kingston residents.

Figure 16

New diagnoses of STIs, Kingston Hospital , 2005 - 2007



Source: KC60 National Data 2007, Health Protection Agency, 2008[48]

48 SWL Health Protection Unit / SWAGNET Sexual Health Data Report, 2007. KC60 National Data, Health Protection Agency 2008 (accessed at (http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/sti_data.htm)

Between 2002 and 2007, there was a 17% increase in the number of new cases of these STIs at the GUM clinic (from 1,266 to 1,477 cases). However, this increase must be interpreted with caution as during the same time period, there was an increase in the number of first attendances of patients at the clinic, from 6,796 visits to 10,305 visits, a rise of 52%.

Between 2005 and 2007, there was a 9% decrease in the number of new cases (from 1,617 to 1,477 cases), mainly caused by a falling number of Chlamydia diagnoses (see Figure 16). This decrease came in spite of a 4% increase in the number of first attendances at the GUM clinic (from 9,881 to 10,305 attendances) between 2005 and 2007. This suggests that the decline in new STI diagnoses is not the result of fewer tests being performed.

Nationally, the number of STI diagnoses rose by 2.4% between 2005 and 2006[49]. The Kingston PCT GUM clinic data are therefore encouraging, suggesting the incidence of these STIs is falling in the population using the clinic.

HIV

New HIV diagnoses in SWL clinics

There were 318 new diagnoses of HIV in South West London clinics in 2006. It is important to note that this figure is provisional and is likely to rise as late reports are received. This represents nearly 5% of all new diagnoses in England and a 10% increase since 2005 (289 cases) (Figure 17).

In the five years since 2002 the number of new HIV cases diagnosed in SWL clinics has increased by 9.6% (290 cases in 2002 to 318 cases in 2006). In the ten years since 1997, when there were 101 cases, numbers have increased by 211%. Part of this rise may reflect increased testing.

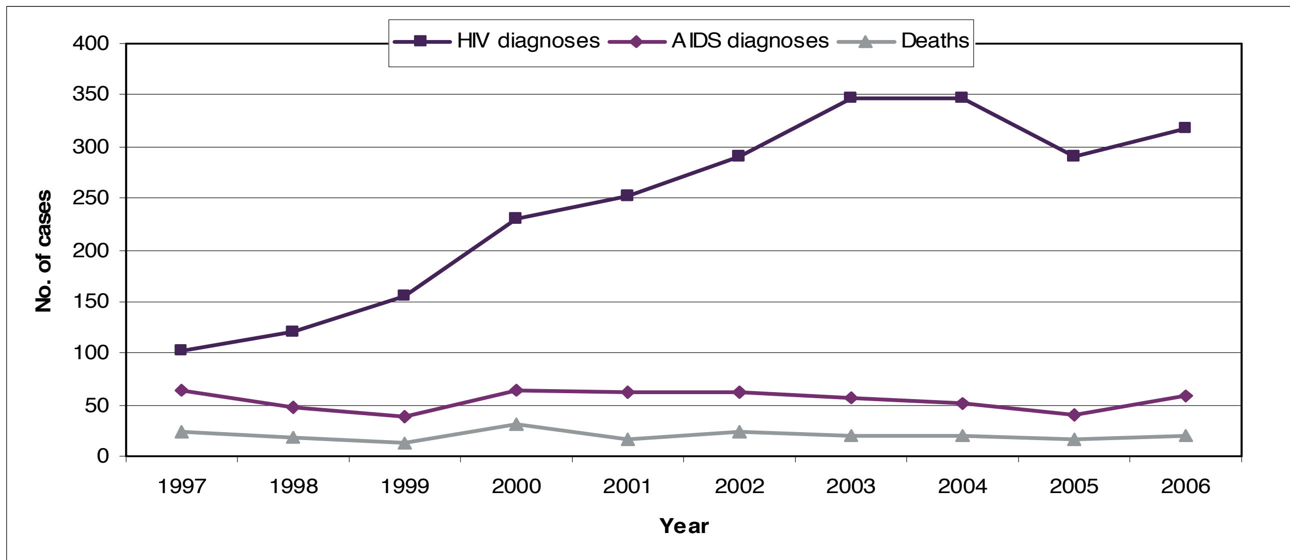
Overall, after dramatic rises in the six years up to 2003, in more recent years the number of new diagnoses has appeared to have stabilised.

The number of people in SWL with newly diagnosed AIDS (59 cases in 2006) and the number of people with HIV who died (20 deaths in 2006), has remained relatively stable over the last ten years despite large rises in new HIV diagnoses. This is mainly because of the effectiveness of highly active anti-retroviral therapies (HAART).

49 Health Protection Agency Annual Report 2006 (accessed at http://www.hpa.org.uk/static/publications/2006/annual_report/web/default.htm

Figure 17

New HIV and AIDS Diagnoses and Deaths by Year of Occurrence[50]



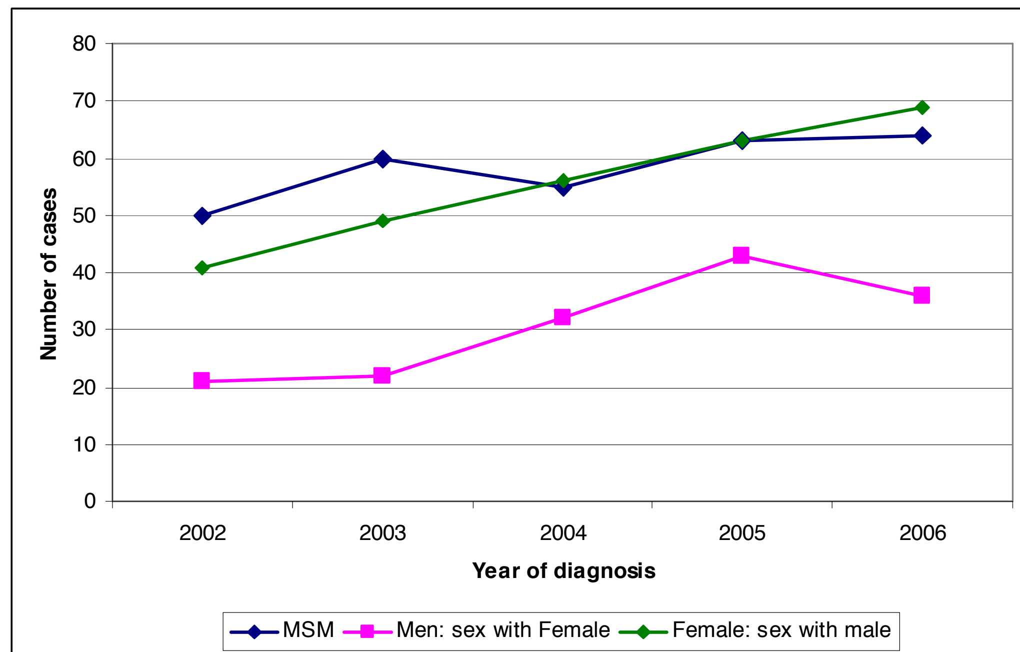
Residents Seeking HIV Treatment:

By 2006 there were 186 people diagnosed with HIV infection living in Kingston. Of these:

- 61% received treatment at Kingston Hospital
- 12% received treatment at the Chelsea and Westminster Hospital in London
- The remaining received treatment at other London hospitals or, in a few cases, at hospitals in the home counties

50 SWL London Health Protection Unit 2006 HIV Report

Figure 18
HIV Prevalence in Kingston by Route of Transmission, 2002 to 2006



MSM: men who have sex with men

Source: SOPHID Data 2007[51]

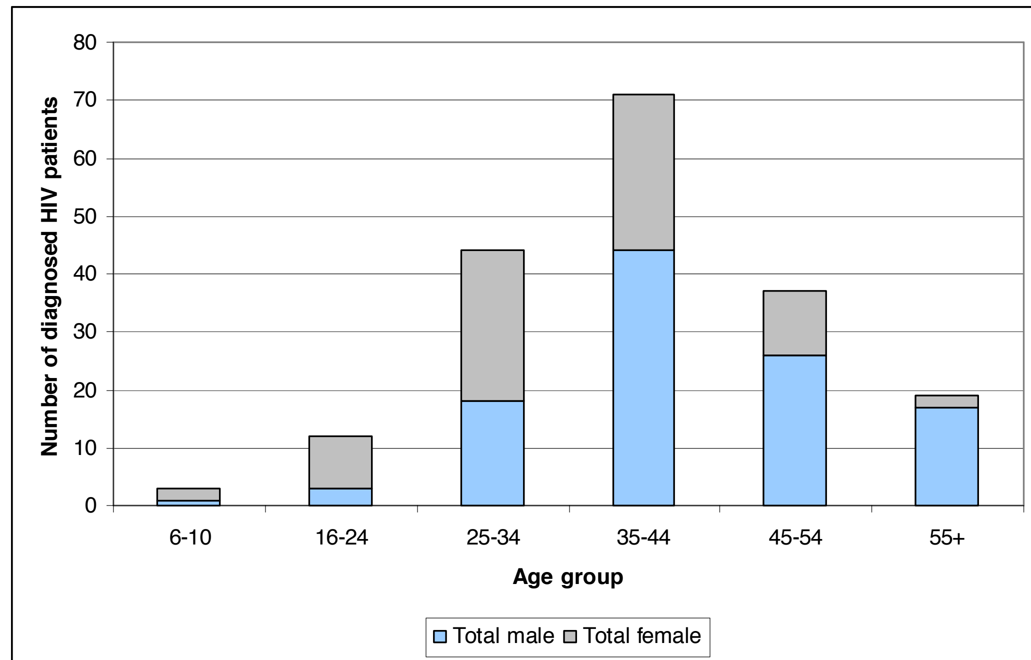
Routes of Transmission:
Figure 18 examines the three major routes of infection and indicates:

- All three routes of infection are increasing
- There are small numbers of people infected via mother-to-child transmission and by blood products routes.

51 SOPHID Data, Health Protection Agency, 2007

Figure 19 provides the age and sex profile of people with HIV in Kingston. The majority of individuals are aged 25-44.

Figure 19
HIV Prevalence in Kingston by Route of Transmission, 2002 to 2006



Source: SOPHID Data, 2007[51]

Table 30
HIV cases by ethnic group: 2002 and 2006

	2002	2006	% change
White	63	89	+41%
Black-Africa	48	82	+71%
Other/not known	8	11	+38%
TOTAL	122	186	+52%

Source: SOPHID Data 2007[51]

Table 30 lists HIV cases in Kingston by ethnic group at two points in time; 2002 and 2006. It shows that the largest increase in numbers is among the Black-African group. The total numbers among the Black-Caribbean and Asian group are small. There has been a 41% increase in cases between 2002 and 2006 among the white group.

The largest number of cases are among white men, followed by Black women. However, by calculating rates using 2005 estimates of ethnic population (for women, aged 16-59, and for men, aged 16-64), the highest rates are in Black-Africans, especially women (Table 31).

Table 31
HIV Cases in Kingston, 2006: ethnic group and sex

	Gender	Total	PCT population*	HIV diagnosed cases per 1,000 (2006)
White	M	77	43,500	1.8
	F	12	39,000	0.3
Black-African	M	23	800	28.8
	F	59	800	73.8
TOTAL POPULATION		186	147,273	1.3

Source: SOPHID Data, 2007[51]

*N.B. Other ethnic groups have been excluded as they are very small in number

Timing of diagnosis

Early diagnosis is key to cost effective HIV treatment strategies and to promote longer, healthier lives for HIV positive residents. SOPHID data returns include a breakdown of CD4 category, an indicator of the stage of HIV at diagnosis and the timing of the diagnosis. A later diagnosis will result in a lower CD4 count. It can be seen in Table 32 that Kingston has one of the lowest CD4 <200 percentages in SW London, indicating that people locally tend to be diagnosed early.

Table 32
Numbers of People and Proportions by CD4 count in South West London PCTs in 2005/06

PCT of Residence	CD4 count <200	CD4 count >=200	Total with CD4 count	% CD4 count <200
Croydon	69	122	191	36%
Kingston	13	28	41	32%
Richmond And Twickenham	9	20	29	31%
Sutton And Merton	51	78	129	40%
Wandsworth	45	80	125	36%

Source: SOPHID Data, 2007[51]

2) Modernisation of contraceptive services

Contraception services in Kingston are provided by the PCT in a community based contraception clinic (Hawk's Road), in specialist young people's sexual health clinics, and through open access services in three general practices. A national target for access to reproductive health care was proposed, starting from April 2007, which includes several measures of the processes used to ensure access for all. A strategy for meeting this target is needed.

Recent guidance from the National Institute of Clinical Effectiveness[52] recommends that women should have access to a full range of contraceptive methods, including long action reversible contraception (LARC), which is more cost effective than other methods of contraception.

Most methods of contraception protect against pregnancy but not against STIs.

Community Contraception Services:

Kingston PCT saw a total of 2,800 clinic attendances in 2006-2007, made by 1,300 different women and 100 different men. Two hundred contacts were to access emergency contraception. Notably, 45% of first contacts were with women under 20 years of age, higher than the national average. This indicates that Community Contraception Services in Kingston PCT are relatively more popular and accessible to young people compared to older age groups. However, data suggest that only 5% of contacts are provided with long acting reversible contraceptive methods (LARCs). This is notably lower than the national average (which was 21% for England in 2006).

GP provision of contraception:

It is estimated that approximately three-quarters of all contraception provision is provided through general practice[53].

Prescribing data, predominantly from GPs as well as independent nurse prescribers, shows that oral contraceptives (OCs) are by far the most common form of contraception supplied in Kingston PCT; with 90% of all contraceptives prescribed in 2007 being oral contraceptives.

Long acting reversible contraception (LARC) methods make up only 10% of contraceptive prescriptions, a figure which is significantly lower than the figures for England (21%) and for London (19%)[54]. This is a concern and work needs to be undertaken with practices to improve this percentage.

52 National Institute for Health and Clinical Excellence. Clinical Guideline 30. Long-acting reversible contraception. NICE 2005.
53 Department of Health. Available from:
http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4001998
54 Table 12. National Statistics Publication on Contraception - 'NHS Contraceptive Services, England. 2006-07

3) Improving access to abortion services and improved local co-ordination

The level of abortions is taken as an indicator of the degree of failure to use contraception or as failure of the contraception itself, although some planned pregnancies may also end in abortion if circumstances change. Access to abortion services is particularly important for teenagers because of the serious health and social impact of becoming a teenage parent.

The earlier in pregnancy an abortion is performed the lower the risk of complications. Medical termination, which can be carried out up to nine weeks gestation, is less invasive than surgical termination.

Abortion

The abortion rate for Kingston PCT is slightly higher, at 20 per 1,000 women aged 15-44, compared with the national average of 18.5.

Table 33
Total NHS funded abortions in Kingston PCT 2006

Under 18	18-19	20-24	25-29	30-34	35+	Total
46	83	209	160	126	111	735

Table 34
British Pregnancy Advisory Service Abortions (NHS funded) in Kingston PCT 2007-08[55]

	Less than 10 weeks gestation	10 or more weeks gestation	Total	Percentage of total medical and surgical
Medical Abortion	206	0	206	33%
Surgical Abortion	296	114	410	67%

In England 68% of abortions were performed at less than 10 weeks whereas in Kingston PCT 77% of NHS funded abortions were performed at less than 10 weeks. 91% of abortions were performed at less than 13 weeks gestation in Kingston, which is just higher than the national average at 89%. Seventy-five percent of NHS-funded abortions are performed prior to 10 weeks of gestation compared to a national average of 65.3%. Kingston PCT is therefore performing above the national average[56] (Table 34).

55 Figures provided direct from BPAS
56 Abortion Statistics - England and Wales 2006

Nationally 30% of abortions are medical abortions, suggesting that Kingston PCT is again performing above the national average, as the local percentage reported by the British Pregnancy Advice Service is 33%.

Teenage conceptions

At 22.4 per 1,000 15-17 year olds, the rate of teenage pregnancy in Kingston is significantly lower than the national rate of 40.4 per 1,000 (see Table 35). Kingston has seen significant decreases in recent years in overall rates of teenage pregnancy, teenage abortion rates, and teenage births. Between 1998 and 2006 teenage pregnancy in Kingston reduced by 27.5% compared to a reduction of 13.3% nationally over the same period. The picture across London over this time period is mixed (Figure 20) with some boroughs showing an increase in the teenage conception rate. Kingston had the third largest decrease in London.

Although Kingston is on track to meet 2010 Teenage Pregnancy target rates, work to address the sexual health needs of young people will need to continue in order to maintain this trend.

Figure 20

A comparison of under 18 conception rates between 1998 - 2006

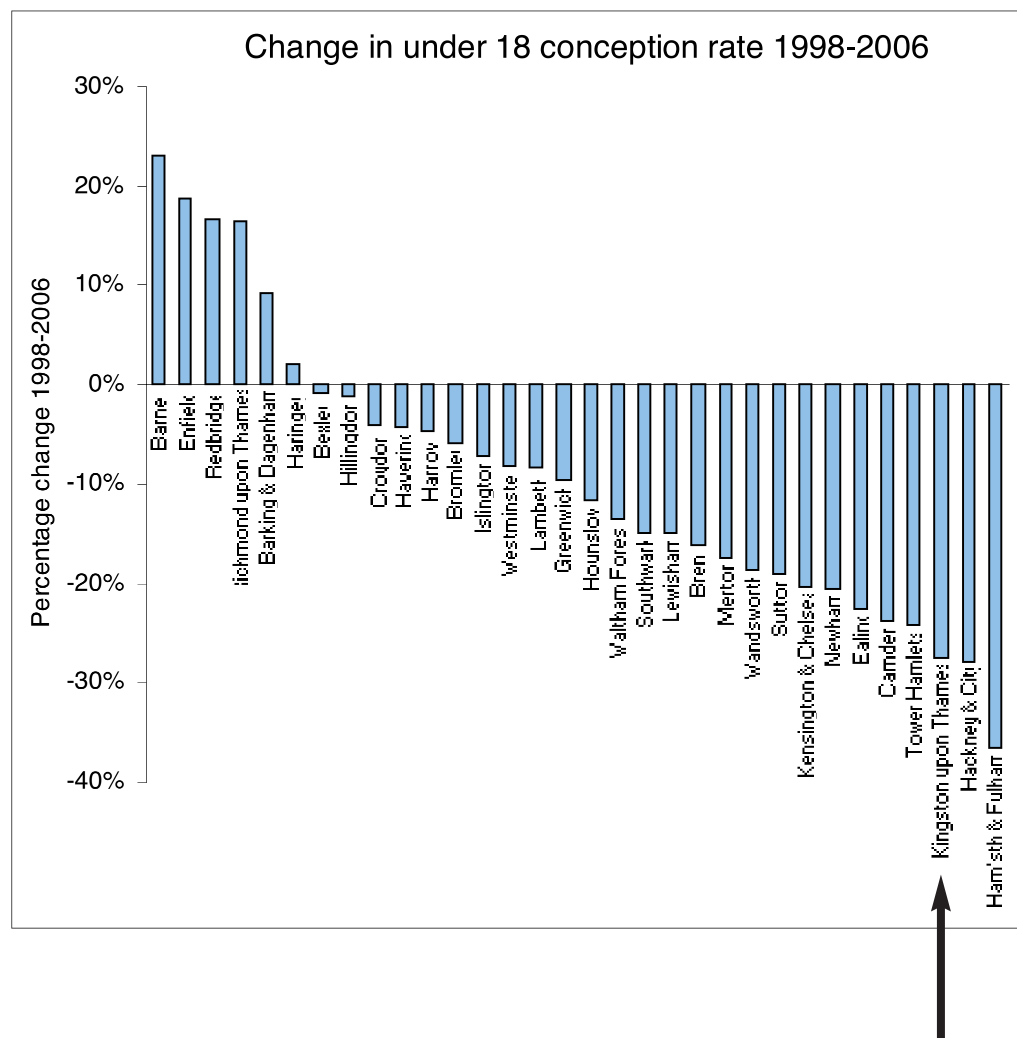


Table 35

Under 18 Conceptions: numbers, rates, and trends, 1998 to 2006[57]

	1998	1999	2000	2001	2002	2003	2004	2005	2006[58]
Number									
Kingston upon Thames	**70**	**65**	**75**	**67**	**68**	**81**	**67**	**70**	**59**
Rate									
ENGLAND	46.6	44.8	44	42.5	42.7	42.2	41.6	41.3	40.4
Kingston upon Thames	**30.9**	**28.3**	**33**	**28.4**	**28.6**	**31.8**	**25.8**	**26.8**	**22.4**

N.B. Under 18 conception rates are per 1,000 females aged 15-17

4) Chlamydia screening

- Genital Chlamydia Trachomatis is the commonest sexually transmitted infection (STI) in England.
- Genital chlamydial infection is an important reproductive health problem. Complications of infection include: pain, infertility and ectopic pregnancy. 10-30% of infected women develop pelvic inflammatory disease (PID).
- A significant proportion of cases, particularly amongst women, are asymptomatic and so are liable to remain undetected putting women at risk of developing PID, and both sexes at risk of future fertility problems.
- Screening for genital Chlamydia infection may reduce the rates of PID and ectopic pregnancy in the future.

The number of diagnoses of uncomplicated genital chlamydial infection in GUM clinics has risen steadily since the mid-1990s with an increase of 207% between 1996 and 2005. National data show that in 2005 the highest rates of diagnoses in women were among those aged 16-19 (13.6/1,000) and in men were among those aged 20-24 (10.7/1,000)[59]. The rise in diagnoses of genital chlamydial infection since the mid-1990s is probably due to a combination of factors including an increase in unprotected sexual intercourse, increased awareness of Chlamydia through population-level campaigns, and the increased availability of diagnostic services.

57 Sources: Office for National Statistics and Teenage Pregnancy Unit, 2008
58 Rates for 2006 are provisional
59 Health Protection Agency, SCIEH, ISD, National Public Health Service for Wales, HPA Northern Ireland, and the UASSG. Mapping the issues. HIV and other sexually transmitted infections in the United Kingdom in 2004. London: Health Protection Agency, November 2005.

Trends in Chlamydia diagnosis are difficult to interpret because of changes in testing policies so that more people attending clinics will now be tested for Chlamydia as awareness of infections has grown. The number of cases of Chlamydia diagnosed in Kingston Hospital has almost doubled between 2001 and 2005, although there was little increase between 2004 and 2005.

It has been recommended that rates of Pelvic Inflammatory Disease and ectopic pregnancy should also be monitored, as these are some of the more serious complications of Chlamydia. In 2004-5 there were 8 women admitted with an ectopic pregnancy in Kingston, giving a rate of 2.2 per 10 000 women age 15-44. There were 27 admissions for pelvic inflammatory disease locally, giving a rate of 7.4 per 10,000 women. Future trends in these conditions should be watched.

The annual cost of Chlamydia and its consequences in the United Kingdom is estimated to be more than £100 million[60]. The National Screening Programme for Chlamydia (NCSP) was included in the Department of Health's (2001) National Strategy for Sexual Health and HIV[46]. The aim of the NCSP is to control Chlamydia through early detection and treatment of asymptomatic infection, to prevent the development of sequelae and reduce onward transmission.

The NSCP is based on opportunistic testing and treatment of infection in asymptomatic, sexually active men and women under 25 who would not normally access or be offered a Chlamydia test, and encourages use of non-traditional sites.

What is happening locally?

The GUM Services

- There is strong clinical and nursing leadership with a skilled workforce, dual trained in GUM and contraception services, with competencies appropriate for integrated service provision
- The workforce aim to be flexible and responsive and have increased capacity based on both the need to progress more rapidly to target, and on client expectations and their needs
- There is an excellent telephone system in place which has made information available to patients and increased access to the service
- Centralised booking is planned for the future
- The GUM service has a mixed economy of walk-in and booked appointments available for patients. This has been shown to increase access and patient choice
- There are some nurse-led symptomatic services, which will increase once the Health Care Assistant role has expanded
- Text messaging of results is available for all patients
- There is a GP registrar role within the clinic, as part of the vocational training rotation, which increases links with primary care colleagues
- Longer term work includes reviewing provision of services outside hospital, and linking with health promotion programmes such as the Healthy Schools Programme to improve people's knowledge of sexual risks and how to stay safe

60 Department of Health. National Screening Programme in England: Programme overview. London, 2004

Modernisation of contraceptive services

- Provision and funding of contraceptive services in Kingston is being clarified, and value for money and quality of the services are under review.
- Publicity for contraception services is an issue, with few people aware of the range of services available, and this is currently being rectified.
- Provision of open access enhanced sexual health services at GPs surgeries is also being reviewed and the role of borough council staff in providing Level 1 sexual health services is also starting to be addressed. Level 1 services include: condom distribution, Chlamydia Screening, pregnancy testing, Sex and Relationships Education (SRE), sexual history taking and risk assessment.
- Emergency Hormonal Contraception is going to be retendered to pharmacies so that it is much more freely accessible to those aged under 25 years.
- A pilot questionnaire was sent to all reproductive and sexual health services (including GPs) to elucidate their training and supervision needs, as well as the range of contraception offered at each site.

Improving access to abortion services and local co-ordination

Provision of termination services has recently been retendered, and access improved by allowing nurse referrals. Medical termination is also available for those who present before 9 weeks gestation. Ongoing evaluation of the new service is needed. Chlamydia screening is offered to all age groups with those under the age of 25 being offered the SW London Chlamydia Screening programme tests. Invasive Long Action Reversible Contraception (LARC) (e.g. implantable contraception and intrauterine devices) will be offered to those who have had an abortion, once an acceptable quantity of LARC removal services are in place in Kingston.

Chlamydia screening

In January 2008 the South West London sector's Chlamydia Screening Programme was launched. Screening facilities are currently offered in Kingston via the Youth Bus (late Friday afternoons); the three KU19 drop-in clinics; the Hawks Road contraception service; Kingston College and Kingston University. There are plans to roll out this provision to GPs and pharmacies, as well as commercial, sports, and occupational settings.

Recent data from the Health Protection Agency's Chlamydia Screening Office for the number of people screened as part of the programme showed 231 screens were undertaken between January and March 2008.

Teenage conceptions

Kingston is making good progress towards achieving the target of a 40% reduction in teenage conceptions by 2010 and if services and support continue to improve then the target should be met. The work to reduce teenage pregnancies in Kingston covers a wide agenda, and is linked closely with the developing Children and Young People's Trust work. There are plans to continue to reduce the rate by providing packages of support for schools to improve sex and relationships education (SRE); and by supporting parents through the new extended schools initiative. A range of training for multi-agency professionals, including basic sexual health, delivering effective SRE, building self-esteem and helping

young people delay sexual activity, are planned. Local information is used to support and target work in borough hotspot areas and the Teenage Pregnancy Action plan is committed to sustaining and increasing the number of community based sexual health services.

Looking Ahead

To facilitate the modernisation of sexual health services, in particular contraception services in Kingston, there is a need to develop a more integrated model of service delivery. The new service model will aim to improve access to these services by local people. A comprehensive integrated sexual health services model is in the process of being developed. To date a revised service specification has been drafted and will go out for public consultation prior to going through the tendering process. It is expected that, subject to consultation, the new integrated services model will be operational by the end of 2009.

Recommendations

- To develop, consult on, tender and launch an integrated sexual health service
- To implement the 48-hour action plan for GUM
- To monitor access to contraception services
- To decide the future provision of contraception services across the PCT
- To publicise contraception services widely
- To develop and implement an action plan to ensure the Healthcare Commission target for access to reproductive health is met
- To continue to implement the Teenage Pregnancy action plan

Emergency Planning

Contact: Sarah Robinson, Emergency Planning Lead, sarah.robinson@kpct.nhs.uk

Introduction

Like all NHS organisations, the PCT has a duty to plan for major incidents or emergencies. An emergency is an event or situation which threatens serious damage to human welfare, the environment or security. It ranges from localised flooding, which causes widespread disruption but may only affect a few residents; to a terrorist attack, resulting in large numbers of people being injured or killed; to a flu pandemic, that may affect the whole country.

All major emergencies require special action to be taken when responding and this is why the PCT is continually planning for such eventualities.

Pandemic flu is judged to be a high risk area by the PCT so the rest of this chapter focuses on this issue.

What is pandemic flu?

Influenza is a familiar infection in the UK, especially during winter. Almost every year new strains of influenza emerge causing illness. Pandemic influenza is different: its emergence and potential impact are both difficult to predict.

It is important to be clear about the differences between seasonal flu, avian flu and pandemic flu. Avian flu is a disease which mainly affects birds. Seasonal flu refers to the viruses that circulate in the human population and cause widespread illness each winter.

A flu pandemic occurs infrequently and is the result of a new influenza A virus subtype emerging, which is markedly different from recently circulating strains, that is able to:

- Infect people (rather than, or in addition to, animals or birds)
- Spread easily from person to person, and
- Cause illness in a high proportion of the people infected, and also
- Spread widely, because a high proportion of the population is susceptible (most people will have little or no immunity to the new virus because they will not have been infected with it before).

New subtypes of influenza have emerged sporadically over the last century. In 1918 a devastating and unusual pandemic caused by influenza A, subtype H1N1 ('Spanish flu') killed between 20 and 40 million people worldwide. Other pandemics that followed had a less devastating impact but were nevertheless severe. These included influenza A, subtype H2N2 ('Asian flu') which emerged in 1957 and H3N2 ('Hong Kong flu') which emerged in 1968.

The World Health Organisation (WHO) has warned that a flu pandemic is both inevitable and imminent. This has been fuelled by a particularly virulent strain of avian flu (H5N1) that experts think could trigger a pandemic. Some cases of H5NI in birds have caused concern but the virus has not yet demonstrated the ability to pass easily between people.

What is being done nationally?

The Department of Health published a National Framework in 2007. It recognises that a pandemic would have significant social and economic impacts as well as have a serious effect on the health of the population.

The Government will establish a National Flu Line. Face-to-face clinical assessment for every patient will not be feasible at the peak of a pandemic so this telephone service will be used to provide initial patient assessment and antiviral authorisation and both functions will then remain operational until the impact of the pandemic and the threat of further waves subside.

The Department of Health has also made several direct interventions including the procurement of antiviral treatments. In addition, they have also purchased 3.3 million doses of H5N1 vaccine for research and the possible vaccination of healthcare workers. An advance supply contract has been agreed for the supply of a pandemic specific vaccine in the event of a pandemic.

How is Kingston PCT preparing for a pandemic?

The PCT is working hard with its partners to prepare Kingston for a flu pandemic. Detailed operational plans are being developed which will ensure we can respond effectively.

A local wave is estimated to last 6-8 weeks and our plans involve considering an attack rate (people becoming infected) of 25 - 50% of the population and a case fatality rate of 0.4 to 2.5%. For Kingston, this means planning for the following reasonable worst case scenario:

- Approximate registered population (as at July 2007) = 184,000
- Number of symptomatic patients over first wave (50%) = 92,000
  - Number with non complicated flu (75%) = 69,000
  - Number with complications (25%) = 23,000
- Number with complications requiring assessment (28.5%) = 26,220
  (Includes those with complications and all children under 3 yrs)
- Number of symptomatic patients requiring hospital admission (4%) = 3,680
  - Number of hospitalisations requiring critical care (25%) = 920
- Number of excess deaths (if case-fatality rate of 2.5%) = 2,300

Kingston PCT runs a multidisciplinary flu pandemic planning committee with membership coming from various health and non-health organisations. This committee considers plans as they are developed and ensures effective communications between agencies.

The PCT have also stockpiled infection control equipment to be used during a flu pandemic. This includes items such as masks, aprons and alcohol gel, and will be used by staff treating patients with flu.

Key messages if you should catch flu during a pandemic

You can reduce, but not eliminate, the risk of catching or spreading flu during a pandemic by:

- Covering your nose and mouth when coughing or sneezing, and using a tissue when possible
- Disposing of dirty tissues promptly and carefully - bag and bin them
- Avoiding non-essential travel and large crowds whenever possible
- Maintaining good basic hygiene, for example washing your hands frequently with soap and water to reduce the spread of the virus from your hands to your face, or to other people.
- Cleaning hard surfaces (e.g. kitchen worktops, door handles) frequently, using a normal cleaning product
- Making sure your children follow this advice.

If you do catch flu during a pandemic:

- Stay at home and rest (those people who suffer complications of flu should receive a home visit)
- Phone the National flu line for advice and information about how to collect your antivirals
- Find a friend or member of your family to collect your antivirals (take these within 48 hours and ideally 12 hours of onset of symptoms)
- Take medicines such as aspirin, ibuprofen or paracetemol to relieve the symptoms (following the instructions with the medicines). Children under 16 must not be given aspirin or ready made flu remedies containing aspirin
- Drink plenty of fluids.

These measures are for your own health and to avoid spreading the illness to others.