

Peter Tallantire
Civil Contingencies Secretariat

22 Whitehall
Kirkland House
London
SW1A 2WH

Telephone 020 7276 5101
Fax 020 7276 5316
Email peter.tallantire@cabinet-office.x.gsi.gov.uk
Web www.cabinetoffice.gov.uk

09 April 2010

Dear Simon

Thank you for the opportunity to input into the review of the 2009 influenza pandemic. Overall, we believe the UK responded well to the challenges posed by the Swine Flu virus, but after any response, however successful, it is important to review what happened and identify and learn lessons to improve our preparedness for a similar event. We are doing so within the Civil Contingencies Secretariat and wait with anticipation the wider recommendations of the Review.

An influenza pandemic was identified five years ago as the top risk facing the UK. As a result, a dedicated programme of work was put in place to ensure the UK as a whole was adequately prepared for such an eventuality. These detailed preparations stood us in good stead and allowed the Government, NHS and local responders to adapt quickly to the challenge posed by the virus. As with all emergencies, the response was shaped to fit the emerging situation with a number of innovations being developed to meet the specific challenges we faced. These steps along with the thorough preparatory work played a major part in ensuring an effective pan-UK response.

I have also attached a number of background papers to help your understanding of the issues and the context at the time. These papers should not be released without the agreement of the Civil Contingencies Secretariat as a number are Cabinet Committee papers while others relate to privileged legal advice.

This response to the call for evidence will focus on the following areas of inquiry: Central government response, communications and wider health issues. However, my team and I are happy to provide input into other areas should it prove useful.

Yours

Peter Tallantire



RESTRICTED

Evidence

19. What was the central government machinery and decision-making structure? Did the approach differ from other crises?

The UK central Government arrangements for responding to an emergency are described in the *Central Government Arrangements for Responding to an Emergency – Concept of Operations* (CONOPS 2005). This guided both planning prior to the outbreak of H1N1 and the decision-making structure adopted during the response. The March 2005 edition of CONOPS was under review when the H1N1 response began so the arrangements during the H1N1 response were also guided by the developing thinking. The updated version of CONOPS was published in March 2010, and includes refinements identified during operations and exercises over the intervening period, including the H1N1 outbreak¹.

Triggers for the activation of the central response for a pandemic influenza are outlined in *Pandemic flu: A National Framework for Responding to an Influenza Pandemic* and further developed in the COBR Response Guide to Pandemic Influenza. These triggers were linked to the system of WHO indicators and alerts. The trigger for activation of CCC/CCC(O) was expected to be a move to Phase 4 of the WHO's pandemic alert levels which would suggest that a virus was becoming increasingly better adapted to humans but may not yet be fully transmissible. However, the uncertain situation in Mexico and potential for travellers from the US and Mexico to bring the virus to the UK were considered sufficient to require a Civil Contingencies Committee meeting at official level (CCC(O)) on Sunday 26th April 2009 to update colleagues on the developing situation and review UK preparation. The Ministerial Civil Contingencies Committee (CCC) first met on the 27th April 2009 to discuss the emerging influenza outbreak in Mexico, the United States and the implications for the UK.

In order to facilitate coordination of the response, the Civil Contingencies Secretariat (CCS) set up the following teams in the COBR facility at 35 Great Smith Street:

- a) Operational Cell - running day to day practical business of COBR)
- b) Policy Cell (including a Business Continuity sub-cell) – policy formulation including the broad shape and direction of both health and non-health aspects of the response
- c) Situation Cell – ensuring a common appreciation of the evolving situation
- d) International Cell – working with DH, FCO and DfID to ensure a common understanding of international developments and a co-ordinated UK position, particularly with the EU and UN.
- e) Stakeholder Cell – ensuring a smooth two-way flow of information between central government and local responders via the Government Offices in the English regions and the devolved administrations.

¹ In-depth of explanation about the role of the Cabinet Office (CONOPS 2010, Page 19) and the role of the DAs under different scenarios.(Pages 18, 39-41and 44), the definition of the SAGE Scientific Advisory mechanism (page 34), and more detail and clarity regarding the structure and role of the IMG (page 28).



RESTRICTED

- f) Legal Cell – advising on the requirement for additional legal powers and how this might best be met
- g) Communications Cell (National Communications Centre or NCC) – maintaining a core media brief for use by central government and local responders

Taken together, the work of the policy, stakeholder, international and legal cells correspond to the functions of the Impact Management Group (IMG) outlined in the CONOPS 2005 model (para 36 and CONOPS 2010, page 28).

In line with CONOPS 2010, a Scientific Advisory Group for Emergencies was also set up to provide independent scientific advice on the development of response measures. SAGE advice informed CCC decision-making and that of the Four Nations Health forum.

References:

- Responding To Emergencies – The UK Central Government Response – Concept of Operations (CONOPS): Cabinet Office, March 2010.
<http://www.cabinetoffice.gov.uk/media/349120/conops-2010.pdf>
- National Framework for Responding to an Influenza Pandemic: Department of Health, Nov 2007.
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080745.pdf

20. What was the rationale for the membership of CCC and CCC(O)?

Membership of the CCC is flexible and can include ministers as well as senior representatives from other organisations to enable it to respond to the changing demands of a situation. For reasons of continuity, the initial CCC and CCC(O) membership was based on that of the Ministerial Committee on Pandemic Influenza Planning (MISC32) and the supporting officials group, the Pandemic Flu Implementation Group (PFIG) under the Chairmanship of the Secretary of State for Health (ref, para 4.3.1 *National Framework for Responding to an Influenza Pandemic*). The health Ministers and officials of the Welsh Assembly, Scottish executive and Northern Ireland Assembly were invited to attend all CCC and CCC(O) meetings respectively (see Guide to Cabinet Committee Business) and the CCS provided teleconferencing facilities for all meetings to facilitate attendance by Ministers and officials if they could not attend in person.

Devolved Administration representation in the CCC was typically through the health Ministers with wider cross-subject input at the official level.

The role of the Department of Health (DH) as lead department in managing human infectious diseases in England is outlined in *'The lead Government Department and its role – Guidance and Best Practice'*: Cabinet Office, March 2004. The CCS provided cross-departmental support to DH's work and co-ordination of the



RESTRICTED

Government's response as the secretariat to CCC and CCC(O). The CCS also chaired meetings of the CCC(O).

Because of the range of cross-cutting issues identified in the planning for pandemic influenza, the majority of Westminster departments were involved in the response.

Throughout the response, CCC attendance was flexible with some departments being represented only when issues relevant to their remit were discussed e.g. the Department for International Development on international aid and the Department for Culture, Media and Sport on mass gatherings.

In line with the CONOPS model, and in order to provide technical advice to the CCC, the Chief Scientific Advisor attended CCC meetings to represent SAGE (ref COBR Response Guide, page 15, para 5.2) and the Chief Medical Officer (CMO)² was invited to provide public health advice and represent the practical considerations of the Department of Health.

The Local Government Association (LGA) was invited to represent local government concerns and perspectives which had previously been built into planning through LGA membership of MISC32.

References

- Terms of Reference for the Ministerial Committee on Pandemic Influenza Planning (MISC32)
<http://www.cabinetoffice.gov.uk/secretariats/committees/misc32.aspx>
- Guide to Cabinet Committee Business
http://www.cabinetoffice.gov.uk/media/98307/guide_to_cabinet.pdf
- The Role of Lead Government Departments in Planning for and Managing Crises
http://www.cabinetoffice.gov.uk/media/132847/lgds_framework.pdf
- The lead Government Department and its role – Guidance and Best Practice: Cabinet Office, March 2004.
<http://www.cabinetoffice.gov.uk/media/132844/lgds.pdf>

21. What was the reason for the introduction of Four Nation Health Ministers meetings? What impact did this have on the response?

² England's Chief Medical Officer acts as the UK Government's principal source of public health advice and information. Each of the devolved administrations also has a Chief Medical Officer and, working collaboratively, they ensure a comprehensive and coordinated UK-wide public health approach. They also give strategic and tactical health policy direction, form a central focal point for clinical advice and expertise, and provide leadership for health professionals and the NHS.



RESTRICTED

As our understanding of the outbreak developed, it became clear that the bulk of the policy issues would fall to the Department of Health and its devolved counterparts. Therefore, in line with the principle of 'subsidiarity'³ and in order to keep meetings focused and provide a forum for detailed health issues to be discussed; a dedicated health forum was formed from June 2009 onwards, with a CCS secretariat. The four Nations' health forum met regularly throughout the remainder of the response. It consisted of official and ministerial level meetings with Ministers meetings chaired by the Secretary of State for Health, and officials meetings chaired by CCS.

This extended operational model was formally endorsed by 4 Nations health Ministers. The note references the importance of expedience in keeping the burden upon Ministers to a minimum where possible, whilst giving health policy decisions the level of detailed attention required for an effective response. The new arrangements would support the discussion of operational health issues across the four home nations, so that the relevant ministers supported by CMOs could explore in more detail the pressures on their respective systems and how these might be addressed (ref para 4.4.1. *National Framework for Responding to an Influenza Pandemic*). Health operational issues not affecting the interests of other departments were taken forward within the four home nations without reference to CCC, although decisions would be briefed where appropriate into CCC for information. Other non-health issues or health issues raising significant implications for the wider response continued to be put to the CCC.

While the then current CONOPS (2005 version) acknowledged and made provision for DA involvement where emergency impacts crossed the Four Nations boundaries, it did not make explicit their role under the scenario of a UK wide emergency (para 58). The updated CONOPS (2010 version) is more explicit, and reflects the approach taken in the H1N1 response for CCC and CCC(O) (para 3.62).

22. What were the expectations on DH as lead department? Did these change over the course of the pandemic?

The role of the lead department is laid out in *The lead Government Department and its role – Guidance and Best Practice: Cabinet Office, March 2004*.

The document outlines the expectation for the lead department to fully undertake assessment, planning, preparation and validation. This was previously well underway under MISC32 and PFIG and is well evidenced in the *National Framework for Responding to an Influenza Pandemic*.

As well as undertaking their normal responsibilities, Health Ministers oversaw and directed the cross-Departmental response; were accountable for the broad shape of the response to Parliament, supported by colleagues as necessary; and had a leading role in presentational activity, supported especially by the CMO.

³ CONOPS 2005, Page 4: Subsidiarity. Decisions should be taken at the lowest appropriate level, with co-ordination at the highest necessary level.



RESTRICTED

More specifically, as lead UK Government department during a response DH was expected to act as communications focal point, coordinating and disseminating information to the public; providing regular situation reporting to their minister and the director of CCS; and accounting to parliament and learning and sharing lessons from the emergency. In addition, the Department of Health coordinated the provision of appropriate medical/scientific advice and logistical policy formulation. The CCS supported the Department of Health on the coordination of non-health issues, commissioning policy work from other departments where issues were cross-cutting or firmly under the remit of the other departments, and in ensuring an effective pan-UK response.

30. Who were the key stakeholders identified in April 2009? What arrangements were in place for engaging them, and how did these develop subsequently?

This response to the call for evidence will focus on stakeholder communication activities by the Civil Contingencies Secretariat with Government Departments, local responders and businesses. The Health Departments and Health Protection Agencies across the UK had a pivotal role in communicating with Parliament, the public and the media.

The *National Framework for Responding to Pandemic Influenza* identifies Government Departments, Devolved Administrations (DAs), the local and regional planning tier, the voluntary sector, businesses and community networks as key stakeholders. Existing networks and contacts lists were used to identify these groups and to engage with them and these lists were updated as the pandemic progressed. Since it was impossible to know or have links with every individual stakeholder, given the volume of them, this was in practice a list of lists with COBR holding a list of “gatekeepers” which had links with relevant networks. Given the volume of stakeholders and associated issues and queries, a dedicated stakeholder cell was set up within COBR to manage stakeholder relations and the National Communications Centre (NCC) was activated to deal with the media and communications with the public. The principles behind the NCC and working with the media can be found in chapter 8 of *Emergency Response and Recovery*.




The tools and networks that were frequently used to engage with stakeholders is summarised in annex 1. The annex outlines the development and background to these tools and networks, their purpose and audience and indicates where examples and more detail can be found. This annex purposefully excludes arrangements for working with the media and products produced by other Departments as this is covered under question 32.

In addition to the regularly used tools and networks listed in annex 1, ad-hoc tailored guidance was also produced for various groups as requirements arose. Tailored guidance documents and where they can be found are listed below. These guidance documents were made available on the UK Resilience section of the Cabinet Office website, Departmental websites, Direct Gov or the Business Link website as appropriate.



RESTRICTED

References and tailored guidance

- Cabinet Office, DH and WAG guidance for the third sector -
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099094
- Cabinet Office Facemask FAQs:

Facemask
FAQS-v5.pdf
- Cabinet Office Guidance for Local Authorities on Facemasks for Social Care Workers:

090505 Guidance for
Local Authorities on F
- Cabinet office and DH Supplementary information for the third sector:

090512
Supplementary Inforr
- Emergency Response and Recovery: HM Government.
<http://www.cabinetoffice.gov.uk/media/238642/err-guidance-120809.pdf>



RESTRICTED

34. How was scientific advice communicated to the media and the public?

The *National Framework for Responding to Pandemic Influenza* outlined the importance of having consistent planning assumptions to avoid confusion, which summarised the potential scale and characteristics of the pandemic for a reasonable worst case scenario to encourage robust planning and preparations. The framework highlighted the need for plans to be: “flexible enough to deal with a range of possibilities and be capable of adjustment as they are implemented” and that the assumptions were “working estimates rather than predictions”.

As is often the case for any disease outbreak, in the early stages of the H1N1 pandemic data were limited and the quality of available data from Mexico questionable. The data in Mexico indicated high fatality rates which was worrying. Consequently, whilst the quality of this data was uncertain it was considered prudent to plan for the worst. For this reason in the initial stages of the pandemic the planning assumptions set out in the National Framework continued to be used with local and regional planners encouraged to use them as a basis for preparations and the UK’s readiness to respond being assessed against them.

As more data became available it was possible to rule out some of the worst scenario as implausible. This narrowed the range of plausible scenarios and revised down the reasonable worst case scenario. In the interest of proportionality and to assist preparations, a H1N1 pandemic specific set of planning assumptions were produced. These assumptions were formulated initially by the modelling sub-group of the Scientific Pandemic Influenza Advisory Committee (SPI-M) and were agreed by the Scientific Advisory Group for Emergencies. These planning assumptions were circulated to local and regional planners, government departments and businesses, via BANF (see Annex 1).

These assumptions were regularly monitored by SPI-M and SAGE. As the pandemic developed and it became apparent the pandemic was less severe than first thought the H1N1 planning assumptions were revised downwards two further times. On the latter occasion, the summary of what to expect was presented as “guidance for planners” because of the increased certainty of what was presented. On both occasions, the assumptions were circulated to local and regional planners, government departments and businesses, via BANF and on both occasions, the guidance was accompanied by a questions and answers section to address anticipated concerns.

The three sets of H1N1 planning assumptions and their associated handling material are attached below.



20090716 - Planning Assumptions.pdf



20090903_Planning Assumptions_Final.pc



20091022_swine flu guidance for planners



20090716 - BM covering letter for Pl&BANF on 3 Sept



090903 Letter to



20091022_Letter covering 22 Oct guid



RESTRICTED

36. What evidence is there on the response to the pandemic of other stakeholders?

The *Civil Contingencies Act 2004* (CCA) places duties on a number of organisations to prepare for emergencies, including pandemic influenza. The CCA also states that within each police area, a Local Resilience Forum (LRF) should be set up to act as a mechanism for cooperation⁴. The CCA can be found at: www.statutelaw.gov.uk and further details on how it should be implemented can be found in *Emergency Preparedness*.

This legislation is designed to enable effective response to and recovery from emergencies. The *Emergency Response and Recovery (ERR)* guidance outlines the key principles for the response and recovery phase and highlights examples of good practice, identified from recent response and recovery efforts. In particular, chapter 4 sets out the arrangements for response in the local tier and chapter 9 sets out regional response and recovery arrangements.

The response of statutory responders covered by the CCA was broadly as outlined in *ERR*. On the 26 April, LRFs were asked to start making non-health preparations and Strategic Co-ordinating Groups (SCGs) were stood up. At the regional level, Regional Co-ordinating Groups (RegCGs - and their equivalents in the DA areas) were established to ensure consistency of response across their area. The Regional Resilience Teams (based in the Government Offices for the Regions) and DAs continued to act as the conduit for communications between local and regional planners and central Government, and provided support and challenge to the SCGs / RegCGs as necessary.

As the response to the outbreak progressed, local and regional responders regularly reviewed the co-ordinating structures outlined above, and as the impacts lessened, these were stood down or replaced with more tactical groups as appropriate.

The National Framework had proposed that Regional Civil Contingency Committees (RCCCs) would be activated in the event of a pandemic. Following the publication of the framework however regional arrangements were refined and the concept of RegCGs was introduced to provide a lighter touch approach to RCCCs (see chapter 9 of *ERR*).

References

- Emergency Preparedness
<http://www.cabinetoffice.gov.uk/ukresilience/preparedness.aspx>

⁴ London is the exception, where 6 LRFs exist within the Metropolitan Police boundaries.



RESTRICTED

38. What work was done on preparing emergency legislation? Was everything necessary in place to enable such legislation, had the pandemic been more severe?

Prior to the outbreak of swine flu, the CCS was leading a piece of work looking at legislation that may need to be relaxed to ensure the UK was in the best possible position to respond to an influenza pandemic whilst maintaining essential services. Officials from the Pandemic Flu Implementation group, a cross-government officials group including representation from the Devolved Administrations, worked with the CCS to identify all regulations of interest. To facilitate proper parliamentary scrutiny of proposals, departments agreed to include response amendments in Bills scheduled to undergo parliamentary review where possible.

When the COBR response to the swine flu pandemic was activated, a legal cell was established to coordinate work on legislative requirements to facilitate the response. The CCC(O) agreed that all legislative requirements should be coordinated via CCC(O) in the first instance, and via CCC should the measure have implications for more than one department or require emergency legislation. As secretariat to the CCC, the CCS provided strategic coordination to the consideration of, and progress with legislative measures in order that they were handled in a coherent and consistent manner. Working with the lead department, the CCS provided a conduit to CCC(O) or CCC as appropriate, to ensure that each proposed measures was subject to the appropriate level of approval and their handling could be managed as part of the broader response and communication arrangements.

Many of the measures identified prior to the outbreak of swine flu were designed to address a variety of issues across the spectrum of risks that could result from a severe pandemic. Therefore many were not required during swine flu; however the process of assessment was useful in itself to refine the thinking of the policy owners. Others required immediate action, either in terms of making secondary amendments, or starting the process to prepare the primary legislation in case it were to be needed.

Secondary Legislation

During the course of the pandemic, a number of changes were made to secondary legislation to facilitate the response. These were predominately relating to health legislation to provide antiviral medicines without the need for a prescription form via the National Pandemic Flu Service.

7. The key changes made on the 7th May 2009 were to:

- a) allow antivirals to be distributed without a prescription form;
- b) remove prescription charges for supply of antivirals by primary care when supplied via the pandemic protocol;



RESTRICTED

c) remove charges in secondary care for non-UK residents for treatment of pandemic influenza;

d) to relax labelling requirements for medicines supplied to children under 1.

Further details about this legislation can be provided by the Department of Health.

39. What work was done on sickness certification? Was everything necessary in place to enable necessary changes to be made, in the event of a more severe pandemic?

Prior to the H1N1 pandemic, a policy to allow self-certification for illness to be lengthened from 7 to 14 days in the event of a pandemic was agreed by both ministers and industry. This policy was designed to ease the burden on GPs' during a pandemic and was based upon the DH assumption that the average length of expected sickness was between 5 and 10 days and DWP consultations with interested parties. (The relevant Misc 32 and PFIG paper are included below).

During the H1N1 Pandemic, SAGE were commissioned to analyse sickness data to determine the average sickness duration for Swine Flu. This information was used to inform a UK-wide review of the pre-pandemic policy and to formulate a number of options.....

BANF was used as the primary mechanism for consulting businesses and, on the 25 August, a workshop to gauge their opinions and preferences was organised. The presentation that was delivered at this workshop is attached below. This consultation highlighted that there was need to more clearly communicate how the current self-certification system worked and indicated that employers were reluctant to accept tamiflu labels as proof of sickness as an interim measure. Businesses stated that: any change should be as a 'last resort'; that it would be easier for them to administer the change if the extension to the self-certification period was brought in for all illnesses, not just for swine flu; that they would want to see the change brought in uniformly across the UK; and also that as much advance notice as possible should be given of any changes as they would need to make adjustments to their sickness reporting procedures and systems. The findings from this workshop and similar events held in the Devolved Administration areas were presented back to CCC(O) and to CCC.



090806 BANF
Sickness Cert Worksh

To address the need for additional clarity on current sickness certification policy, UK-wide guidance was developed and published on the business link and DirectGov websites (links below). To provide feedback on how the workshop findings had been used: a letter was issued to GPs via the resilience Gateway; information was presented back to BANF at their 19 October meeting and this presentation was disseminated. (These documents are attached below).



INVESTOR IN PEOPLE

RESTRICTED

<http://www.businesslink.gov.uk/bdotg/action/detail?type=RESOURCES&itemId=1083560353>

http://www.direct.gov.uk/en/Swineflu/DG_180996



Gateway Letter Sick SLIDES - BANF 19th
Cert Comms GPs 210: October (for circulatik

Although on the 8 October Ministers agreed that on the basis of information from GPs on pressures, an extension for the self-certification sickness period was not required, the information from the workshop enabled policy to be further refined and meant the UK was better prepared in case an extension to the self-certification period was ever required. DWP agreed to stand ready to revise the sickness extension from 14 to 10 days, if this was ever required.



RESTRICTED



INVESTOR IN PEOPLE