

FLU REVIEW AREAS OF INQUIRY – response from DWP including HSE

General

1. What aspects of the Pandemic Flu Response worked well? What would you wish to do differently in another pandemic?

The CCC meeting structure/ battle rhythm worked well. The production of clear outcomes and the steer on communications maintained the “common picture”.

Directgov was successfully used to provide 24/7 cross-government messages to the public via web and mobile and Digital TV.

The external message ‘catch it, bin it, kill it’ produced a clear ‘brand’ which was recognisable throughout the pandemic by both public and industry.

The joint (HSE, DH, HPA) production of the face-fit testing guide/posters was a valuable exercise which further encouraged effective cross-departmental working.

For future pandemics, it is important that respirators are ordered from more than one manufacturer to take account of guidance in respect of having more than one make of mask available to gain the best fit for a diversity of users.

It may be helpful in future pandemics for workplace guidance to be primarily generic rather than sector specific (not withstanding the need for specific guidance in sectors such as health and social care) to ensure clear and consistent messaging.

2. What aspects of the Pandemic Flu Response would have had to change in the event of a more severe pandemic?

Consideration to be given to holding meetings via telekit rather than face to face – all key senior managers in one room does introduce the risk of cross infection.

National planning assumptions would probably need to be issued to HMG and Industry more frequently, with clear evidence based trigger points moving response up to the next stage. This would allow rapid implementation of pre-planned business continuity measures in response to rapidly changing circumstances.

There might be merit in re-visiting the UK National Alert Levels up to full Pandemic status.

The information available on external websites was prepared for avian flu or something of similar severity. It might be worth considering the benefit of a

wider range of guidance, tied in to planning assumptions based around 'lesser' flu and tailored to the particular alert levels. There was clear guidance available for when the pandemic was declared; less for the 'pre-pandemic' phase April – June 2009.

For a future pandemic, and due to the experience of in most cases the 'relatively mild' H1N1, the primary challenge might be that of communication and encouraging the public to treat it as a serious threat

The CCS sessions for businesses (BANF) were valuable. However, in a more severe pandemic it might be inappropriate to convene large meetings due to the risk of cross-infection and other communications channels will need to be utilised.

Vaccines

3. What lead to the decision made to opt for 100% rather than 45% coverage of the population, based on two doses per patient?
4. On what grounds was the decision to purchase 30m extra doses of vaccine made?
5. What drove the procurement policy (e.g. number of companies, break points etc)?
6. What were the factors driving the distribution policy of focusing on high risk groups?
7. What was the impact of the WHO alert levels on procurement of vaccines, for example in relation to APAs?
8. Which options were considered for delivering vaccines and what lead to the choice of GPs?
9. Could negotiations with GPs have been initiated in advance of any pandemic emerging?

Containment

10. How were the decisions made on containment? What issues drove the policy?
11. What were the triggers for moving away from containment, and what were these based on?
12. What drove the policy on school closures, and how were individual decisions made?
13. What was the policy on port health inspections, and what issues drove this policy?

14. What was the policy on travel advice, and what issues drove this policy?
15. What was the policy on mass gatherings, and what issues drove this policy?
16. What was the policy on prophylaxis and what issues drove this policy?

Treatment

17. What was the policy on antivirals procurement and distribution, and what factors under-pinned this policy?
18. What issues drove the different implementation decisions across the Four Nations? [NB: we are not seeking to assess the operational decisions in the Four Nations, but rather trying to elucidate how far the UK-wide response facilitated locally-sensitive responses]

Central Government Response

19. What was the central government machinery and decision-making structure? Did the approach differ from other crises?
20. What was the rationale for the membership of CCC and CCC(O)?
21. What was the reason for the introduction of Four Nation Health Ministers meetings? What impact did this have on the response?

Health and safety at work legislation is not devolved within Great Britain (though there is separate legislation for NI). In order to best fulfil its role as a category 2 responder HSE would welcome early involvement in health discussions among the responder community that might relate to workplace health and safety issues.

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

Scientific/Clinical Advice

23. What scientific advice was available to Government, and how was this presented to Ministers?
24. What was the balance of expertise on SAGE?
25. How was the relationship between SAGE and JCVI?
26. What was the role of PICO in relation to SAGE?

27. What surveillance systems were in place in April across the different countries of the UK, and how did these develop over the course of the pandemic?
28. What data was collected and how was it used?
29. What was the role of the Standing Committee on Ethics in decision-making?

Communications

30. Who were with key stakeholders identified in April 2009. What arrangements were in place for engaging them, and how did these develop subsequently?
31. What arrangements were in place or put in place to ensure a consistent set of messages across the four nations?
32. How were the media and social networks monitored and engaged?
33. What evidence is there on public responses to the handling of the pandemic?
34. How was scientific advice communicated to the media and public?

Some groups will attract increased media interest, e.g. children and pregnant women. The science underpinning advice in respect of these groups might come under particular scrutiny from the media and the scientific community. This reinforces the need for robust peer review of scientific evidence and for anticipating, if and where possible, likely questions in respect of these groups and that evidence.

35. What evidence is there on clinical responses to the handling of the pandemic?
36. What evidence is there on the response to the pandemic of other stakeholders?

Wider Health Issues

37. What work was done on preparing for more deaths? How prepared was the system for the impact of a more severe pandemic?

DWP reviewed the process for dealing with claims for Bereavement Benefit to address the potential excessive increase in claims based on the original National Planning Assumptions. This included a detailed analysis of the impact of increased customer deaths across its delivery channels - including telephony usage, visits to Jobcentres, the impact on Directgov and correspondence - to identify mitigating strategies required to respond effectively to increases in enquiries and claims.

The work concluded that DWP was well placed to deliver an effective service to customers in need using the existing channels

HSE worked in collaboration with DH and HPA to produce H1N1 specific infection control guidance.

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

It was agreed prior to the pandemic that the issue of relaxing or suspending Health and Safety legislation did not need to be taken further, due to the flexible provisions already available within such legislation. During the pandemic HSE produced guidance for its inspectors entering certain health and social care premises, as well as actively working with DECC and Oil and Gas UK (OGUK) to ensure business continuity at gas, electricity and nuclear sites.

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?

DWP supported DoH in this issue, including attending discussions with employers and other key stakeholders about an extension to the period of self certification for Statutory Sick Pay and benefit purposes. The outcome was the agreement that officials should continue to stand ready for legislative change should it be necessary in the event of increasing demands from a second wave of swine flu.

Whilst there was no immediate requirement for legislative change, it was recommended that officials should continue to plan for it in the event of a possible further significant wave this autumn and winter. Taking into account the views of employers, and if legislative change becomes demonstrably necessary, this will be introduced:

- For a 10 day period of self-certification.*
- With a sunset clause of three months in the first instance, with the proviso that this period could be extended if UK wide pressures on GPs were to remain high.*
- Any legislative change would be GB wide with NI matching legislation and should apply to all illnesses not just flu-like symptoms.*

The Legislative vehicle is the Statutory Sick Pay (Medical Evidence) Regulations 1985 and the Social Security (Medical Evidence) Regulations 1976. All necessary steps were in place to quickly introduce modification regulations by negative resolution procedure. These regulations will have a limited life span for use during a pandemic only.