

## East of England H1N1 Influenza Outbreak 2009 Debrief 7 May 2010

### Introduction

The aim of the multi-agency regional LRF debrief was to provide an opportunity for **constructive** feedback, facilitate sharing and discussion and identify:

- lessons to be learned / areas for improvement
- good practice and areas of success
- issues for consideration, action & implementation

The day was divided into four discussion periods, each based on a distinct stage of the response. Before each discussion period, one or two partners gave presentations on what that stage had meant for them.

Around 40 delegates from a range of organisations separated into 5 groups, with a cross-section of health and non-health representation in each group. Each group was asked to identify two positive and two negative issues for each phase.

### Activation Phase

#### Positives:

- Teleconferencing emerged as a very useful operational tool as more partners became used to it
- The local partnerships and previous planning that underpinned the flu plans helped partners mount a flexible response outside the pre-planned procedures
- Conops was useful, and the systems worked even if the plan itself did not
- The instigation of local and regional command and control worked well
- Early notification of the possible pandemic was welcomed by all and also acted as a catalyst for those needing to complete their flu planning.

#### Negatives:

- The existing plans were not scalable, and were not appropriate to the incident
- It was clear there were two strands of communications and two ways of thinking – DH being much more comfortable with command & control issues for the Health Service than the CCS line could be in dealing with the wider multi-agency partners
- WHO alert levels were reliant on the initial host nation having good surveillance
- Ethical and practical issues generally appeared not to have been sufficiently thought through – there was insufficient guidance
- There were too many lines of communication. Reporting was an additional burden that would have become unsustainable if the outbreak had been severe. There was a feeling locally that central govt acted as if flu was the only thing happening
- Should have moved to exception reporting once the initial situation was established and it became clear most reports were either nil returns or padded out with data that was perhaps locally interesting but not of national strategic value
- Easy to lose key information in the unwieldy sitreps

## Containment Phase

### Positives:

- The targeted approach to cases and establishment of the Flu Response Centre bought time for the setting up of the National Pandemic Flu Service and for the development of further guidance.
- Although the Flu Response Centre and containment phase were not part of any existing plans, the health network locally successfully implemented them
- There was good co-operative working during the school outbreaks between NHS, HPA and Local Authorities/schools.
- Organisations quickly identified the need to focus on business continuity, with a significant raise in BC profile which still persists as a legacy
- Good media – being seen to take action increased public confidence in the response

### Negatives:

- The containment phase was not planned for, the parameters changed as thinking developed, and swabbing results were slower and slower to come through
- There were unreasonable expectations of what information could be provided to schools to allow informed decision making
- Some authorities did not have appropriate contact details available
- The FRC affected the relationship between PCTs and GPs
- FRC and HPA algorithms appeared to affect the confidence of GPs and effectively “de-skill” them
- Lack of “joined-up” thinking around school reporting, and also inconsistent messages
- Partners frustrated by the inability to share information about where outbreaks were because of data protection and Caldecott rules
- Differences in approach, particularly for schools, were difficult to manage because the transition from containment to treatment was not made quickly and cleanly
- Wastage of antivirals – only 10% of those tested were shown to have needed the antivirals supplied to them, and many of those who were supplied a/v’s did not complete their courses for various reasons (eg side effects)

## Treatment Phase

### Positives:

- Use of pharmacies and ability to apply local solutions, wherever possible trying to keep to ‘normal ways of working’
- Partnership working ensured ACPs were set up on time, and were effective. Joint working undertaken to identify premises
- NPFS took pressure off stretched GPs
- Issues with antiviral solution were dealt with through good mutual aid
- PCTs had to employ their business continuity plans
- Innovative ideas adopted for flu friends
- Transportation of a/v supplies to PCTs
- Support for data entry at ACPs from PCTs. The daily data supplied by the NPFS was very helpful

### **Negatives:**

- Real issues for acutes/PCT/Ambulance during treatment phase
- Complexity of treatment requirements for in patients
- Insurance for flu friends not always clearly resolved
- Original planning assumed all non-critical LA services would be closed freeing premises for use as ACPs – was not the case
- More consistency of criteria and guidance required, too much shifting of goalposts
- Planning appeared London-centric, insufficient regard to rural issues (eg initial negative view of pharmacies)
- Inconsistency of approach to the flu friend system
- LAs expected to take on roles that should be down to NHS – eg issuing of drugs
- Treatment for all was a burden that was not clinically justified

### **Vaccination Phase**

#### **Positives:**

- Having a vaccine available
- Immform was a good system
- Need to set up community vaccination clinics because GPs refused to do u5s led to useful child health status surveillance which identified other issues
- Occupational health at LAs were trained to deliver their own vaccinations
- NHS East of England highlighted as best practice for getting contracts in place with GPs to deliver the vaccines
- Good take up of vaccine
- Positive messages from senior clinicians, and delivery to front-line health care workers by own staff both led to better take up, as did delivery in the workplace
- Delivery was efficient and cold chains were maintained
- DH did eventually contribute towards cost of vaccinating social care staff

#### **Negatives:**

- Staff have a duty of care which is imperfectly understood, needs to be part of the professional conduct requirement
- The lack of GP engagement – remuneration for GPs was poor
- GPs were engaged in delivery of seasonal vaccine – most failed to identify concurrent vaccination as a business opportunity even if dissatisfied with rates for delivering pandemic vaccine
- Multi-dose vials were wasteful – eg difficult for GPs to offer opportune vaccinations
- Equipment to deliver the vaccine inadequate
- Lack of depth in the pre-planning – insufficient detailed planning
- Lack of flexibility from the contractors delivering vaccine to PCTs
- DH lack knowledge about how social care is delivered locally
- Inconsistencies across the Region
- Demand for the vaccine from the public was not there
- Responsibility for children outside the LA area was an issue
- Clinicians not acting as positive role models

## Recommendations

- Management of information needs to be better managed to avoid separate communication lines (DH/NHS – CCS/LRF).
- Central direction needs to be strategic, start early, be consistent but also sensitive to local situations
- View NHS and Care Services as a whole system (Health & Social Care), and undertake joint planning with NHS and social care
- Requests for information should be clear in what they aim to achieve and proportionate to the effort required in gathering the data
- Ensure role of GPs is defined and can be relied upon to be delivered as part of the public service / make GPs category 1 responders?
  
- Planning at all levels needs to build in support for information gathering systems for all types of incidents where there is a significant central government demand for information
- Plans must be flexible and scaleable, dealing with consequences and generic arrangements – infectious disease plan rather than just a pan flu plan
- Planning needs to provide space for local variation where required – provide as a framework rather than a plan
- Alerting, activation and communication lines need to be much clearer and focussed
- Situation Reports need to be streamlined to ensure key information is not lost
- More planning is required for issues of community and social care
- Lessons identified need to be reflected in future commissioning and outsourcing, eg contractors/external providers complying with BS25999
- Use existing structures, facilities and expertise to deliver – eg surgeries and health centres for vaccines and antivirals.
- Develop full list of social care providers and better communications arrangements
- Go to the target group (eg social care staff) to get adequate take up, rather than expect them to come to some central point
- Local plans should be independently validated and exercised