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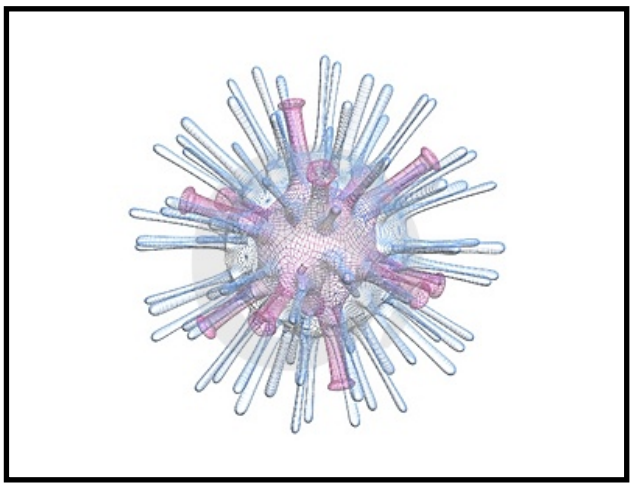
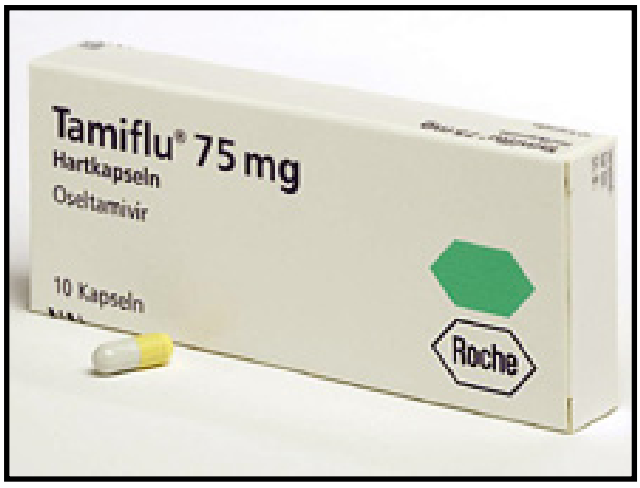
Swine Flu Review Submission





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1 Introduction

This document has been prepared by Serco Group plc as a submission to the Cabinet Office's Swine Flu Review. It incorporates the observations and lessons identified from a recent internal review of Serco's response to the H1N1 (2009) influenza outbreak during the period April 2009 to February 2010.

Serco Group is a UK-listed company responsible for the management and / or operation of some significant UK public sector services including prisons, hospitals, health services, schools, defence facilities, local government services and transport (road, rail, air and marine) with similar contracts internationally. The company employs more than 70,000 staff worldwide of whom approximately 40,000 are located in the UK.

2 Preparation and Planning

2.1 Contingency Plans

Pandemic flu was been added to Serco Group's corporate risk register in April 2006 and a Group Contingency Plan developed that generally followed the 2005 national pandemic flu plan in terms of the response stages. The Group's plan was significantly updated in November 2007 to reflect the more detailed guidance set out in the 2007 national pandemic flu plan. In conjunction with the Contingency Plan, a set of Pandemic Flu Policies and HR Policies were also issued. An important feature of the Contingency Plan was that specific actions / control measures were linked directly to the announcement of the World Health Organization (WHO) pandemic phases and the UK Alert Levels in line with the national plan.

2.2 Planning Scenarios

A pandemic flu briefing note was produced in 2007 and regularly updated, the most recent version being issued in August 2009. This document provided basic advice and guidance and set out planning assumptions (based on an H5N1 outbreak) and reference was made to the UK planning presumptions contained in the national plan.

2.3 Exercises

A pandemic flu table-top exercise (Exercise Fever Pitch) based on an H5N1 pandemic outbreak was developed and has been run for a number of Serco business units since 2007. A Group-wide pandemic flu exercise (Exercise Spring Fever) based on a similar scenario was run over an 8 day period in late January 2008 and involved 22 business unit locations. Both exercises focused on the operational and business impacts of a possible pandemic rather than the public health issues and proved useful in the development and validation of more robust contingency plans. The exercise scenario was driven by a model of the workplace absence rates by UK postcode during a 15-week pandemic wave that was produced for Serco by the Department of Infectious Disease Epidemiology of Imperial College, London.

Colleagues in the United States developed a number of similar exercises for various State Health Authorities specifically designed to test the medical response of hospitals and health care facilities.

3 Pandemic Response

3.1 Contingency Plans

At the start of the H1N1 (2009) influenza outbreak in April 2009, the 2007 versions of the Contingency Plan and Policies were used as the basis for the Group's response, led by the Panflu Crisis Team which was activated on 27 April 2009.

The Contingency Plan and Policies were significantly updated in August 2009 in the light of the experience of the outbreak to that date, in particular the 2007 version of the Group Contingency Plan did not provide for a scalable response depending on the severity of the disease. This was addressed in the revision of August 2009 where responses such as quarantine and travel restrictions were changed from "*implement*" to "*consider implementing*" based on local circumstances. A number of social distancing and business continuity measures were not implemented as originally planned because of the very limited impact of the disease on staff and business activities.

3.2 Planning Scenario

A Planning Scenario document was produced in May 2009 and subsequently updated in August 2009 and two Scenario Updates were produced in September and December 2009. These documents set out projections (not predictions) for the future course of events and the impact of the disease based on the best available evidence from multiple national and international sources including the Health Protection Agency (HPA) and the European Centre for Disease Prevention and Control (ECDC). The projections were expressed in probabilistic terms to reflect the considerable uncertainty about the outcomes, particularly in the early stages of the outbreak. A copy of the August 2009 version of this document is attached for information [**Ref A**].

3.3 Information for Staff

As part of Serco's Contingency Plan, a programme of internal communications for staff was implemented which included poster / notice board information, direct emails and information pages on the company's intranet sites. While much of the information included in the staff communications reflected general public health information, a number of leaflets were produced early in the outbreak to provide basic information; these were supplemented by "Frequently Asked Questions" which set out specific company measures such as quarantine / social distancing arrangements and changes to sickness / absence reporting. An example of a leaflet produced in April 2009 is attached [**Ref B**].

4 Information Requirements

The primary function of the Serco Group Panflu Crisis Team was to make any necessary decisions to protect Serco's staff, the company's ability to delivery essential services to customers and the continuity of key internal processes. The key requirement was for reliable information and early warning indications of possible changes in the nature and extent of the disease together with informed projections of the future course of the disease worldwide.

A wide range of UK and international information sources (primarily web sites) were consulted during the swine flu outbreak with the requirement to identify:

a. Current government advice / guidance / policy.
b. Indications of the spread of the disease in terms of the numbers of cases.
c. Indications of the severity of the disease
d. Projections about the future course of the disease

The following table identifies the main sources of information referred to during the outbreak and indicates their relative usefulness (● = Not very useful, ●●●●● = Very useful).

Country	Source	Usefulness
UK	Cabinet Office (UK Resilience)	●
UK	Department of Health	●
UK	Health Protection Agency (web site)	●●●
UK	Health Protection Agency (Hampshire & IOW Office)	---
UK	National Travel Health Network & Centre (NaTHNaC)	●
UK	Foreign & Commonwealth Office	●
UK	NHS Choices	●●●
UK	National Pandemic Flu Service	●●
UK	direct.gov	●●
EU	European Centre for Disease Prevention & Control (ECDC)	●●●●●
USA	Centers for Disease Control & Prevention (CDC)	●●●
USA	flu.gov	●●
CAN	Public Health Agency of Canada	●●
AUS	Department of Health & Ageing	●●●●
NZ	Ministry of Health	●●
Hong Kong SAR	Centre for Health Protection	●●
India	Ministry of Health & Family Welfare	●
South Africa	National Institute for Communicable Diseases	●●
UN	World Health Organization (WHO)	●●●
--	National & international press / broadcast media	●●

Most of the national authority sites provided very similar information based on WHO guidance and their own national plans. The Australian site was particularly useful in tracking the effect of the H1N1 (2009) virus during their winter flu period and it is noted that the Australian Government made a significant change to their pandemic alert phases by introducing a new "*Protect*" phase in September 2009 to reflect the relatively mild nature of the disease.

The primary source of detailed information was the ECDC which not only produced summary data on the numbers of cases across the EU countries but published regular and detailed risk assessments and forward-look risk assessments which contributed significantly to our Planning Scenario documents (see para 3.2 above).

Contact was made with the local HPA office covering Hampshire and the Isle of Wight, but it was made clear that the HPA's remit was to provide "*support and advice to the NHS, local authorities, emergency services, other arms length bodies, the Department of Health and the devolved administrations*" and not to commercial organisations, even those providing important public services.

In terms of tracking the spread of the disease in the UK in a way that was relevant to our business needs, we used the HPA data published on their web site on:

a. Total number of reported cases until these was discontinued in July 2009. We attempted to extract the number of new cases per day as an indicator of the prevalence of the disease although this proved difficult, particularly over weekends and holiday periods.

b. Number of GP Consultations from July 2009 as an indicator of the risk / decline of the disease rather than actual number of new infections. This information was available graphically on the HPA web site and, while useful as an indicator, did not provide a direct link to the actual number of new cases, particularly once the National Pandemic Flu Service opened when GP consultations probably dropped as people were able to obtain anti-viral drug prescriptions without visiting their GP.

In addition to the public data, we tracked our internal sickness levels through our Occupational Health service and were able to identify a generic "coughs, colds and flu" reason for absence, although it was not possible to identify confirmed cases of H1N1 virus infections as most cases were not formally diagnosed.

5 Identified Issues

The following key issues in respect of the UK Government's response and information provision are:

a. The National Contingency Plan was, and remains, a valuable document. It needs to be revised in the light of the experience of the H1N1 (2009) outbreak to take into account the possibility of a much faster spread of a much milder disease. The Australian "*Health Management Plan for Pandemic Influenza*" might be a useful model.

b. The UK Alert Levels were not formally announced although it was readily apparent when the criteria for the relevant levels were crossed. The lack of a formal announcement caused some difficulty because most contingency plans in UK Government organisations (and probably more widely) were specifically linked to these Alert Levels. The process and method for declaring the Alert Levels and whether they apply nationally or regionally should be clarified.

c. The description of the UK Alert Levels should also include a recovery phase during which the measures imposed during the spread of the disease are successively reduced / removed. The process for reducing the alert level nationally or regionally should be defined. The Australian plan contains a useful model of alert stages which includes a "*Recover*" phase.

d. The planned national response measures were not scalable depending on the severity of the disease. In the United States, the Centers for Disease Control & Prevention (CDC) have produced a 5-category "*Pandemic Severity Index*" together with proposed community strategies for the different levels. It is not clear whether CDC formally announced the predicted category of the H1N1 (2009) outbreak, but the principle of a scalable response would seem to be worth considering.

e. The availability of usable, timely information on which to base effective and proportional decisions is essential. Information on the numbers of daily new cases (rather than

cumulative numbers) by geographic (eg Strategic Health Authority) region would provide an indication of the rise and decline of the disease incidence. GP consultations provide a less direct measure, but in the later stages of the outbreak may be the only data available, particularly when once on-line diagnosis and prescription of anti-viral drugs has started.

f. Information should be provided simultaneously and in a consistent format for the whole of the UK. Commercial organisations with operations across the UK do not necessarily recognise the national / regional boundaries used by government.

g. The role of the HPA in providing information to large commercial organisations within their area should be reviewed. With much of the UK public services now delivered by private-sector companies, the need for formal channels of communication about public health issues needs to be addressed.

h. One particular issue arose with the HPA "*Algorithms for the management of patients*" used by the NHS Direct call centre which were not updated fast enough and were still using as the primary criteria "Recent visitor to Mexico" when the disease was already prevalent in London, Birmingham and Glasgow. A number of highly probable cases of H1N1 in Birmingham were rejected for further processing by the call centre because the algorithm did not reflect the fast-moving nature of the outbreak.

i. The ECDC web site provided the most valuable source of information and forward-look risk assessments. This could be used as a model for the future provision of information by the HPA.

6 Attachments

The following Serco documents are attached for information:

Ref	Doc Ref	Document Title
A	PFG2	H1N1 Influenza ("Swine Flu") – Planning Scenario (Issue 2, 7 Aug 2009)
B	PFG8	"The Flu and You" leaflet (Apr 2009)

7 Contact Details

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