UK PANDEMIC FLU REVIEW – SCOTTISH GOVERNMENT RESPONSE TO CABINET OFFICE CALL FOR EVIDENCE

General

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

Worked Well

Scottish Government Approach

- The establishment of Emergency Pandemic Flu teams within Scottish Government Health Directorates and Scottish Resilience worked well. The establishment of these teams provided a co-ordinated response across the Scottish Government and consistency of advice and support to Ministers.
- The approach taken by the Cabinet Secretary for Health and Wellbeing and the CMO Scotland to proactively engage with the media from the start of the outbreak worked extremely well. Their daily media briefings enabled us to get clear, consistent messages to the public. It is recognised, however, that this model might not work in all situations.
- The Director General Health and Chief Executive of NHS Scotland held formal weekly teleconferences with the Chief Executives of NHS Boards which enabled the transfer of information around local and national developments. This was augmented by regular, informal discussions with NHS contacts which helped us assess the pressures being faced by NHS staff throughout the pandemic.
- A Readiness Assessment (showing the RAG status of the preparedness of the key sectors in Scotland) was drawn up and proved very helpful in providing Ministers and senior officials with a clear overview of where additional work was required.

Policy/Decisions

- The early decision to be guided by scientific advice when making policy decisions worked well. Whilst the speed by which advice was provided may have been challenging at times, it ensured a consistency of approach. However, there are some elements of the scientific advice and how we access this which need to be reviewed.
- The Containment phase worked well in trying to stem the spread of the virus in the early stages and demonstrated positive action/response from Government and the NHS . We do need to reflect on the length of this phase, however, as it placed significant pressure on services.
- The administration and delivery of the vaccine programme were significant achievements. The media played a very important, and responsible, role in this which demonstrated the importance of the effort which had been dedicated to cultivating relationships with the media from the earliest stages.

Four Nations Approach

- The brokering role played by Cabinet Office in the Four Nations arenas worked extremely well and facilitated the fair and frank exchange of views, much quicker decision-making and the effective resolution of disputes.
- Four nations critical care teleconferences were also extremely productive and the use of the 4 nations format for dealing with specific "hot issues" is one that we would strongly advocate.
- In Scotland, the establishment of the Scottish Flu Response Centre which provided specialist advice around H1N1 to the public and health professionals was very important. This service helped to take the pressure off primary care and was a key contributory factor in our decision not to activate the NPFS in Scotland. This was also linked to our target approach to antiviral prescribing.
- The established communication links between the Department for Transport and Transport Scotland worked well.

What would you wish to do differently?

Four Nations Approach

- There is a need for a clearer understanding of roles and responsibilities across the four nations and for this to be kept updated. This would help to save time during an emergency.

Surveillance and Modelling

- It appeared that there were inconsistent surveillance arrangements in place in the four countries – this led to differences, e.g. around the reporting of deaths and hospitalised cases. It would have been helpful to have had more comparable and compatible arrangements in place.
- Whilst recognising the limitations of modelling, it would have been helpful to have been able to update the planning assumptions more quickly to reflect the picture on the ground. This would have provided the most likely scenario, rather than the worst case scenario.
- When information from cases and epidemiology from SAGE was available, the turnaround to changing the planning assumptions was far too slow. The projections of casualty rates and potential death toll led to increased media speculation and confusion.

Policy/Decisions

- Whilst we recognise that thinking is underway about this, there needs to be a review of the APAs for vaccines.

Planning

- There is a need for more frequent testing of sectoral pandemic flu planning – this should be ongoing and not just during a pandemic.

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

There would need to be greater management of public expectation around delivery of health services, given the increased pressures on the NHS arising from a more severe pandemic and the likelihood of curtailed services in some areas.

Public expectation with regard to public transport provision would need to be managed differently as disruption would be far more likely. There would also be a need for clear understanding about the level of detail of information that would be available where transport providers were concentrating on providing services.

More generally, because the non-health sectors were not really tested during this pandemic just how well they would cope in a severe pandemic is an unknown factor. Much would depend on the quality of emergency and contingency planning and whilst we have assurances that this is place, the real test would arise when they are activated.

Vaccines

It seems unlikely that a pandemic-specific vaccine could be produced and delivered sufficiently quickly to influence attack rates in the first wave. We should be honest about this and plan accordingly.

We should also ensure there are very robust penalty clauses in contracts with suppliers of vaccine to encourage them to deliver the required quality, specificity and volume by agreed dates. Furthermore break clauses should be inserted into contracts to respond to changing circumstances as evidence is gathered on the profile and severity of the pandemic.

3. What led to the decision made to opt for 100% rather than 45% coverage of the population, based on the two doses per patient?

The 45% figure was based on a broad assessment of the at-risk population, including all over 65s. The decision to procure 100% was based on pre-pandemic vaccine knowledge based on H5N1 vaccine studies, and on the expert scientific advice received in the early stages of the pandemic, using the relatively small body of evidence available at the time. Advice at that stage indicated that 2 doses were required for each individual and that vaccine should be procured to cover 100% of the population.

This was based on planning using the precautionary principle (ie, planning for worst case scenario) which required 100% coverage of the population, based on experience in this and other pandemics and the evidence gathered from surveillance and estimates of severity of illness. 100% coverage was also assessed as providing a solid benefit in terms of public health cost effectiveness (ie, investment in the vaccine was outweighed by possible public health benefit of 100% coverage) and in

terms of cost effectiveness in relation to wider economic costs (ie, potential costs to the UK economy of leaving population unprotected against a pandemic were assessed as outweighing the costs of procuring vaccine for protecting 100% of the population.)

4. On what grounds was the decision to purchase 30m extra doses of vaccine made?

On the basis that Baxter's yields were low and this left a numbers gap. The precautionary principle was followed planning for the worst case scenario, rather than the most likely scenario.

5. What drove the procurement policy (e.g. number of companies, break points etc)?

The need to get a vaccine delivered as soon as possible was a key factor and therefore the fact that we had an Advanced Purchase Agreement with GSK, which placed us at the head of the international queue, had a bearing on the decision to procure the bulk from them.

The Baxter vaccine was manufactured in a different way (ie, without eggs), which allowed for some diversification in the type of vaccine held.

6. What were the factors driving the distribution policy of focusing on high risk groups?

The focus on high risk groups was driven by a need to prioritise those at greatest risk of suffering significant health harm first. This decision was taken in the knowledge that not everyone could receive a vaccination all at once and that the vaccine would take some weeks to trickle into the UK to begin with and would therefore need to be deployed to those most in need to begin with.

7. What was the impact of the WHO alert levels on procurement of vaccines, for example in APAs?

The declaration of a pandemic was a trigger point for the APAs and distinguished pandemic vaccine from pre-pandemic vaccine, which in turn had an impact on the working of the APAs and the approach of vaccine companies to delivering on those contracts. Throughout, the UK's policy position remained consistent – ie; to procure for 100% coverage of the population as soon as possible.

8. Which options were considered for delivering vaccines and what led to the choice of GPs?

In Scotland, Board-led delivery options were considered which included non-GP delivery . GPs were identified as the best delivery route on the basis that they had contact with, and the data for, the at-risk groups which were prioritised by JCVI. The view was also taken that this route was what the public were most familiar with as a provider of vaccination. It was also judged that GPs had the greatest store of expertise in vaccination and in administering vaccination programmes in their local

communities. Essentially, it was felt that we should use primary care as the pre-existing health point of connection (and data collection) with local communities rather than seek to set up a new mechanism.

9. Could negotiations with GPs have been initiated in advance of any pandemic emerging?

In theory it would be preferable to have initial discussions with GPs around the administration of the vaccine, prior to a pandemic emerging. However, in practice, this would prove extremely difficult as the extent to which we will wish to use GPs to deliver the vaccine will be dependent on the severity and virulence of the virus. In a severe pandemic, mass vaccination clinics will be the preferred mechanism for administering the vaccine.

During the H1N1 pandemic, it would have been prudent to have engaged with GPs in advance of making any decision for them to administer the vaccine.

Containment

10. How were the decisions made on containment? What issues drove the policy?

Decisions on containment were made on a UK basis, primarily based on public health concerns. The containment phase demonstrated positive action in tackling the virus. However, it did place considerable strain on frontline resources and could not have been sustained for any significant length of time beyond that which was achieved.

11. What were the triggers for moving away from containment, and what were these based on?

The containment policy of contact tracing and offering antivirals on a treatment and prophylaxis basis was felt to have slowed the spread of the virus in Scotland at the time.

The key trigger was that by the second week in June, it was the view of Health Protection Scotland that sustained community transmission was taking place in Scotland. This view was shared by HPA and SAGE. The decision to move away from containment was based on surveillance information of the transmission of the virus within communities. In areas where there was a wider spread of the virus, it was recognised that it was less beneficial to seek to contain the virus and that it was more appropriate to focus on the treatment of individuals with the virus and managing the contacts of those individuals according to the level of risk.

The UK Containment Framework was therefore adjusted to introduce some refinements to the strategy. The following modifications were introduced:

- Clinical diagnosis (without laboratory testing) to confirm cases with a high probability of being H1N1, where there was already evidence of community

transmission e.g. individuals showing symptoms with clear close contact links to previously confirmed cases;
- Antiviral treatment of all cases continued;
- Prophylactic use of antivirals in accordance with local risk assessment and limited to those most at risk of having contracted the virus.;
- Tracing of contacts of cases limited to household, household-like and close school contacts.

This revised framework allowed tiers of escalation according to local public health risk. In Scotland, this worked in the following way:

- Tier One – Where there are still a small number of confirmed cases, Boards were required to maintain the current level of containment undertaken by local health protection teams and follow current public health guidance on management of the virus via schools;
- Tier Two – Where more sizable clusters have arisen, escalate the response by activating assistance from SFReC and mutual aid agreements between Boards to work with local health protection teams and primary care services to maintain the current (highest) level of containment;
- Tier Three – Where transmission of the virus indicates sustained transmission in the community and a public health risk assessment has been conducted, apply the modified containment approach outlined above.

The formal move to the treatment phase on 2 July was based on the evidence gathered during the containment phase around the severity and behaviour of this virus. The picture in Scotland with regards to this was the same as in the rest of the UK so the move to the Treatment Phase did not cause us any difficulties, rather it freed up a great deal of capacity within Boards to enable them to focus on treating those most at risk from the virus.

12. What drove the policy on school closures, and how were individual decisions made?

During the Containment Phase, decisions were taken to close schools and nurseries where children/staff who were ‘probable’ (i.e. those who had flu-like symptoms and who tested positive for Influenza A) or confirmed cases of H1N1 had attended. Decisions to close schools were taken on a case by case basis, following a risk Assessment by Health Protection Scotland (HPS) and the local Health Board. The Scottish Government was kept informed but was not directly involved in the decisions to close schools or nurseries.

Following the assessment by HPS and the Health Board, if there was felt to be a risk of transmission to other children, the school or nursery was closed for 7 days. Close contacts of the affected children were also offered antivirals as a prophylactic and were advised to remain off school or nursery for 7 days. The principle behind this was to support the containment of the virus as far as possible, recognising that children shed viruses more easily that adults.

Following the move to the treatment phase, the policy on school closures changed. Due to the level of the virus which was circulating in communities throughout the country, it was no longer routinely recommended to close schools in order to try to contain the virus. The advice was that all children who were not showing symptoms should continue to attend school as normal, even in schools who had cases of H1N1. School closures were only considered in exceptional circumstances, e.g. if a number of staff were off sick, making it unsafe to open the school.

Since the start of the new school year in August 2009, there have be two further school closures (a special school and an independent school) in Scotland, both reopened after a few days on the advice of their local Health Boards. Local Authorities have provided weekly returns indicating trends of absence rates (pupils and staff) across their schools since August 2009. This helped to build up a national picture of overall absence rates and trends. This monitoring did not show any regional patterns of absence, instances tended to focus on individual schools, not necessarily spreading to nearby schools.

Overall the policy worked very well due to the very close liaison established between the Scottish Government, local authorities and schools. Regular communication ensured a proportionate response to local outbreaks and allowed effective management of media responses and consequent parental concerns. Proactive dissemination of health promotion information in schools was integral to the policy.

13. What was the policy on port health inspections, and what issues drove this policy?

Department for Transport issued notes to transport industry stakeholders periodically throughout which were sent to Scottish stakeholders and covered areas which are reserved. Guidance on passengers/crew disembarking when a Scottish seaport was the first port of call in the UK was issued by Health Protection Scotland as part of the containment strategy.

There were issues regarding the distribution of UK Borders Agency swine flu leaflets and posters at Scottish ports. These were largely a lack of communication between Scotland and the UK, with this not being targeted at the right ports, in addition guidance regarding distribution to cruise ships and timing of the availability of leaflets for the cruise ship season could have been better.

14. What was the policy on travel advice, and what issues drove this policy?

Scotland referred to the FCO website for international travel advice. This ensured that we were in step with the rest of the UK. The advice remained that it was safe to travel within Scotland. Good hand and respiratory hygiene messages were reiterated.

There was no reported disruption to the transport network in Scotland as a result of the 2009 influenza outbreak.

On a separate note, the regular FCO telegrams were an invaluable resource and enabled us to monitor H1N1 activity internationally.

15. What was the policy on mass gatherings, and what issues drove this policy?

There were no formal changes to the policy on mass gatherings in Scotland. The advice remained that organisers of large public events who had any concerns, should contact local public health officials for advice. In the vast majority of cases, it was recognised that mass gatherings would be able to go ahead.

16. What was the policy on prophylaxis and what issues drove this policy?

The Scottish Pandemic Flu Framework, 2007 states:

It is also possible to use antiviral medicines as a preventative measure (prophylaxis) to protect against infection. Although some prophylactic use may help contain spread from initial cases, and thus slow the development of the pandemic, protecting significant numbers of people for its entire duration would consume large numbers of treatment courses and still leave those treated susceptible to infection as soon as they stopped taking the medicine. Therefore, apart from attempts to contain initial spread, general prophylaxis is not currently regarded as an effective or practical response strategy.

An alternative may be 'household prophylaxis' which provides post-exposure prophylaxis to immediate contacts at the same time as treating a symptomatic patient on the grounds that some of the contacts may already be incubating the infection. This could mitigate and delay the progress of a pandemic particularly when combined with measures such as school closures.

At the start of the outbreak, in Scotland, all close contacts of confirmed cases were offered antiviral treatment. Close contact was defined as being exposed to a probable or confirmed case within the previous seven days for longer than an hour, and within a distance of one metre or less. This approach was in line with the Pandemic Flu Plan and was intended to limit the spread of the virus. This approach was replicated across the UK.

On 11 June, a more targeted use of antivirals in those who do not have the virus was introduced in some areas of the country with high levels of the virus. This approach included restricting the use of antivirals to household contacts of confirmed cases, or in schools, to those at the surrounding desks. Again, this approach was part of a UK framework. This change was introduced in light of the evidence that community transmission was underway in several parts of the country and there was now a reduced opportunity to limit the spread of the virus through antiviral prophylaxis.

Following the move to the Treatment Phase on 2 July, the use of antivirals as prophylaxis was no longer considered to be effective or practical. Thereafter, in Scotland, antivirals were only offered to those most at risk from the virus.

Treatment

17. What was the policy on antivirals procurement and distribution and what factors under-pinned this policy?

Antivirals were procured on a UK basis and we worked with Department of Health to develop the policy and scientific evidence that underpinned those procurement decisions.

Antiviral distribution operated differently in Scotland. As we did not use the NPFS, patients who thought they may have flu accessed care by contacting their GP or NHS24. If they were assessed as requiring an antiviral they followed the normal process of receiving a prescription. In most cases they took the prescription to the normal location e.g. community pharmacy, although some NHS boards with high numbers of cases set up additional collection points, to relieve pressure on community pharmacies.

The antiviral stock was distributed from the central Scottish stockpile to one location in the 14 NHS Boards, although during the major outbreak in Dunoon we sent stock directly there as it was a considerable distance from the main Highland location in Inverness. There was an initial push of stock to Boards, then they contacted the Emergency Planning Team in Scottish Government to request additional stock when needed. The team had a record of the number of antivirals (adult's, children's and suspension) that had been distributed to each Board and the Boards sent a weekly return of their antiviral stock holdings. This enabled SG to have an accurate record of exactly how much Relenza and Tamiflu had been used by each Board. This simple mechanism worked well as it gave SG the information we needed to manage the stockpile and provide updates to Ministers, and it gave the Boards a straightforward mechanism to access further stock, building on normal distribution routes.

18. What issues drove the different implementation decisions across the Four Nations (how far the UK-wide response facilitated locally sensitive responses)

The decision to activate the NPFS in England drove the policy decisions around antiviral prescribing. The decision not to adopt a treat all approach to antivirals in Scotland was correct, based on what we were seeing on the ground.

As a result of the establishment of the Scottish Flu Response Centre, pressure had been eased from other Primary Care Services.

Following the move to the Treatment Phase, Scotland also took a different approach to the administration of antivirals. GPs used their clinical discretion when prescribing this medication, and it was only prescribed to those felt to be most at risk from the virus.

Our preference was to continue to enable the public to use familiar processes for accessing care and medicines and to receive assessment from trained medical professionals or experienced call handlers with clinical supervision. As long as the level of service received from that model was not significantly affected by pressures from the number of cases (which it wasn't), we felt this was preferable to signing up to NPFS.

Central Government Response

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

The adaptation of the CCC and CCC(O) structures to include 4 Nations (Ministers) and 4 Nations (Officials) was a welcome development and ensured that key decisions were taken much more speedily and greatly enhanced the overall response.

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

This was determined by pre-existing Cabinet Office guidelines.

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

CCC meetings were felt to be too cumbersome when it was becoming increasingly clear that this was mainly a health issue. It was felt to be difficult to get quick decisions made within the CCC forum. This was not just a frustration for Scotland but one which appeared to be shared by colleagues across the UK.

The introduction of the Four Nations Health Ministers/Officials Meetings streamlined the response. From the Scottish perspective, we felt able to put our views across in this environment and to have these listened to. The role of Cabinet Office in chairing these meetings was invaluable. This enabled an equal sharing of views and in Scotland we felt that it provided an even playing field for all nations to put forward their views.

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

Not Applicable.

Scientific/Clinical Advice

23. What scientific advice was available to Government, and how was this presented to Ministers?

It was not always clear why certain decisions had been taken by these

scientific groups. It would have been more helpful to get an insight into reasons behind their decisions, e.g. on what basis decisions were made, what factors had been considered etc. This would have supported officials' interrogation of the advice and the subsequent presentation of advice to Ministers. Furthermore, there would also have been merit in Ministers being able to engage directly with the scientific committees at times to gain an understanding of the rationale of the advice being provided.

The advice around the priority groups for vaccination was especially helpful, as was the advice around phase 3 of the programme. This enabled decisions on this to be taken very quickly and with confidence.

24. What was the balance of expertise on SAGE?

Scotland had a representative who dialled into all SAGE meetings and reflected the discussions at these meeting to SG policy colleagues. This was an extremely helpful arrangement which shortened lines of communication between SG and SAGE.

We do have concerns, however, about the governance arrangements for this group. We feel that there is a need to review the constitution of SAGE to make the group accountable to all Four Nations Health Ministers, and not solely the Secretary of State for Health.

As part of this review of the constitution, we would like to see the protocol for convening SAGE to be amended to allow each of the Four Nations Health Ministers to nominate representatives to sit on this group. This would provide more equal, formal representation from each of the four nations.

25. How was the relationship between SAGE and JCVI?

The relationship between these two groups was not always clear.

JCVI advice was passed through SAGE which added an unnecessary layer of vetting to an established expert group's output and simply added delay into the advice cycle.

26. What was the role of PICO in relation to SAGE?

Difficult to say, ostensibly it was there to provide consensus clinical advice and guidance. It needed a much more explicit link to the HPA/HPS public health guidance set up. It was not established overtly enough and its routes for outputs were difficult to understand.

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?

It was noticeable that the surveillance systems and reporting diverged quite early on. Scotland took a purist and accurate approach to all surveillance. England adapted its surveillance to report estimated numbers of hospitalisations and did not report deaths in the same real time way as Scotland. England adapted surveillance to cover the NPFS. The differences were publicly obvious but never picked up and highlighted. For example the very obvious difference in death rates between the 4 administrations.

In Scotland, we had several different surveillance systems which collected data on a range of key indicators. When reviewed together, these indicators provided a picture of H1N1 activity in Scotland.

GP Surveillance

We monitored the GP consultation rates for Influenza Like Illness through the following evolving surveillance schemes.

In April, the PIPeR surveillance system was in place in Scotland. This scheme consists of 37 GP practices in central Scotland which are part of the Practice Team Information (PTI) network and which also run the General Practice Administration System for Scotland (GPass). This is an established system with 5 years of historical data which permits the interpretation of current trends relative to previous trends. About 4% of the population of Scotland is covered by this scheme.

At the beginning of June 2009, and enhancement of the PIPeR system was brought in to increase the geographical and population coverage. This Sentinel system covered 58 practices within the PTI network and covered 6% of the population.

In August, the Scottish Influenza Surveillance Reporting Scheme was introduced. This system gathered the same information as the Sentinel and PIPeR schemes but covered a much wider population. This scheme covered almost all GP practices in Scotland
and provided much wider population coverage.

Health Protection Scotland obtained investigation information from a proportion of those consulting their GP with Influenza Like Illness/Acute Respiratory Infection who have evidence of H1N1 infection, via the Sentinel Swabbing Scheme set up in 100 general practices across all NHS Boards. The system required submission of nose/throat swabs from up to 5 patients per week from each participating practice.

NHS24/Scottish Flu Response Centre (SFReC)

NHS24 - Online and telephone based service which provides health information and advice out of hours.

SFReC- This service was established by NHS24 to provide vital information, advice and reassurance to the public and to health professionals about the H1N1 virus and how it may affect them.

We gathered daily updates on call demand for NHS 24's core service and for

SFReC. This provided a further indication of flu activity in the community. It also provided information of whether NHS24 and SFReC was coping with demand.

Hospitalised Cases

NHS Boards provided daily updates on the number of hospitalised H1N1 cases in their hospitals, and also the number of patients being treated in ICU and HDU. This provided an overview of the severity of the virus and the pressures on our acute care services.

Deaths

For H1N1- related deaths, public health teams in NHS Boards were requested to inform the Senior Medical Officers within the CMO team in SG of every H1N1-related deaths. The information was also sent to HPS via the ECOSS system by individual Board hospital infection control teams. This information was co-ordinated with HPS and enabled the Cabinet Secretary for Health and Wellbeing and officials in Scottish Government Health Directorates to have an immediate and constantly updated overview of the number of deaths related to H1N1. Again, this enabled us to closely monitor the severity of the virus, and also to continually review which groups appeared to be most at risk from the virus.

School absences

Local Authorities provided weekly returns indicating trends of absence rates (pupils and staff) across their schools since August 2009. This has helped to build up a national picture of overall absence rates and trends around pandemic flu. This monitoring did not show any regional patterns of absence, instances tended to focus on individual schools, not necessarily spreading to nearby schools.

28. What data was collected and how was is used?

As above

29. Role of the Standing Committee on Ethics in decision-making?

This was not tested as clinical prioritisation decisions about rationing services like ITU and ECMO were not really needed.

Communications

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

NHS Staff	Specific marketing materials aimed at NHS staff and the social care sector were developing in partnership with the other UK Administrations. During the pandemic, we engaged NHS staff engaged with NHS Staff via NHS Comms leads/Letters from CMO/NHS Chief Executive. In Scotland, we also held weekly teleconferences in with NHS Chief Executives to discuss local and national developments around H1N1. This dialogue was further supplemented by daily teleconferences with public health teams within Health Boards during the early weeks of the outbreaks. NHS Scotland Communications Gateway – This site was created in late summer 2009. All national materials were uploaded onto the site. This meant that all NHS Board strategic Communicators could access the site as soon as the materials became available for use in their local area.
Social Care Sector	Engaged via existing networks within SG. This includes the links we have with the Convention for Scottish Local Authorities (COSLA) who provided information to all their members (i.e. all Local Authorities in Scotland) We also engaged with the Care Commission, who regulate all adult, child and independent healthcare services in Scotland, who also provided information to all the agencies they are in contact with.
Third Sector orgs	These groups were identified via a four nations approach. Where there were Scotland-specific branches of these organisations, these were contacted separately, e.g. to attend workshops. We also developed newsletters that we sent to the third sector.
General Public	Pandemic materials had been developed on a four nations basis. Given the presentation of the virus, this material was inappropriate. Being able to turn the DH respiratory and hand hygiene campaign from 2008/09 into the campaign for H1N1 within a matter of days was invaluable. Materials were developed on a four nations basis for all subsequent RHH campaigns, the seasonal flu campaign and the H1N1 vaccination campaign. In addition to the marketing materials, the Cabinet Secretary for Health and Wellbeing and CMO Scotland held daily media briefings during the early stages of the pandemic, these were reduced to an exception basis as the pandemic developed. These briefings were extremely successful in enabling us to get our key messages out via the media. While this model was

undoubtedly extremely valuable during this pandemic, it should not be automatically replicated in future as its success will depend on the personalities involved and the type of emergency we are faced with.

Strategic Co-Ordinating Groups (SCGs)

SCGs in Scotland are responsible for co-ordinating the local multi-agency emergency preparation and response of the lead responder organisation in Scotland, i.e. the emergency and health services, local authorities as well as others such as utilities and transport operators.

SCG responder organisations were alerted to the available publicity materials and were directed to the 23 Red website to access these. This was done via the regular flu communications emails sent to SCGs and also via the regular teleconferences between the SCGs and Scottish Government. SCGs were responsible for ensuring the cascade of information through their networks locally.

Businesses

In March 2009, DH and the DAs appointed the partnership agency 23 Red. 23 Red were initially tasked with identifying key UK commercial partners to carry Swine Flu information.
23 Red were tasked with developing a File Transfer Protocol (FTP) site which enabled businesses to download the pan flu information materials. This site was also relevant for businesses in Scotland.
When the outbreak developed, 23 Red were also tasked with engaging with the Third Sector.

Businesses and Third Sector organisations could also download the marketing materials from the SG website, or go to their local NHS Board website.

31. What arrangements were in place or put in place to ensure a consistent set of messages across the Four Nations?

A master UK Communications plan was developed following discussion between all four nations. This plan was developed based on a significant amount of research with the public. The insights from the research studies helped to inform the development of the marketing materials that were used at the start of the response.

In Scotland, we also developed a Scotland-specific communications plan. This plan supports the UK Framework and recognises that DH has the overall UK lead. The plan acknowledges that DH will be the primary source of health-related messages and that they will work closely with all four health departments/directorates etc to deliver a nationally co-ordinated communications strategy.

Health Communications and Marketing leads from all four nations met on a 6-weekly basis pre-pandemic to discuss the development of materials etc. During the

pandemic, there was daily, sometimes several times a day, contact between the pandemic flu marketing leads in the four nations. This was extremely helpful in ensuring all interests were covered and all parties were kept informed of developments.

Twice weekly teleconferences continued until February 2010 and Government Pan Flu Comms leads in all four nations also continued to travel to London every 6 weeks or so to meet up in person. All of this was invaluable during the response.

Following the establishment of the National Pandemic Flu Service in England, the main challenge we had was that people in Scotland may have been exposed to marketing materials as well as national news stories, promoting the NPFS. Comms leads outwith England had to work hard to counter this and ensure that the marketing materials did not appear in newspapers in Scotland.

32. How were the media and social networks monitored and engaged?

As highlighted above at question 30, the Cabinet Secretary and CMO held regular media briefings which were very successful in engaging the media. This proactive approach meant we were able to get our messages out via the media. It was also felt to reduce the pressure on our press teams.

33. What evidence is there on public responses to the handling of the pandemic?

In Scotland, a weekly omnibus was undertaken. This omnibus was separate to the one undertaken on a UK basis which had a much smaller Scotland sample (Scotland sample in UK omnibus was 200, in Scotland-specific omnibus was 1000). The broad objectives of this research were to track Scotland's general public responses and attitudes during the pandemic. The research aimed to:

- Establish a baseline of the public's understanding/knowledge of, and attitudes towards, pandemic influenza and the surrounding issues.
- Understand how attitudes and knowledge changed in light of events throughout the pandemic; and
- To identify new concerns and fears as they arose, to inform communications strategies throughout the pandemic.

A full management summary of the omnibus is being prepared and will be available at the beginning of April. An overview of the results of each wave of the omnibus have already been provided.

Further information on this will be extracted from the Public Evaluation Research currently being undertaken by DH.

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

As detailed above, the Cabinet Secretary for Health and Wellbeing and the CMO held media briefings on a regular basis.

The Cabinet Secretary and the CMO therefore communicated the key messages throughout the pandemic, highlighting relevant scientific advice where appropriate. This worked reasonably well where the scientific advice could be practically applied, e.g. to the vaccine priority groups.

The messages around the planning assumptions were slightly more difficult to communicate as they did not always reflect what was happening on the ground. The decision to announce the potential number of deaths during the pandemic should possibly be examined as this caused a large degree of public alarm – which was unwarranted based on the actual presentation of the virus.

35. What evidence is there on clinical responses to the handling of the pandemic?

NHS Boards in Scotland responded to all the pressures caused by the pandemic, while continuing to deliver all other services. It is important that we do not lose sight of this.

We like to highlight in particular the efforts of NHS Boards to double critical care capacity. In delivering this commitment, NHS Boards provided relevant ICU training to large numbers of staff, predominately nursing staff, as well as developing measures to increase flexibility in the physical environment within extremely tight timescales. The response of Boards in managing patients requiring Extra-Corporeal Membrane Oxygenation (ECMO) therapy has also been highlighted as a success.

We will investigate the role of the NHS in Scotland during this pandemic further in the work we are planning to take forward with NHS Boards to explore lessons learned throughout the outbreak.

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

We do not have any formal evidence of this at this time.

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?

If fatalities occur at anything above the lowest end of the range of pandemic framework planning assumptions, it will be essential to remove all obstacles that might delay the management of the deceased, e.g.

- Out of hours services should plan specifically for how they will ensure certification of deaths occurring in the community (if this takes more than 24 hours a back-log is likely leading to insufficient mortuary space).
- Additional mortuary space should be identified to allow increased "throughput", not storage to defer work to a later date.
- In England, Wales and Northern Ireland the capacity of HM Coroners may be a rate limiting factor.

In the recent pandemic, mortality rates were low enough that these issues did not arise, but there was little evidence that these points had been considered, still less acted upon.

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

We conducted a trawl across the Scottish Government of regulations that could potentially constrain our ability to respond flexibly to significant workforce shortages caused by the pandemic. This was completed by November 2009. We considered the potential legislative vehicles for effecting change, and – in one area – consulted with stakeholders on the potential impacts. Draft legislation was prepared with solicitors, ready for deployment as necessary. This could either have been done through a single emergency Bill, or in a more targeted way as appropriate. The Scottish Cabinet Sub-Committee on Resilience were kept informed throughout, gave Ministerial direction to this work, and were satisfied with our ability to respond if necessary.

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

This was a reserved issue but we were well consulted by the UK Departments, including DWP who were in the lead. We had meetings with business organisations and with the Scottish TUC. We also consulted key SG officials with a policy interest. Business organisations in Scotland were strongly opposed to any extension to the period that can be self-certificated beyond the current 7 days, and this was ultimately the position taken at the UK level (given the lower than expected demand on GPs). Should legislative action have been necessary, we would have worked with UK officials to bring the issue quickly to CCC for Ministerial consideration and approval.