

LONDON RESILIENCE



preparing for emergencies

London Regional Resilience Forum

Swine Flu Debrief

January 2010

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Accessibility

The Partnership recognises the need to ensure that all staff are able to respond to an emergency. Therefore, partners need to ensure that all buildings identified for an incident response are fully accessible to deaf and disabled people. This includes all meeting venues, media facilities etc. This may require an access audit to be carried out on the venue.

It is also important that communicators adopt an inclusive approach and consider all audiences including deaf and disabled people to ensure that all communications are accessible and clearly inform both responders and the public about the incident.

This requirement will be taken into account by the media cell and addressed in any communications strategy that is developed by the media cell for the incident.

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LONDON REGIONAL RESILIENCE FORUM

Swine Flu Debrief – January 2010

1. Introduction

- 1.1 At the end of April 2009, the world became aware of cases of illness caused by a novel influenza virus, termed swine influenza A/H1N1. Over the following five days, the World Health Organisation (WHO) announced that the global pandemic alert level had increased from WHO Phase 3 to WHO Phase 5. On 11 June, WHO declared WHO Phase 6 and the official start of the first pandemic of the 21st century. The virus is officially designated pandemic influenza A(H1N1)v 2009.
- 1.2 The first UK cases were reported in Scotland on 27 April, and the first case in London on 30 April. Further cases continued to be reported across the country and in London, although exact numbers are no longer available due to a change in the surveillance techniques utilised.
- 1.3 The pandemic was originally managed through containment measures (treating cases and providing antiviral prophylaxis to their contacts) which included some school closures. There was a brief period of outbreak management in London (a less stringent version of containment – limited prophylaxis and contact tracing), before the whole country moved to the treatment phase (no prophylaxis or contact tracing).
- 1.4 For the majority of cases, the virus causes a mild illness which can be treated with antivirals, over-the-counter medicines, bed rest and fluids. However, there have been some more serious cases requiring hospitalisation, extended periods of critical care, and some deaths (69 in London as of 21 January 2010).
- 1.5 The majority of cases appeared to be in younger age groups than those normally affected by influenza, with relatively few cases in older people. Pregnant women and the morbidly obese proved to be unanticipated risk groups with regards the influenza pandemic A(H1N1)v 2009 virus. There was a proportion of cases and deaths in people who have no previously identified underlying conditions.
- 1.6 Cases in London peaked in July 2009, with a second wave that started in autumn 2009 and peaked in November. The second wave was

coupled with the usual winter pressures of cold weather and seasonal illness, in what is reported to be the coldest winter for around 30 years.

- 1.7 The swine flu pandemic has thus far proved to be less severe than the original national planning assumptions; such that the Cabinet Office has twice issued revised planning assumptions which each time reduced the worst case scenario.
- 1.8 It is not known if there will be a third wave of this virus or if seasonal influenza will present the usual challenges in 2010. Additionally, the pandemic influenza A(H1N1)v virus could present a significant threat in subsequent years, either as a drifted virus or a significantly mutated form which would prove more challenging. Furthermore, highly pathogenic avian influenza A(H5N1) remains a real threat, having caused 72 cases including 32 deaths in 2009, more than in 2008. All of this means it is essential not to be complacent.
- 1.9 Debriefing all organisations, not just health, involved in the planning and response to the 2009 pandemic is a key to ensuring that future responses to pandemic influenza building on lessons learnt and identified over the past nine months. Additionally there may be some issues that should be incorporated into business as usual processes.
- 1.10 To this end, a London Resilience multi-agency debrief was held on Wednesday 13 January 2010 to review the multi-agency response to the swine flu pandemic and to identify any areas for improvement in advance of any future pandemic.

2. Multi Agency Co-ordination

- 2.1 The first meeting of the London Resilience Partnership was held on 27 April 2009 and, over the course of the next eight months, regular meetings were held with the Partnership.
- 2.2 As per arrangements outlined in the *London Regional Resilience Flu Pandemic Response Plan*, the Regional Co-ordinating Group¹ meetings were chaired and co-ordinated by Government Office for London (GOL). The purpose of these meetings was to ensure a co-ordinated multi-agency response to the swine flu pandemic and to ensure that all the necessary arrangements were in place and implemented as required.
- 2.3 London's readiness to the swine flu pandemic was reviewed at each meeting through assessment of a number of key requirements that were set out in the *Pandemic Influenza London Readiness Assessment*. This assessment was also discussed at each meeting of the London Regional Resilience Forum since the initial outbreak, and was recognised as good practice by Cabinet Office.
- 2.4 Overall, the arrangements that were set out in the *London Regional Resilience Flu Pandemic Response Plan* worked very well. Meetings were chaired effectively by Government Office for London's Regional Director, and were well attended by all partners at the right level.
- 2.5 National Health Service (NHS) London, in particular, found the meetings to be invaluable for gaining oversight of the wider picture and ascertaining impacts on other partners. Generally, partners found the meetings useful for providing advice and assisting with specific organisational queries and/or concerns.
- 2.6 The number and frequency of meetings was felt to be appropriate to the situation, as was the timing of the first meeting which was held prior to the first case of swine flu in London. In the *London Regional Resilience Flu Pandemic Response Plan*, UK Pandemic Alert Levels act as triggers for meetings of the Partnership. However, the outbreak of the swine flu pandemic did not unfold in line with planning assumptions and the UK Alert Levels were not activated. Instead, the trigger for the first meeting was a tripartite discussion between London Resilience Team, NHS London and the Health Protection Agency (HPA), and it was felt that this model was appropriate as it allowed the key organisations to make a co-ordinated assessment and informed judgement of the situation.

¹ In the *London Regional Resilience Flu Pandemic Response Plan*, the regional level meetings are referred to as "Regional Civil Contingencies Committees" (RCCC). However, Cabinet Office issued new guidance in Spring 2009, and these meetings are now referred to as Regional Co-ordinating Groups unless the Government declares emergency powers, in which case the RCG escalates into a RCCC. This change in name will be incorporated into the next version of the *London Regional Resilience Flu Pandemic Response Plan*.

Recommendation 1

The principle of using tripartite discussions to trigger meetings of the Regional Co-ordinating Group should be incorporated into the *London Regional Resilience Flu Pandemic Response Plan*, in line with the Command and Control Protocol.

- 2.7 In addition to meetings of the Regional Co-ordinating Group, other specific groups were convened, which included the communications and business continuity sub groups. The Business Continuity Group, chaired by the London Fire Brigade, was tasked to consider business continuity issues and challenges for the Partnership. The establishment of a London Resilience Swine Flu Business Continuity Group was considered to be a positive initiative for fostering consistency and sharing good practice that should be considered in any future pandemic.

Recommendation 2

The establishment of a Business Continuity Group should be incorporated into the *London Regional Resilience Flu Pandemic Response Plan*, and the general principle of business continuity groups should be incorporated into the Command and Control Protocol, with respect to rising tide incidents.

- 2.8 Further health co-ordination took place through the joint HPA/NHS London Flu Response Centre. The Centre was established on 19 May 2009 for health care professionals to discuss possible cases of swine flu and for all healthcare professionals' queries relating to swine flu, in the absence of a National Pandemic Flu Service. The centres were established in all regions following a national decision to do so. It was felt that it would not necessarily be appropriate to establish a London Flu Response Centre in a future pandemic as a National Pandemic Flu Service is now operational; however, it is important to capture the learning from establishing a joint Centre as this may be a suitable model for responding to other large public health incidents.

Recommendation 3

Learning from the London Flu Response Centre should be captured by NHS London and HPA via their debrief processes.

- 2.9 At the local level, Influenza Pandemic Committees (IPCs) met to co-ordinate the multi-agency response and to ensure that all

arrangements were in place and ready to be implemented. IPCs exist at Primary Care Trust (PCT) level and are chaired by health, usually the local PCT Director of Public Health (DPH).

- 2.10 In Spring 2009 the London Resilience Team, NHS London and London Resilience Local Authorities Panel (LAP) undertook an audit of the IPC's to assess their preparedness for the non health impacts of pandemic flu. This audit identified a number of recommendations and IPC reported progress against completing these recommendations in September 2009. The progress assessment illustrated that the majority of recommendations were completed or in hand and that overall IPC's demonstrated that robust arrangements were in place for the pandemic flu.
- 2.11 It was felt that the IPCs worked fairly well and should be used as a model for flexible, local level multi-agency engagement. It was agreed that IPCs should be advised to conduct multi-agency debriefs, with a particular focus on reviewing arrangements in place for responding to the needs of vulnerable people. It was felt that feedback from the multi-agency debriefs should be reviewed with a view to ascertaining levels of consistency between IPC's.

Recommendation 4

IPCs should be advised to conduct multi-agency debriefs via the NHS London health debrief process, with a particular focus on reviewing arrangements in place for responding to the needs of vulnerable people.

3. Information Sharing and Reporting

- 3.1 From the onset of the pandemic, information was shared on a regular basis between the local, regional and national levels.
- 3.2 The Regional Co-ordinating Group provided a forum for sharing information face-to-face, and partners reported to the London Resilience Team on a daily basis regarding non-health impacts. In turn, the London Resilience Team reported daily, reducing to weekly, to the Cabinet Office (CO) through the London Situation Report (Sitrep) which outlined non-health impacts of the pandemic in London across a range of sectors.
- 3.3 At a later stage in the pandemic, reporting on social care impacts was introduced, after a pilot with five Local Authorities across the country, including the London Boroughs of Southwark and Merton. Reporting on social care impacts is a new requirement, and the effectiveness and value of social care reporting is being reviewed by the Department of Health (DH).
- 3.4 Alongside this, NHS London co-ordinated the reporting on health impacts in the Capital to DH, and produced noon briefs on a daily basis for local health organisations and other Partnership organisations. Furthermore, top line briefs and frequently asked questions (FAQs) were issued on a regular basis by Cabinet Office and cascaded to all partners by LRT.
- 3.5 It was felt that the level and frequency of information sharing was appropriate to the situation, and the various reports and documents were seen to be very useful tools, enabling partners to easily cascade key information in their respective organisations. It was noted that the National Resilience Extranet would have proved useful, as a one-stop-shop for information.
- 3.6 However, it was noted that the protective marking of documents was not always clear and the frequency of reporting to the Cabinet Office during the second wave of the pandemic was excessive. It was felt that the notification to stand down non NHS organisations should have occurred earlier.

Recommendation 5

All communications should have clear protective marking, both on any attachments and in the email.

Recommendation 6

LRT and NHS London to feed comments regarding exit strategies for reporting into DH and Cabinet Office for central review.

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- 3.7 Whilst the need for two reporting channels was recognised (one channel reporting to DH on health impacts and one channel reporting to CO on non-health impacts), it was also acknowledged that this resulted in some miscommunication between partners.

Recommendation 7

London Resilience Team and NHS London should ensure that an appropriate procedure is established to ensure sharing of information of both non-health and health impacts at the regional level.

- 3.8 Exact numbers of swine flu cases were no longer available once the UK moved into the treatment phases and surveillance techniques changed; whilst the necessity for this is understood, it was felt that there was an information gap during the second wave in terms of case levels.

Recommendation 8

NHS and the HPA should agree who is providing the main data and whether it is possible to gather more detailed data from the HPA on case levels when no longer in the containment phase.

- 3.9 Before and during the pandemic, numerous pieces of guidance were issued by Central Government. Overall, partners were happy with the level and detail of the guidance, with a few exceptions:

- face mask policy should have been communicated more clearly;
- guidance for faith communities should have been clearer and more comprehensive;
- clearer advice for people with underlying health conditions should have been issued; and
- insufficient guidance was available on excess deaths management.

Recommendation 9

Relevant Central Government departments should ensure that any policy gaps are filled as soon as possible, and that mechanisms are in place for clearly communicating policy. NHS London and LRT should feed this back to DH and Cabinet Office

4. London Regional Resilience Flu Pandemic Response Plan

- 4.1 The latest version of the *London Regional Resilience Flu Pandemic Response Plan* was issued in March 2009. The Plan proved useful during the pandemic and partners were able to adapt relevant parts of the plan to the situation. Roles and responsibilities in the plan were accurate. It was generally accepted that the planning process is often more important than the plan itself.
- 4.2 However, the bulk of the Plan is structured around the UK Alert Levels, and it was acknowledged that there was a need to make the plan more flexible as the UK Alert Levels were not activated during swine flu.

Recommendation 10

The London Regional Resilience Pandemic Flu Plan should be revised with a view to making the plan more flexible once swine flu debrief processes have been completed by partners and Central Government, and taking on board any new guidance that is issued.

- 4.3 Alongside revision of the London Regional Resilience Flu Pandemic Response Plan, work will also be undertaken by the London Resilience Team and NHS London to produce a generic human infectious diseases plan by the end of 2010, to ensure that London is prepared as possible for a range of infectious diseases.

5. Health and Social Care

- 5.1 As per the *NHS London Strategic Pandemic Flu Plan*, at the start of the pandemic NHS London convened the Influenza Incident Management Team (IMT) which met daily with representatives of the HPA and London Ambulance Service. The Team ensured consistency in the health response across London.
- 5.2 It was generally acknowledged that the health response in London was very good, and thorough health debriefs will be conducted by NHS London independently, HPA has held internal national, regional and local debriefs and has contributed to multi agency debriefs. NHS London developed a pack for all NHS organisations to enable a structured and uniformed debrief across London. This pack included an agenda, slide set, and a report template. It was recommended that each debrief should take place in a multi-agency health economy forum (eg the IPC), led by the PCT, involving all local health and social care partners.
- 5.3 It was also noted that a great deal was learnt about social care provision, and the mechanisms and structures in place in London to deliver social care. Much stronger links had been forged between health and social care as a result of the pandemic, and it was recognised that this learning should be captured and having direct representation from social care on the Regional Co-ordinating Group should be considered.

Recommendation 11

Learning of social care provision and structures should be captured by NHS London and shared with other partners to increase awareness and understanding.

Recommendation 12

Representation from social care on the Regional Co-ordinating Group should be considered by LRT and NHS London.

6. School Closures

- 6.1 At the peak of the first wave of the swine flu pandemic, between 50-100 schools were closed across London, with over 1,200 schools reporting cases of swine flu. At the end of the first wave and during the second wave, limited school closures occurred due to the move into treatment phase and the fact that the end of the first wave coincided with school holidays.
- 6.2 Throughout this period, regular reporting on school closures and numbers of schools with cases of swine flu occurred, co-ordinated in London by the London Local Authority Co-ordination Centre (LLACC). It was agreed that clear communication channels existed between national, regional and local levels to share information on school closures.
- 6.3 Whilst there were isolated incidents which highlighted the need to ensure that information is communicated sensitively to schools and parents, these issues were resolved locally.

Recommendation 13

Any lessons regarding communication of infectious disease policy to schools and parents, including decisions to close schools, should be captured and learnt by NHS London, HPA and London Local Authorities.

7. Emergency Services, Transport, Business and Wider Sectoral Impacts

- 7.1 Throughout the pandemic, essential services continued to be delivered throughout London, and there were no significant impacts on police, fire and transport services.
- 7.2 The London Ambulance Service (LAS) experienced very high call volumes and there was a great deal of pressure on services; however, LAS continued to meet targets and capacity planning has been enhanced as a result.
- 7.3 It was felt that if the pandemic had been more severe, there may have been a requirement for key emergency services personnel to be prioritised for vaccination. It was agreed that the priority list for vaccination needs to be reviewed on a pandemic by pandemic basis, taking into account the particular nature of the situation. It was recognised this was a national decision but that this could have had regional impacts.

Recommendation 14

Priority lists for vaccination should be reviewed on a pandemic by pandemic basis by Central Government.

- 7.4 Whilst there were slightly higher than normal staff absence rates in some businesses, this had no reported adverse impact, and it was felt that this reflected the extent of business continuity planning.
- 7.5 A number of partners have provided briefing to businesses, both prior to and during the pandemic, to highlight the need for robust business continuity planning. The importance of briefing businesses was recognised and it was also acknowledged that these briefings need to occur in a trusted environment to be fully effective.

Recommendation 15

All partners should continue to brief businesses on the importance of business continuity planning and share their own lessons and experiences, and businesses, in turn, should ensure that information received is treated appropriately.

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- 7.6 A specific meeting was also held for the voluntary and faiths sector groups to ensure that their issues were considered and provided a forum to update these groups.
- 7.7 It was also recognised that there were no formal mechanisms for reporting on wider sectoral impacts, for example, tourism, and this should be explored further.

Recommendation 16

Mechanisms for reporting on wider sectoral impacts should be considered by LRT.

8. Media and External Communications

- 8.1 The Partnership's Communications Cell provided a forum to provide reassurance and agree mutually supportive key messages. The Partnership's communications cell met early via teleconferences. NHS London provided key messages to the group and a consistent London narrative was developed by LRT and shared with the Communications Cell.
- 8.2 NHS London was identified as the key operational communications lead with support from the Health Protection Agency. NHS London chaired the Communications Cell and the group agreed the key spokespersons were to be health professionals, rather than activate the Mayor as the 'Voice of London'. Operationally, there were good communications and suitable spokespersons available to the media.
- 8.3 The number and frequency of the Partnership's communications cell teleconferences were considered adequate initially, but due to the prolonged nature of the incident those teleconferences became infrequent.

Recommendation 17

The Chair of the Communications Cell and all partners should proactively and consistently update and share lines over sustained periods, either via e-mail or teleconference, and continue to do so as the incident becomes 'business as usual'.

Recommendation 18

All partners should review whether they have sufficient resource to lead the Communications Cell for a prolonged period, including out of hours.

Annex A Summary of Recommendations

No	Recommendation	Owner	Time Frame
1	The principle of using tripartite discussions for triggering meetings of the Regional Co-ordinating Group should be incorporated into the London Resilience Command and Control Protocol.	LRT	Dec 2010
2	Establishment of a Business Continuity Group should be considered at the first meeting of Pandemic Flu Regional Co-ordinating Group.	LRT	Dec 2010
3	Learning from the London Flu Response Centre should be captured by NHS London and HPA via their debrief processes	NHS and HPA	April 2010
4	IPCs should be advised to conduct multi-agency debriefs via the NHS London health debrief process, with a particular focus on reviewing arrangements in place for responding to the needs of vulnerable people.	NHS	April 2010
5	All communications should have clear protective marking, both on any attachments and in the email.	All	Ongoing
6	LRT and NHS London to feed comments regarding exit strategies for reporting into the Department for Health and Cabinet Office for central review.	LRT and NHS	April 2010
7	London Resilience Team and NHS London should ensure that an appropriate procedure is established to ensure sharing of information of both non-health and health impacts at the regional level.	LRT and NHS	April 2010
8	The HPA should consider whether it is possible to provide more detailed data on case levels when no longer in the containment phase.	HPA	June 2010
9	Relevant Central Government departments should ensure that any policy gaps are filled as soon as possible, and that mechanisms are in place for clearly communicating policy. NHS London and LRT should feed this back to DH and Cabinet Office	LRT and NHS	April 2010
10	The London Regional Resilience Pandemic Flu Plan should be revised with a view to making the plan more flexible once swine flu debrief processes have been completed by partners and Central Government, and	LRT	Dec 2010

	taking on board any new guidance that is issued.		
11	Learning of social care provision and structures should be captured by NHS London and shared with other partners to increase awareness and understanding.	NHS	April 2010
12	Representation from social care on the Regional Co-ordinating Group should be considered by LRT and NHS London.	LRT and NHS	April 2010
13	Any lessons regarding communication of infectious disease policy to schools and parents, including decisions to close schools, should be captured and learnt by NHS London, HPA and London Local Authorities.	NHS, HPA and LLACC	June 2010
14	Priority lists for vaccination should be reviewed on a pandemic by pandemic basis by Central Government.	DH	Ongoing
15	All partners should continue to brief businesses on the importance of business continuity planning and share their own lessons and experiences, and businesses, in turn, should ensure that information received is treated appropriately.	All	Ongoing
16	Mechanisms for reporting on wider sectoral impacts should be considered by LRT.	LRT	June 2010
17	Chair of Communications Cell and all partners should proactively and consistently update and share lines over sustained periods, either via e-mail or teleconference, and continue to do so as the incident becomes 'business as usual'.	All	Ongoing
18	All partners should review whether they have sufficient resource to lead the Communications Cell for a prolonged period, including out of hours.	All	Ongoing

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