THIS PAPER IS FOR INFORMATION **CSC-SGoR(10)10**

CABINET SUB-COMMITTEE ON SCOTTISH GOVERNMENT RESILIENCE

INFLUENZA A (H1N1) PANDEMIC – REVIEW OF THE SCOTTISH GOVERNMENT RESPONSE

PAPER BY THE CABINET SECRETARY FOR HEALTH AND WELLBEING

Purpose

1. This paper provides an assessment of the Scottish Government's response to the influenza A (H1N1) pandemic and identifies a number of lessons to be learned in light of that response. It provides an opportunity for Cabinet Sub-Committee members to note:

- The positive aspects of the response;
- The less positive aspects and areas for improvement; and
- The actions proposed to address the less positive aspects and areas for improvement.

Timing

2. For consideration at the Cabinet Sub-Committee meeting on 14 April.

Context

3. Despite initial fears, based on the information coming from the USA and Mexico, the impact of the 2009-10 influenza pandemic was not as serious as previous pandemics.

- The global count of fatalities currently stands at an estimated 16,813, as opposed to 50 million in 1918, and 3 million in 1968; and
- There were 1541 hospitalisations as a result of influenza A(H1N1) in Scotland. This placed pressure on acute care services but did not require the activation of plans to double critical care capacity.

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4. There is, therefore, a limit to which we can draw generic lessons about how best to respond to future influenza pandemics. Nevertheless, the pandemic did impact on responders in Scotland, particularly the health services. Scotland was at the forefront of the UK's response. We saw the first cases in the UK; the first hospitalisations; the first "cluster" effects; and, unfortunately the first deaths (a timeline of the pandemic is attached at **Annex A**). In all of these aspects, Scotland led the way in reacting to the spread and infection rate from a previously unknown strain of the influenza virus. This meant that we were the first Nation in the UK to put into practice previous planning models and also the first to move away from these when the reality on the ground demanded it.

5. Throughout the response, Scotland was regarded by the rest of the UK as being at the vanguard of the fight against the virus and this position stood us in good stead when it came to persuading the other 3 Nations to adopt a more pragmatic approach. Whilst we were not successful in achieving this on all occasions, our ability to influence policy across the UK should not be underestimated.

6. During the initial stages of the response, the NHS in Scotland was severely tested in some areas, particularly those which experienced the first "cluster" of infection in individual communities such as Dunoon. Overall, NHS Boards coped extremely well with the demands placed on them. However, had the virus been more severe, or lasted for a longer period, this would have resulted in considerable disruption to the normal function of the NHS. There were few wider consequences on sectors other than health, with no significant disruptions reported to public services, private business, transport or other key sectors. However, it was right for the Scottish Government to have taken a cross-cutting approach to the pandemic, given all the potential implications across Scottish society. The joint leadership of Health and Scottish Resilience in this regard was crucial.

Overview

7. A review has been carried out by officials in Health Directorates and Scottish Resilience Pandemic Flu Teams in order to assess the success of the Government's response and where lessons could be learned in responding to future pandemics. This was largely an internal (cross-Directorate) exercise, although Strategic Coordinating Groups (SCGs) were also asked to collate views at a local level. The review looked at the mechanisms put in place to deal with the response, as well as key aspects including leadership, decision-making and communications. It also attempted to highlight what the key lessons might be for improving future emergency responses and sharpening our on-going planning and preparedness.

8. Similar internal reviews are being conducted across the other 3 Nations, and in addition a UK Response Review (looking at the way that the administrations worked together) is currently underway which is expected to report before summer recess. The information gathered during our internal review will feed into the wider UK review, which is being chaired by Dame Deirdre Hine. This will look at 7 areas of

inquiry including; vaccines, containment, treatment, the central response, scientific advice, communications and wider non-health issues.

9. The UK Review is being led by the Cabinet Office and the Scottish Government is working closely with them to ensure that the views of Scotland are represented. For example, we have a seat on the reference group which will oversee the general direction of the review. The review has issued a call for evidence and I have already cleared our submission in response to that call. In addition, the Chair will visit Scotland later in the month for a meeting with me and key officials who were involved in the response.

10. In Scotland, over the coming months, we will also be working with NHS Chief Executives and their senior executives to conduct a lessons learned exercise for NHS Scotland which will in turn have a bearing on future planning processes and frameworks.

Key Findings

11. The review found that the Scottish Government's response benefited considerably from the following 4 key aspects: **leadership, decision-making, speed and communications/engagement**. A brief summary of each of these is set out below:

Leadership

- The role of the Scottish Government and Ministers was described by respondents (representatives from across Scottish Government Directorates and Strategic Co-ordinating Groups) as professional and authoritative, providing clear, honest, and consistent direction and assurance. This was viewed as being helpful to both the media and the public in a time of crisis. This, coupled with the input from the Chief Medical Officer (CMO) leading on the scientific/expert advice, was regarded as invaluable, and a possible 'spokesperson' model for future scenarios, subject to the nature of the event and the Ministers/lead officials in post at the time. Evidence from the weekly public opinion omnibus supports this. Taking the average over the 39 waves that this omnibus ran in Scotland, 83% of respondents said they were very/fairly satisfied with the amount of information available to them around the pandemic. In addition, 74% of respondents felt that the Scottish Government was well very/fairly well prepared for the pandemic.

Decision-making

- In general, respondents were positive about the approach to decision making. The strategic approach to "prepare for the worst; hope for the best" was praised, with respondents sharing the view that Government had an obligation to prepare for a very significant threat to public health and society as a whole. In this context, the decision to procure enough vaccine to cover 100% of the

Scottish population was recognised as the correct one, based on the information available at the time;

- The subsequent operational implementation of, and the administrative arrangements for, delivery of the vaccination programme was supported by respondents. It was recognised that the delivery of this vaccination? programme was a significant achievement in terms of its scale (it was estimated that there were around 1.3 million people in the identified priority groups), the timescales involved (the vaccination programme began on 21 October 2009 and it was intended that the majority of those in the priority groups would have received their vaccine by the end of March 2010), and uptake (to date 54.6% of the phase 1 priority group and 53.4% of frontline health and social care workers have been vaccinated);
- Other important decisions included the explicit commitment to base policy decisions on scientific/expert advice, which was maintained throughout the pandemic;
- Several respondents highlighted the importance of the Scottish Government being able to go its own way on decisions, where it was best for Scotland. A clear example of this was the decision not to opt into the National Pandemic Flu Service in Scotland which meant that patients in Scotland could continue to use familiar Primary Care routes to for assessment and treatment.

Flexibility of response

- Within the Scottish Government, the review noted in particular how managers moved quickly to deploy specialist teams in the Health Directorates and Scottish Resilience, and the subsequent energy and focus displayed by staff. The coordination of activities across/between directorates was also seen as a strength. Some, including SCGs, were less sure that the very early response had enough focus, clarity, speed, and coordination (see below);
- The review also noted the exceptional response from the NHS in Scotland, in particular their efforts 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, was also highlighted as a success.

Communications/engagement

- Respondents were happy with the speed and effectiveness of reaching and involving stakeholders (including driving coordination between different agencies) and providing support and guidance, based on the evolving situation. These included regular/ongoing briefing sessions and teleconferences with key stakeholders. In particular, it was noted that the weekly teleconferences with NHS Chief Executives worked well in ensuring a flow of information and intelligence in both directions. It was also recognised

that considerable effort had gone into maximising pre-established links (e.g. with COSLA, Health Protection Scotland, and the Association of Directors of Social Work) and that this had supported the response.

12. Where we did less well was in the following: **clarity of roles and responsibilities, assessing sectoral preparedness, and deployment of the planning assumptions.** A brief summary of each is set out below:

Clarity of roles and responsibilities

- As with other emergency situations, the pandemic brought to the fore some confusion around the respective roles of SGoRR and those with responsibility for the policy in question, in this case pandemic flu;
- Respondents felt that a clear definition of roles, responsibilities and lead structures is required for use in both short and long-term scenarios to avoid confusion, duplication of effort, and communication gaps;
- In particular, there is a need for a greater understanding of SGoRR's role in (a) responding to the very initial emergency, but then (b) handing on specialist work to the most appropriate policy team. This is explored in Paper CSC-SGoR(10)11 with suggestions for how to improve this in future.

Assurance on the level of preparedness

- Respondents welcomed the development of the Readiness Assessment – a Red, Amber, Green analysis of different sectors' states of readiness to deal with consequences of widespread disruption. However, many felt that a more sophisticated challenge function was needed, to ensure that information reflected what was happening on the ground;
- There is some evidence that we were relatively unsuccessful in reaching small businesses and small scale operations in the voluntary sector areas during the planning phase and the response, and we need to reflect on how we ensure that information is better disseminated.

Planning Assumptions

- Respondents recognised the limitations of modelling, however it was felt that it would have been helpful to have updated the planning assumptions more quickly to reflect the picture on the ground. In effect, reflecting the most likely scenario, rather than the worst case scenario. Respondents felt it would have been helpful for the process of testing the planning assumptions to be more explicit;
- The planning assumptions which were published did not hold much weight with responders on the grounds that they did not reflect what they were experiencing.

Assessment

13. Viewed overall, the Scottish Government can be justifiably proud of the way in which it responded to the influenza A(H1N1) pandemic. The pandemic tested our systems and resources in a way which helped us to identify lessons for the future. However, we should not make the error of drawing generic conclusions, as future pandemics could be much more severe than in 2009-10. The results of the UK review and our assessment of how NHS Boards performed, will inform our future planning both locally and nationally.

Conclusion and Recommendations

14. Recognising that each pandemic/emergency will pose different challenges makes it crucial that we learn and sharpen key elements of response and preparedness as a consequence of the pandemic. A number of issues have been identified which now need to be taken forward in order to ensure greater success in future potentially more severe, scenarios. An overview of these is provided at **Annex B**.

15. Key in all this is the need to ensure effective and robust pre-planning/ preparation. This will enable us to build confidence and assurance that, in a future scenario, we will be able to react with speed and certainty by applying well-rehearsed and clearly defined/understood emergency procedures. We must also ensure that we communicate and engage throughout the planning and response stages to any future pandemic through clear/comprehensive communication strategies. We must be clear that we make decisions by applying the best available, and trusted science/evidence. As far as possible, it is vital that we ensure that we risk assess and plan financially, through effective contracting, scoping and economic impact forecasting.

16. The Cabinet Sub-Committee is invited to:

- note the summary findings of the review as reflected in this paper; and
- note the action officials plan to take to learn from this experience to inform our response to any future pandemic (Annex B).

Annex A

H1N1 INFLUENZA PANDEMIC – REVIEW OF SCOTTISH GOVERNMENT RESPONSE

Timeline

2009	
April	• Scottish Government is informed of cases of H1N1 in Mexico and USA; • First two cases in UK identified in Scotland. • Health Directorates Pandemic Flu Team established. • Cabinet Secretary for Health and Wellbeing provided first statement to Parliament on H1N1 – top priority at this stage is to disrupt the virus and contain the spread of infection by tracing contacts of all suspected cases. • WHO raise alert level from 3 through to 5 over the month.
May	• Cabinet Secretary provided 2 further updates to Parliament on situation with H1N1. • First school closures – on advice from local Public Health teams. • The UK Government and the Devolved Administrations agreed the signing of pre-pandemic contract, securing maximum supplies of vaccine. • The four UK Health Ministers take the decision to vaccination 100% of the population. • By the end of the month there were 19 confirmed cases in Scotland.
June	• Dunoon 'cluster' of cases is identified. This is the first cluster of cases in the UK • Further full and partial school closures took place across Scotland • Scottish Flu Response Centre was activated. • WHO confirmed move to Pandemic Alert level 6 – Influenza A (H1N1) is now classified as a global threat. • Tragically, Scotland experienced the first two deaths from H1N1 in the UK • By the end of June, there were 1,162 confirmed cases in Scotland.
July	• Move from Containment Phase to Treatment Phase across the UK • Cabinet Secretary for Health and Wellbeing provided further update to Parliament. • There were two more H1N1-related deaths during July – taking the total in Scotland to 4. • The National Pandemic Flu Service was launched in England only.

	• At the end of July, Health Protection Scotland estimated that 4,300 people have contracted the virus since the start of the outbreak.
August	• Priority groups for H1N1 vaccination were announced, these are clinical at risk groups, pregnant women and frontline health and social care workers. • There were three further H1N1-related deaths in Scotland, taking the total to 7 since the start of the outbreak.
September	• The Cabinet Secretary for Health and Wellbeing provided a further update to Parliament on position with H1N1 following the summer. • Revised planning assumptions were published which indicate that 30% of the population may become ill with flu at some point over the course of the pandemic – a reduction from the original assumption of 50%. • Four UK Nations agreed to commit to increasing critical care capacity by 100% in each of the four nations. • H1N1 Vaccination arrangements were announced – the vaccine will be delivered by GPs. • The Cabinet Secretary for Health and Wellbeing announced the establishment of an expert group to consider the medium and longer term provision of adult Extra Corporeal Membrane Oxygenation (ECMO) therapy in Scotland. • There were two further H1N1-related deaths in Scotland, taking the total to 9 since the start of the outbreak. • 165 people had been hospitalised with H1N1 since the start of the outbreak.
October	• UK Health Ministers agreed to double the adult ECMO provision at the UK centre in Leicester. • Revised planning assumptions were published which indicated a clinical attack rate of 12%. • Scottish Government announced it will cover the re-registration costs of all midwives and nurses returning to work to help in the worsening of the H1N1 outbreak. • Delivery of the vaccination programme began. • There were 17 further H1N1-related deaths, taking to total to 26 since the start of the outbreak.
November	• Cabinet Secretary for Health and Wellbeing announced plans for the second phase of the vaccination programme – the vaccine is now available all children aged between 6 months and 5 years. • There were 22 further H1N1-related deaths this month, taking the total in Scotland to 48 since the start of the outbreak.
December	• Phase two of the vaccination programme began. • There were 14 further H1N1-related deaths this month,

	taking the total in Scotland to 62 since the start of the outbreak.
2010	
January	• There were 5 further H1N1-related deaths this month, taking the total in Scotland to 68 since the start of the outbreak.
February	
March	• There was one further H1N1-related death this month, taking the total in Scotland to 68 since the start of the outbreak. • HPS confirmed that there have been 1541 laboratory confirmed H1N1 hospitalised cases since the start of the outbreak.

Annex B

H1N1 INFLUENZA PANDEMIC – REVIEW OF SCOTTISH GOVERNMENT RESPONSE

Actions to be taken forward following the internal Scottish Government review

- Difficulties recognised in ensuring small businesses are kept up to date – *this will be reviewed within the multi-agency sub-group of the Resilience Advisory Board which has recently been established to review the way in which information around business continuity is disseminated.*
- Investigate development of challenge function in future Pandemic Flu readiness assessments – *the relationship between the Scottish Government and SCGs in an emergency is being reviewed in light of lessons identified and the recent Audit Scotland report on civil contingencies planning.* A consultation paper on this will issue at the end of 2010.
- Need to review engagement with SCGs and their role during the pandemic – *as above.*

Actions to be taken forward as part of the UK-wide Review into the influenza A (H1N1) response.

We will oversee the work of the Review Team through Scottish Government representation on the reference group. We will consider the implications for Scotland of the emerging findings, specifically those relating to:

- A phased approach to a pandemic (containment, treatment);
- The collection, assessment and dissemination of scientific advice;
- Future strategy on vaccine procurement, including decisions around the efficacy of Advanced Purchase Agreements;
- Management of medical and consumables stockpiles;
- Future iterations of the Pandemic Flu Framework.

Planned NHS Board/SG lessons learned exercise.

- We will develop a questionnaire to issue to Boards to gain an initial insight into their experiences of the pandemic; what went well, what could be done differently etc. This will be issued to Chief Executives, with recommendations that specific sections should be reviewed by different operational leads within Boards. Policy leads within Health Directorates will also be asked to discuss this with their stakeholders at operational levels within Boards to gain their insights;

- We will use Boards' returns from these questionnaires to pull out the key issues . These will then be investigated in more detail through discussion with focus groups made up of representatives from various sectors of the health

service and from a range of Boards. This may also be supplemented by visits to specific health boards who raise issues of particular interest/importance in their returns to discuss their experiences in more detail;

- The outcomes of this work should help to inform future pandemic flu planning, both nationally and locally. It may also help to inform planning for other seasonal pressures, for example whether the measures put in place to increase critical care capacity during the pandemic could be activated locally if Boards experience particular pressure due to cases of seasonal flu etc;
- The first discussion on this with NHS Chief Executives will take place at their monthly meeting with DG Health on 21 April.