Appendix 1

Barking & Dagenham Partnership

Review of the

Barking and Dagenham

Response to the H1N1 Flu Pandemic 2009/2010

Prepared for
Matthew Cole: Joint Director Health Improvement
By *Dawne Bloodworth: Pandemic Flu Director (Temp) with support from Roger Brett: Group Manager Emergency Planning & Dr Sue Levi: Public Health Consultant*

This version 28.04.2010

Contents

1. INTRODUCTION

In April 2009 the world became aware of cases of illness caused by a novel influenza virus, then 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 Pandemic Phase 6 and the official start of the first pandemic of the 21st century.

The first UK cases were reported in Scotland on 27 April, and the first in London on 30 April 2009. Cases continued to increase and London saw the peak of the first wave in July.

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) in response to the rapidly increasing number of cases.

Following the first wave London saw a reduction in the number of cases over the school summer holidays which started to increase around the beginning of September when children returned to schools, a second wave commenced and the number of cases increased.

In November, the vaccine became available and was offered to the first at-risk groups, those being pregnant women, household contacts of the immune-compromised, people aged 6 months to under 65 years in the seasonal flu risk groups and those aged over 65 years in the clinical seasonal flu risk groups; and frontline health and social care workers. When more vaccine became available the vaccine was offered to healthy children aged between 6 months and 5 years old.

In January and February 2010, the numbers of cases reduced to an extent that the National Pandemic Flu Service was decommissioned (11 February) and new flu cases were managed through GP consultations.

In 2009/10 NHS Barking and Dagenham (NHSBD) and our partners, especially London Borough of Barking and Dagenham (LBBD) focused on strengthening our joint plans for responding to pandemic flu. This involved running a number of major multi-agency events, and table-top exercises, designed to test and/or review the plans of the participating agencies in their response to pandemic flu. These events involved the NHSDB, LBBD, other local NHS organisations, the Police, Ambulance Service, Fire Brigade and local community organisations and considered our preparedness and our collective plans to maintain essential services during a flu pandemic and also to care for those ill with flu.

The aim of the 2009/10 exercises/events was to inform and test the revised plans in particular the trigger points for organisations and demonstrating partners' co dependencies and their joint resilience (see Table 1 below).

NHSBD and LBBD planned a joint 'recovery event' and debrief during March 2010 which focussed on identifying issues for recovery from pandemic flu and in identifying gaps in recovery plans and formulate actions to address those gaps. A more detailed joint report has been produced from this event to inform the partnership (see '*Exercise Cold Play 2 – Report').* This review provides a summary of findings for the Barking and Dagenham Partnership and will be forwarded to NHS London (NHSL) and is based on responses from

key individuals and teams involved in the Barking and Dagenham response to the H1N1 Flu Pandemic 2009/10.

Table 1: List of Events held in B&D in 2009/10

• IPC Introductory Exercise	6th April
• Influenza Provider Event • IPC Follow Up Event	3rd May 20th May
• LBBD Pandemic Flu Planning Event	8th June
• Cold Play 2 Exercise	15th October
• Winter/Flu Resilience Event	6th November
• Peer Review of Flu Resilience Plans	27th November
• Cold Play Recovery & Debrief Event	25th March

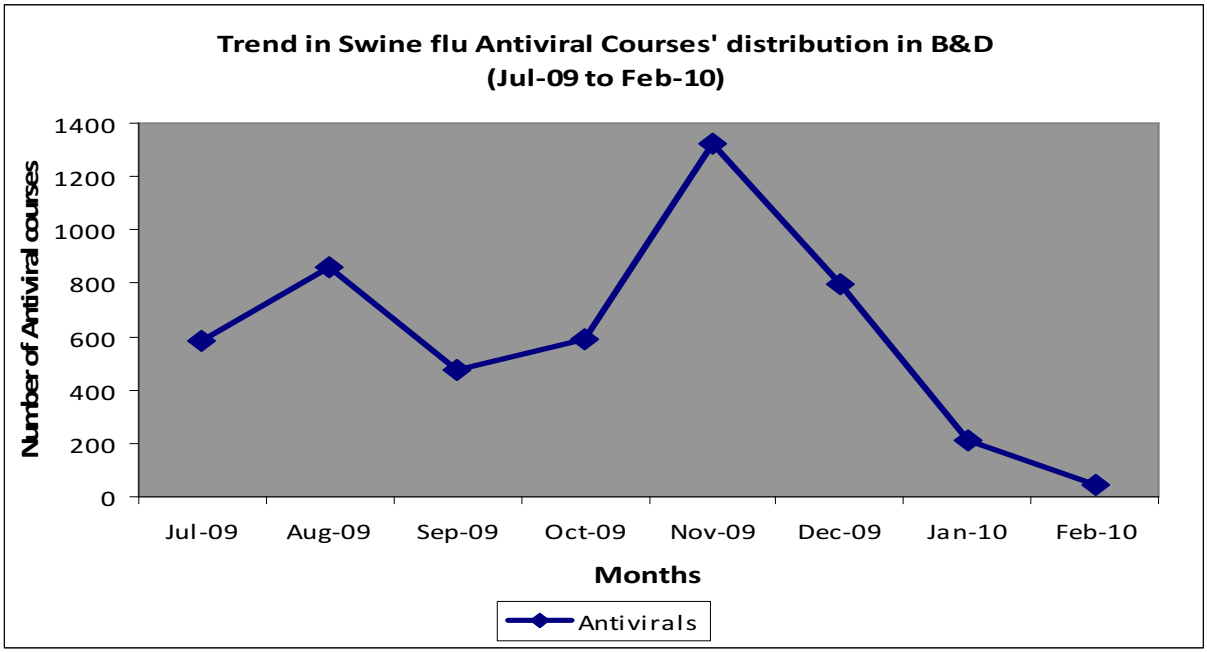
Local Epidemiology

Locally, the first case of H1N1 was confirmed 2nd June 2009. The initial Containment Phase involved testing those with symptoms, treating those confirmed as infected and providing antiviral prophylaxis to contacts.

This phase ended on the 2nd July 2009 when the country entered the Treatment Phase when patients were given antiviral drugs if they had classic symptoms. In Barking and Dagenham 30 people were diagnosed with swine flu by testing (swabbing) prior to the switch to treating all those with suggestive symptoms.

The peak week for flu diagnoses in London was the week beginning the 13th July 2009 whereas Barking and Dagenham peaked in November that year. Locally 4,893 courses of antivirals were dispensed and this figure provides an estimate of the total number of suspected cases seeking healthcare.

The National Pandemic Flu service (NPFS) opened on 23rd July 2009 and provided a telephone service for patients to confirm if their symptoms suggested flu. If flu was likely then patients went to collect drugs from an antiviral collection point (ACP). The NPFS closed on 11th February and ACPs were closed on 31st March 2010.



The hospitals, Queens and King George's, admitted 61 people from Barking and Dagenham with suspected flu but only 15 (one quarter) were subsequently found to be actual cases. The peak months for diagnosis in hospital inpatients were July and November 2009 and the age group that was most affected, for Barking and Dagenham residents, was the group 15 to 24 years age with 6 confirmed cases.

The acute trust admitted 260 patients with suspected swine flu from its entire catchment area in 2009. There were less than 5 deaths from swine flu in Barking and Dagenham including those where flu was a coincidental finding and not the actual cause of death.

Summary of local epidemiology
This pandemic did not result in a large number of cases or significant disruption of healthcare in Barking and Dagenham
Barking and Dagenham experienced the first case and community peak a number of weeks later than the London overall.
The hospitals experienced two peaks of admission of suspected cases from Barking and Dagenham – one in July when London experienced a community peak and one in November which was the local peak.
Barking and Dagenham residents only constituted one quarter of the total hospital admissions for swine flu for the acute trust across its catchment area
On this occasion the number of admissions were small and only one quarter – about 15 patients - were confirmed as having H1N1 influenza
The post pandemic multi-agency review (25th March 2010) identified some useful learning from the pandemic including greater skill in coordinating major incidents involving all partners and how to optimise communication.

2. COMMAND AND CONTROL

The Civil Contingencies Act 2004 requires that NHSD prepare for major incidents and other civil emergencies which may affect our borough and its population. NHSBD delivers this work through an Emergency Planning Group where partner agencies are involved, close working with the LBBD and the Health Protection Agency (HPA), and through development, testing, and regular updating of plans to deal with major emergencies. The *NHS Emergency Planning Guidance 2005* stipulates arrangements in implementing the Act and *Standards for Better Health* requires the NHSBD Board to assure themselves that emergency preparedness arrangements for the organisation are in place, exercised regularly and show evidence of continuous improvement.

NHSBD in partnership with LBBD, the Police and Fire Services and the Voluntary Agencies have established a Joint Influenza Pandemic Contingency Plan the purpose of which is to assist all agencies in the response to a Pandemic. The Plan operates on the same system of command and control as for any other Major Incident:

Gold – A Multi-agency Group chaired by the Chief Executive of the Local Authority with membership from the Emergency Services and the Health Sector. The purpose of the Group is to provide leadership for Barking and Dagenham in dealing with the local implications of a flu pandemic

Silver – A Multi-Agency Group chaired by the Director of Adult and Community Services with membership from each of the Bronze Groups. The purpose of the group is to:

- To maintain essential public services wherever possible
- To work collaboratively with all agencies, including local businesses and others
- To encourage community cohesiveness, resilience and self-help

- To ensure full normal services are resumed as soon as possible
- To make decisions about deployment of local resources, including restricting or withdrawing the usual standard of services in order to minimise the overall loss of life in the population at large during the epidemic
- To ensure co-ordination of bronze group activity and maintain overview
- To co-ordinate the public sector response to the pandemic

Bronze – There are a number of Bronze Multi-Agency Groups delivering the operational response. The groups are chaired by a number of people at Director or Head of Service level and cover the areas of

- Health and Social Care
- Medicines Management
- Infection Control
- Communications
- Human Resources
- Facilities
- Special District Immunisation Committee
- Information Management

2.1 Lessons identified – Command and Control

Good practice

- The command and control structure from Department of Health (DH) to NHS London (NHSL) to NHSBD was very clear.
- Working with NHS London was quite difficult. However when a full time programme manager was appointed there was capacity and assistance to manage this.
- The command and control structure within Barking and Dagenham was very clear to all involved with strong leadership, clarification of roles and integrated joint working arrangements
- Full executive/organisational support for management of pan flu preparations
- Health Protection Agency (HPA) and DH website information was useful
- Daily noon briefs and internal cascading of noon briefs with relevant highlighted points for action
- All teleconferences set up were useful to save time and travelling to give and receive information and feedback

Areas for development

- UK alerts levels not being declared resulted in the IPC being unclear when it was appropriate for the group to change from a planning to response group. All plans from national to regional to local had fluid plans however they all refer to UK alert levels being declared. This requires a review by DH as to why the UK alert levels were not used and what triggers/escalation process will be used in the future.
- Failure of ONEL command and control. This failed to engage council officers.
- There should be a balance between being responsive to issues from NHS London, when they are sent out and how they would like this managed at a later time. With hindsight it would have been more helpful if command and control had taken time to prepare instructions.
- Overall leadership & instructions overlapping and, at times contradictory or illogical with a large number of agencies involved e.g. CMO, NHSL, HPA, GOL & COBRA.
- Organisation of emergency preparedness generally needs to be strengthened to ensure clarity on contingency arrangements. London has two command and control structures in place for all Major Incidents called the 'London Emergency Services Liaison Panel Major Incident Procedure Manual' (LESLP) and the 'London Command and Control Protocol'. All Category 1 responders sign up to both of these and neither of them were enacted. Some NHS participants felt that the LESLP Gold/Silver/Bronze command and control structure was new to them and was a major learning curve during the event.
- Some NHS participants felt that the LESLP Gold/Silver/Bronze command and control structure was new to them and was a major learning curve during the event.
- Routine review of business continuity plans to ensure implementation is delivered quickly
- Scenario planning on workforce issues and the impact on individual services and hence on

interrelationship between services within NHS and across the wider partnerships. Contingency plans need to mitigate these.
- Dedicated support for emergency planning and associated administration to improve liaison and/or problem solving between Command & Control (C&C) groups
- Appointment of dedicated flu lead earlier (started October) prior to this large workload fell on others
- IT connectivity issues between LBBD and NHSBD critical if command centre is to function 24/7 (now resolved)
- Financial impact and risks understood as part of the control function as in the speed to react and prepare for mass vaccination costs were incurred and the facilities not then utilised.
- Overall it was felt that the same structure for Recovery should be used as for Response and that specific decisions should be taken to change the focus of activity and to stand groups down after reporting that their specific pandemic activity had come to an end.
- The newly implemented ACU cluster, i.e. NHS Outer North East London (ONEL) was not used for local management and its role in C&C in a major incident needs to be clarified.

3 INTERNAL COMMUNICATIONS

The Communications Group produced a strategy and action plan. This was linked to the NHSL communication strategy. All media was handled by the communications team and NHSL guidance followed for briefing upwards for both communications and Serious Untoward Incidents (SUI). Updates were provided weekly for staff through 'The Loop' staff newsletter and communications with primary care providers via, letters, email etc as required.

3.1 Lessons identified – Internal Communications

Good practice
- Communication strategy from NHSL around noon brief and wider cascade for daily updates helped clarify key points and deadlines
- The communications team being the conduit for all information being sent out and regular updates
- Communication team cascaded key points through out the organisation weekly and as required through The Loop staff magazine and the importance of healthcare staff being immunised

Areas for development
- Coordination of administration and communications as when meetings we called urgently or were rearranged quickly not all members were informed or aware
  National templates for artwork and the quality of the national templates were poor

4 EXTERNAL COMMUNICATIONS

The Trust Internet site was kept up to date with all appropriate swine flu information. Information was made available in different formats and languages utilising whatever was available from DH. Factsheets, leaflets and posters distributed to clinics, health centres, GP surgeries, pharmacy and public venues in line with DH requirements. Some specific leaflets were developed for target audiences, for example Barking and Dagenham Carers.

4.1 Lessons identified – External Communications

Good practice
- Barking and Dagenham communication network proved to work very well and proactive press releases to local media
- National Pandemic Flu Service once the initial problems were resolved
- NHS London setting up the flu centre and providing one avenue for communication was highlighted by the group as being an invaluable source of support.
- Noon brief was found to be very useful.

Areas for development

- National Media communication caused unnecessary panic
- Too much duplication of information received from different sources, this included DH, NHSL, HPA and at times the information received was conflicting. It would have been helpful if DH had delegated authority for NHSL to be the main conduit of information and requests at all times.
- DH stating that information was available on the communication website and it was not there particularly relevant to literature required in different languages.

5 WORKING WITH PARTNERS – INFLUENZA PANDEMIC COMMITTEES (IPCs)

A Multi-agency Group chaired by the Chief Executive of the Local Authority with membership from the Emergency Services and the Health Sector met monthly or as required.

5.1 Lessons identified – Working with Partners

Good practice

- C&C structure clear and having continuity of IPC membership and attendance proved invaluable and commitment of all IPC members
- Group representatives attended meetings as required and enhanced sense of shared ownership was recognised across partnership
- NHS ONEL partners Flu Leads communication/teleconference/training
- Community Health Services providing vaccine to housebound
- Barking Havering Redbridge University Hospital NHS Trust (BHRUT) providing vaccination to pregnant women and other specific groups

Areas for development

- Clarity and coordination of communication as sometimes there was so much going on it could be difficult to follow it all and be clear about responsibilities. Not enough informal communication across the different partnership groups (individuals need to recognise their organisational role as well as specific job role)
- Coordination of membership lists and organisational charts needed to clarify who was doing what to ensure those directly and indirectly involved are aware
- Clearer communication between NHSBD and the Primary Care Contractors perhaps through a regular newsletter would have assisted
- Joined up IT and Software capabilities
- Need to consider how NHS partners in ONEL sector can ensure coordination, support and communication across the economy to reduce duplication of effort and share best practice.

6 VULNERABLE GROUPS

Working with partners we have identified and provided additional services to patients, especially those with long term conditions, disabilities and their carers. We have also provided additional support to the house bound and those in care homes. The flu friend service was provided through the borough adult social services team.

6.1 Lessons identified – Vulnerable Group

Good practice

- Individual organisations and partners working together to clarify and identify vulnerable groups within the community and ensure support available

Areas for development

- Better utilisation of voluntary/third sector partners in coordination in this area and utilising established links/services already in place

7 PERSONAL PROTECTIVE EQUIPMENT (PPE)

NHSBD managed the storage, stock management and distribution of the PPE from the national stockpile.

7.1 Lessons identified – PPE

Good practice

- Adequate amount of PPE distributed in the first stages of the pandemic
- Fit testing was critical

Areas for development

- PPE (as with vaccine) to be delivered direct to source.
- While the PPE distribution in the first stages was reassuring; the further deliveries of stock were excessive and the ability to order as required to prevent bulk storage solutions and stock going out of date in individual organisations
- Advance storage availability if required must be identified
- Secure finances and systems for urgent purchasing for such outbreaks

8 ANTIVIRALS (AVs)

Initially the antiviral drugs were available through stocks held by the HPA in a few London hospitals. This changed on the 7 May 2009 when stocks of antiviral drugs were provided by the Department of Health to local NHS organisations. Within NHSBD we commissioned eight community pharmacies as Antiviral Collection Points (ACPs). These were opened in a phased approach in readiness to switch to the 'Treatment Phase'. Using our community pharmacies as local antiviral collection points ensured our residents had easy access to antivirals across Barking and Dagenham.

8.1 Lessons identified – Antivirals

Good practice

- Once stockpile was commissioned the contingency with regard to AV stock reporting and delivery worked well.
- Speed of set up of ACP and ability to flex to local demand i.e. shutting down as demand fell
- Use of community pharmacists as ACPs.
- Introduction of the National Pandemic Flu Service was excellent.

Vaccination programme

- Senior clinical leaders taking vaccine
- Vaccine administration was undertaken locally by Occupational Health staff who held drop in clinics cross sites
- Training and accreditation of some Community Pharmacists to provide vaccination in future

Areas for development

- The failure to negotiate a national contract for community pharmacies caused many problems. Ideally a national contract in place in England as there was in Wales.
- To provide clear and concise information at the start of the pandemic regarding storage and monitoring of antivirals
- Central stockpile not individual organisations. It would have worked better if the antivirals were delivered centrally and a separate agency commissioned to deliver stocks to the collection points.
- To review the requirements for surveillance and stock monitoring. The first system of using excel spreadsheets proved to be very time consuming and while it was acknowledged it was only temporary the changing of systems during the pandemic caused confusion to staff in both PCT and ACP.
- The need for support staff to ensure coordination, training and reporting highlighted as an issue

- Inadequate functions on the SMS, where certain errors and mistakes could not be rectified as and when required caused operational difficulties and delays. The entire SMS needs to be reviewed and tested to ensure that it is fit for purpose.
- More clarity is required on how antivirals should be prescribed and who should prescribe them. Changes to the doses of antivirals in children twice also created potential for wrong doses to be prescribed/ dispensed. In addition the issues around AV vouchers being rejected by the Local Medical Council (LMC) led to various systems being used by GPs to authorise antivirals.
- The process for setting up an ACP and the resources required will be documented for future utilisation as setting up Anti-Viral Collections points proved to be problematic with lack of clarity on timing, and both people and financial resources unclear.
- The perception of antiviral points is that some were close to PCT boundaries e.g. collection points were virtually next door to each other. Boundaries need to be checked, possibly by NHS London.

Vaccination programme

- Early clarification if more than one vaccine available
- Ability to manage mixed messages and get clear guidance re use of vaccines
  Need to develop a robust programme for seasonal Flu vaccine delivered locally for staff.

9 VACCINE AND VACCINE CONSUMABLES

NHSBD managed the storage, stock management, distribution and delivery of the vaccine consumables. NHSBD commissioned Barking Havering Redbridge University Hospital Trust's (BHRUT) to provide vaccination to pregnant women. NHSBD also commissioned Occupational Health in London Borough of Barking and Dagenham to provide vaccination programme for front line health care workers, social services staff and others including local Police and school staff.

Most practices within NHSBD agreed to offer the vaccine to the priority groups registered in the practice. The patients from the two practices who did not agree were provided with alternative access via the Community Health Services immunisation team. Services were available for those people unregistered with a GP who fell within the priority groups. NHSBD further commissioned its Community Health Service to complete the vaccination of at risk housebound patients.

9.1 Lessons identified – Vaccine and vaccine consumables

Good practice

- Area of strength was the way the immunisation programme was managed and rolled out locally.
- Providing vaccination clinics at places of work at various times including evening to accommodate staff.
- Working in partnership with BHRUT for immunising pregnant women.
  GP's willingness to provide vaccination to at risk community and inclusion of pharmacists and dentists within the vaccination programme

Areas for development

- Better national promotion of benefits of immunisation.
- Vaccine consumables to have been delivered at the same time as the vaccine.
- Vaccine packaging produced a lot of wastage.

10 INCREASING CAPACITY

General Practice: GP practices have been guided to develop business continuity plans and for GP out of hour's services we are assured that our GP out of hours service has robust business continuity plans and surge capacity plans.

Community Pharmacies: Our community pharmacies provide a wide range of extended services and many participate in the trusts minor ailment scheme. We have emergency community rota in place and a high percentage of pharmacists indicate they would be able to offer extended opening. Some have been undertaking accreditation to be able to provide vaccination in future years

Dentists: we are assured that our dentists had business continuity plans.

Intermediate care capacity: There is a weekly meeting of community health and social care teams to address any capacity issues and commission extra capacity in nursing homes.

Social care capacity: LBBD Adult Social Services Commissioning & Contract Section has a quarterly providers' forum for providers of care homes of which local health colleagues are regular attendees providing information and advice related to preventive measure to avoid hospital admissions and facilitate timely return after hospital stay. Weekly problem solving meetings chaired by the Director of Adult Social Services take place to seek resolution to possible delayed discharges.

Acute & Critical Care capacity – our acute trust developed plans for increasing critical care capacity but there was significant risks, e.g. staffing and Paediatric ICU and Maternity services were also highlighted as a risk area.

10.1 Lessons identified – Increasing Capacity

Good practice • The use of robust business continuity planning by the NHSBD, partners and independent contractors • Working in partnership with the local authority to increase social capacity and improve care packages.
Areas for development • Improved collaborative working required on workforce issues and use of workforce data – better and earlier scenario mapping needed. • Paediatric ITU requires further development across London. • Recruiting temporary staff there are restraints by system which we need to clarify especially around retired or returning staff and CRB etc

11 REPORTING

Information group coordinated reporting arrangements and a named lead and contingency identified for each report, all necessary staff were provided with the appropriate access, this provided resilience for response. A reporting database was set up which was monitored by the swine flu incident team to ensure that all reports were completed within the set timeframes.

11.1 Lessons identified – Reporting

Good practice

- Sharing of weekly reports from NHSL was very informative.
- Daily dashboard shared with local authority partners to provide understanding of current position
- Vaccine reporting after some difficulty at first with system
- Barking & Dagenham groups utilised action report log style for reporting which worked well once established

Areas for development

- Workforce information – daily reporting of sickness could have been improved as there was often delay with real time status
- Timescales at times were too tight especially if no explanation of why reports were needed and initially no feedback provided; perhaps reports could be provided by exception only.
- The ImmForm website ran extremely slow at times and crashed 70% of the time due to problems with the Server. Although the technical team did all they could to rectify the situation, strategic planning on the data entry process could have anticipated this
- Concerns expressed about too many different reports to be produced for too many different organisations and additional resources were required to be compliant with reporting demands
- Survey deadlines and timescales were subject to change due to unforeseen circumstances which added to resource burden
- Guidance on relaxation of data protection never resolved. NHSBD have a draft document which is still for consideration.
- Information sharing protocols need to be in place & would be useful in emergencies IT liaison
- Initially we invested resources devising local solutions to certain issues e.g. flu vaccine reporting template. However, in most circumstances a highly structured regimen was subsequently provided. Clarity on what can be progressed locally versus command and control from regional/national planners need to be considered further.

12 FLU/WINTER ASSURANCE PROCESSES

NHSL London Winter/Flu Resilience Assurance Process for 2009/10 which built on the processes and formats used in 2008/09 included the requirement to provide a high degree of assurance. This requirement to provide assurance on the leadership, governance and resilience processes for NHSBD made sure that the trust focused on ensuring that it had plans and processes in place that were both robust and fit for purpose. NHSBD worked in partnership with local health and social care providers to ensure that we had a health economy wide approach.

12.1 Lessons identified – Flu/Winter Assurance

Good practice

- Inter-agency discussion of plans and working in partnership to provide a health economy wide approach.
- Assurance process provided a clear framework to work against.

Areas for development

- Responsiveness of all services to times of increased demand

13 NEXT STEPS

The report ‘Cold Play 2 – Recovery’ and this review report will be taken to the Barking and Dagenham Gold meeting in April, and copied to NHSL. An action plan produced from the Cold Play 2 event is being discussed at Emergency Planning group in May. Following this

both this review report and the action plan will be taken to NHSBD Executive and Board meetings and also to Executive group in LBBD. The IPC will monitor the progress against the action plan.

14 FUNDING

The overall budget for the financial year 2009/10 amounts to approximately £700,000 from NHSBD this includes agency costings but does not take into account staffing and factoring this in could amount to approximately £1.2million. In respect of the council resources this was more difficult to identify as it was wrapped up in human resource time in taking people away from their day to day work. The non-pay element of the council's budget amount to £40,000 but this is a gross under-estimate of the cost which is put in the region of circa. £350,000.

15 CONCLUSION

Barking and Dagenham Partnership through the IPC has been planning for the event of a pandemic influenza for many years. While the 2009 incident has been a huge learning curve to all involved, it clearly highlighted the firm foundations built over this time. The continuity and commitment of the membership and having a robust multiagency plan in place proved to be pivotal in the success of the Barking and Dagenham response to the swine flu incident. The contributions made by individuals, teams and organisations are officially recognised.