Northern Ireland
Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT (Hansard)

Departmental Briefing on Swine Flu

10 September 2009

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mrs Dolores Kelly
Mr John McCallister
Ms Sue Ramsey

Witnesses:
Dr Michael McBride)
Mr Edmund McCosh) Department of Health, Social, Services and Public Safety
Dr Elizabeth Mitchell)
Dr Norman Morrow)

The Chairperson (Mr Wells):

Lady and gentlemen, welcome to the Committee. This is my first time in the Chair, although, in previous guises, I have met almost everyone here. The issues for discussion are swine flu and the proposed statutory rule.

I shall introduce the witnesses to the Committee: Dr Michael McBride is the Chief Medical Officer; Dr Elizabeth Mitchell is the Deputy Chief Medical Officer; Dr Edmund McCosh —

Mr Edmund McCosh (Department of Health, Social Services and Public Safety):
I am not a doctor.

The Chairperson:
You are the only non-doctor present. Perhaps you are a consultant?

Mr McCosh:
No.

The Chairperson:
Mr Edmund McCosh is from the Department's pharmacy and prescribing branch, and Dr Norman Morrow is the Chief Pharmaceutical Officer. I hope that that title is correct.

Dr McBride and Dr Mitchell will provide an overview of the current swine-flu situation, and their two colleagues will give us some information on the proposed statutory rule. There is a considerable degree of interest in the matter, so I invite you to make your presentation, after which I will call Committee members to ask questions in the order in which they indicate their desire to do so to the Committee Clerk.

Dr Michael McBride (Department of Health, Social Services and Public Safety):
I thank you for the opportunity to update the Committee on the Northern Ireland response to swine flu — the H1N1 virus. During the summer recess, there has been a number of significant developments, which I shall summarise.

To date, as of noon on 9 September 2009, we have had 189 laboratory-confirmed cases of H1N1. However, as members will be aware, routine laboratory testing of suspected flu cases ceased when, throughout the UK, we moved from the containment to the treatment phase, which occurred on 2 July 2009. As a result, the true figure may be somewhat higher. To date, 78 people have been hospitalised with swine flu in Northern Ireland and, so far, one death has been attributed to the virus. However, we can be certain that we will see an increasing number of cases.

Over recent weeks, we have experienced a decrease in a number of the key indicators of the

disease and, although the level of flu and flu-like illness remains significantly higher than that which was recorded for the same weeks in previous years, we have been witnessing a reduction in GP-consultation rates. In addition, over the past five weeks, the number of antiviral prescriptions has decreased. However, based on experiences with previous pandemics and on expert scientific and medical advice, we continue to put plans in place for a further upsurge in cases and for a potentially more severe pandemic.

Rates of flu-like illness and related activity continue to fall throughout England and are relatively stable at present in Scotland and in Wales. The Health Protection Agency (HPA) modelling for England gives a picture of decreasing activity from week to week in all age groups and regions. Reporting of swine flu across the UK is now provided weekly, as the Committee will know. In the UK, there have been 13,192 laboratory-confirmed cases. It is important to emphasise that that figure may not be representative of the true number of cases. As of 3 September, the total deaths associated with the H1N1 virus across the UK was 70: 61 in England; seven in Scotland; one in Wales; and one in Northern Ireland. Worldwide, there have been more than 254,000 cases and more than 2,800 deaths. In Europe, the total number of confirmed and reported cases to date is 46,635, including 105 deaths. The virus continues to be relatively moderate and self-limiting, although it can be severe for some people, as we know.

Last week, the Minister issued revised planning assumptions for the progression of the pandemic. Those included a reduction in the hospitalisation rates from 2% to 1%, together with a reduction in the upper limit of the case-fatality rate from 0·35% to 0·1%. A substantial peak may now not occur until October.

I must emphasise that those are planning assumptions; they are not predictions. They are appropriate for use until mid-May 2010. However, it is important to emphasise that the impact of the vaccination programme has not been factored into those estimates. That aspect will be kept under review, and the revised planning assumptions have now been issued across the UK and are available on our departmental website. We also used those to underpin the critical-care plan, which was prepared by the four UK health Departments to detail the increased critical-care capacity that is required to address the predicted rise in demand.

The UK has advance-supply agreements, or sleeping contracts, in place with leading manufacturers to produce a vaccine once sufficient information becomes available to allow the

vaccine to be typed. Generally, that takes three to six months. A pandemic-specific vaccine is now being produced, and the first batch of doses has arrived in the UK and will be fully delivered by November 2010. Plans are in place to procure enough vaccine to vaccinate 100% of the United Kingdom population. Vaccines will arrive on a phased basis throughout the year and in sufficient quantities to ensure that the entire population of Northern Ireland can be vaccinated, if needed.

On 13 August, the Minister announced the priority groups that will be the first to receive the H1N1 vaccine. Those include individuals who are aged between six months and 65 years of age in the current seasonal flu clinical at-risk groups; all pregnant women, subject to licensing considerations; household contacts of immunocompromised individuals; and people aged 65 and over in the current seasonal flu clinical at-risk groups.

Those priority groups were selected because they are at higher risk of severe illness from swine flu. Front line health and social care workers will also be among the first to be vaccinated. The close contact that they have with patients daily makes them much more susceptible to becoming infected and then passing on the virus to patients. It is vital that we also protect our health and social care workers and staff to ensure that the health and social care service is available to deliver care to the sick and vulnerable. We will have sufficient vaccine for all those priority groups to receive two doses of the vaccine by the end of November 2009. Preparations continue to be made to extend the programme beyond those initial priority groups. The Joint Committee on Vaccination and Immunisation (JCVI) will consider that matter further and report back in due course.

The JCVI has advised that the vaccination programme should not begin until the vaccine is licensed, which is expected around the end of September or beginning of October 2009. That means that the programme for the vaccination of the initial priority groups should begin in October 2009 and be completed by around late November 2009. We estimate that around 500,000 individuals fall into the four initial risk groups, including health and social care workers.

Owing to the high numbers of confirmed swine-flu cases in England, an interim National Pandemic Flu Service for accessing antivirals has been operational there since 23 July 2009. The service completed more than 1·2 million assessments between 23 July and 3 September. Since its introduction, there has been a steady decline in activity. The service is based on a treat-all

approach so that all those whose responses mean that they have reached the end of the telephone or web-based questionnaire receive antivirals. To date, the number of cases in Northern Ireland, as in Scotland and Wales, has not yet merited the introduction of that interim solution. The situation is being monitored. Should the need arise, that facility will be introduced.

By the end of October, a number of enhancements will be incorporated into the system. In Northern Ireland, individuals with symptoms suggestive of swine flu should contact their GP or out-of-hours doctor, who will assess whether an antiviral is appropriate. To prevent the risk of spreading the virus, they should not attend the GP practice or A&E. All community pharmacists, dispensing doctors and out-of-hours services currently have supplies of antivirals.

More than 8,500 courses of antivirals have been issued in Northern Ireland to date. As we moved to a treatment phase on 2 July using clinical diagnosis rather than solely laboratory diagnosis, the number of people prescribed antivirals by GPs is a good indication of the level of flu activity in the community and reflects trends in GP consultations.

As the pandemic takes hold, contingency arrangements are being put in place to maintain pharmaceutical services to ensure antivirals and the continued supply of normal medicines. The Health and Social Care Board is working to identify suitable venues that could act as antiviral collection points in the event that the normal supply routes are overstretched. It is expected that those backup arrangements may be required only for certain periods at the peak of a pandemic, when normal routes are compromised.

The scientific evidence has supported schools, colleges and universities reopening as usual after the summer holidays. However, all symptomatic pupils, students, teaching staff and ancillary staff should stay at home. They should phone their GP for advice and remain at home until the symptoms have gone. Parents should be vigilant for signs of swine flu and should keep children at home if they seem unwell. Schools, colleges and universities should have arrangements in place for managing students and staff who become symptomatic while in attendance. Symptomatic individuals should be kept away from others, and arrangements should be made for them to return home as soon as possible.

Minister McGimpsey met Minister Ruane and Sir Reg Empey on 20 August to discuss swine-flu preparations for the new academic year in schools, colleges and universities. The Public

Health Agency is available to provide specific public health advice to individual schools if they experience an outbreak of H1N1. Guidance has also been issued to school principals on how to reduce the risk of infection and to deal with any cases that arise. In addition, advice has been prepared for parents and carers of school-age children and for those in the early-years setting.

In Northern Ireland, the Office of the First Minister and deputy First Minister (OFMDFM) is responsible for co-ordinating non-health issues, including the impact on local businesses and employers. If the pandemic proves to be more severe in the autumn and winter, we can expect to see other sectors being affected. That will be particularly notable in absenteeism rates. The recent planning assumptions that I referred to suggest that upwards of 12% of the workforce could be ill at the peak of a pandemic. On top of that, a large number of parents may need to look after sick children. That will have a major impact on services and businesses. Robust business-continuity plans will be essential across all sectors to maintain service provision at the height of the pandemic.

In conclusion, I wish to emphasise that, although the severity of the disease continues to be monitored, to date it has been generally mild in most people but is proving severe in a small minority of cases.

A great deal of work has been carried out in conjunction with colleagues across the UK, with much more still to be done. The Health Service in the United Kingdom is in a good state of preparedness, and the UK continues to be one of the best-prepared countries in the world.

The Chairperson:

Thank you, Dr McBride. Dr Mitchell was grilled by the Deputy Chairperson and me on the subject a few weeks ago. After an hour and half, we had covered a great many points. At that meeting, I made the point that the regular swine-flu update that MLAs receive is extremely valuable, and that openness, transparency and honesty will reassure the community. I commend the Department for that and urge it to continue in that vein. Even if it is bad news, it is important that it is out there and that people understand the implications of any such news.

Someone in the room still has a mobile phone switched on, and that was interfering with the recording of Dr McBride's evidence, which is important. Please ensure that mobile phones are turned off, even if they are on silent. Oh, it is Dr McBride himself. *[Laughter.]* In that case, I do

not feel so guilty. Hansard is tearing its hair out trying to record this vital evidence. I urge people to break the habit of a lifetime and switch off their phones.

I will enquire about one small technical point, after which I will ask a more detailed question. At the meeting that we attended, you provided a list of all the front line professionals who will be the first to receive the vaccine. Along with other MLAs yesterday — it may have been the day before — I met a group of student nurses, who made the point that they could not find any reference to themselves on that list. Many student nurses are on the wards, helping and learning. Is there any provision for those individuals to be vaccinated?

Dr McBride:

Obviously, the current initial priority list is based on clinical risk. It is about prioritising the initial supplies of the vaccine to those who are at greatest clinical risk of succumbing to complications. Furthermore, it is about ensuring that front line health and social care workers, who certainly face an increased risk of acquiring the infection and of transmitting the virus to others, are vaccinated. All those workers who are involved in delivering front line health and social care will be offered vaccination.

The Chairperson:

Is that a yes?

Dr McBride:

That is a yes.

The Chairperson:

Many people have said that we in Northern Ireland benefited from the fact that our school holidays started earlier than those on the mainland. The tradition here is that our school holidays start on 1 July, while they do not start until after mid-July on the mainland. The Scottish schools have gone back earlier than we have. Are there any indications that that is leading to a further spread of swine flu? In England, the indications are that the virus was spread mainly through schools.

Dr McBride:

This is a new virus, and there has been much debate about the factors that resulted in the

significant decrease in cases of swine flu over the summer. A number of factors may have contributed to that. The fact that schools were closed over the summer may well have been significant, but we have also seen normal seasonal variation with the influenza virus, which may also have been a factor. As you said, the widespread public information campaigns that have encouraged people to change their behaviour when making social contact, such as practising good hand and respiratory hygiene, have also been important.

It is important to note that, following on from the school holidays, we saw a 30% decline in all the indicators of flu activity in the community. We are liaising closely with our counterparts throughout the rest of the UK, particularly our colleagues in Scotland, to monitor any impact that the reopening of schools will have on the number of cases of swine flu. The scientific evidence suggests that the reopening of schools, colleges and universities should proceed as normal. That is the course of action that was taken across the UK and across the rest of Europe.

The Chairperson:

At the meeting in July, we asked about the situation down South. At that time, you told us that you were liaising closely with your counterparts in the Republic. What is the latest situation down there? It is obvious that people are travelling up and down across the border — not by train, unfortunately, at the moment — by bus and by car. What is the latest from your colleagues in Dublin?

Dr Mc Bride:

I shall ask Liz Mitchell to provide an update on the latest figures that we have from colleagues in the Republic of Ireland, but I reiterate that there is ongoing, very active liaison with our counterparts in the Republic of Ireland, at ministerial level and with permanent secretaries, the Chief Medical Officer and officials. There is regular contact, and ongoing discussions on, for instance, mutual aid in supporting the delivery of front line health and social care services to the population both in Northern Ireland and in the Republic of Ireland. Liz, are you in a position to provide any further update?

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety):

I looked at the most recent weekly update from the Republic of Ireland. I cannot remember the exact figures, so I will not offer those, but I noticed that, similar to here, the flu levels there have declined but are still higher than they would be in a normal summer. The levels of flu being

experienced there are similar to a winter pattern rather than a summer pattern. To date, there have been two deaths. Similar to here, in the Republic of Ireland, they are still preparing for an expected surge. We had a teleconference with officials there last week on clinical capacity and on whether there is any scope for mutual aid as services are pressurised, particularly critical-care services.

Mrs O'Neill:

Thank you. I commend the good work that has been going on in the Department, and cross-departmentally. My son was given a note about swine flu to take home from school; it is good that parents are aware and alert. We have read media reports about Tamiflu's ending up on the black market because no checks and balances are in place, and we spoke in August about procedures that could be put in place, such as requiring everyone to provide their medical number if the situation reaches the level at which a pandemic flu service phone line needs to be in operation. However, not everyone will have that medical number to hand. Have you given any more thought to issuing people with their medical card so that if we did find ourselves in that situation, that would not be an issue?

Dr Mitchell:

We have given more consideration to that, but, in view of time pressures, it has been decided that that is probably not the way to go. However, with colleagues across the UK, we have been looking at the possibility of using other identifiers, such as date of birth, address, and other details that would enable the system to look up a person's health and social care number in Northern Ireland if he or she did not know it. Obviously, if people know that number, that is great, but that would be the backup for people who may not be able to find their medical card with the number on it.

As Dr McBride said, a number of enhancements has been built in to the system so that if we did have to activate a national pandemic flu service, more checks and balances would be in place than were in the interim system that was activated in England.

Mrs O'Neill:

Some media reports have suggested that antivirals are not safe for children, and that obviously scared people. Mothers are afraid to give their children something in which they do not have 100% faith. Can you give an assurance that that is not the case?

Dr McBride:

The prescribing of antivirals is different in Northern Ireland than in England at present. It is vital that each individual case be assessed on its own merits. The vast majority of people will recover from H1N1/swine flu without antivirals, but it is important that those who have underlying conditions, and who are at risk of experiencing complications as a result, access those antivirals quickly, preferably within 48 hours.

The vast majority of children will make a full and rapid recovery. It is important, particularly with young children, that contact be made with the general practitioner or the out-of-hours service. That general practitioner, in consultation with the parent, and after an assessment of the child has been made, will make an informed decision about whether antivirals are required.

It is important to bear in mind that, before the vaccine is made available, antivirals constitute the front line of treatment. Prevention is vital, and there is much that we can do as a society, and as parents, to educate our children about the importance of using tissues when they cough and sneeze and of washing their hands regularly to protect them from acquiring the virus.

If a general practitioner assesses that antivirals are required for an individual child, I would be inclined to take that clinical advice. All medications have side effects. The benefit of the treatment must be balanced against the side effects that occur with all medication.

Dr Norman Morrow (Department of Health, Social Services and Public Safety):

The medication dosage is titrated depending on age, from young children up to adults. That is another safety feature that is built in to ensure the correct dosage for children in particular. The antiviral's most common side effect is nausea.

Mr Easton:

Is the Minister covered in the first tranche of people to be vaccinated?

Mr McCallister:

It is good that you are so concerned about him.

Mr Easton:

I was diagnosed with swine flu a month ago, but it turned out to be something different. From that personal experience, I am curious about the figures. The Department has a record of the number of laboratory-confirmed cases and people who have been prescribed antiviral drugs. In my case, I was not given Tamiflu because a certain number of hours had passed since I had taken ill, and it would not have been effective. As it turned out, I had shingles. My daughter has now been diagnosed with swine flu, although I suspect that she does not have it. Could as many as 16,000 people have been diagnosed but not been laboratory-tested?

I assume that the vaccine is still being tested. Are there any side effects, because it would be good for people to know what they are?

There is a financial shortfall for everything that we are doing. The Department has done a fabulous job, and I fully support what has been done. Has there been any movement in trying to cover the costs?

Dr McBride:

I will pick up on some of those issues and bring colleagues in where appropriate.

The priority groups are based on clinical risk, and they were outlined in my briefing. I am not in a position to comment on whether the Minister suffers from an underlying medical condition. We have been advised of the priority groups by the Joint Committee on Vaccination and Immunisation.

The method that we use to measure and report weekly on rates of the H1N1 virus on the community is tried and tested, and we have used it for many years to report on seasonal flu. There is a strong correlation between GP consultation rates for flu and influenza-like illness, rates of antiviral prescriptions and flu activity. Our weekly report represents that correlation.

There are ongoing tests on the safety of the vaccination in the UK and in other parts of the world. It is important to point out that the vaccine does not differ substantially from the normal seasonal flu vaccine. We are simply substituting the strain that is covered in the vaccine with the H1N1 strain.

Many trials of the avian flu, H5NI, vaccine have taken place, and the seasonal flu vaccine is generally well tolerated by the individuals who receive it. Therefore, although the trials are ongoing, there is no reason to suspect that this vaccine will give rise to issues that differ from those that apply to the vaccine for normal seasonal flu. It is vital to get that message across, because there has been much media speculation about the safety of the H1N1 vaccine. It is important to emphasise that the vaccine is the single intervention that will protect the population from acquiring swine flu. When the vaccine is being rolled out, we will launch a major public-awareness campaign that will focus on the importance of people availing themselves of the vaccine and its safety.

It will be costly to ensure that there are adequate supplies of antivirals, vaccines and personal protective equipment (PPE) to protect those working on the front line in health and social care, and to build capacity in the system to respond to the increased demands in primary and secondary care. However, we must ensure that the population in Northern Ireland is as well protected as people in the rest of the UK.

To date, we have incurred expenditure of circa £30 million. We have produced models for a number of possible scenarios based on the latest available information about the likely attack rate of the virus, the percentage of the population that might be affected and the likely rates of complications and hospitalisation. The figures range from a best-case scenario of £68 million to a worst-case scenario of £96 million. Significant cost is, therefore, associated with being appropriately prepared to respond to swine flu. We have not yet secured any additional money from the Treasury or the Executive, but discussions at ministerial level are ongoing to progress that matter.

Mrs D Kelly:

Is there any evidence from the 189 confirmed cases to show how contagious the disease is? In other words, has contact between a person who has been confirmed as being infected and his or her family members given rise to any concern?

Of the 78 people who have been hospitalised, some have required beds in intensive care. How ready are we to provide beds in intensive care? What is the impact on those who have other illnesses and require the beds, whether because of a stroke or a car accident? In particular, given that such beds, with the exception of those in the Royal Belfast Hospital for Sick Children, are

generally not suited to children and young people, will you give me some idea of how their needs will be met?

In connection with contingency plans, does departmental guidance or the individual trust dictate whether patients are automatically discharged from intensive care to terminal care pathways after 48 hours?

Dr McBride:

The H1N1 virus is similar to all influenza viruses; it is very infectious. The likelihood of contracting the virus is strongly associated with contact with infected individuals. The risk can be significantly reduced through individuals who are infected by the H1N1 virus isolating themselves at home and practising good respiratory hygiene, which means covering their mouths when they cough and sneeze, disposing of tissues and using a fresh tissue on each occasion, and regularly washing their hands. By heeding that advice, other family members will be protected from acquiring the virus.

It is an extremely infectious virus and, from our experience to date, it appears that the H1N1 virus is more infectious than the seasonal flu virus. We will keep the H1N1 virus under constant review because there is a distinct possibility that it may change, mutate, become more virulent or less virulent.

I reassure you that detailed planning for critical care has taken place on a national level, across the four jurisdictions in the UK and, as Dr Mitchell said, in conjunction with colleagues in the Republic of Ireland. Of the 1% of individuals who are hospitalised, more than 25% may require critical care support for a time. It is important to ensure that we have the appropriate levels of adult and paediatric critical care to support individuals for the time required. We have been working at a national level, and with colleagues in the Republic of Ireland, to ensure that we use our critical care capacity maximally. As we saw before the summer, that will involve dealing with local hot spots. As Dr Mitchell said, there will be mutual aid if we see peaks of activity — for instance, in England or Scotland. If that happens, we will work collectively to ensure that we make the best use of the critical care capacity in the United Kingdom.

Our trusts are not being left on their own to plan for this. There is national, regional and local planning. We are working closely with the critical care network in Northern Ireland, its clinical

lead, its nursing lead and its manager. There are plans in place to ensure that, in the local trusts, we manage that capacity as an entire system across Northern Ireland and that we flex the use of beds, as we would normally do in the winter or when there are excess pressures on critical services. Detailed plans are in place to increase paediatric critical care capacity and to flex it across the current adult and critical care bed stock. Those plans involve training and upskilling nursing staff, and updating nursing staff who have had previous experience working in adult or paediatric critical care. I assure you that we have very detailed plans.

Those plans do not factor in the vaccine that is available. We will have sufficient vaccine to vaccinate all those most at risk of complications and, therefore, most at risk of being hospitalised and taking up a critical care bed. If all goes according to plan, we should have all the at-risk groups vaccinated by the end of November.

Dr Mitchell:

The plans include consideration of the provision of intensive care for children and young people beyond the Royal Belfast Hospital for Sick Children in the other area hospitals. The plans include a provision for older children and teenagers to use adult intensive care units. There is a stepped plan, if necessary, to flex the capacity in adult intensive care units to look after children.

A national clinical advisory group has been set up in which Northern Ireland is represented by the lead of our critical care network, Dr Gavin Lavery. That group will help clinicians through some of the challenging decisions about how best to use our intensive care capacity. The planning assumptions include the fact that there will be an ongoing intensive care requirement for people who have been involved in road traffic accidents, and so on. That has been factored into our plan.

Dr McBride:

We have plans in place to increase our adult critical care capacity by 100% within a matter of days. That is a vital point, and the Minister will make a statement to the Assembly next week.

Mr Gardiner:

Mr Chairperson, I congratulate you on your appointment; I do not think that any other member has done so.

I remind Mr Easton that, before the recess, I asked the Minister of Finance and Personnel, Mr Sammy Wilson, whether he would make funds available to the Minister of Health, Social Services and Public Safety for the epidemic that we now face. He refused to give me an answer, and he started to play party politics with the issue. The Minister of Finance and Personnel left me none the wiser, but he did say that he would consider the issue after the recess.

Regrettably, one person has died from swine flu in Northern Ireland. When someone dies, does the virus die with them? Are undertakers told to wear special protective clothing? Should the coffin be closed? Should the relatives be told not to touch the body?

Dr McBride:

That is an important area; we have been planning for pandemic flu in Northern Ireland for some five years. A group has been considering the issue of the excess deaths that are anticipated with pandemic flu. Indeed, the latest planning assumptions for swine flu factor in excess deaths. It is impossible to be precise on the exact numbers.

We have developed guidance for health workers for the appropriate and dignified aftercare of the remains following the death of individual patients who die in hospital. We have also developed guidance and advice for undertakers, and that will include advice for the next of kin in such circumstances.

The virus does not die with the unfortunate death of a patient. The risk of transmission is reduced because the virus is largely transmitted through individuals coughing and sneezing, but it can also be transmitted by hand-to-face contact if individuals come into contact with the virus. Detailed planning and work has been ongoing for quite some time, and we are revisiting that in the light of our experience with swine flu.

Mr Gardiner:

At funeral homes, I have seen relatives kiss the corpse. Do you advise against that? I ask that so that the public know what the situation is if someone dies from swine flu.

Dr McBride:

We will certainly give specific advice to individual relatives on how they can minimise their risk.

Mr Gardiner:

Have you issued any such advice to date?

Dr McBride:

One death has taken place in Northern Ireland, and, tragically, over 70 people have died in the United Kingdom. Each case is assessed, and advice is given to relatives on how to reduce the risk of infection. Individuals will consider the advice that is given and respond accordingly.

The Chairperson:

Are you happy with that?

Mr Gardiner:

No; that is not a clear answer. The advice comes too late; people should know what to do in advance.

Mr Easton:

It is down to your Minister.

Mr Gardiner:

It is not; it is down to the officials.

The Chairperson:

Will you avoid making the issue a party political football? It is too important to go down that road. Members will have another opportunity to ask questions when we talk about the regulations.

Mrs Hanna:

I hope that I am not mixing regulations. When you spoke about preparing for numbers in a worst-case scenario, you used the word "when" rather than "if". Is it difficult to predict the numbers that may be affected and the severity of an outbreak? Do you expect that we are in for a fairly rough time? You are probably aware that the public seem to have been talking about swine flu for a long time. An outbreak did not happen, and some people are beginning to wonder whether it is really happening and whether it will get worse. I know that you do not have divine inspiration, but your use of the word "when" makes me wonder what you are anticipating.

You said that the anticipated spend could be between £68 million and £98 million. Roughly, what percentage of that is to be spent on vaccinations? Confidence in the vaccination and the fact that it is similar to the regular vaccination were mentioned. The media were talked about, and I heard interviews with GPs who said that they did not plan to get the vaccination. That did not come across very well. Has it been discussed with the BMA? If GPs do not want to receive the vaccination, why on earth would the public have it?

Were most of the people who were diagnosed laboratory-tested for swine flu? I am not sure whether people suffering from flu symptoms would know the difference. It is right that they should follow the same hygiene advice, but they will not know whether it is normal flu or swine flu. Is it simply assumed that they have swine flu, or what happens?

Dr McBride:

On the question of my use of the word "when" rather than "if", the planning assumptions to which I referred are published on the Department's website and are produced by the scientific advisory group on emergencies. The group comprises the best scientists in the United Kingdom, who are seeking to model the likely consequences and possible scenarios that we may see with swine flu as we move into seasonal flu in the autumn and winter. Their work is based on the best information available in the United Kingdom and through liaising with experts around the world.

Planning assumptions are just that: they allow us to plan and prepare appropriately for whatever lies ahead. However, I emphasise that they are not projections, predictions or forecasts. Indeed, as I stressed at the outset and in answer to an earlier question, at present, they take no account of the vaccination programme. Therefore, those planning assumptions will be revisited on an ongoing and regular basis.

For instance, if the virus changes, becomes less virulent or there are lower rates of complications and hospital admissions, those planning assumptions will be revised downwards, as seen by the Committee in the latest figures published compared with those in July. When we begin to vaccinate the population, the planning assumptions must be revisited.

I do not have exact figures for the costs associated with the vaccine, but I am happy to write to the Committee with those figures. From memory, some £18·7 million is associated with

purchasing the vaccine, and the cost of administration is additional to that. Therefore, a significant cost is associated with the vaccination, and, as I said, the Department has incurred expenditure of £30 million to date for the totality of its preparedness at this stage, with much more spending anticipated.

The member is absolutely right about the media. I return to the point that was made by the Chairperson at the outset: complete openness and transparency with the public is vital throughout the pandemic period. The comments that have been made in some media outlets about the safety of the vaccine are unfortunate and not fully informed. The Department is liaising with the BMA, with nursing colleagues in the Nursing and Midwifery Council and with all other professional colleagues in relation to important public messages. The public must be confident that professionals have confidence in the protection afforded by, and the safety of, the vaccine.

Routine laboratory-testing ended when the Department moved from the containment phase to the treatment phase on 2 July, but that testing continues in suspected swine flu cases treated in hospital because of complications. As I said earlier in answer to Mr Easton's question, the rates of prescription of antiviral drugs on consultation with GPs for people presenting with flu or flu-like symptoms bear a strong correlation to actual rates of infection. Therefore, I am confident that what is being seen, and had been seen before the summer, is that the increasing rates of consultation and the rising rates of antiviral prescriptions reflect a significant increase in flu and swine flu in the community. I am also confident that what we have seen up to and over the past weeks is a true and genuine decline. I hope that that answers the member's questions.

The Chairperson:

You flagged up the fact that the Minister will make a statement in the House next week, so members will have an opportunity to ask questions then. I will wrap up with a couple of questions. There was a meeting with the Minister on 18 August to discuss the submission of a £55 million bid to cover additional costs. Has the Treasury made any response to that bid? Has there been any success on that front?

Dr McBride:

I am not aware of there having been any favourable response from the Treasury. As I indicated earlier, I am confident that there will be ongoing discussions with Ministers, at UK and Executive level, about the costs associated with swine flu. However, I am not aware of any progress on

funding the costs associated with swine flu.

The Chairperson:

The Department has already spent £30 million. Are you paying GPs individually for administering the vaccine, or is that part of their overall contract?

Dr McBride:

Negotiations about the administration of the vaccine are ongoing at a national level, and those are not yet completed. I am not in a position to advise of the detail of those negotiations, because nothing has been agreed yet. However, we will endeavour to ensure that the population at risk, and, ultimately, the entire population, is vaccinated as efficiently, expeditiously and cost-effectively as possible.

The Chairperson:

I understand that you cannot comment on the matter. However, given the very generous settlement that GPs received as a result of national negotiations, I think that administering the vaccine voluntarily as part of their contract is the least that they could do. I realise that it is a hot potato, but GPs did exceptionally well in those negotiations.

Dr McBride:

As I have said, negotiations are ongoing at a national level. I am confident that those negotiations will be concluded in the best interests of the population across the UK.

The Chairperson:

Is there any evidence in the UK, or anywhere in western Europe, of people with no underlying health problems whatsoever contracting swine flu and having a serious illness or even dying from it? I am talking about a 25-year-old athlete, for example, or someone who is in perfect health. Can we say with a fair degree of certainty that the people who are most at risk in the 18-to-40 age category are those who have an underlying complaint, even if it is undiscovered? Can we still say that normal, healthy people do not have much to worry about?

Dr McBride:

What we can say — and it is important to remind ourselves of this fact — is that there are deaths associated with normal seasonal flu every year, despite there being a vaccine that is effective

against normal seasonal flu. Indeed, individuals who do not have any underlying health problems die with seasonal flu each year, although that is an unusual set of circumstances. I cannot provide any further assurance other than to say that the vast majority of people who become infected with swine flu will have a mild illness. We know that the vast majority of people who have developed complications or died have had underlying health problems. However, by no means all the individuals who have died have had underlying health problems.

The Chairperson:

Thank you.