Northern Ireland
Assembly

# COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

# OFFICIAL REPORT
(Hansard)

## Update on Swine Flu

22 October 2009

**NORTHERN IRELAND ASSEMBLY**

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# COMMITTE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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**Members present for all or part of the proceedings:**
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mrs Carmel Hanna
Mr John McCallister
Mrs Claire McGill

**Witnesses:**
Dr Michael McBride )
Dr Andrew McCormick ) Department of Health, Social Services and Public Safety
Dr Liz Reaney )

**The Chairperson (Mr Wells):**

I welcome Dr Michael McBride, the Chief Medical Officer; Dr Andrew McCormick, permanent secretary at the Department of Health, Social Services and Public Safety; and Ms Reaney, the chief public health officer. They have agreed, at short notice, to give the Committee a briefing on special needs children, given the concern felt by many at the news of the past few days. The Deputy Chairperson and I received a pre-briefing on the issue and were informed of significant material that will be announced today. I will hand over to Dr McCormick. Please take as much time as you need on this important issue.

**Dr Andrew McCormick (Department of Health, Social Services and Public Safety):** We are glad to be here to update the Committee on the changing situation. The Department is giving its fullest attention to the issue to assure the public that it is doing all the right things. It is important that we do that.

Today, we will update members on recent local developments, including the tragic deaths in the past few days, and the actions that we are taking. We will also provide an update on the planning assumption changes that will be announced across the UK this afternoon. Our timing is good in the sense that we are able to convey that information to the Committee now. We always want to make ourselves as available as we can to the Committee to make sure that members are kept in the picture. However, the situation is moving fast, and the priority for Michael and his team, who are working flat out, is to manage the issues and ensure that the right course of action is being pursued. That is our total commitment; to ensure that the public gets the best possible attention, interventions and information on the issue.

I will ask Michael to update the Committee on what is happening locally and why we are doing what we are doing; and how the vaccination programme, which, as you saw yesterday, has just started, will unfold in the coming days and weeks. We can discuss that, if the Committee agrees, and then we can move to the new information on the planning assumptions.

**Dr Michael McBride (Department of Health, Social Services and Public Safety):** I welcome the opportunity to update members on the rapidly changing situation. This is week 42, and we have seen a further and significant increase in consultation rates with general practitioners (GPs) from 220·5 per 100,000 to 241·1 per 100,000 — a 9% increase on last week. The last time we met, I said that the previous figure was the highest ever recorded; this week's figure is higher again and is the highest ever rate of consultation for flu-like illnesses that we have seen in the nine years that we have been recording data. Despite that, it is a tribute to our front-line health professionals and GPs, healthcare workers, nurses and doctors, and those in secondary care that they are responding well to the increased pressure. The rates of the virus remain highest in those aged 14 and 15. There has also been a significant increase in hospitalisations — an 82% increase over the past week.

Andrew mentioned the recent tragic deaths. This week, there have been a further three swine-flu-related deaths, which brings the total number in Northern Ireland to eight. I am sure that the

Committee will wish to join me in expressing sincere condolences to the families concerned at this sad time for them, and we wish to allow them the time and space to grieve in peace. That follows on from media coverage earlier this week of the distress caused to a family by the delay in informing them that their daughter had been confirmed as having swine flu. The Minister has asked me to carry out a full investigation into all aspects of that matter. The investigation is ongoing, and I will produce a report for the Minister soon. However, I have advised the Minister that we must take immediate steps to ensure that it does not happen again. Those steps have now been taken. The Minister and I have made full apologies for what was, undoubtedly, an unacceptable breakdown in communication with the family, which clearly added to their distress and anxiety. It was unacceptable and should not have happened.

When we last met, we advised the Committee of the initial priority groups for the vaccination programme. The recommendations were made on the advice of the Joint Committee on Vaccination and Immunisation (JCVI), which advises the four Health Departments across the UK. We have been studying the emerging situation in Northern Ireland and revising those vaccination plans as our experience with the virus develops. We are now putting plans in place to offer the swine flu vaccine to children and young people in special schools for those with a severe learning disability as soon as possible. Our experience in Northern Ireland is that the virus is having a disproportionate impact on children and young people attending those schools. Our first priority is to protect those at greatest risk, and, increasingly, our experience is that those children and young people are at significantly greater risk.

I have taken several further steps based on our experience over the past few days, including issuing additional communication to GPs that re-emphasises the importance of prescribing antivirals, particularly to people with underlying health conditions and to pregnant women with swine flu. Based on recent experience of the emerging swine flu situation, I also issued further guidance to health professionals about the follow-up and communication of all positive results to patients.

The vaccination programme is our key defence; it is the main response and is aimed at preventing the spread of swine flu and protecting the most vulnerable in our society. We are critically dependent on the manufacturers to deliver supplies of the vaccine to Northern Ireland, and I am pleased to inform the Committee that that is on track and that we expect the delivery of vaccines on schedule. I am also pleased to report that the vaccination campaign commenced here

yesterday, as members will be aware, simultaneously with the rest of the UK. We started the programme with front-line health and social care workers to prevent them transmitting the virus to vulnerable people in hospitals, at-risk groups in hospitals, and pregnant women. That is in line with the advice from the JCVI, which advises the four Health Ministers.

At the Minister's request, we brought forward our plans to immunise children in special schools for severe learning disability. We communicated our experience with the other Health Departments, and the Secretary of State has asked the UK Chief Medical Officers to consider whether children in special schools throughout the UK should be vaccinated as a priority. We fed in our experience of the virus, and of the disproportionate impact it is having on children with severe health problems in schools for children with severe learning disabilities. As a result, other jurisdictions in the UK will take that information on board and will respond appropriately.

Under arrangements that have been put in place in Northern Ireland, starting today, the vaccine will be offered to around 2,500 pupils in more than 20 special schools for children with severe learning disability. Many of those pupils are those who are most at risk from complications of swine flu, and we aim to complete the vaccination of those children before the half-term holidays. Special arrangements have been put in place in several schools to ensure that that is completed.

I am also pleased to say that, starting from 26 October 2009, all GP practices will have supplies of the vaccine, and the next phase of the vaccination programme will begin. That will ensure that, by December 2009, we will have vaccinated the individuals in Northern Ireland who are most at risk of complications from swine flu. To date, as you may be aware, we have received 55,000 doses of the GlaxoSmithKline (GSK) vaccine. As we speak, those are being distributed across health and social care trusts and GP practices. We expect 31,000 doses of the Baxter vaccine to arrive on Tuesday 27 October.

As far as the rest of the population is concerned, I and my three colleagues from across the UK have been tasked with developing proposals for Ministers on how we might extend the next phase of the vaccine programme. The vaccination of individuals who are most at risk of complications from swine flu represents the first phase of the programme, after which we will make the vaccine more generally available to the rest of the public. Details of that will be provided in due course following a ministerial decision.

Andrew mentioned the revised planning assumptions. I am happy to pause and take questions, and we can come back to the revised planning assumptions that will be announced across the UK today.

**The Chairperson:**
Thank you, Dr McBride. Dr Reaney, I apologise for calling you Ms Reaney earlier.

**Dr Liz Reaney (Department of Health, Social Services and Public Safety):**
I am the senior medical officer.

**The Chairperson:**
Yes; I had you down as the chief executive of the Health Promotion Agency.

We are pleased to hear of the speed with which the Department acted to vaccinate special needs children with underlying medical problems. Calls have been made for teachers in those schools to be vaccinated and, more widely, for teachers in general to be vaccinated. What is your reaction to those calls from the unions?

**Dr McBride:**
I will start, and perhaps Dr Reaney will also contribute.

The Minister's priority, and my priority as Chief Medical Officer, is to ensure that we protect the most vulnerable people. The first stage of the vaccination programme is the targeting of individuals who are most at risk: people between the ages of six months and 65 years who have underlying health problems and are at risk of complications; people who are household contacts of those who are immunocompromised; pregnant women; and people over 65 who have an increased risk because of underlying health problems and normally receive the seasonal flu vaccine. Those are the initial priority groups, because those are the people who are at risk of complications from the virus.

It is important to bear in mind that swine flu remains a mild-to-moderate illness for the vast majority of people. The first objective must be to protect those who are at greatest risk. We anticipate that vaccinations for the first wave of the first-priority group will be completed by early

December, when we will make the vaccine more widely available. The other three Chief Medical Officers in the UK and I will present a paper to Ministers advising who should be considered for receiving the vaccine next.

**Dr Reaney:**

Teachers with underlying conditions, such as severe asthma or diabetes, are eligible for the vaccine. In general, we focus on folk who are most at risk of complications should they develop swine flu.

**Dr McCormick:**

It is important to emphasise that Ministers across the UK are acting consistently and on the basis of the authoritative advice of the JCVI that an evidence-based approach to targeting the vaccine should be taken. It depends on the supply of the vaccine coming in, and it is important that the first supply is used for the priority groups. That is the public health advice that has been given.

**Dr McBride:**

I echo that point. Any recommendation that the Chief Medical Officers make to Ministers will be entirely consistent and in line with the JCVI advice.

We are considering the practical implications of rolling out the vaccine in the next phase, bearing in mind, as Andrew said, that it is an unusual vaccine programme. Dr Deeny will be familiar with the normal seasonal flu vaccine programme in which supplies are kept in warehouses, GPs' surgeries and trusts for those who might need them. However, this virus is new. People have not encountered it before, and few have inherent immunity, although there is evidence that older people might have been exposed to a similar virus in the past.

Our priority must be to make the vaccine available to those at greatest risk as rapidly as possible as soon as we get it into Northern Ireland, and that is what we have been doing. It is vital, given the fact that the rate-limiting factor is the supply of vaccine from the manufacturer, that we use the vaccine wisely to protect those at greatest risk.

**The Chairperson:**

It is early days, but are schools co-operating and are parents making sure that their children are being vaccinated? Are any parents reluctant to have their children vaccinated?

**Dr McBride:**

I will answer first and then Liz can comment. Given that the virus and the vaccine are new, there has been a great deal of speculation in the media about the safety of the vaccine. It is important to point out that for most people swine flu is a mild to moderate illness. For a few individuals, it can be severe; and, tragically, in some cases it has led to deaths in the UK, including Northern Ireland.

Although the virus is new, the process by which we manufacture the vaccines for it is tried and tested; they are not dissimilar to the normal seasonal flu vaccines. Having considered the trial and safety information on the vaccines, the regulatory bodies submitted it to the European Medicines Agency. The European Commission has licensed the vaccines for administration, and the JCVI, which advises UK Ministers, has said that they are safe to use on children. Indeed, the World Health Organization advised that vaccines that have been licensed by the regulatory bodies, as both vaccines have, are safe to use. We have a wealth of information on the safety profile of the vaccines.

As with any vaccine campaign, it comes down to comparing the risks with the benefits of the vaccine. The risk from the virus is significant for a small, but not insignificant, number of people. In that context, the benefits of the vaccine outweigh the risks. As with all medical treatments, vaccines can have side effects; however, this vaccine has a good safety profile, and its side effects are generally limited to pain and discomfort and to local reaction around the site of the injection.

**Dr Reaney:**

You asked about the response of the public. It is early days yet. We started vaccinating healthcare workers in the hospital trusts only yesterday, and I understand that the response was good. We will be interested to hear the response from the special schools. The number of telephone calls to the Department, the Public Health Agency and GPs is a fair indication of people's desire to have their children vaccinated. Yesterday's sad events have added to that desire and have fuelled concerns. As Michael said, everyone is aware that the virus is mild for most people. However, it poses a significant risk to vulnerable people and children.

**Mrs O'Neill:**

Thank you for coming to the meeting today. I commend the Department's good work, although, sadly, we have lost eight people to swine flu, including Ashleigh and Orla, the two young people with special needs. You said that plans are already under way and that vaccinations started yesterday for children considered to be in priority, high-risk groups, such as those with severe learning disability. When do you expect all those children to be vaccinated? Can you provide a definitive time frame?

**Dr McBride:**

The events of the past few days have been particularly tragic and have caused concern for the parents of those children and young people. The vast majority of children and young people — approximately 2,500 — will be vaccinated by tomorrow. We have made arrangements for one school to receive the vaccine early next week.

**Dr Reaney:**

One school's holidays were slightly different, and it was due to be closed. However, I understand that arrangements have been made for parents to bring children to the school to receive vaccinations from the school health team. The vaccine is available, and teams are administering it as quickly as possible in schools for children with severe learning disabilities. We recognise that some children with complex disabilities and health needs may not attend schools for children with severe learning disabilities: therefore, we had to make plans to catch those children as well.

The Public Health Agency has written to community paediatricians and children's nursing teams, who are aware of children with complex need, to ask them to list, and to make GPs aware of, children who do not attend schools for children with severe learning disabilities. In effect, that will put a safety net in place to ensure that those children are included. Michael referred to the original priority groups that were designated by JCVI; children from the age of six months and people up to the age of 65 in at-risk groups are the first priority. Those children were already in those groups, and, in effect, we have ensured that they are vaccinated first.

Although the entire group is at risk, those children are particularly vulnerable. I am talking about children with conditions such as cerebral palsy, chronic lung disease or other conditions that affect their lungs, cause difficulties with breathing or make them prone to chest infections. That vulnerability in the lungs makes them susceptible. As members are aware, the vaccination is

a primary prevention and aims to provide protection to people. In the long term, the vaccine is much more effective than antivirals, which are useful for tackling symptoms or preventing disease for a short time. However, the vaccine is a long-term protection and is our best defence against the virus.

**Mrs O'Neill:**

I welcome that information. As parents, we are all concerned about our children. However, parents with children who have underlying health problems are particularly worried at this time.

Pregnant women are the other high-priority group. There has been much talk in the media that the vaccine contains mercury. Pregnant women have asked me about that; they think that we, as elected representatives, know much more about the ins and outs of health than we do. I am not a health professional. However, a Department directive states that pregnant women should not receive mercury fillings from the dentist, yet there have been claims that the vaccine contains mercury. Can you allay those fears?

**Dr McBride:**

I will make a general comment about pregnancy, after which Liz will comment on the mercury issue that has been raised in the media. We all recognise that pregnant women are in a difficult situation. Pregnancy is a time when a woman's primary concern is for her unborn child and to take steps to protect her baby. As I said earlier, both vaccines are licensed for use during pregnancy by the European Medicines Agency, endorsed by JCVI and recommended by the World Health Organization. The weight of scientific evidence is that the vaccines are safe to use in pregnancy.

The GSK vaccine contains tiny amounts of mercury as a preservative; indeed, mercury is present in other vaccines. The JCVI is aware of that, and it recommended that the GSK vaccine be the vaccine of choice for pregnant women, given the fact that it is one dose. It is one dose that will protect pregnant women, whereas the Baxter vaccine is a two-dose schedule with an interval of several weeks between the first and second doses.

The primary purpose of offering the vaccine to pregnant women is to give them protection. Pregnant women are at four times the risk of complications and at approximately five times the risk of hospitalisation as a result of complications from swine flu. Tragically, several pregnant

women across the UK have died. We have also had difficult experiences in Northern Ireland, where several pregnant women have required intensive care treatment. Indeed, there was the sad case of the pregnant woman who required transfer to Leicester for extracorporeal membrane oxygenation (ECMO) specialist treatment. The virus carries significant risks for some pregnant women.

The message that I want to relay to pregnant women is to consider the information provided to you and consider the risks. There will always be risks associated with vaccines, although this vaccine has an excellent safety record. Pregnant women should also consider the benefits of protecting themselves, their pregnancies and their babies. There is an increased risk of preterm labour with swine flu. It is a matter of protecting the baby, and that is the message that I want to communicate today.

Liz, will you elaborate on the issue of mercury?

**Dr Reaney:**

There have been concerns about mercury for a number of years. In vaccines, a substance called thiomersal contains a small amount of mercury that is used as a preservative. There has been no evidence of risk; any risk is theoretical. Michael talked about the risks of swine flu infection in pregnant women. We aim to balance the risks: on the one hand, there is a theoretical risk from a trace amount of mercury in a vaccine; on the other hand, there is what we know from experience in Northern Ireland, the UK and beyond of the risks of this infection to pregnant women and their babies. It is a matter of considering the risks, and the balance is strongly in favour of vaccination.

I was at the most recent JCVI meeting in London. It is amending the green book, which contains the recommendations that health professionals work to for all vaccines in the UK. A section on thiomersal is being removed, because there is simply no evidence of risk, and the green book is being updated.

**Mr Easton:**

We are all aware of the unfortunate and sad death in the past 24 hours. It has made people take more notice of swine flu and, perhaps, it has unsettled some people in the community. What can you add today to reassure the population? How long will it take to roll out the entire phase 1 of the vaccination programme so that we can move on to the rest of the population?

The annual flu is no doubt starting to bite as well. Is swine flu spreading more rapidly than ordinary flu? When people with symptoms contact their GP, will there be problems diagnosing swine flu as opposed to ordinary flu? How will you deal with that? My final question is about the family of the unfortunate individual not being notified that she had swine flu. Can you give a cast-iron guarantee today that that situation will not happen again?

**Dr McBride:**

I will start, and Liz will provide the background to the latest figures on the detection rate of the H1N1 outbreak in the population.

I reiterate the comments that I made previously when reassuring the public. We have been planning and preparing for a long time, and the World Health Organization recognised that the UK is among the best-prepared countries in the world. There have been tragic deaths recently, but they were not unexpected; we anticipated that we would have deaths, and every one of them is a tragedy. However, we have been planning for the outbreak, and we are prepared. Our primary care services and hospital services are planned and prepared, and the Public Health Agency has responded supremely. A vaccination programme is now in place, whereas we did not have a vaccine on 24 April when the virus appeared. It is astounding that, for the first time, we have been able to vaccinate the population and protect those at greatest risk during a pandemic.

I reassure the public that they should not be alarmed and that they should not panic. We are planning, we are prepared, we are in control, and we are on top of the situation and that will continue. Our responsibility is to protect the population, and we will continue to do that. Our Health Service will respond to meet the pressures and demands that it will experience in the weeks and months ahead. We are likely to experience a difficult winter.

We have launched the seasonal flu vaccine campaign. The experience throughout the rest of the world is that the H1N1 virus, the swine flu virus, has, largely, elbowed out other flu viruses. However, we cannot take any false reassurance from that, because there is the prospect of having a first, and significant, wave of swine flu this year. There is the potential for a second wave of seasonal flu. It could be a long and difficult winter for the Health Service; it could be among the most difficult winters in decades.

In Northern Ireland, approximately 63% of all of the isolates in the surveillance practices and hospital practices are H1N1 flu consultations. At the moment, a high level of the H1N1 virus and low levels of other viruses are circulating in the community. However, it is early in the seasonal flu season. It is hard to imagine that it is only October, and yet flu is at its highest level of the past nine years. We must be cautious about what lies ahead. My fundamental message to the public is that we have planned, we are prepared, we have a grip on the situation and we are in control. Liz, will you update the Committee on the figures?

**Dr Reaney:**

There are several sentinel GP practices across Northern Ireland that watch out for cases of flu. They take swabs from patients who present with flu or flu-like illness and send those to the laboratory. We monitor a sample of practices across Northern Ireland. Of the samples that have been sent in, 63% have been positive. Part of that may be because those particular GPs are becoming more experienced in diagnosing swine flu. We also get samples sent in from other GPs and hospitals. When they are put together, the results show that 35% are positive.

In the early days, we saw one or two individual cases. We then moved to a level of occasional cases of swine flu and, at that stage, a lot of samples were of different types of flu, and swine flu made up less than 10%. In the early stages of the outbreak, when the hot spots in the west Midlands and London became more widespread through community transmission, the positivity rate increased.

For us, the positivity rate has increased from less than 10% to 35%, as a whole, or 63%, if one considers only the subset of sentinel practices.

Mr Easton asked about the spread of seasonal flu. The seasonal flu vaccination programme is under way. Many GPs tend to blitz that at the start of the flu season to get as many of their patients vaccinated as possible. Swine flu symptoms are fairly non-specific; there is not much difference between those and the symptoms of seasonal flu, and it is difficult to distinguish between the two. We know from the samples being collated that those people who have not tested positive for swine flu have a range of other conditions. There is little seasonal flu at the moment, but we expect it to increase.

As Michael explained, the swine flu H1N1 tends to elbow out the other H1N1 virus, but

viruses, such as H3N2 and influenza B can still cause seasonal flu. Part of our concern is that, as well as the swine flu pandemic, there may be an outbreak of seasonal flu. That could happen at the same time, it could follow on from swine flu, or the two could mix. It is difficult to know what will happen.

**Dr McCormick:**

I will comment on the handling of issues. I repeat the apologies for what happened in the tragic case last week. That was most regrettable, but I can give some guarantees. The trend is that the situation will get worse. I will speak in a moment about the planning assumptions and what we can foresee on the basis of the best scientific evidence available. There will be more pressure on the service. The guarantee is that everyone in the health and social care system will rise to meet that challenge.

Since I moved to the healthcare system four years ago, I have been continually impressed by the way people willingly give of themselves, especially when things are tough. Everyone here knows how willingly health and social care professionals respond to problems and commit themselves to providing the best possible care. However, it will be tough, and there will be problems ahead.

That probably means that people will make more mistakes, but we should not blame them for that. They will be under intense pressure and doing the best that they can, but sometimes they may miss the opportunity or responsibility to communicate. That may happen, but I guarantee that we will learn the lessons from those cases, as we have from what happened recently. We will ensure that people are informed and advised as best as we possibly can, but there will be tricky times ahead. We all need to recognise that and acknowledge the good work that is being done by the professionals.

**Mr Easton:**

Thank you for all that you have done; I know that you are doing a good job overall. Normal flu viruses tend to die out or return the following year as something else. Is that likely to be the case with swine flu? Will it eventually just disappear?

**Dr McBride:**

I think that the virus will be around for a while. Traditionally, we think of flu as something that

happens in winter, but pandemic viruses do not happen only in winter. Some have caused a significant problem in winter and returned in summer. That is why the vaccination campaign is so important. We simply do not know how this virus will behave. For instance, we do not know what its impact will be on seasonal flu, whether there will be a big peak in swine flu or seasonal flu, or whether both will occur at the same time. What is clear is that a particularly challenging winter lies ahead of us. The virus could re-emerge, which is why it is so important to ensure that we vaccinate the people most at risk. The virus could be around for many months. It will be around into next year and, potentially, into next winter.

Over time, new viruses will emerge, because flu viruses are unpredictable. They mutate, which is why we have to change the seasonal flu vaccine each year. There are different strains of the virus circulating, and the vaccine is changed annually to reflect the fact that viruses are changing continually.

**Dr Reaney:**

As Michael said, the content of the flu vaccine is changed slightly every year to reflect the viruses that are circulating. There are some early thoughts that the H1N1 virus may become part of next year's seasonal flu and may overtake the other current strain of H1N1 that is in our seasonal flu vaccine this year. There are general thoughts among experts and the virologists, who try to predict what viruses will need to go into next year's seasonal flu vaccine, that that may well happen. If that is the case, the swine flu vaccine should give people some protection for next year.

**Dr McCormick:**

I will move on to the new information that we have for the Committee, which may answer some of the questions that people were going to ask.

**The Chairperson:**

I want to say to members of the media that the new information will not be released nationally until 3.00 pm. I say that in case somebody dashes out and tries to leak it. You have 10 minutes to sit on it.

**Dr McBride:**

You should not have told them that. *[Laughter.]*

**Dr McCormick:**

We have a revision of the planning assumptions, which is based on firmer and better information, because the modellers now have better information from Europe and the rest of the world on how the pandemic has unfolded.

We are moving towards firmer guidance, which means an improvement in our position. We were basing our planning assumptions on the worst-case scenario. The situation remains challenging and there is no cause for complacency. It remains vital that the vaccination programme is rolled-out and that people avail themselves of it, because, as my colleagues explained, the situation is still challenging and the risk to some people is material.

We now have firm information, and the impact will be less severe than previously allowed for. That is the important point. I will let Michael detail the projections for clinical attack rates and hospitalisation rates.

**Dr McBride:**

The details of the revised planning assumptions will be released to the public shortly and will be available on the Department's website. As Andrew said, we are continually revising and refining our planning assumptions in light of growing evidence on the virus in the UK and internationally.

The planning assumptions show a reduction in the clinical-attack rate from the previous level of 30%, which was contained in the document published on 3 September2009, to 12%. That percentage covers the planning period from 1 October 2009 to mid-May 2010. As I said, planners will continue to study the information and, if they need to revise those planning assumptions further, they will reissue them. It is important to make the point that, although the overall clinical attack rate is 12%, the virus is having a disproportionate impact on young people. We may see clinical attack rates of up to 30% in children.

There has also been a reduction in the peak clinical attack rate. As members know, the virus occurs in waves that reach their peak; each wave can last upward of 16 weeks. There has been a reduction in the peak clinical attack rate from 6·5% to 2·5% nationally. We must bear in mind that there will be variation in that rate across the jurisdictions. An important point to make is that our experience in Northern Ireland was different to that in the rest of the UK over the summer.

Members will recall that, when the virus first emerged, parts of England in particular and Scotland saw a significant peak in activity. We were spared the worst excesses of that, and because the schools were closed over the summer, our levels of infection dropped fairly quickly. Although the figures are not strictly comparable across the UK, we now see a much more pronounced peak in Northern Ireland compared with any other part of the United Kingdom.

The fact that we did not have such a peak before means that there are, undoubtedly, more people here who have not encountered the virus before but will do so as we move into winter and the normal seasonal flu period. Therefore, the impact of the virus in Northern Ireland, given that we did not have as much exposure in the first wave, may well be greater.

What does that mean? It means that, across the UK, there may be approximately 1·8 million GP consultations. We will have our fair share of those in Northern Ireland, proportionate to our population. Fewer people will be admitted to hospital, which is good news, because we have a chance of meeting that additional pressure, but it still means that up to 35,000 more people may be admitted to hospital across the UK than would normally be the case. Of those, upwards of 5,000 may require admission to intensive care. At that point, it is important to highlight that we are already experiencing pressure on intensive care facilities across the UK. In the winter, we normally see increased pressures on critical care and intensive care in any event, and it is clear that there will be additional pressure on our critical care capacity.

The good news is that the worst-case scenarios have now moved to "most likely" status. We have continually seen a downward revision in the likely numbers of deaths in the UK; from 64,000 to approximately 9,000 and now to approximately 1,000, of which we might expect our proportionate share in Northern Ireland. That is really good news, because we were anticipating many more excess deaths. However, our experience with the virus has demonstrated that, as Dr Reaney said earlier, it is a mild or moderate illness for the vast majority of people, but for a smaller number it is, unfortunately, serious. Nevertheless, we can be more confident in saying that the number of deaths is likely to be lower.

The virus predominantly attacks younger people, and people over 65, and certainly people born before 1957, seem to have had some previous exposure to variants of the virus. Given that, we must bear in mind that a disproportionate number of deaths will occur among younger people,

as we have already experienced, tragically, in Northern Ireland, particularly among young people with underlying health problems.

There is good news about the likely impact on the workforce; the anticipated absentee rate is down from a potential 12% to 5%. It is important to emphasise that that makes the situation potentially manageable. We still, perhaps, face what will be one of the most challenging winters in decades, and our primary care and hospital services will be under significant strain. In the peak weeks across the UK, it remains likely that more than 200,000 people each day will develop swine flu and contact their GPs, and a proportion of that number will require admission to hospital and to intensive care. As I said earlier, the impact, in combination with seasonal flu, is unpredictable. It will be a long and difficult winter, but I assure the Committee and the public that we have been planning, we are prepared, and we will continue to revise those plans so that we are able to continue to provide treatment and care and protect the most vulnerable people in society.

**Mr McCallister:**

I associate myself with the remarks made by others at the start of the meeting. Our thoughts are with the families of those who have died in tragic circumstances.

Has the modelling been pretty accurate to date? Are the figures roughly what you expected them to be by now that, in October, Northern Ireland, as a region of the UK, is heading into peak season?

Is your decision to immunise children who attend special-needs schools a slight deviation from the JCVI's initial advice on priority groups, albeit a welcome one? Has Northern Ireland's experience been fed into that decision?

The figures that you provided are encouraging. I hope that they are borne out as we proceed. The Department's preparation and work seem to be paying off.

How can we speed up getting the vaccine to the wider school population to avoid school closures? Is there a programme to consider how that might be achieved? As you have mentioned a couple of times, Dr McBride, young people seem to be at disproportionate risk.

Older people are at the other end of the spectrum. Are there any built-in measures to ensure that people do not mix up the vaccines that they receive? They might think that they have been treated with one vaccine, when, in fact, they have been treated with the other. I am concerned about that. As Alex mentioned, the two strains of flu are not significantly different. Some of the groups that you will target initially are the same groups that would be targeted for the seasonal flu vaccine.

**Dr McBride:**

I shall leave it to Liz to deal with your final question about the vaccines and the risk that people may be confused as to which one they have received.

We have said all along, including when previous figures were published in July and September, that the figures were not the modellers' projections or forecasts; they were a set of reasonable worst-case scenarios. They always covered a range of clinical-attack rates. For planning purposes, they were intended to ensure that we could respond to whatever lay ahead. As the Minister has said throughout the incident, we have been planning for the worst outcome and hoping for the best outcome.

It is good news that the planning assumptions appear to have been revised downwards. However, let us be under no illusion: the virus poses a significant risk to public health. Our experience of the virus in the initial wave was different. We must bear that point in mind. The virus will pose serious challenges.

Vaccinations of children who attend special schools, and who have severe learning disabilities and underlying health problems, do not deviate from the JCVI recommendation. On the basis of experience locally in Northern Ireland, and the disproportionate impact that the virus has had on young people and children who attend those schools and who have underlying health conditions, such as those that Liz Reaney described, the Minister asked whether he could bring forward plans that were already in place to vaccinate those children to ensure that they were protected.

On the basis of our experience of the virus in Northern Ireland, that was the right thing to do. We have shared that experience with colleagues throughout the UK, so that they can consider it.

As regards school closures, I take the Committee back to the situation prior to 2 July 2009.

Members will recall that, at that stage, we were chasing the virus. We were putting the brakes on it. We were slowing the spread of the virus to buy time until the vaccine had been developed and we could start to protect the population. That was successful. The Public Health Agency, GPs and front-line healthcare professionals, particularly doctors and nurses, did a superb job and bought us time.

By 2 July 2009, it was clear that the virus was out in the community and was being transmitted widely. We saw the first wave of swine flu. At that stage, we stopped taking a series of measures, such as swabbing every suspected case. We also stopped following up everyone who had been in contact with a person with swine flu and offering them antivirals. We did that for the simple reason that the virus was spreading widely in the community and, therefore, that approach would no longer have been effective. A fundamental point is that the primary objective of closing schools was to prevent the spread of the virus.

Since then, we have moved to a different situation. As I said earlier, the virus is circulating widely in the community. Children are as likely to be exposed to the virus in their homes, through contact with heir brothers, sisters and parents, as in school. The disproportionate impact that school closures would have on society must be considered.

We must also consider that special schools provide an important therapeutic environment for children. In addition to the educational aspect of the environment, they receive a range of treatment and care there. Those schools put in place extensive arrangements for ongoing infection control.

There has been much media coverage of the school closures. The national advice, based on scientific evidence, is being followed in Northern Ireland. In our discussions on how to deal with cases in schools, we follow the best available scientific and public-health advice, and we will continue to do that. It is unfortunate and extremely regrettable that, in recent days, much of the media speculation has been unhelpful and has caused undue public concern.

Liz will talk about any potential for the public to be confused about which vaccine they have received.

**Dr Reaney:**

People may get confused between seasonal flu and swine flu. The seasonal flu vaccination programme has been in place for several years, and people are well used to it. Older people and people from at-risk groups know that they get called to receive the vaccine each year, so they are familiar with that process.

We have tried to make it clear that two separate vaccines are required and that a seasonal flu vaccine does not protect against swine flu, and a swine flu vaccine does not protect against seasonal flu. We have developed information leaflets that will be given out to people who receive the vaccine. Those leaflets make it clear which vaccine is being given and state that it does not protect against the other type of flu. A national communications campaign is being developed to get the message out about the importance of receiving the swine flu vaccine. That does not contradict our existing programmes for seasonal flu.

**Dr Deeny:**

Thank you, Liz and gentlemen, for all the work that you are doing. I agree with you that it is an exceptional time. I have worked for well over 20 years as a GP, and I have never seen a situation like this.

Many people have asked me about schools. Further clarification on that situation is needed, because people are receiving conflicting information. They hear that they should not go to health centres, to their place of work, to social gatherings or to their place of worship because of the danger of this contagious, droplet-spread infection. Despite that, they are told that it is OK to go to a school that has already had a number of cases of swine flu. That is a major concern.

As a family doctor, I pass on my condolences to the families that have lost children because of other health conditions that were brought on by this terrible virus. Two people have died, and three others have the disease. We know that there is a latent period, so other children may have picked up the virus but not yet developed symptoms. I was asked whether I would allow my child to go to a school in which there had been cases of swine flu. That is a difficult position for me.

Your protocol that people should contact their GP is right and sensible, because GPs know their patients best and can give advice.

However, more GPs will be asked whether they should let their child go to a school in which, unfortunately, there have been two deaths and three people have contracted had the virus. That is a difficult question, because we know that the virus is in the building and that other children have probably picked it up but are not yet sick. At the same time, people are being told to stay at home because it is safer. I do not agree, Michael, that one is just as likely to pick up the virus at home.

There are 160 pupils at Foyle View School in Derry. Every September, GPs see a significant increase in viral infections because of children mixing at school. There is a major concern among the public. If parents were to ask me now, as a GP, whether they should let their child go to a school at which there have been two deaths and three cases of swine flu, I would say no and advise them to keep their child at home. Let us vaccinate all those children as soon as possible. I am not talking about a blanket vaccination, just that one school. If that is not made clear and some people at the school become sick, parents will say that they should have been told to keep their children at home.

**Dr McBride:**

Members have reflected, quite rightly, some of the concerns that have been raised by the media and that people have raised with you as MLAs and members of the Committee. Unfortunately, the current level of anxiety has been fuelled by the regrettable media coverage that I mentioned earlier.

The Public Health Agency advice, based on national advice from the Health Protection Agency, is clear about what to do in these circumstances. Kieran, I know that you are simply reflecting views that have been expressed elsewhere, but the scenario that you outlined is not in keeping with national guidance or the advice of the Public Health Agency, which will make a full risk assessment in each case and advise schools accordingly.

I heard the principal of Foyle View School being interviewed this morning, and he spoke remarkably well about his experience of being in direct contact with patients who are pupils at the school. I do not wish to misquote him, but I think that he said that not a single parent had asked him to close the school. The children in that school whose parents have given their consent are receiving the vaccine as we speak. That school provides the best caring, therapeutic and

supportive environment for those children and their parents. The headmaster's words probably mean more than anything that I could say on the matter.

Liz will talk about the situation from the Public Health Agency's perspective.

**Dr Reaney:**

I am glad that the issue has been raised, because it is important to emphasise the public health messages. First, it is important to remember that people are infectious only when symptomatic. Anyone who is symptomatic should not attend school, work, church or wherever. It is important for anyone who is symptomatic to stay at home and minimise contact with others. It is important that a child who becomes symptomatic at school or a person who becomes symptomatic at work to get home as quickly as possible while minimising contact with others. That is the best possible advice. If none of the children in a school are symptomatic, they pose no risk.

I am glad that you mentioned environmental cleaning because people must be careful about cleaning, particularly surfaces and door handles. Everyone has seen the posters and television advertisements that stress the importance of maintaining environmental cleanliness.

I want to stress that someone who is symptomatic should minimise contact and return home as soon as possible, from where, if necessary, he or she can contact their GP by phone, rather than turning up at the surgery or A&E. The minimising of contact with others minimises the risk of spreading infection.

We have all seen the 'Catch it, Bin it, Kill it' message about respiratory hygiene, and that is what we wish to emphasise. Nevertheless, given that children have died, people are, understandably, anxious and regard schools as dangerous places where they might catch the infection. However, we must remember how the infection is spread and the importance of people who are well not becoming alarmed.

Members of the public often ask whether contact with someone who is ill means that they can pass the infection on to someone else. However, if people are well and have been in contact with someone who has swine flu, they are not restricted from going about their normal business. If they become symptomatic, obviously, they must then minimise their contact with others. It is important that we get that message out to the public. If people understand how the infection is

spread, where the dangers exist and that we do not consider schools to be particularly dangerous places, that will help to calm the situation. As Michael said, schools are no more dangerous than anywhere else. The infection is spread by symptomatic people when they cough and sneeze, regardless of where that happens.

**Dr McCormick:**

In addition, there is good interaction on this issue between the health and social care sector and the education sector. This morning, my counterpart in the Department of Education, Will Haire, had another in a series of routine meetings with my colleagues from the Public Health Agency to ensure that the guidance for schools is kept under review and that the right measures are being carried out as clearly as possible on the basis that Michael McBride and Liz Reaney explained. Therefore, measures are in place to deal with issues as they arise in individual schools. The circumstances and context in which those issues arise will be carefully examined, and judgements will be made about the right thing to do on a case-by-case basis.

I am confident that we have good ways to deal with the issues, and we will adopt a balanced approach and ensure that they are dealt with sensibly. All the circumstances and issues that people have highlighted will be taken into account and, in that context, specific judgements will be made. I hope that the fact that we have good working relationships with, and the buy-in and confidence of, various sectors provides members with some reassurance.

**Mrs Hanna:**

I add my sincere sympathy to the bereaved families. Michael, you spoke about the disproportionate impact that swine flu has had on young people with learning disabilities. Is that impact mirrored in the UK and the Republic of Ireland? Secondly, does the 82% increase in people who require hospitalisation made up entirely from the anticipated groups of people with underling health problems? Thirdly, is the one-dose vaccine as effective as the two-dose one, or is the treatment regime determined by the order in which the supplies come in? Given the choice, I presume that people would opt for the one-dose treatment. Finally, a family with a vulnerable child might be concerned that he or she has swine flu rather than normal flu. Is taking a swab the only definitive way to diagnose swine flu?

**Dr Reaney:**

As far as I am aware, the number of pregnant women, and vulnerable adults and children who

have underlying medical conditions, that we see is mirrored elsewhere. In Northern Ireland, the figures have been brought into stark relief because four of the eight deaths here have involved children with considerable underlying health conditions and complex needs. For us, that brought a particular emphasis to the situation, which is why — although those children would already have been eligible for the swine flu vaccine — we decided to bring them to the head of the queue, so that they are vaccinated as quickly as possible to protect them. As far as I am aware, England, Scotland, Wales and the Republic of Ireland have had a similar experience, as one would expect. Reports and papers from the United States provide comparable information.

Based on our example of vaccinating pupils in schools for children with severe learning disabilities, this morning, before 9.00 am, I had received e-mails from my counterparts in Scotland and Wales. They asked what we were doing and how we were doing it because they wanted to do the same. I sent them the information that we have developed, so they are closely following our example. As far as I am aware, England is doing so too.

Does that answer your first question?

**Mrs Hanna:**

Yes, that is fine. Thank you.

**Dr Reaney:**

Reports show an 82% increase in the number of hospitalisations this week. There have been 62 hospitalisations this week, which is week 42. In week 41, for some reason about which we are not clear, that number dipped to 34. During week 40, there were 61 hospitalisations. In a sense, recent hospitalisation has formed a V-shape pattern. However, the 62 hospitalisations this week is the highest number of any week to date.

**Mrs Hanna:**

Those people had underlying health problems. That is really —

**Dr Reaney:**

Not necessarily all of them. I do not have the breakdown of the figures with me, but they cover the full range of ages. Those most commonly affected are aged between 15 and 44, and there has also been an increase in the numbers aged between nought and four this week. It varies from

week to week. Many of those people have underlying health conditions, but we cannot say that all of them have.

Your question about the vaccine doses —

**Mrs Hanna:**

My question was about one dose or two doses.

**Dr Reaney:**

There are two different types of vaccine. Pandemrix, which is produced by GSK, is the vaccine of which we currently have supplies. The advice is that people who are younger than 10 years old require two half-doses, separated by a minimum of three weeks. People who are aged between 10 and 60 definitely require only one dose. We are still waiting for some research on the effectiveness of the vaccine for people who are aged over 60. It is possible that they may require a second dose. However, the JCVI decided that the priority is to give everyone one dose so that they are protected. If evidence emerges that people who are aged over 60 need a second dose, they can be called to receive that at a later date. We will not have that evidence for some time yet.

The current advice is that people will require two doses of the Baxter's vaccine. Yesterday, however, I heard that Baxter's has applied to the European Medicines Agency for a change to its product licence that would enable it to give a single dose. That depends on the effectiveness of the vaccine, the clinical trials and the emerging evidence. Nobody wants to have two injections, but we want to make sure that people are adequately protected.

Your final question was about diagnosis.

**Mrs Hanna:**

It was about the definitive diagnosis: can that be done only by swab?

**Dr Reaney:**

The definitive diagnosis is by swab. As I explained to some of your colleagues, the symptoms of swine flu are fairly non-specific. As they do not differ greatly, or even at all, from seasonal flu, it is difficult to make a clinical diagnosis at times. All our figures are based on consultations on flu

and flu-like illness. We now know that, if swabbed, a reasonable percentage of those would turn out to be swine flu. At present, that is the only definitive way of being sure that the illness in question is swine flu as opposed to some other sort of flu.

**Mrs McGill:**

You are welcome and thank you for your work. I extend my sympathy to the families of those who have died; I also extend my sympathy to the staff and principal of Foyle View School. Constituents of mine have a child who attends Foyle View School. When I asked them how things were after the death of Orla, they assured me that they were content with the protocols that the school was following. That was after the death of the first child, and I have not spoken to them since.

How many of the sentinel GP practices are in the west?

**Mr Easton:**

Do you mean in Strabane?

**Mrs McGill:**

I mean the west and the north-west. It is important that the sentinel practices cover a good geographical spread. Given what happened at Foyle View School, which is in the west, I am interested in finding out the figures.

Carmel asked about a definitive diagnosis, about which there seems to be confusion. I hear that when one phones a GP, they might say, "It sounds as if you have swine flu." Is that it? I am not sure that that is sufficient; I am not entirely happy with such an arrangement. We have been told that on no account should we go near our GPs, which runs contrary to what normally happens. I heard a comment on the media this morning that that arrangement should be reviewed. I have no view on that; as the Chairperson said, we are not medical experts. Nevertheless, there is uncertainty. Surely, when one phones one's GP one ought to hear something more than, "It sounds as if you have swine flu." I am not sure that that is enough.

Dr McBride, you said that it is no longer effective to swab, but is that the only way of getting a definitive diagnosis?

**Dr McBride:**

I said that, on 2 July 2009, a UK-wide decision was made that we had gone beyond the stage of trying to contain the virus, during which we confirmed every case by swab and offered antivirals to those in contact with all confirmed cases to slow down the virus to give ourselves time or perhaps even stop it in its tracks.

However, since the virus is now widespread throughout the UK and Northern Ireland, a decision was made to move to clinical diagnosis. I think that that was the point that Carmel made. We communicated at the time that that would mean that we would report developments differently. We would report swine flu as we had always reported seasonal flu by recording the number of consultations for influenza and flu-like illness by GPs and out-of-hours services and by tracking the prescription of antivirals and moving to clinical diagnosis. Our priority shifted from slowing down the spread of the virus to diagnosis and treatment.

We moved from a phase of containment to one of treatment. When many viruses are circulating and many people are being infected, our priority shifts from stopping the virus — because we have gone beyond that stage — to treating people who are unwell.

**Mrs McGill:**

At what stage does the definitive clinical diagnosis come? I am thinking particularly of the phone calls.

**Dr McBride:**

You are absolutely right: that is now a clinical diagnosis.

**Mrs McGill:**

Is a definitive clinical diagnosis made on the phone?

**Dr McBride:**

Yes. As Liz pointed out, the several sentinel GP practices that cover approximately 11% of the population of Northern Ireland monitor the level of H1N1. They are tracker practices, if you will.

The Department moved to clinical diagnosis on 2 July 2009, based on the symptoms contained in the leaflets that were distributed to everyone's home between 8 May 2009 and 14 May 2009;

those symptoms are also detailed on the Department's website.

There will be instances of people being swabbed in GP practices for surveillance purposes and of individuals being swabbed for public health reasons.

I will allow Liz to answer the questions on the geographical coverage of the sentinel practices and whether there could be local variations in flu activity.

**Mrs McGill:**

I am still unclear from Dr McBride's response whether a patient will get a specific diagnosis of swine flu when they phone their GP. Dr McBride almost suggested that patients will diagnose themselves.

**Dr McBride:**

It is like any other clinical diagnosis that is made when a patient describes his or her symptoms to the GP. GPs now have a significant level of experience in diagnosing and treating people with swine flu in Northern Ireland, because there is a great deal of it around.

As Liz explained, the symptoms of swine flu are not dissimilar to seasonal flu and when a patient calls their GP, he or she will be taken through a series of questions and asked to describe their symptoms. The GP will also ask the patient how unwell he or she feels to assess how severe the illness is and enquire whether the patient has any underlying health problems. From that conversation, the GP will be able to ascertain whether the patient's symptoms are consistent with swine flu and whether the patient is in any of the risk groups as a result of underlying health problems. If the GP feels that the symptoms are sufficiently severe, or that the patient is at an increased risk, he or she will then decide whether to prescribe antivirals. In some instances, the GP may decide to visit the patient at home, because of the severity of the symptoms or underlying health problems. During that visit, the GP will make a further assessment.

That is the sequence of events that would occur if a GP felt that a patient's symptoms were particularly severe or if there was something unusual or something to worry about given the patient's underlying health problems. That is a clinical judgement.

**Mrs McGill:**

The last comments that Dr McBride made about the GP needing to see a patient in their own home was what I was trying to extract.

**Dr McBride:**

I apologise for taking so long to explain that, Claire.

**Mrs McGill:**

No; that is fine. As I said earlier, I am not the medical expert.

The GP may decide that he or she needs to visit the patient at home.

**Dr McBride:**

Yes; if that is his or her judgement.

**Mrs McGill:**

That contradicts the previous advice that patients should not see their GP if they feel they have swine flu. There is a distinction.

**Dr Reaney:**

As Mrs McGill said, the advice that has been given on swine flu differs from the normal expectations of patients, which is that, if they are ill, they visit their GP. However, the concern is that, if the patient has swine flu and goes to the practice, he or she will take that infection into a crowded waiting room and spread it. That is why the Department has encouraged people to contact their GPs by phone.

Mrs McGill also asked about sentinel GP practices, and, unfortunately I do not have the exact figures for those practices with me; however, those practices cover approximately 11% of the Northern Ireland population. The Department tried to establish those practices across Northern Ireland, but there tended to be fewer of them in the north and west of the Province.

When the swine flu epidemic began in earnest, the Department was conscious of the coverage provided and of creating a balance throughout Northern Ireland. To do that, the communicable

disease surveillance centre, which is now part of the Public Health Agency, worked closely with GPs to try to get more of them on board.

Obviously, there is additional work involved for GPs who work in a spotter practice, because they are responsible for sending in returns for the number of patients that they see each week with flu or flu-like illnesses and for swabbing some of those patients to get definitive information back from the lab. We have increased our coverage of the sentinel practices, and we would be happy to get that information for you.

**Mrs McGill:**

I would welcome that. Given, as you say, that that means extra work for GPs, is there any resistance to that?

**Dr Reaney:**

In general, GPs are willing to do the extra work. Many of them may have a particular interest in swine flu and may decide to become involved for that reason. As you are aware, GPs are busy people with a lot of different work to cover, and some GPs may be more interested in one aspect of medicine than another. However, we have recruited more practices since the start of the swine flu pandemic.

**Mrs McGill:**

Is their involvement voluntary?

**Dr Reaney:**

As far as I am aware, it is.

**The Deputy Chairperson:**

Thank you all for coming today and for staying with us for so long; as you know, members had many questions. As you said, the situation is changing rapidly, so I am sure that you will be back to speak to the Committee as things develop.