Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Update on Swine Flu

3 December 2009

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mrs Dolores Kelly
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:
Dr Liz Mitchell) Department of Health, Social Services and Public Safety
Dr Liz Reaney)

The Chairperson (Mr Wells):

I welcome Dr Liz Mitchell and Dr Liz Reaney. I ask Dr Mitchell and Dr Reaney to provide the Committee with a further update on the important issue of swine flu.

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

Thank you for allowing us to update you on swine flu. The Committee has previously met my colleague Dr Liz Reaney. On 22 October, she accompanied Dr Michael McBride to update the Committee on swine flu. I will say a few brief words of introduction, after which I will hand over to Dr Reaney, who will take members through the presentation that we submitted to the

Committee. We will also touch on the updated figures that became available today.

There have been some encouraging signs on swine flu, but there has been a slight increase in GP consultations. One reason may be that, as we noticed this week, there has been an increase in another viral infection, particularly among children who are under four years of age. Most winters, the respiratory syncytial virus (RSV) causes outbreaks among young children and is responsible for a significant number of hospital admissions of children who are under four years of age. This year, that virus has started slightly later than last winter, and the figures are now rising. The symptoms of RSV may, initially, be similar to those of swine flu, so some of the increase in reported GP consultations for flu and flu-like illness may be related to that because the increases are mainly in the nought-to-four age group.

I will hand over to Dr Reaney to take you through the presentation. After that, we will be glad to answer any questions.

Dr Liz Reaney (Department of Health, Social Services and Public Safety):
Thank you for the opportunity to update you on swine flu. The Committee has been provided with a presentation, which I submitted a couple of weeks ago, and, as I work my way though that, members may wish to refer to the graphs and tables that are included. I have divided the presentation into four sections. First, I will discuss influenza pandemics in the last century; secondly, I will give an overview of the swine flu pandemic to date; thirdly, I will provide an update from today, 3 December, on our recently published information; and fourthly, I will say a few words in summary.

Members are probably well aware that, in the last century, there were three pandemics. In the 1957–58 pandemic, the pattern was a slow increase in the number of cases, a large peak of infection, a rapid decrease, followed by few smaller peaks. In contrast, the 1968–70 pandemic had a smaller first peak of infection, after which everything went quiet for some six to eight months in which nothing seemed to happen. Suddenly, around Christmas, there was a second higher and more intense peak. Those contrasts demonstrate the fact that pandemics are unpredictable. We are not sure what they will look like, and it is only in retrospect that we can comment on the situation.

The difference between those twentieth-century pandemics and swine flu is that we had plans

in place. Pandemic planning had been ongoing for many years before the swine flu pandemic hit. Those plans had to be general because of the unpredictable nature of pandemics. We plan for the worst and hope for the best. When an infection occurs — in this case, swine flu — we tailor the plans to fit the behaviour and characteristics of the virus. The presentation contains a table of planning assumptions, of which there have been three different versions. As we acquire more information and observe how the virus has behaved in other countries and in the rest of the UK, we can tailor the planning assumptions and plans to fit the swine flu virus.

At the end of April 2009, the news hit the headlines that infections were occurring in Mexico. Three key elements are needed for a pandemic, and those were in place at that time. The virus must be novel, people must not have encountered it previously and, therefore, have no immunity to it. The virus has to be transmissible, passing easily from person to person, thus leading to a rapid spread of the infection. The virus must be virulent, causing significant disease, hospitalisation and death. That was the case in Mexico at the end of April.

The Department of Health, Social Services and Public Safety (DHSSPS) responded with the establishment of a Northern Ireland helpline on 30 April 2009. A few weeks later, a leaflet drop was carried out to all households in Northern Ireland and in the rest of the UK. Northern Ireland's first case of swine flu was confirmed on 18 May, and, on 11 June, the World Health Organization (WHO) announced phase 6, meaning that a pandemic was occurring in community transmission in more than two regions of the world.

On 2 July, we came to the end of the containment phase and moved to the treatment phase. Initially, most cases were imported by people returning from abroad. We tested patients to ensure that they had laboratory-confirmed swine flu, patients were given antiviral drugs, and immediate household contacts were given antiviral prophylaxis to build a defence and to prevent the further spread of infection.

However, we reached a stage at which the infection was widespread. Our tactic worked well: it bought time, delayed the progress of the virus and gave us the opportunity to refine our plans and make other preparations. The containment strategy had been successful, and then we moved to a treatment strategy.

I will now focus on vaccination. Vaccination is true primary prevention. It prevents people

contracting the infection in the first place, which means that they cannot pass it on to others. On 13 August, priority groups were announced. After that, we were able to get the vaccination programme up and running rapidly across the UK, starting on 21 October. I met the Committee on 22 October, when we were considering the vaccination of children in special schools for severe learning disability. We were able to do that quickly in response to two very sad deaths among those very vulnerable children. On 26 October, we widened the vaccination programme through GP practices. Our most recent milestone was 19 November, when it was announced that vaccination was to be extended to children aged from six months to five years.

The Committee has received the information that was current on 19 November. Obviously, I had to send the presentation to the Committee in advance of our meeting, but I now have two further weeks of information. Today, members received the Chief Medical Officer's weekly media brief.

GP consultation rates declined again last week — week 47 — and there was then a slight rise in week 48. That might be due the respiratory syncytial virus: we are monitoring that closely. Out-of-hours calls have dropped steadily over the past couple of weeks to 272; prescription of antiviral drugs has also dropped over the past couple of weeks to 586; and new hospitalised cases have dropped to 17 last week and eight this week. All those signs are encouraging, and they suggest that we have passed the peak and that swine flu infection is on the decline.

My presentation contains a graph of consultation rates and virology for influenza and influenza-like illnesses. The peak to the left of the graph represents the consultation rate for last year's seasonal flu, which sets the context for the current peaks. There follows the first wave of swine flu, which occurred mostly before the summer holidays or around that time, and then there is a decrease. The second wave brings the highest levels of consultation that we have seen in the nine or 10 years since we began to collect such data. At last week, the graph shows a further decline, and, this week, there is a slight increase but not to the level of week 46.

Not all age groups are equally affected by swine flu or by our measurement of the consultation rate. The highest peak has been among schoolchildren between the ages of five and 14. However, the number of instances in that age group is now falling, and, in the past couple of weeks, the highest consultation rate has been among children between nought and four years of age. Rates of consultation in the over-65 age group have been low all along, and it is thought that

there is some residual immunity in people who were born before 1957.

The Chairperson:

Sadly, that applies to quite a few of us.

Dr Reaney:

I will make no comment about that.

The Chairperson:

We are as safe as houses, because we have lived through two pandemics.

Ms S Ramsey:

Speak for yourself.

Dr Reaney:

I am sorry if I have touched a raw nerve.

The Chairperson:

I am sure that neither of the witnesses saw the 1957 pandemic.

Dr Reaney:

I will now talk about the number of swine flu cases confirmed in hospital by week. Although, for most people, swine flu is a mild infection, it can be severe for some people. A number of hospitalisations have resulted from swine flu. Fortunately, in the past couple of weeks, hospitalisations are continuing to decrease, and the number of people who are being admitted to intensive care units has decreased. A snapshot from yesterday reported that 21 patients with swine flu were in hospital, four of whom were in intensive care units. In the past couple of weeks, those numbers have decreased gradually, and we are pleased by that.

Twenty-five per cent of hospitalised patients have been in the nought-to-four age group, and only 5% of hospitalised patients have been over the age of 65. That is a further reason why we are concerned about preschool children, and the decision on the next phase of vaccination reflects that. It is certainly true that patients with underlying health conditions, or co-morbidities, are more at risk of swine flu. However, only 17% of nought-to-four-year-olds who were hospitalised

had underlying health conditions, while over two thirds of hospitalised patients who were over the age of 45 had underlying health conditions. That adds further weight to the decision to give priority to children between the ages of six months and five years in phase 2 of the vaccination process.

I am glad to say that there have been no swine flu deaths in Northern Ireland since we prepared our presentation. The number of deaths still stands at 13, and we are very relieved about that. The numbers have increased across the rest of the UK. Last week's UK total was 245, and the updated figures for this week will be released and announced any time now, so I do not have them yet.

I have made a list of the priority groups in phase 1 of the vaccination process, but the Committee will be more interested to hear about the number of people who have been vaccinated so far. The information that I have covers returns up to 28 November, and the Committee should recognise that people have been vaccinated this week, so the numbers are increasing all the time. Thirty thousand front-line health and social care workers have now been vaccinated, and over 9,000 pregnant women have been vaccinated. Over 2,100 children in schools for severe learning disability have received the vaccine. That programme is largely complete, and children under the age of 10 are now getting their second dose to complete their vaccination.

Over 2,400 university healthcare students, including student nurses, medical students and physiotherapy students, have received the vaccine, and 550 at-risk inpatients have received it. We know of 120,000 at-risk GP patients who have been vaccinated so far. That relates to 81% of practices, and a number of returns are not through yet, so the number is likely to be considerably higher than that. That adds up to 164,500 people who had received the vaccine by the end of last week, and that figure is likely to be higher, given the number of people who have been vaccinated this week so far and the others from GP practices whose returns have not yet been submitted. We are very encouraged by that response.

Under phase 2 of the process, the Joint Committee on Vaccination and Immunisation (JCVI) has recommended that we vaccinate children aged between six months and five years. There are approximately 100,000 children in that age band. However, children with underlying health conditions may have received the vaccine during phase 1. The final arrangements and details of how phase 2 will be delivered are under discussion. However, we hope to begin to vaccinate that

cohort after the completion of phase 1, which is due to finish in the middle of December.

My presentation includes information on critical care capacity. We know that patients with swine flu who are severely ill may need ventilation in intensive care units. The presentation summarises the existing capacity in Northern Ireland and outlines plans for possible expansion. If it had been necessary, we could have increased our critical care provision. For example, we could have increased the number of adult beds from 57 to 158. Fortunately, it seems less likely that those expansions will be needed on this occasion. However, the work has been done, and plans have been put in place. It is encouraging to know that it is possible to increase capacity to that extent.

Earlier, I referred to planning assumptions. Even though we made massive efforts to increase capacity to the numbers outlined in our initial planning assumptions, a considerable gap would have remained between those assumptions and the likely demand in the event that the pandemic was as bad as we had initially expected. Even with the reductions in the planning assumptions, the gap narrowed. We are thankful that it appears that that will not be required at this stage.

A couple of weeks ago, reports suggested that viruses that are resistant to Tamiflu — the antiviral medication that is used to treat swine flu — had been confirmed in patients on a hospital ward in Wales. However, those patients were immunocompromised patients who were likely to pick up infections. I am glad to say that the results of samples from Northern Ireland show no evidence of Tamiflu resistance. We monitor that situation. It is a rare occurrence, approximately 75 examples of which have been detected worldwide. There have been few instances — only two, I think — of human-to-human transmission of those viruses worldwide. In that situation, viruses are often referred to as “less fit”; they do not transmit from person to person. It is a laboratory finding.

Pandemics are unpredictable. Although activity has decreased, we should not become complacent. The response to vaccination is encouraging, and we are pleased with progress. It will have a major impact on the likelihood of future infection and future peaks. If required, the plans to increase critical care capacity are in place, and we continue to monitor the situation closely. In conclusion, no swine flu presentation is complete without the message: catch it, bin it, kill it.

The Chairperson:

People who lived through the 1958 and 1968 pandemics are, apparently, as safe as houses because they have built up resistance. That is the advantage of having lived through both pandemics; not that either of you ladies has done so.

Mrs I Robinson:

That is charming. *[Laughter.]*

The Chairperson:

There is no doubt that the information is encouraging and reassuring. The trends seem to be moving downwards, and, fortunately, no more people have died as a result of this awful outbreak. We must pay tribute to the staff in the Department and in the Public Health Agency, who have done so much to promote the issue and to encourage vaccination and the use of Tamiflu. You said that 164,500 people have been vaccinated. Have any of them subsequently caught swine flu? In other words, has the vaccine worked in every case?

Dr Mitchell:

Vaccination is a biological process that tries to help people to develop antibodies to fight the infection. That takes a certain amount of time. After a person is vaccinated, there is period of time within which it is still possible for him or her to get the infection. It takes up to two weeks for a person to develop sufficient immunity to the infection. One of the reasons why we have promoted the GlaxoSmithKline (GSK) vaccine Pandemrix in particular is because it requires only one dose to provide immunity, whereas the Baxter vaccine requires a two-dose schedule to give sufficient immunity. If a person develops swine flu in the couple of weeks after he or she has been vaccinated, that does not mean that the vaccine failed. Rather, it means that it has taken time for the vaccine to work.

The Chairperson:

If a person is vaccinated and does not contract swine flu within two weeks, does that mean that he or she has no chance of getting it?

Dr Mitchell:

Any vaccine has a certain amount of efficacy. The seasonal flu vaccine has about 70% efficacy, which means that 70% of the people vaccinated will have immunity to prevent them from getting

the infection. However, there may be others whose infection will be lessened only by the vaccination should they get swine flu. Nonetheless, most people will be immune to the infection two weeks after they have been vaccinated.

The Chairperson:

The statistics on the number of hospitalisations are particularly encouraging. Of the cumulative total of 524 hospitalisations, only eight were admitted to hospital between 21 and 27 November. That is a small number of people, and, given that those figures are not up to date, the number of hospitalisations is probably even higher now.

Dr Reaney:

The number of hospitalisations is now up to 563.

The Chairperson:

Eight hospitalisations out of a cumulative total of 563 is a tiny percentage overall, which is very encouraging. Do the folk who have had swine flu and who have been hospitalised make a full recovery, or are they left with long-term health damage as a result of contracting the infection? Sadly, 13 folk have passed away, but do most folk emerge fit and healthy after hospitalisation?

Dr Reaney:

That depends on the individual patient. We expect the majority of people to make a full recovery, as they do with seasonal flu. Swine flu is not a particularly nice illness. People may be hospitalised if they develop a secondary bacterial infection that needs treatment, and some patients may be admitted to intensive care if they need a period of ventilation. However, we expect most patients to make a full recovery. Obviously, if people have been extremely ill, it may take some time for them to recover, and they may have some residual problems. It is not possible to make a blanket statement that everybody will recover, but we expect the vast majority to do so.

The Chairperson:

The demand for hospital services starts to peak around Christmas. Do you know whether many folk are still in hospital? I know of the eight people who are still in hospital, but what about the rest?

Dr Reaney:

As of yesterday, 21 people were still in hospital, four of whom were in intensive care.

The Chairperson:

That is 21 people who are still in hospital out of a cumulative total of 563. That is a low percentage; it is about 5%.

Dr Reaney:

I think that the highest number of hospitalisations was about 50 or 60. We receive daily reports of how many people are in hospital and how many are in intensive are. At one stage, some 50 or 60 people were in hospital, and the number of people who were in intensive care was in the teens. The number of people being admitted to hospital has certainly decreased. The figures are slowly decreasing, and there is some fluctuation, but we are encouraged by what we see.

The Chairperson:

We must finish the evidence session by 4.00 pm, because we are due to receive an informal presentation from the hospice staff, followed by a tour. We are on a tight schedule here, unlike at Stormont, where we can be more laid-back about timings. Therefore, I will rattle through the list of folk who wish to ask questions as quickly as I can.

Mr Easton:

The trend is quite encouraging, and the way in which the Department and the trusts have dealt with swine flu has been positive. I congratulate you on that. But — there is always a "but" — what is the percentage of staff take-up of the vaccine?

If the trend is a continuing decrease, will we need to have spent so much money? Will we be able to retrieve any of those costs if the current trend continues? Last week on the news, I saw a piece about a school in England that was carrying out blood tests. Many children at the school had swine flu, but many of them did not present with any symptoms and were not administered Tamiflu, yet it was discovered through blood tests that they did have swine flu. Many people do not display any symptoms. Could it be the case in Northern Ireland that many people may have had swine flu but did not know?

Dr Mitchell:

Some costs have already been incurred because Northern Ireland is part of the national procurement of vaccines, antivirals, personal protective equipment for staff and antibiotics. That money is committed and has been spent. Other moneys will be spent only as necessary. There will be a commitment if GPs have to vaccinate or if hospitals have to use certain treatments. Money is being spent on the surge, and some of those costs were predicted. We will spend only what we need to.

Mr Easton:

Therefore, the treatment of swine flu may not be as expensive as we thought?

Dr Mitchell:

Around £27 million or £28 million was already committed as our share of national procurement. The rest will be spent as it is needed. One would hope that, because we have not experienced as high a surge as we had anticipated, the costs will be less.

Dr Reaney:

As of 28 November, just under 50% of the trusts' front-line staff had taken up the offer of the vaccine. It may now be higher than that, because the vaccination programme is continuing. There has been a take-up of around 27% or 28% among primary-care staff and around 25% among independent sector staff.

Part of the problem in working out a percentage is identifying the denominator — who falls into the category of front-line staff. That can make things difficult. The uptake has been good and has been higher than with seasonal flu, and we have been encouraged by that. The programme has worked particularly well through the occupational health departments of the trusts, which have worked hard to make provisions for the staff.

Mr Easton:

Have some staff chosen not to have the vaccination?

Dr Reaney:

There will always be three groups of people: those who immediately want to get the vaccination; those who are adamant that they are not taking it up under any circumstances; and those in the

middle who could be convinced to be vaccinated. Public health consultants and others held training sessions with staff, which helped many undecided people to make up their minds because their questions were answered and information was presented to them. When faced with the facts, some people made the decision to take up the vaccination. I suspect that we are now reaching the point at which that will tail off. People who definitely want the vaccination have already had it. We are still trying to work with people who are undecided. For the folk who are not going to have the vaccination under any circumstances, the decision is theirs.

With seasonal flu, for every person who displays symptoms, we can count on another person being immune. They become asymptomatic or have only very mild symptoms. Some studies, such as the one involving blood samples in the school that Mr Easton mentioned, show that, for every person who had full-blown swine flu, there were a couple of people who had mild illnesses that did not meet the full definition of swine flu and, perhaps, two or three people who became immune without having had the full-blown infection. There is, therefore, a spectrum of illness, and some people will have developed immunity even though they have not had the infection.

The good thing about that is that the number of people who are now immune and will not become infected is probably higher than we estimated. People who have been vaccinated, people who have had full-blown swine flu and people who have converted serologically after being in contact with swine flu are all out of the equation as regards future infection. As the pool of susceptible people decreases greatly, the likelihood of another major peak in the future reduces.

Dr Deeny:

I will try to be as quick as I can. Thank you, ladies, for your presentation. I was going to call you Liz and Liz, but that sounds like the name of a solicitors' firm so I will not bother.

The nature of pandemics is that they are unpredictable. There is a possibility — perhaps a probability — that swine flu could recur next winter and, indeed, the winter after that. I want to thank the Department for the great deal of work that it has done to tackle swine flu. It has been worthwhile. There is huge interest in receiving the vaccine, and many people cannot be vaccinated as it is not yet their turn.

We believe that swine flu may return next winter. Is it the Department's aim to vaccinate the entire population? If that is the case, when will the maximum vaccination target be achieved?

Will that require GPs to continue to vaccinate throughout 2010?

A number of Health Service staff have asked me whether, after children who are aged between six months and five years have been vaccinated, which will start around mid-December, it will be open house as far as vaccination is concerned. People are asking for the vaccination now. If you do not mind, I want to make a suggestion. Liz Reaney mentioned the vaccination of front-line healthcare staff. Should receptionists, staff working in outpatients and, indeed, anyone who deals with patients not be included in that as well?

Several people have brought to my attention that they consider it unfair that they are also being exposed to the same virus and patients as the doctors, nurses and certain other staff who are being vaccinated. That group in the Health Service should be the next focus of vaccination after those aged from six months to five years and before the programme is opened to the general public.

Dr Mitchell:

I will start, and Liz will fill in any gaps. As for the probability of the virus recurring next winter, I believe that the WHO will recommend, if it has not already done so, that we incorporate swine flu into the seasonal flu vaccine. It would, therefore, become part of the normal seasonal flu programme.

We will be guided by the advice of the Joint Committee on Vaccination and Immunisation on whether to extend the programme of vaccination after the group of those aged between six months and five years has been vaccinated. The JCVI is still studying the evolution of the pandemic here and abroad and considering what advice to offer. It will weigh up the benefits of any extension to the programme.

We have told occupational health departments and trusts that, when they have issued the vaccine to their cohorts of front-line clinical staff, they can open up the programme of vaccination to ancillary staff in trusts, GPs' receptionists and other staff who come into contact with patients. That is now under way, and GPs' staff should be able to avail themselves of the vaccination through their local occupational health departments and trusts.

Liz, will you provide fuller answers on some of those points?

Dr Reaney:

Dr Deeny, in response to your final point, the Chief Medical Officer issued a letter last week that referred to the extension of the vaccination from front-line staff to other staff who are not designated as such but who have considerable contact with patients; for example, receptionists and porters. We recognise the contribution of those staff and the vital role that they play. We are keen that when front-line staff, who were prioritised on the basis of risk, have been vaccinated, the offer should be extended to other staff. The Public Health Agency has written to clarify arrangements for those staff to receive the vaccine as well, and we are pleased to be able to extend the programme of vaccination to them.

Dr Deeny:

Should the Joint Committee on Vaccination and Immunisation's recommend that the vaccine programme stop after children aged between six months and five years, do you not foresee a problem? People will still ask for the vaccine, and they will not be satisfied by being told to wait until next winter to receive the normal flu vaccine combined with the swine flu vaccine. If GPs stop administering the vaccine after children aged between six months and five years have been vaccinated, I forecast that many people will ask me for the vaccine to protect them.

Dr Mitchell:

A decision has not yet been made. We continue to observe events, and, before taking a final decision, we will take into account whether people are still seeking to avail themselves of the vaccine.

Ms S Ramsey:

You will be glad to know that I have the cold; it is not swine flu.

Dr Deeny:

I will take your temperature.

Ms D Kelly:

Let the doctor decide.

Ms S Ramsey:

I will not ask Dr Deeny to give me a jab because it could cost me about £7.

I join previous members in giving credit where credit is due: we must commend the departmental staff and the Minister for the focus that they have placed on swine flu. There was a real sense of panic a couple of months ago, and, therefore, their focus is to be commended. I congratulate you and the Department.

However, £64 million was committed to tackling swine flu. You may not have the figures here, and I have submitted a written question on the same issue, but can you give us a breakdown of where that money was spent? My concern is similar to the point that Dr Deeny made about other groups being able to get the jab. There is the issue of people who care for vulnerable people being vaccinated. They have requested to be included on the list for vaccination, and I hope that we will consider that.

Joint discussions have taken place in England. You talked about the second phase of the jab but said that negotiations with the BMA about its implementation are ongoing. Will you update the Committee on what is happening? Is it true that the negotiations have stalled because of money?

You said that, of the 164,500 people who have been vaccinated, some 44,500 received it outside their GP's surgery, particularly pregnant women, children in special schools, people in universities and those working in front-line services. Who gave the jab to those people, and was additional money given to them for doing so?

My final question is about seasonal flu and trolley waits. Alex Easton and the Chairperson mentioned that money has already been committed to increase the capacity of critical care, through an addition to the number of adult and paediatric beds, etc. If that money is already in place and should the number of swine flu cases continue to go down, can you guarantee no trolley waits over the Christmas period because swine flu will not take up that additional capacity?

The Chairperson:

There are some simple questions for you.

Dr Mitchell:

First, about £27·5 million — slightly less than half of the £64 million — was for the procurement of vaccines, antivirals, personal protective equipment and antibiotics as part of the national agreement. About £12 million was spent on surge planning costs in hospitals and community services, and about £2 million went to address pressures across the primary care sector. Some of the money will not necessarily have been spent. The original figure of £64 million was indicative of what might be spent over the period, so I do not know exactly how much of it has been spent. However, £4·3 million was for the purchase of additional critical care equipment, and about £4 million was associated with the storage and distribution of the antivirals, vaccines and personal protective equipment. As you said, Sue, you have submitted a written Assembly question, and a more detailed breakdown will come as part of the response to that.

Additional ventilators had to be available, should we require them, but we also had to ensure that nursing staff and others were trained in the use of that equipment, and that training incurred costs. Some of that money has already been spent on making those preparations, but some other costs may not have been incurred because they depended on the number of patients for whom we had to care.

Dr Reaney:

I will pick up on the issue of carers. The JCVI identified a group of elderly or disabled people who would face extreme difficulties should their carers fall ill. Those folk are already offered seasonal flu vaccination, and it was felt that they should be encouraged to take up the offer of swine flu vaccination. Our priority, as we move into phase 2, is children aged six months to five years. As I explained in the presentation, they are more likely to be hospitalised and fewer will have underlying health conditions, so we regard them as the priority at present.

Discussions are ongoing on what will happen after that, and consideration is being given as to how we might identify carers and, subsequently, how any programme of vaccination might be delivered to them. The negotiations with the BMA are under way, but I am not involved directly in them.

The Chairperson:

I know what question Sue will ask —

Dr Reaney:

Those are national negotiations, in which all four countries are included.

Ms S Ramsey:

Where are they happening — in Dublin? *[Laughter.]*

The Chairperson:

That was political: keep such comments out of this Committee. *[Laughter.]*

Ms S Ramsey:

Are you ready for the second phase of the vaccination programme? According to Dr Mitchell, everything is in place. Are the negotiations with the BMA in England causing the hold-up? If those negotiations were to succeed today, would you be ready to move tomorrow?

Dr Reaney:

We are coming to the end of the priority groups in phase 1, which will be completed in the next week or two.

Ms S Ramsey:

Is it true that there is an issue about additional money being paid to GPs for giving the jabs?

Dr Reaney:

Arrangements are being finalised for the requirements of the next stage of the vaccination programme.

Ms S Ramsey:

Was additional money given to those who provided the jab for the 44,500 at-risk people who did not receive it from their GPs?

Dr Reaney:

Some money was given to trusts for the work with front-line health and social care workers and clinics for pregnant women. The school health authorities administered the programme in schools for children with severe learning disabilities. I am not sure about the detailed arrangements for university students, but a lump sum was given to the trusts to undertake

vaccination of those groups. It was not on our —

Ms S Ramsey:

That is interesting; thank you.

The Chairperson:

We are running rapidly out of time. To ensure that everyone is included, I must restrict members to two questions each. If there is time for folk to come back after that, I will allow them to do so.

Mrs I Robinson:

I will play devil's advocate. As the predictions about swine flu commenced, who decided that tens of thousands of people would die from this terrible pandemic? There was talk of body bags and cold storage for bodies. Where did all that come from? Thank goodness, the number of people who have been affected by the pandemic is much lower than was first predicted, but how did we get it so wrong?

Dr Reaney:

Let me take you back to the start of my presentation. As pandemics are unpredictable, we must prepare for the worst, and that is what we did. The news from Mexico at the end of April suggested that swine flu was an extremely virulent virus. Mexico experienced high rates of attack, hospitalisation and fatality. We are not entirely sure why, although part of the explanation may be that Mexican recording systems are not as well-developed as ours. All the information that we received initially suggested that we were dealing with a virulent virus.

In such a situation, we have a choice. We can deal with it according to the information we have at the time and prepare accordingly. Alternatively, we can dismiss the information as being overstated, think that the situation here will never be that bad and underestimate the danger, in which case we could have been badly caught out. At the start, information was limited and it was a new virus. Therefore, we had no experience against which we could judge how it would behave. There were always additional concerns about how the virus might mutate. We had to put preparations in place to deal with a worst-case scenario.

With every day that passed, more information became available, and we were able to say with greater certainty what was likely to happen. That work is carried out by the statistical modellers,

one group in the Health Protection Agency in England and another associated with Imperial College London. Those scientists study the evidence and then work out a mathematical model of what that might mean when applied to certain populations.

Mrs I Robinson:

Was the drug company not involved in that?

Dr Reaney:

No.

Mrs I Robinson:

Based on the figures that were being provided, was there an over-provision of drugs and vaccines? I ask that because the vaccine may have a limited shelf life.

Dr Reaney:

We had to prepare for the worst, so, in the early stages, we prepared antivirals for 50% of the population and, subsequently, that increased to 80% of the population. We were conscious of the shelf life and how the drugs would be used in sequence.

The other word of caution that I would add is that we are referring to pandemics as though they are all the same, but each is caused by a different virus. Just because we have experienced this swine flu pandemic, that does not mean that we can sit back and think that we are safe for another 40 years, because something could happen next year. That sounds alarmist, but we must maintain a stockpile in case we face another pandemic, caused by a completely different virus, in the future.

Mrs I Robinson:

How long is the shelf life of a vaccine?

Dr Reaney:

Vaccines are specific to a particular virus. The shelf life of a vaccine tends to be at least a couple of years, and the shelf life of antivirals is probably similar.

Mrs Hanna:

I assume that we will return to two of the issues that Sue raised: the further reimbursement of GPs and how much money might be saved and returned to the Health Service should we be lucky enough that the incidence of swine flu declines to a lower plateau.

We all understand that pandemics are unpredictable. However, given the declining number of cases and your hope that that decline will continue, are you still urging particular groups, such as pregnant women, to come forward for vaccination? Given the positive outlook, should pregnant women still turn up for vaccination, or should they wait and see for a couple of weeks?

Dr Mitchell:

We are still encouraging pregnant women to be vaccinated, because the virus still circulating in the community. Given that some pregnant women are still being hospitalised, that group remains vulnerable. When the vaccination programme for younger children starts, we will encourage them to come forward too. Dr Reaney referred to previous pandemics, and it can look as though a pandemic is over only for it to bounce back. We are anxious that complacency does not set in.

Dr Reaney made another point about planning. A couple of years ago, we were concerned about avian flu, which still circulates in other parts of the world and retains the potential to become a pandemic. Although we have experienced the swine flu pandemic, we must keep our preparations in place and our guard up in case of any future pandemic related to a different type of flu. Our preparations are in no way nugatory, because they helped to reduce the impact of the current swine flu pandemic, and they will also help should there be any future pandemics.

The Chairperson:

Dr Reaney, when we met six weeks ago, you reassured us that the vaccination had no side effects. The Department has now given out 164,000 vaccinations. Do you have any evidence of people being hospitalised or feeling ill after receiving the vaccination?

Dr Reaney:

Anyone who received the vaccination said that they had a sore arm afterwards. That is a recognised side effect, albeit not a major one. Across Europe, 10 million doses of the vaccine have been given. The Medicines and Healthcare products Regulatory Agency (MHRA) monitors medicines and new vaccines for side effects, and it is closely monitoring reaction to the vaccine

and providing weekly updates. There have been reports of possible side effects, but nothing causes us particular concern. Occasionally, some children experience a rise in temperature for a short time after receiving the vaccine, but there are no side effects other than those recognised mild ones that happen with other vaccines.

The Chairperson:

That is reassuring.

Mr Gardiner:

Thank you, Dr Reaney and Dr Mitchell, for your enlightening information. Will you provide a breakdown, by trust area, of the number of people affected by swine flu?

Dr Mitchell:

Our office keeps data for general practices according to the former legacy boards, but I do not know whether we have that with us. We also have information on the number of hospitalisations in each trust area. We have compared the consultation rates for GPs in the former board areas with the hospitalisation rates in the local trusts. We have been carrying out those analyses, but we do not have the detail of them with us.

Mr Gardiner:

Do you mind giving me that information?

Dr Mitchell:

In which aspect are you particularly interested?

Mr Gardiner:

Last week, there were eight hospitalisations due to swine flu. I want to know in which thrusts those cases occurred. Are there more cases in Belfast than, for example, around the Antrim coast?

Dr Mitchell:

During the outbreak, we have seen peaks in the numbers of cases at slightly different times in the different trust areas. I do not know whether there is any particular difference between the trusts at present, but, at one point, the Western Trust had high hospitalisation and GP consultation rates

and, at another time, the Belfast Trust had higher rates. Therefore, the numbers have varied, and we can provide you with the breakdown of recent cases.

Mr Gardiner:

I am just trying to establish whether certain areas were affected more than others. For example, is a built-up area more affected by swine flu than a seaside resort where there is more fresh air?

Dr Reaney:

The pandemic has probably done the rounds everywhere, but, as Liz said, at different stages, it might have been more common in certain areas than in others. We do not have much evidence that any area has been affected disproportionately.

Dr Mitchell:

Swine flu is no respecter of boundaries.

The Chairperson:

Thank you; we have finished spot on time, which is quite remarkable. What you said today is reassuring. In a way, I had hoped never to see you again.

[Laughter.]

Mrs I Robinson:

They may feel the same way about you.

[Laughter.]

The Chairperson:

I hope that swine flu will adopt a gentle downward pattern and peter out, and, therefore, that we will have no need to call on you again. The Committee is reassured greatly by what you have said. Congratulations on a job well done, and I hope that the downward trend continues.