

TUESDAY 25 NOVEMBER 2008

Present

Colwyn, L
Crickhowell, L
Finlay of Llandaff, B
Haskel, L
Jenkin of Roding, L
Krebs, L
Methuen, L
Patel, L
Selborne, E
Sutherland of Houndwood, L (Chairman)
Warner, L
Whitaker, B

Witnesses: **Rt Hon Dawn Primarolo**, a Member of the House of Commons, Minister of State for Public Health, Department for Health, **Professor Lindsey Davies CBE**, National Director of Pandemic Influenza Preparedness, Department for Health, **Dr Becky Kirby**, Head of Human Health, Civil Contingencies Secretariat, Cabinet Office, **Mr Richard Drummond**, Deputy Director, Food and Farming Group, Defra and **Mr John Worley**, Acting Head of Profession – Health, Department for International Development, examined.

Q1 Chairman: Minister, may I, in the distance, welcome you and your colleagues to this committee meeting. We appreciate your willingness to give us time. The room is embarrassingly large. Fortunately, we are not doing macular disease or something of that sort, there would be too many unfortunate jokes. We know that ministers have a very busy schedule, but I think you will agree with us that this topic is one of the highest importance. It is one to which the committee, as you know, is returning, having already done some, we believe, significant work in this area. We are named around the table, if you can read the signs at a distance, but perhaps it would be very helpful if you and your colleagues would like formally to introduce yourselves and we will take it from there.

Dawn Primarolo: Thank you very much. I am very grateful for the opportunity to speak to you and answer your questions this morning. I do not take this symbolism of discussing pandemic, we are all down here and you are up there, to mean anything. I am hoping to be able to give you all the answers on this very important subject, both the work of the UK and our international work. If I can just put a personal plea in before I introduce my officials. I have been working in Libya over the weekend for the Department, and I returned late last night so I am hoping that my brain will stay connected with what I want to say, but please forgive me if something fails me and I ask an official to provide the detail. Perhaps if I can introduce those with me this morning. On my right is Professor Lindsey Davies, she is from the Department for Health leading the preparedness. Next to her is Dr Becky Kirby, she is from the Cabinet Office, and that will be for the details perhaps around the civil contingency on emergency preparedness. On my left, I have, firstly, Richard Drummond, he is from Defra. We are very grateful for the opportunity to hear from the officials directly in other departments. It is not unusual for a Treasury minister to speak for all departments at the moment, but it is unusual for a health minister. Next to him is John Worley from Dfid and again, the specific issues, perhaps, around animals, the poultry industry, et cetera, Defra will be picking up the detail on those.

Q2 Chairman: Thank you very much indeed. Just as a technicality, since this is being recorded, as and when your colleagues do speak for the first time, if they could say who they are for the sake of the record and those who transcribe it, that would be very helpful. We look forward to hearing from all of you. We are interested in information and understanding rather than minister baiting, I can assure you of that. I wonder if I might start with a question about the preparedness of the health sector should such a pandemic alight on us. How well prepared is the UK hospital system? It would be very helpful if you could also relate particularly to local hospitals because inevitably that is where many of the cases will emerge and turn up.

Do they have adequate support available in terms of ventilatory support through the intensive care unit, and so on? It would be very helpful if you could tell us a little bit about that.

Dawn Primarolo: Certainly, my Lord Chairman. I think you have touched on the importance for hospitals - in fact, the local health service, primary and secondary care, but concentrate specifically at the moment on hospitals - of needing to be very clear on increased workloads, depletion of workforce, critical care and discharge of patients. They will also need to be very aware of the required ongoing care that could be necessary in the patient's home, the medical supplies, including pharmacy and equipment, the full range, regrettably including sufficient mortuary provision. We also expect them to be very clear on the stockpile of antivirals including collection points, and I know we will come on to that later.

Q3 Chairman: Indeed.

Dawn Primarolo: In addition to all of the guidance and some of the issues we will touch on in other questions - capacity, preparedness, guidance - the operating framework for the National Health Service for 2008-09 required as a priority that NHS preparedness and all NHS organisations have robust pandemic influenza plans in place by December 2008, and to forward those to the Department covering all of the areas that you would expect us to touch on. Obviously that cannot be perfect because there are a number of disruptive challenges that will be very difficult to actually forecast - and I need to be careful as I say this because the operating framework for next year has not been published yet, it is to be published soon - but I think it would be appropriate for me to tell the Committee that on receipt of the plans for every hospital tied in to the priorities that will be in the operating framework for next year will be a detailed look at each of those plans and their resilience and, if necessary, discussions - I hope that will not be necessary because I hope they will be prepared - with each hospital. It is quite soon that the framework will be out, in the next week or so, so I would be able to send the specific details of how we intend to push it forward as a priority in the next year but,

regrettably, I am not able to pre-announce it, even though I would have really liked to and I pressed the Department quite hard but there are other issues around, so I hope your Lordships will forgive me on this point. By the time we have the plans in December 2008, a consideration and an assessment of those plans and their resilience and, if necessary, return to the hospitals' local providers, the Department will have formed an opinion on the preparedness of all these issues.

Q4 Chairman: It would be very helpful to receive a copy when the public announcement is made. I am sure we can distribute it to members of the Committee. Can I press a bit on how wide-ranging hospital plans are expected to be? Are they detailed or are they simply general saying, "well, we are ready to go?" For example, will it involve change of practice, isolation rooms are not that numerous but they might be in great demand or in heavy use, training of staff in advance, equipment and so on?

Dawn Primarolo: This is now cascading, the questions you are asking about what if we have a shortage of medical professionals, what do we do about that, surge capacity, supply chains. I think what might be helpful, if you allow me, is to ask Professor Davies to link that with the surge capacity work that is going on. It will then lead us into some of your other questions about securing enough health professionals to be able to deliver what might be considered to be the necessary intensive care, et cetera.

Professor Davies: I am Lindsey Davies, I am the National Director of the Pandemic Influenza Preparedness at the Department of Health. We have worked very closely with hospitals across the UK over the last few years to develop their plans and the plans we are expecting from them at the end of the year are comprehensive ones. They certainly are expected to go well beyond just a few platitudes explaining that they are planning, we know that they can do that and write back to us, what we want to know is what those plans entail. We want to know that they are robust implementable plans, that is what has been required.

They are expected to answer a whole range of questions. They have already seen the self-assessment tool and the assessment tool we will be giving to them and we are certainly happy to supply you with that if you would find that interesting. The sorts of plans we would expect them to have in place will include how they are going to develop extra capacity within their hospitals should the need arise. To help them with this we have published recently some surge capacity guidance. It is currently in its final draft form for discussion, it has not been quite finalised yet, but we do not expect it to change very much from the draft they have seen already. The responses have been very positive. What that guidance includes is a comprehensive approach to how hospitals could, in the early stage of a pandemic, begin to get their services in order, look at those that they need to prioritise as an assessment tool which enables them to think in advance now about in what order they would prioritise services, what is really crucial for them and what is less so and for the population they serve. So, to look in the early stages as the pandemic wave arises and passes through their community to have planned which will create capacity which will then make best use of that capacity and staff they have got and that may mean, initially, as I say, perhaps looking at postponing elective operations, cancelling them, cancelling outpatient appointments and things like that, and then moving through to prioritising patients for admission, who really needs to come in and who does not, who have got life-threatening illnesses and who have not. Then moving again beyond that to the recovery phase where you then think, “Well, how are we going to put services back in order in a systematic way?” We are very clear that we expect people to look at all phases of that and not just to think how are we going to stop, but also how are we going to restart in a measured way being sensitive to the fact that staff, of course, will have had quite probably their own quite traumatic experiences over a period of time. We have had a number of conversations, and very helpful ones, with professional bodies, the medical royal colleges, GMC, BMA and so on, who have been very actively engaged. It has been a

pleasure for me over the last couple of years to work with them so constructively to respond to the challenges.

Q5 Lord Crickhowell: I think that is very helpful and an encouraging introduction, Minister. The guidance says that the challenge during a pandemic is to ensure as far as possible there is sufficient appropriate staffing and levels of competencies in the areas most in need. You, Minister, referred to possible depletion of workforce, you talked about surge capability, and so on. I must say reading Exercise Winter Willow, which identifies a number of things that can go quite smoothly, communication for example, we will come back to the importance of relations with the devolved bodies, there is a concentration on the availability of medical supplies, masks, antibiotics, and so on, but I did not get any clear picture out of that that the personnel issue was being examined in that exercise as I would have liked it. I have been encouraged by hearing what Professor Davies said, but there is nothing like a real emergency to suddenly show up things. It just so happened - different circumstance - when I was Secretary of State for Wales we had a massive blizzard on a Sunday and all the plans had worked on the assumption that people would be in their offices. Well, of course, the officials in local government and the health service, everywhere, were not in their offices, they were at home, they could not get to their offices, so the entire communications system broke down. What is likely to happen here - could happen here - is that the people on whom the whole thing will depend are actually smitten quite severely themselves, and it may happen, particularly severely in particular health authorities or particular hospitals and the people simply will not be there to deliver the services. In a sense, you began to answer because you talked about the robust plans and the way you are examining them, but it does seem to me that on this question of the availability of people, if the people who are providing the service are ill themselves or become ill and there are shortages, can you develop a little further on what seems to me to be a very critical issue?

Dawn Primarolo: Perhaps I should ask Lindsey to give more detail with regard to the work we have done with the royal colleges, the RCN, the BMA, specifically around three big sets of issues and more. Firstly, unavailability of some staff, whether there are retired medical staff, the level perhaps of student staff that we can bring in, that requires then a working through, which I know they are doing about appropriate care, how that could be provided and by whom if we did not have exactly the staff that we would normally be used to having and a re-casting, if you like, of the clinical team, drawing in skills and abilities that we might not necessarily have used in normal times. That did come up recently in the flooding and the issues we had around that, particularly in Gloucestershire. There were issues about getting staff to work, which we have seen, but these are new, where we have seen a high level of absenteeism of critical staff and that is also where a great deal of work has been done. Lindsey, again, could you unpack that, please, and give some examples of where we are.

Professor Davies: We are very sensitive to the fact that unlike some of the emergencies we are perhaps more used to responding to, a bomb or something, and we see masses of medical staff coming and wanting to help, this will be very different. It will take its course over a period of time and will be something which will potentially directly affect the families of those involved, so this is a very new and different set of circumstances which we have had to explore very carefully with the professions. We have issued some guidance on staffing and employment, the Human Resources Guidance, which sets out a lot of this in more detail, but I think our response covers a number of areas. Firstly, talking to staff now and helping them understand and think through for themselves what the specific challenges will be that they as individuals will face, and how they might respond to those, whether domestically or whatever, to enable them to get to work. A clear expectation that if anybody is ill they should not soldier on and come to work, but they must go home as soon as they are ill, because once they are better they will be absolute treasures to the health service, and we will need to use them

wherever we can. That is a really important message, and, again, it is counterintuitive to much of the way that many staff will want to soldier on whatever in normal circumstances, so we want to be very clear about that. The other, of course, is the surge preparations, which we were mentioning earlier so that staff and hospitals understand and have really thought through what they will do if up to a third of their staff are off at any one time. There is no simple answer to that, each hospital will have their own challenges and resources, but we are encouraging them to think about that and develop the capacity as far as possible. One way of developing capacity is to look at who else you have got in the area you might be able to use, and in some areas there will be medical students at different levels of preparation. We spoke to the GMC and medical schools about how that might best work. Obviously we will need students to have appropriate supervision and support but, on the other hand, there are many practical things they could usefully do to release others to get on with other things. Similarly, retired doctors, the BMA have a retired doctors' group, they have encouraged them to sign up to offer to be prepared to help in the pandemic, and we are exploring with them ways in which we could make it easier for this to work. There are obvious issues about registration and about training and being up-to-date, but there will be a range of things that retired doctors might do. One area, for example, is death certification. Again, we might touch on that later on. So, availability, encouraging people to think through what they would do, but then, within the hospital now and in a continuing way, looking at how one might use staff who perhaps work in one specialty area in another way during the pandemic, making sure that as far as possible we have got those who know how to use the ventilatory equipment and things which are there should that be required. I think one has to be realistic about that because in a pandemic situation, of course, people will still be getting the other illnesses that they normally get and one cannot divert the whole and one should not divert the whole of the hospital towards flu because there will be people who get their appendicitis or get their heart attacks

and who have their babies who will equally need to be looked after. We are conscious of that in the planning and doing what we can to take an holistic approach. We are supporting it nationally where we can with training packages. We have even got a quiz which hospital staff can use to get themselves up to speed at the moment.

Q6 Lord Patel: Mine is a simple question: would it not be more helpful if there was a generic guidance issued rather than each PCT or hospital developing their own plans as to which services they must continue with, a generic guidance that these core services need to continue, but others may not, so that there is a plan nationally of which services? You mentioned maternity and cardiovascular, heart attacks, yes, they continue, but everybody knows pandemic flu occurs and shuts those services down.

Professor Davies: In the draft surge capacity guidance we have a priority service assessment tool which takes people through a series of questions and steers them towards the sorts of generic answers you are talking about. We did not say this must continue or that must continue because different hospitals have different pressures on them and their own context is different. In developing the surge guidance we wanted to be as useful to everybody across the UK as possible. It really is a UK, “This is a tool, work it through.” That said, within England, each Strategic Health Authority will be working with its local hospitals, its local communities to ensure that there is a proper package across the patch to ensure there is the best possible balance of services to serve that whole population. Again, looking at any individual hospital in isolation, there is a limit to what they can do. In some areas, for example – and we are encouraging this – the tertiary very specialist hospitals are looking at ways in which their own very specialised consultants can use telephone support more actively to enable people in the field to perhaps look after more complex cases than they would normally do. It is about a balance and ensuring that over a community you get the right

mixture, but we are looking to those who have an overview of those communities to get the balance right.

Chairman: Of course we have got a few superannuated doctors here in the House of Lords, but I will not press that point.

Lord Patel: My Lord Chairman, they will all be recruited.

Lord Colwyn: What about superannuated dentists!

Q7 Baroness Finlay of Llandaff: As an active practising employed doctor could I just ask, before I get on to my main question, a very simple short question: when you are asking for the reports in, are you monitoring how the training of staff at ground level, all the junior staff as well as the senior staff, is currently happening?

Dawn Primarolo: The short answer is yes, but perhaps you would want to be reassured on how we were doing that.

Q8 Baroness Finlay of Llandaff: I ask it because I have a concern from talking to junior doctors that some of them have not had any pandemic flu training for a time, but I would like to move on to my main question, if I may.

Dawn Primarolo: Perhaps we should take note of that and come back to that.

Q9 Chairman: That would be helpful.

Dawn Primarolo: It is quite a big issue and it is important.

Q10 Chairman: If there are any written answers you want to send us afterwards, that would be very helpful.

Dawn Primarolo: Of course.

Q11 Baroness Finlay of Llandaff: With the extensive national guidance which describes how the UK would respond, early containment does not seem to be clearly addressed. Has the Government planned for an early containment of a possibly highly pathogenic avian influenza human outbreak with things such as buffer zones, antiviral prophylaxis, social distancing, closing down social movements and so on at an early stage before the pandemic has actually taken hold?

Dawn Primarolo: The short answer is yes. Although the expert advice is that it is incredibly unlikely to originate in the UK, the Government clearly has to plan for that early containment regardless, particularly of an outbreak, as you say, of a highly pathogenic avian influenza. Such situations will be dealt with in line with the health protection agencies' national incident and emergency planned response where there is guidance on treatment algorithms for clinicians on handling cases, obviously the suspected cases going through isolation, prophylaxis planning, to make that containment if it is required and, of course, for the local assessment about what level of information we would then also be making available in that community in terms of advice on what individuals should do. We do have that within the planning process and if it has not been made clear enough to the Committee perhaps we should provide more detail of how that would work. Even though it is considered to be unlikely we cannot rule it out.

Q12 Baroness Finlay of Llandaff: Could I push you a little bit further and ask you, if the estimates are right that there may be between 50,000 and 750,000 deaths in the UK, at what point would you say that a curfew should be imposed to minimise the number of deaths so that there would be no movement between different cities and each area within the city, and places that people congregate would no longer be used as potential places of cross-infection?

Dawn Primarolo: We would not go as far as curfews in terms of the management and containment. We are already preparing and the health advice we give out now is pushing all

the time to “stay at home, services will come to you” which will be the Flu Line because this has to be a balance between the expectations of the population and panic and being able to continue the work. This is obviously a difficult area but having curfews is counter to the two messages that we very clearly need to put out. We need to put out a “business as usual” wherever we can, otherwise how do we get people to work and keep the supply but, equally, for those infected we need to be getting a very clear message through to them which is “Stay at home if you are sick. Contact the Flu Line and assistance will come to you”. The early containment regardless of where it breaks out is about encouraging those and supporting those who need to be isolated without bringing a whole community to an absolute grinding halt with catastrophic conditions or circumstances being caused elsewhere. All our planning is predicated on those two very important principles: how do you manage that and keep those who are sick isolated and those who are well still providing all the systems that we need in order to support those who are sick, and a curfew is not seen at the moment as a sensible way forward. I hope that answers it. I am happy to provide more in writing about how we came to that decision. We looked at the evidence and the challenges.

Q13 Baroness Finlay of Llandaff: One of the concerns is about people being infected before they develop symptoms in that presymptomatic phase, but I think we need to move on with our questioning.

Dawn Primarolo: Lindsey could just touch on that point.

Q14 Chairman: Briefly that would be helpful and then we will move on.

Professor Davies: I think that is a very valid concern. All the scientific advice that we have had suggests that people are most unlikely to be infectious before they are showing symptoms because of the way that flu is spread, as far as we know, which is in droplets which come out when you cough or sneeze, so if you are not coughing or sneezing the droplets are not coming

out, and therefore as long as people go home and stay at home the moment they start coughing and sneezing and as long as they catch their coughs and sneezes in a tissue and throw it away and wash their hands a lot - hence our huge message to people now to get into good hygiene practices - so long as that happens then that really goes a long way to minimising the risk.

Q15 Lord Jenkin of Roding: This leads on very nicely to a question which I have been very concerned about for some time which is the question of the availability and distribution of antivirals in the case of a major flu pandemic. I raised this at the time of the last report of the Committee in the debate on the Report. At that stage there had only been table-top exercises, this was apparent, so I read the report on Winter Willow, which Lord Crickhowell mentioned, with great interest until I got to the sentence on page 15 of that report: “The system of access and UK-wide distribution to the public of antivirals was not tested as part of the exercise scenario.” Could I ask when you intend to test it?

Dawn Primarolo: The answer is next year on an end-to-end process. The information will be supplied in the plans that we have for us to test that in December 2008.¹ It is the relationship between the local collection points and how that fits into the distribution that will go from the local collection points and how those local collection points fit into where we will hold additional stocks, and the movement between those if we see greater demand in one area than another, or if we need to intervene in order to change slightly the availability and the use of them because there is greater pressure or there is more information around as we are in the pandemic.

Q16 Lord Jenkin of Roding: I get the impression not only from what you have just said about but also from the report that a great deal of attention is being devoted to, as it were, the

¹ This is clarified in Paper C.

top-down organisation and administration and communication of all that. I have got very little impression as to what is being done to make sure that it works locally on the ground. I am not allowed to give evidence but I discussed this recently with an extremely able pharmacist from whom I get my supplies - I am kept alive by the pharmaceutical industry - and he is worried that he will have riots outside his shop because people will not know how or where to get it. One other question, you mentioned the Flu Line a moment ago and the papers make it perfectly clear that the Flu Line is not yet up and running. What testing is going to be done with that?

Dawn Primarolo: There are quite a lot of points there which I am happy to pick up. On the Flu Line it is straightforward; we are in the final negotiations for the Flu Line to be set up. That is imminent and is dependent on contracts. In terms of the supply chain and the availability, firstly, where the local collection points will be (and we will know as part of these plans how they will interact) part of the consideration is that we will then test in exercises next year. We are going to come on to the question of exercises done and what we have learned and exercises still to do and where we will end up. The last point when you were talking about the pharmacist, that is part of a wider discussion on the supply chain as well. It is necessary for us to complete some other discussions that we are also having with the industry at the present time on the PPR. That has concluded so the wider discussions about how we ensure a supply so the pressures do not arise as you are indicating are taking place now. We will be in a position to test all that, including the Flu Line, with the public in the next year. That is the preparation that is necessary in order to get us to test those.

Q17 Lord Jenkin of Roding: Chairman, it is three years since this Committee looked at this problem and produced a comprehensive report which was debated in this House and in which I took part. This was identified as a key issue. Here you are three years later saying it is still being studied and you have not got any plans. I do not understand what you have been doing

on this. Distribution and availability at the local level is going to be absolutely the key to the initial treatment and maybe also to the prophylactic effect of antivirals. Am I unjustified in feeling this concern?

Dawn Primarolo: It is not for me to say. I think it is for me to say perhaps I have not answered it clearly enough that we are at the stage of testing the arrangements rather than speculating what they may be, which is exactly the point that you are raising, and perhaps as another attempt to answer the question in a better-informed way I will ask Lindsey to actually come back and reassure you that since three years of this report actually a great deal has gone on and we have moved on considerably to actually having in place what we think the distribution would be and testing it, which is a bit more than just thinking about the necessity of it.

Q18 Lord Jenkin of Roding: We are going to come back to testing. When is this going to be tested on the ground?

Dawn Primarolo: Next year. We are going into December, we are talking about 2009 and that is when we plan to test it to see that it works.

Professor Davies: We are. We share those concerns entirely and have been working very closely with those in the field, particularly the PCTs whose job it is to make sure that there are the arrangements in place to supply and distribute the antivirals to their population, but it is very complicated. In order to get an effective system of distribution which we have confidence will work at all stages of the pandemic and will get the antivirals from their distribution centres right out to individual collection points in the right amounts, depending on demand in that local community at the time, we need not only to have the distribution system set up, and we are a very long way towards doing that, but we also need to have effective information and surveillance procedures. There is another whole workstream to put these in place so that we will get the information from the collection points about how much they have

got, what the demand is, and how quickly it is going so that we can adjust the supplies accordingly. That whole system is at a very advanced level of preparation now. We hope that we will have the Flu Line in place probably in early summer next year. That is what we are working towards but again it is taking us time to get that in place. We do not want to have something that is going to fail. We are very conscious of the need for public confidence and for the confidence of staff in all of this as well, so when we do have something in place we want it to be robust, and that is why we are taking the time to plan it properly, but we are also planning and testing in various stages both with the public and internal systems themselves. In the meantime we have been asking the NHS in its plans to plan for now. In the knowledge that the Flu Line is not there, it is not operational yet, they have had for the last couple of years a clear expectation on them to consider how they would do things and what they would do in the absence at the moment of the Flu Line. Having given you the timetable of next summer I think we would also say that if a pandemic were announced now we would work as quickly as we could to get a Flu Line system in place absolutely as quickly as we could do that so we would get the best we could do in place. We have asked the Health Service and Social Services and all local partners to be honest in their planning. That is what Winter Willow started with. It was to say do not plan for some ethereal “maybe it will be like this”; plan for what is actually there on the ground. After Winter Willow, although we did not include the Flu Line within that, we have subsequently been asking them to think exactly how they would do this and what they would do. There will not be ideal solutions but in their plans in December they are expected to tell us exactly how they would do it.

Q19 Lord Jenkin of Roding: Forgive some probing questions from, if I might describe myself, a superannuated Secretary of State, but I think I would find it extremely helpful if we could have some more specific information describing what Professor Davies has been

putting to us because at the moment I have to say I have very little confidence in what is currently being told us.

Dawn Primarolo: Okay, absolutely.

Q20 Chairman: If we could ask for something in writing that would be immensely helpful.

Dawn Primarolo: We will get that and hopefully we will deal with it and if not we could have another question session.

Q21 Lord Krebs: I have a small follow-up question to Lord Jenkin's question which is to do with the plan and when you do the trial to practise it. As I understand it, it is very important that the antiviral is taken by the patient within 24 hours of becoming symptomatic, so in your trial run how are you going to evaluate whether you can achieve that?

Dawn Primarolo: I think you should just answer that. I do not want to tread into areas that I do not answer correctly.

Professor Davies: We are currently developing how we are going to do the pilot so I cannot give you a detailed answer for how we are going to do that. We do know that we need to get antivirals to people ideally within 12 hours and definitely within 48, so in testing the system we will be looking at how quickly we can get people individually through the whole process. I cannot give you the details of exactly how we are doing it because we are currently working that up at the moment to make sure that it does test exactly what you are asking.

Lord Patel: I have one or two supplementaries but also another one on the answer that you just gave. This is the crucial issue: according to the paper, we have 38 million doses of antivirals that the Government has ordered, and it is important that this drug is used appropriately and at its most effective. We know that it will be most effective if it is administered within 48 hours of the symptoms and it is no use after that, so the right people have to get it at the right time, and that is going to be a tall order and require the best

organisation to do that. Some of the other things are peripheral issues. What are the plans to make sure that that happens? Secondly, what other assessment has been done, if it is the Tamiflu that has been ordered whether that is the right drug for all of the people? What if there is a high level of resistance that comes about by the time the pandemic occurs? Have we got plans to use other antivirals such as Relenza? Is oral medication the most effective way or is vapourised medication more effective for some people? What about children, how will they get the drug given to them? Also, antivirals can be used for treatment not just for prophylaxes, so how would antivirals be delivered for therapy purposes and would we have a stock of them? I have two more supplementaries after that.

Q22 Chairman: That is the first bite. You will need to move on, I have to say, but let us take this one.

Professor Davies: Shall I pick up some of those detailed points and again we are happy to come back in writing or further questioning if you wish. We are setting up a Clinical Information Network which will enable us to get as much information as we can about the effect of the virus on individuals in reality and on what works and what does not, so we will have a number of clinicians who will be sharing information on a day-to-day basis with ourselves so that we can advise and adjust the recommendation on how to respond, both in terms of antivirals and how well they are working but also in terms of other treatment modalities and how they are doing. We are also putting in place a surveillance system for incidents to see how it is around the country based largely, but not entirely, on the existing flu surveillance systems. We are developing those and for the first few hundred cases the HPA has developed a systematic approach for identifying them as clearly as we can but really working very closely with the clinicians looking after them so that again we get as much information as possible from those first few hundred cases to advise us on how this virus is working and affecting the population in the UK, so we will be bringing those various bits of

information together, both at the beginning of the pandemic in the UK and also as things progress, so that we can see if resistance is developing or it is not and where that is. We have looked at the pros and cons of a range of different antivirals and we are mindful of the advice that we have had from a range of bodies and committees about the need to get a mixture. At the moment we are in the process of procuring a mixture of antivirals with exactly the intent in mind that you say; that there may be resistance or people may find some easier to take than others, so we are doing our best at the moment to get the right balance of that in place as we develop the stockpile. Also, as I said, we want to ensure that our surveillance and distribution systems are sensitive enough to be able to alter the way that we distribute things and look at the balance of the antivirals going down the chain should that be necessary. In terms of children, yes, we have got advice for clinicians on children. Again, we can give you the details on this, but for older children it is fine for them to use the normal Tamiflu. There is also an oral solution for the much younger ones, for the under-ones, and that is going to be made up by a number of specific hospital pharmacies. They know how to do it and we will have separate distribution arrangements for little ones. We are just finalising the details of that because obviously it is important that GPs or health professionals see those very vulnerable babies. We have got a whole piece of work just finalising that at the moment.

Q23 Lord Patel: Knowing that there is some evidence scientifically already that a generic vaccine to H5N1 might give some protection to key workers, are there any plans to have a generic vaccine developed for H5N1 which might be used for key workers in the hope that some of them get an immune response to that?

Professor Davies: We do already have a stock of H5N1 vaccine which we have bought.

Q24 Lord Patel: How big a stock?

Dr Davies: 3.3 million doses, which is enough for front-line healthcare staff, and that is the plan: it should be offered to them if a pandemic were to break out now. We do not know how effective that would be (it is to a specific strain) but we would certainly be offering it. We are really interested in the new research that has come out and in our thinking about the pros and cons of that, we are looking at the science, we are looking at the potential costs, and we do think it is definitely worth exploring, so we are looking at that energetically at the moment. We have not come to any conclusions yet because we want to make sure that we are testing the evidence as fast as we can and at the same time we are not delaying unnecessarily so there is a balance there, but we are currently collecting the data and will be advising ministers.

Dawn Primarolo: It might be appropriate to deal with the question of protection of care staff and health staff beyond that baseline.

Dr Davies: Vaccine is one way in which staff might be protected but they will also want to be reassured that when they are coming to work they are not going to be unreasonably exposed to catching a virus which could have an impact on them and their families if they took it home and transmitted it to them, so we are committed to purchasing a stockpile of face masks for healthcare and social care workers, and again that procurement is in the process of being taken forward at the moment. The plan there would be that any worker coming within a metre (so in close contact) with a patient with flu would be advised to wear just an ordinary surgical face mask because it is the droplet transmission that we think is the problem. For aerosol-generating procedures then staff would be advised to wear special bigger respirators and those are going to be stockpiled as well.

Q25 Lord Patel: On what basis did you make the assessment that only 50 per cent of the population at the most will get infected?²

² Please see letter.

Dawn Primarolo: I was advised by the science. We took the top range and we looked at the worst case scenarios coming from previous pandemics. It is not an absolute guarantee but through discussions and assessments of the science and working very closely with the WHO, who by the way think that the UK is the most advanced and prepared country, whatever our frustrations about the speed --

Q26 Lord Patel: --- That is because the others are so awful!

Dawn Primarolo: Well yes. The question and the point about scientific evidence is also to ensure that it is considered by a scientific advisory group that guides us in that. Wherever possible, we are trying to follow what the science informs us of the likelihoods, including the possible infection rate, in order to predicate our plans and testing and, frankly, I think that is the best that we can do. We can only stay vigilant, as Lindsey has already said, about any newly developing evidence that we are able to take on board and adjust our plans if necessary.

Chairman: A last one on this specific topic and then we must move on. Lady Finlay?

Q27 Baroness Finlay of Llandaff: Quite specifically going back to the vaccine, given that you are stating that you have a number of doses of potential vaccine already available, are you planning to give that now to front-line staff and replenish that stock so that you begin to build up a degree of herd immunity in the ones who are probably going to have the maximal exposure to sick people (who would probably be those in A&E medical admissions units and some GPs)?

Dawn Primarolo: We are not planning to give it now but the wider question of replenishment is also being dealt with on two levels, which is a contract that has gone through the process of the *Official Journal of the European Union*, and that is covering replenishment on use and replenishment on the dating of the stocks that we hold so that we keep it both up-to-date and

at the levels that we want, and those contracts are nearly at their conclusion. Sorry, I am talking about the wrong thing again so go on.

Professor Davies: We are replacing the antivirals. We have already got 25 per cent of the antivirals and some of that will be going out of date in the next year or two so we are looking at the best ways in which we replenish that sensibly as well as expanding to cover 50 per cent of the population. On the vaccines, the H5N1 that we have got at the moment, we are testing it regularly to see if it is still active or whether there is any chance of it being less effective than it might have been. As long as it stays okay we are keeping it. As I say, we would offer it to staff once we knew that a pandemic was imminent, so that is when that would work. We are again looking at the possibility of offering it to staff sooner. There was this interesting paper recently which showed that having a bit of a boost now might make it even quicker to boost the immunity in a pandemic, so again we are just looking at that. It is early stages because the paper is relatively new and again we have got to explore it properly but we are asking our Scientific Advisory Committee and the JCBI to look at it for us. That is where we are getting our advice.

Q28 Lord Methuen: Looking at currently available resources in the healthcare system, where do you think there will be major gaps in these resources, for instance in pharmaceuticals, medical equipment, infrastructures, isolation facilities, staff?

Dawn Primarolo: The biggest challenge perhaps is the question of supplies and the supply chain. We have the drugs in the system and that is an issue which we are addressing ourselves about securing that supply chain. I am not talking about the distribution centres but actually getting hold of the drugs in the first place and replenishing them at a rate and also the alternatives. The second area of priority would then be the isolation and how we would manage that and then, of course, followed very quickly with staff and the sort of things that we talked about at the beginning - realistic assessments of what we can expect and not expect

in the demand on the Health Service regardless of the pandemic. I suppose that is the way that we are cascading it. Lindsey has touched on that very extensively in terms of the testing of the system and the points that Lord Jenkin rightly made, feeling his frustration that we should be further ahead on this.

Chairman: We have been dealing largely with human ill-health but animal health is relevant, too. I wonder if Baroness Whitaker would like to take up the discussion.

Q29 Baroness Whitaker: Minister, we had some conversation about this in the Intergovernmental Organisations Committee and I am glad to be able to continue it. Of course, pandemic flu comes almost certainly from outside our boundaries. I understand that there has been criticism by the poultry industry that current EU information on animal outbreaks is not very widely or speedily shared. I know that there is an EU Framework DG-SANCO for notification and control but perhaps you and your colleagues could tell us how you respond to the criticism. Is it well-founded and what sort of links are there between DG-SANCO and the European Centre for Disease Control, because when we talked to them they told us that they had no remit to pick up information about animal outbreaks? Perhaps you could give some examples of how it is working well; that would be helpful.

Dawn Primarolo: I am going to ask Defra to deal with this. We have had some discussions on this in another committee but they are going to deal with the detail.

Mr Drummond: Thank you and good morning. I am Richard Drummond, a Deputy Director in the Veterinary Science Team in the Food and Farming Group in Defra. The first thing to say is that there is a well-established mechanism for sharing information about outbreaks of disease not just within the EU but worldwide through the OIE which is the world animal health organisation, and that is well established and the 172 countries of the OIE who are members contribute information, and that information is shared and disseminated very quickly. Within the EU each of the EU Member States has a responsibility for letting both the

OIE and, more importantly, the European Commission know very quickly about suspected outbreaks of disease. Even at the point before we have confirmed the disease through laboratory testing, we will have informed the Commission and they will usually send information round to the other Member States' chief veterinary officers. When we hear about outbreaks of disease, either in another Member State or in a third country, we usually would carry out a veterinary risk assessment which goes into our evaluation of the threat posed by that outbreak and we would construct that quickly and make it available on our public website. Where we believe the risk is assessed as exceeding the normal low background level, we would expect to hold urgent meetings with the key representatives of the poultry industry bodies, and this is something that we have actually done in practice in the past. What we cannot do, mind you, is to act on the basis of informal information that we might receive through industry contacts about a disease that may be breaking out in one of the Member States. We do need to wait for official notification before we can take action to make sure of course that we are not raising anxiety unnecessarily and therefore the impact that that would have on trading links. In cases where we have identified a higher level of risk that would require some urgent action to be taken, we have an established network through what we call our Poultry Database which is essentially a collection of the information of all of those owners of flocks greater than 50 birds. We can communicate with these owners through text messages and again this is something that we have done to keep them informed about our assessment of any increased risk. The final thing to say is that we do work very closely with industry representatives. We have regular meetings between outbreaks and of course during outbreaks and we do look to them and work with them in getting information out to their members as quickly as possible.

Q30 Baroness Whitaker: All that sounds very fine so can you tell me are the poultry industry misinformed? Have they got the wrong end of the stick in their criticism? Also

informal information which you feel does not have enough weight behind it to put it out on the website, do you then check that back with your colleagues in other European Union States and why can the ECDC not link in with all this?

Mr Drummond: I am afraid I cannot comment in detail (because I do not know) on the links between the ECDC and the European Commission but, I have to say, my impression was that those links were there. To what extent they are developed and how much they talk on a day-to-day basis I do not know. What I can say is that there is an extremely well-developed informal network of information sharing within the EU Member States. That comes about through the network of laboratories that are responsible for the diagnosis of the disease - in the UK we have the Community Reference Laboratory for avian influenza - and by the exchange of information between the scientists in these laboratories we get some very good information very quickly about what is happening in the other Member States, so there is both the formal and the informal and we are using both to good effect.

Dawn Primarolo: This point came up before about the connections between the reporting mechanisms particularly at a European and international level and surveillance for animals and humans. I remember it well when you asked me and I sat here explaining how it was all working fine, but afterwards we reflected and we pursued this. Obviously Defra is not in a position to answer today but I think it might be helpful if we did a note saying that yes we have noted and have attempted to raise this and take it forward and to reassure ourselves that the links in theory are working in practice.

Baroness Whitaker: I am sure that would be very helpful, thank you.

Q31 Lord Krebs: I just wanted to follow that up. In your written response you refer to a survey of wild birds to look for the possibility of the virus in wild birds. I wonder if you could give us a feeling for how many birds have been sampled and how big the survey is? In the cases where there have been identified wild birds affected, such as the swans at

Abbotsbury, how many birds were sampled in those particular cases? What is the total sample and the sample in the case of particular identified infections?

Mr Drummond: I am afraid I do not have the exact figures with me on that. What I can say is that over the last two or three years we will have sampled several thousand wild birds. In 2005 when we expanded the level of surveillance in the Wild Bird Survey, we introduced some new elements which were around sampling of wild birds using one of our ornithological organisations, so they were catching birds live and then releasing them. We enhanced the reporting mechanism for people who found dead birds under suspicious circumstances or circumstances believed to be suspicious so they could be collected and sampled. We even expanded it so that birds that were shot as part of the normal wildfowling activities could be submitted for examination as well. That element has now stopped but the others continue. As a result of that sampling we revealed surprisingly little in the way of avian influenza infection in general and even less so in relation to H5N1 highly pathogenic AI. We are continuing with that surveillance because we believe that it is at least an element that may - and I stress the may - give us a chance of early detection of infection but, equally, we are conscious that avian influenza viruses do circulate freely in wild bird populations, and without investing huge sums of public money it is very difficult to have a statistically valid sampling. We can only do it as a risk mitigation measure.

Chairman: I think we will change direction a little again and I will ask Lord Warner to take the discussion.

Q32 Lord Warner: Can I say to the Minister having been interrogated on the floor of the House of Lords by many of the people at this end of the table on this subject I have a good deal of sympathy for the situation she finds herself in!

Dawn Primarolo: Is this going to be a “but”?

Chairman: And I would tell you that he does not coach us on how to do it.

Q33 Lord Warner: I did find it reassuring earlier on that you have incorporated in the Annual Operating Framework for the NHS pandemic flu preparation as a priority area, not that I believe that the NHS always does everything that is in the operational framework but it is a good start. However, it was pretty clear in the Winter Willow exercise that there was a need to improve linkages between what you might call established regional and local resilience fora and NHS structures and bodies. To what extent do you think that local services and emergency services are now ready for a pandemic flu outbreak and how are you actually monitoring that to keep on top of that particular issue?

Dawn Primarolo: I absolutely agree with you, Lord Warner, about the need - and I will put it delicately because I am still a Health Minister - to ensure that plans developed are actually held to, hence the return in the next operating framework to assess them. You are quite right, the key role of PCTs in local resilience fora is very important in taking forward the preparedness but, in particular, in following the Civil Contingency Secretariat issued guidance in 2008. I thought it would be appropriate to ask the Cabinet Office, and that means Dr Kirby, to take you through the points with regard to ensuring that there is - and I was going to say a seamless whole, but anyway - this collaboration and partnership and it is developing in the way we would expect across all of the emergency services and local authorities.

Dr Kirby: I am Dr Becky Kirby and I head up the Human Health Desk in the Civil Contingency Secretariat at the Cabinet Office. Part of the programme that we have been taking through since the lessons identified from Exercise Winter Willow came out is looking specifically at local and regional planning on pandemic flu and making sure not only that they have plans in place but also that they are fit for purpose. The 2008 National Capabilities Survey, which was published in January this year, showed that 86 per cent of local resilience fora had multi-agency plans in place and that 70 per cent of them had been exercised through multi-agency exercises. Those figures look good but it was not 100 per cent. Also, although

we knew that they had planned, how could we be sure that they were fit for purpose and implementable when a pandemic hit, so we took forward a work programme whereby my team validated and provided feedback on every local resilience forum multi-agency plan. Following that we held a large conference to enable them to share best practice and we published supplementary guidance in order to help them fill the gaps that we thought were within their plans, specifically around data collection, the management of excess deaths for example. We are now working through a process with regional resilience directors to validate those plans and to exercise them, so by the end of this year, by the end of December, all local resilience fora plans will have been validated and they will all be published on the UK Resilience website. By the end of the financial year a series of exercises will have been completed at the local level in order to make sure that we have confidence that those plans are operational. In terms of the link with the health system, I can tell you that primary care trusts, the HPA, hospitals, et cetera are all represented on local resilience fora multi-agency planning committees so I am confident now those links are in place and that all LRFs have those linkages in the right places. You mentioned essential services and although in the Cabinet we co-ordinate the cross-government response and take forward planning for the non-health elements of pandemic flu, it is really down to lead government departments to drive forward planning within their sectors, so for example we rely on the Department for Transport to drive forward planning in the transport sector and BERR and DECC in the energy sector. However, I can tell you that with the electricity, gas and nuclear industries for example, we are confident that they have plans in place. We sit on a number of pandemic-specific sub-committees on which those groups are represented and ourselves and the lead departments for those industries feed into them on a regular basis to make sure not only that they have plans but also that they are exercised, which we see as fundamentally important. The same is true with the Department for Transport looking at those essential services.

Dawn Primarolo: I think you will probably recollect this: it comes into government level through the Ministerial Committee which is interdepartmental and which the Secretary of State chairs, where again there is pressure to bring all of this together both across devolved administrations and departments. I sit on that as Health because the Secretary of State is taking that forward. One of the questions we ensure that the NHS answers and part of their assessment locally is the detail of how they are working on delivery, so we are putting the pressure as best we can on the other side, on the NHS, to continue to show us where the connections are and that these inter-agency and local authority plans are working.

Q34 Lord Warner: Could any of you elaborate a little bit more on where the weak spots are because we know from previous exercises like the SARS experience in Hong Kong that some linkages are more critical than others and the police and healthcare system links in the SARS epidemic were very important? How reassured are you, and can you give us some examples, that the key linkages between health and some of these other agencies are really, really robust, or which are the ones where you would have some anxieties in a significant number of places?

Dr Kirby: I certainly think that we are in a much better position now than we were at the start of the year and once we have completed our exercise programme we then have a feedback mechanism back up to the centre to make sure that if any continued weaknesses are identified that they are addressed. Before we started this programme, as I mentioned already, the management on the non-health side, for example the management of excess deaths, was an issue. We have published some new guidance on that including an indication of the types of legislation that we would look to amend or relax in order to facilitate planning in that area. As Lindsey and the Minister have said, those linkages across health and non-health now are in place driven from the top down but also from the bottom up in local resilience fora as well.

Professor Davies: I think I would agree with that. None of us could guarantee that in every location across the UK everybody is working together perfectly, but the information that we have had through all our various networks is just incredibly encouraging. We go out and about a lot. I think all of us are on conference and workshop platforms most weeks talking to people in different regions and different parts of the UK about what they are really doing and the conversations over lunch there I think are most pertinent where people say, “How is it really for you?” I really have noticed a sea change certainly in the couple of years that I have been doing this. I was working to a region before and I knew what it was like to be there and linking. I now know that the feedback that I am getting and even the body language from the people round the table is much more positive. They know each other, they know who is who and they know what is supposed to be happening.

Chairman: I think this leads very easily to Lord Crickhowell who has some further questions in this general area.

Q35 Lord Crickhowell: Can we just have a look at the devolved administrations. Again in the Winter Willow report you say fairly that there are some policy areas where there might be differences of approach in dealing with local need. On the other hand, as we heard in the opening evidence session, there clearly are some very important planning and testing of planning processes going on at a national level, and it seems to be absolutely vital to me with the fact that we have got devolved administrations that we do not open up a gap between the two. No-one will actually be very sympathetic, even those enthusiastic for devolution, to the whole process if it is found that things are less good in Wales or Scotland than they are in England or vice versa. As some problems were identified in Winter Willow, particularly making sure that there was a real understanding of where responsibilities are, can you elaborate on how far we have got in sorting that one out?

Dawn Primarolo: You are quite right that it is a national plan and they are taking forward within the devolved administrations their work in delivering to the same level, but they are also integrated in terms of communication between ministers in making sure that we are agreed that this is a sensible way forward. In terms of them being represented, it is at every level in the policy development or discussions, from the MISC 32 Committee, the Ministerial Committee, through to using the expertise that they have to develop for the whole of the plan some particular advice. For instance, I think it was Scotland which did some of the development work around the surge capacity at each point to make sure they are fully involved in development of policy exercises, guidance, frequent discussions and communication between ministers about directions of policy development, response to new research, and in their own cases taking forward the delivery for their administrations. However, it is clearly set within a UK-wide response and everybody is at the same place doing the same thing to the same standards and we are following the same guidelines, so I hope that the national framework and the practice has now - and that is certainly the advice to me - delivered that very clear and close working at all levels.

Q36 Lord Crickhowell: And just to follow up, I live quite close to the English border in the south but if you take particularly North East Wales and Cheshire and so on, when I had responsibility for health in Wales we always had pretty close co-operation between hospital services on both sides and we were using facilities in the English hospitals when we had not got them in the Welsh hospitals and so on. Are you satisfied that in the event of this kind of emergency there could be effective cross-border co-operation and that we will not get into a wholly absurd separation “that is nothing to do with us because it is a different country or different administration”?

Dawn Primarolo: No absolutely, what you are describing in terms of the UK response with UK resources, and making sure that across the devolved administrations as well that we are

seeing the response to a pandemic and that there is not a demarcation line saying “that is England” or “that is Wales”. Those partnerships, as you are rightly describing, have gone on for some time in terms of planning capacity anyway with regard to the Health Service and still do. I think we are satisfied on that. We would pay attention to that and certainly in the discussions (mainly done in writing because there is agreement) with the ministers in the devolved administrations, we are all on the same page on this and are all progressing in the same way.

Q37 Lord Crickhowell: Can I go down to PCTs. You talked about the availability of resources and so on in answer to the previous question. What about consistency of response between local PCTs? Some are very good; some are rather less good. In Wales I happen to have a simply marvellous local service and I am full of the highest praise for it but there are others I know that are rather less good. Are you satisfying yourselves that at that level there is a consistency of approach and standards?

Dawn Primarolo: Yes we are. Perhaps I should ask Lindsey to detail how we are progressing through what might be considered as a delicate area in terms of the standards being provided across all PCTs and making sure that happens.

Q38 Lord Crickhowell: How?

Professor Davies: In a number of different ways. Firstly, by issuing not just the UK National Framework but a whole suite of different sets of guidance. One of those sets is for PCTs and we are in fact refreshing that and going to be publishing a revised PCT guidance imminently, so that is one thing. That is there to guide them. How do they interpret that in practice and can we ensure consistency there? Firstly, regarding the expectations around the NHS plans there is a whole set of self-assessment questions for PCTs that set out quite clearly what is expected of them and how they might do it, so their response to that is important, but at the

local level we are encouraging PCTs to work closely with their own community within their boundaries - it depends on the size of the PCT a bit - but also with local PCTs to share plans. On some occasions a local resilience forum will have several PCTs as part of it so that forces the engagement. We have asked each strategic health authority as the head of the NHS in their area to nominate a pandemic influenza lead and also each PCT to nominate a pandemic influenza lead. The SHA flu leads meet with me monthly to talk about plans and expectations and what they are doing and to share what they are doing, and that is obviously an important forum for consistency across the country at that level. They have similar meetings with their PCT leads and are going out regularly with them engaging with them to talk one-to-one, to talk at conferences, workshops, whatever, so that is another route. Finally, I send every month out to the NHS through the flu leads a publication called *Flu News* which keeps people up to date with expectations and points them to guidance that is happening but also identifies any new links, any new things of which they should be aware. We have a whole web-based information forum service for them that people can just ask to have their names put on and they get access to all the guidance and everything they need to know, and they can also talk to each other through that and share experience, so we hope the range works.

Chairman: Thank you very much. Dr Kirby mentioned in her last question an issue that I think we want to go back to and I do not want to lose, which is legislation, and Lord Selborne will take the discussion.

Q39 Earl of Selborne: The Civil Contingency Act 2004 allows in the case of an emergency for the appointment of regionally nominated co-ordinators. Would you expect in the event of a pandemic event this part of the Act to be activated? Would there be other provisions of the Civil Contingency Act that might be activated or would you simply rely on the established linkages between the regional and local resilience structures?

Dr Kirby: As mentioned already, one of the lessons coming out of Exercise Winter Willow was to identify now a whole host of legislation that we might need to amend or relax during a pandemic, and obviously Part II of the Civil Contingencies Act forms part of those considerations. However, emergency powers under the Civil Contingencies Act should be viewed as a last resort. When the Bill went through Parliament it was agreed that there was a triple-lock mechanism and that three particular pieces of criteria needed to be met before it could be considered to be used. One of those was that an emergency was imminent. Although we do not know when a pandemic could happen, I do not think I could say it was imminent, so what we are doing now is identifying other legislative vehicles, for example amendments to primary and secondary legislation, that we can draft and have on the stocks now ready to go through Parliament or if there is a particular bill that is going through Parliament that is there is scope so that these preparations are made in advance of a pandemic and therefore would negate the need to use emergency powers once a pandemic emerged. However, that said, it is there and emergency powers should be used if they are needed in order to facilitate the response to a pandemic, but only if the criteria upon which it was agreed are fully met and if we have exhausted all other possibilities.

Q40 Earl of Selborne: Could you give us some hint as to what these different legislative opportunities are other than the Civil Contingency Act? You referred in your written evidence to a raft of possible legislation which may need changing; what is this?

Dr Kirby: I can give you a few examples and I can provide more examples in writing afterwards. I can give you examples about the ones that we have already made public. However, we are keen that planners plan on the basis that we are not going to use emergency powers because otherwise their plans might just assume that we will and therefore will not be particularly robust. If I take excess deaths for example and just give you some examples about the legislation that we are looking at in order to facilitate the response there, we are

looking at ways of increasing capacity for coroners by making specific changes to the Coroners Act 1988 and the Coroners Rules of 1984 which increase the flexibility for example of who can hear coroner cases, where post mortems can be carried out, arrangements for investigating deaths from abroad, who can sign death certifications, extending the amount of time to register stillbirths, in order to improve or increase the capacity of coroners. Those changes can be made by making amendments to bills that have already been passed rather than by having to use emergency powers and there are others that we have identified where we would make changes to existing legislation rather than put something through using emergency powers.

Q41 Earl of Selborne: If we could go back to the regionally nominated co-ordinators which, as you say, might be the last stop, what powers would such co-ordinators have? For example, we have heard earlier that curfews are not seen to be a sensible way forward. Supposing the regional co-ordinator thought that that might be an appropriate way forward in that particular region, would there be powers to enforce that curfew?

Dr Kirby: I would prefer to come back to you on that in writing if you do not mind. What we have established is linkages and information flows so that any issues arising at a regional or a local level are fed back through the system so that centrally we can look across the piece to know if the South West are having a particular problem and are thinking about the need to implement curfews so that we can have a UK-wide joined-up approach rather than one region acting in a different way to others, so by ensuring that those information flows are in place I hope that we would negate the need for one region to act in isolation in such a way.

Earl of Selborne: Thank you.

Q42 Lord Haskel: The Minister spoke about business as usual in the event of a pandemic and this means, of course, keeping the essential services going. It means keeping transport,

food distribution, electricity, the Internet and telephone services going. In your paper you say that the Government is working closely with the private sector to strengthen business continuity planning. Dr Kirby said that the departments have got plans in place and that you have been working with the various sectors of industry. Can you tell us where you expect the greatest challenges to take place? Where do you think the failures are going to be? Where do you think the problems are going to lie outside the Health Service but in the central services that will need to keep going?

Dr Kirby: As you already mentioned, we have been working hard with all of the essential services and especially with category one responders because they have a duty under Part I of the Civil Contingencies Act to make sure that they have business continuity plans in place so that not only can they respond to the emergency but also do what else they should be doing as well. In terms of liaising with business we have the Business Advisory Group on Civil Protection and a standing agenda item for that meeting is pandemic flu preparedness. Representation includes the CBI, the Federation for Small Businesses and also some of the other large industry groups, and through that mechanism and by individual meetings with businesses we are helping them to drive forward their business continuity planning. In fact, some essential services and some businesses have agreed that we can publish their business continuity plans on the UK Resilience website so that we can share that best practice across the piece. You asked where we think the biggest challenges will be outside of the health sector. It has already been mentioned at this meeting that staff absenteeism is going to be one of the biggest challenges because it will impact across the piece. I could not tell you which particular industry would be most impacted by that but I can tell you that they all have business continuity plans in place to deal with the highest staff absenteeism rates which involve looking at their priorities, looking at staff training, making sure that they have identified the particular functions that they could curtail during a pandemic because they are

non-essential, identifying those that are essential and making sure that more staff are trained to do those roles to build in that contingency. The National Capability Survey, which the Civil Contingencies Secretariat runs every two years, does indicate a significant increase in the number of not only category one responders but other essential services and businesses that have business continuity plans which are specific for pandemic flu.

Q43 Lord Haskel: Following on from the previous question then, if an essential service or a business falls down on the job and fails to continue providing the essential service, is the Government prepared to legislate to mitigate the damage or disruption? How would you deal with that?

Dr Kirby: Firstly, I hope that through the information and data collection networks that we have established now that we would find out that there was a problem before anything fell over. I think that is really key, so the mechanisms feeding into the COBR mechanism during a pandemic, that a particular essential service or group of businesses is struggling would be our first mitigation strategy, identifying that early on and then putting something in place, and if that requires legislative changes then we would have to be prepared to be able to do that.

Chairman: That is very helpful. We are running very close against time but there is one further question that I would like to take a few minutes on and, if that is acceptable, would Lord Colwyn take up the discussion.

Q44 Lord Colwyn: This is a question about finances. We are aware and we have seen in your written evidence details of the contributions you have made via the European Commission and of the UK pledge of £35 million towards the international effort to tackle avian influenza and for the preparation for a future pandemic. We are also aware of the ways in which some of this money has already been spent. What is the overall estimated cost of the Government's contingency planning and has this been subject to a cost/benefit analysis?

Dawn Primarolo: The Government has already committed £350 million. That includes the purchasing of medicine and securing supplies. You have mentioned in addition the monies that we are committed to internationally, and that is a dimension that we have not been able to touch on very much today in terms of surveillance and capacity in other countries, particularly in the most vulnerable ones. In addition, DFID - and perhaps I could ask John here - in terms of working with countries in reprioritising projects and looking at the work that could be done there, the Government's approach is that we need to contain those costs in normal spending arrangements within government. Again, we mentioned the concluding of contracts soon both on the Flu Line and on future purchase for ourselves of increased stocks, but I wonder whether on the international issue, John, you can touch on some of the issues and the costs and continuing costs.

Mr Worley: My name is John Worley and I am the acting Head of Profession for Health in DFID. DFID focuses its health spending essentially in supporting poor countries strengthen their health systems. That does not overlap necessarily with those countries where pandemic flu is the greatest risk, so we also provide significant amounts of multi-lateral support to the UN system and particularly the work of the WHO and the FAO and support for the UN Systems Influenza Co-ordinator, Dr Nabarro. Through our country programmes increasingly we are supporting as part of our health system strengthening approach the strengthening of capacity and systems for disease surveillance in a number of countries that have asked for that, including China, Kenya and Uganda, as well as countries that more recently have suffered disease as a result of earthquakes and other natural disasters such as Pakistan where avian flu is now one of the sentinel markers in the disease early warning system that we are supporting there. As the Minister said, we intend to continue to support the international response through our usual programme and budgeting mechanisms as well as to consider, when they are presented to us, the options for supporting a global vaccine stockpile. That will

probably be discussed at the forthcoming December inter-governmental meeting that the WHO will hold.

Q45 Lord Colwyn: The Minister mentioned £350 million I think and I am not quite sure how that is allocated.

Dawn Primarolo: That is for the purchase to which we are already committed in terms of spending for the antiviral medicines and supply of vaccines. Over and above that there are costs not included in that which we are concluding now with the business cases for procurement on the additional counter-measures, so that is spending here in the UK and then these are the monies that we are devoting through international co-operation particularly if there is surveillance and resilience in other countries as we respond to the requirements for the WHO. I can tell you that it is £350 million now but when those contracts are concluded, which is imminent, I will be able to tell you the next level of committed expenditure I cannot tell you that at this point in time beyond the £350 million.

Q46 Chairman: We have covered a lot of ground. There is much more that my colleagues want to cover. I am being inundated with bits of paper and questions that they would like to ask. We will certainly be continuing our discussion of this. It would be very helpful to have fairly soon the various written follow-ups that you have indicated we could have. I know people are busy but it would be appreciated. What we would like to do is withdraw into our Committee, talk further about what we have heard and about what people send to us and possibly send some more questions, and then it may be that further discussion would be useful and helpful. I appreciate that we have given you a lively time and I thank you very much for giving up your time, all five of you.

Dawn Primarolo: Thank you very much. We did not touch on GPs' guidance either. We will certainly do our best to get the information that we have already promised to you as

quickly as possible. I am absolutely happy to facilitate responses in writing and should your Lordships wish to return to this in an evidence session such as today's I am more than happy on this biggest challenge to public health, frankly, that we face, and I am sure that you will give us a great deal of help and guidance on this. Thank you very much for your time.

Chairman: Thank you very much indeed.