Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session on Swine Flu

13 January 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Mr Pól Callaghan
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Mr John Compton	)	Health and Social Care Board
Dr Carolyn Harper	)	Public Health Agency

The Chairperson (Mr Wells):

We know both witnesses. John Compton has been before us many times. He is the chief executive of the Health and Social Care Board. Unless I am mistaken, Dr Carolyn Harper, are you the chief executive, as described in the media?

Dr Carolyn Harper (Public Health Agency):

No; I am the director of public health in the Public Health Agency (PHA).

The Chairperson:

I did not think that that was correct. I am sure that someone in your office would have questioned that designation.

You are very welcome. You will have a fair idea of the issues that may emerge at this morning's meeting. We have received copies of your briefing, which I presume was the basis of your press conference, or media release, at 10.15 am today. I will just make sure that all members are aware of that document and have seen it, as it is particularly relevant to the situation this morning.

I invite Dr Harper and Mr Compton to give an opening statement on the issue, and I will then throw the session open to questions.

Dr Harper:

I will take members through the more detailed briefing pack of which they have copies. I hope that it will help with their understanding. I will take members through the systems for monitoring swine flu this year and the current pattern of flu in Northern Ireland. I will also provide up-to-date figures and a breakdown of swine flu deaths and then touch on the vaccination programme.

The first slide mentions "Systems for monitoring swine flu". During last year's pandemic, special arrangements were put in place to give detailed data on deaths at regular media briefings. The flu season this year is more of a normal flu season, and, therefore normal reporting arrangements were reinstated. That meant that we published weekly bulletins, issued a press release and usually gave media interviews. However, in light of the increased public and media interest last week, particularly in the number of swine flu deaths, we are now also publishing the number of swine flu deaths. Those are now part of our flu bulletin, and we gave our first full media briefing on that this morning.

Moving on to the current pattern of flu in Northern Ireland, I will take members through a number of the slides in the presentation to try to explain the current trends. The slide entitled "Number of New Flu Cases" has a graph representing the number of new laboratory-confirmed

swine flu cases in Northern Ireland. Members can see that the number started to increase around the middle of November and increased quite sharply through December, but that the rate of increase in new confirmed cases has slowed over the past couple of weeks. There has been an increase of just 2% over the past couple of weeks; between the week before and last week. I do not want to over-interpret that, but it may be that there are some encouraging signs that we might be coming towards the peak of this year's flu season. We will continue to monitor that trend.

I will try to give a sense of how much flu is in the system. GP consultation rates for flu and flu-like illness are a good indicator of that. GPs are continuing to see a significant number of patients in person and dealing with telephone inquiries. Last week, we reported that our rates were similar to the flu levels in 2008. This week, the data shows that the flu levels are similar to those of last year. The pattern of high level of flu activity is similar to that in regions across England and Wales. The graph from the Health Protection Agency (HPA) shows a similar pattern. The line that represents Northern Ireland is similar to those representing regions in England and Wales in that it shows a sharp increase in flu-like activity and illness.

A slightly different pattern on the graph shows GP consultation rates for flu outside normal hours. GP consultation rates for flu-like illness outside normal hours have decreased slightly during the Christmas and new year period, which was a slightly unusual holiday period. We do not want to over-interpret that, but it may also be an indication that any increase in levels of flu is at least slowing.

I have also provided a graph showing how different age groups are being affected. There has been much media discussion about the impact of swine flu on children. The main message from the graph is that, compared with last year, there has been a modest increase in flu consultation rates and, therefore, in the level of flu in 15- to 64-year-olds. That has increased from typically between 200 and 270 last year to between 300 and 370 this year. There has been an increase in that age group, but nothing too unusual.

More dramatically though, compared with last year, there was a significant decrease in flu and flu-like illness among children. Last year, flu consultation rates for children were between 400 and 600. This year, the rate is typically around 150. That is a dramatic difference from the flu experience of last year. Children in Northern Ireland are less affected by flu this year compared with last year.

Why might that be, and who is already immune? The studies that we carried out after last year's flu outbreak assessed the degree to which different age groups were immune or had some level of immunity. The level of H1N1 or swine flu antibodies is a good indicator of levels of immunity. In the five- to14-year-old age group, 60% to 70% have some level of immunity. That decreases with increasing age. The children either have more natural immunity now than they had previously or have more immunity through the vaccination. That may be why we see fewer cases less in children this year compared with last year, whereas, among the 15- to 44-year old age group, a significant number of people still do not have immunity, and, therefore, the virus can continue to affect those age groups.

Last year, we vaccinated nought-to-five-year-olds specifically on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) and in line with the Department of Health, Social Services and Public Safety's (DHSSPS) vaccination policy. Members will recall that we also had a special programme of vaccination for children in special schools, again, at the request of the Department.

I have also provided a graph, which is included in our flu bulletin every week, showing registered deaths from selected respiratory infections. It shows the impact of flu on the population as a whole. As you can see, in the first week of this year, there was a sharp increase in the number of registered deaths, which is similar to the pattern last year. That simply reflects the high levels of flu in the community. For a small number of patients, that works its way through to serious complications and, for some, to death. That is now being reflected in the death rates.

I have provided updated figures on swine flu deaths here, which show, exactly, the positions last year and this year. This year, so far, we have been notified of 17 confirmed swine flu deaths. The breakdown of those is that 14 had an underlying condition, two did not, and we are still collecting the clinical information on one.

Last year, 18 of the individuals had an underlying condition and one has yet to be confirmed, and we will be able to confirm that in next week's bulletin. There were 19 cases in total last year. Overall, when you look at the experience of the past two years, the figures show that, by far, the people at much increased risk from complications of flu are those with underlying conditions. It is important to recognise that those who are otherwise healthy can be affected, but the overall risk

to them is much lower.

I will compare the current pattern in Northern Ireland with that in the UK. Let us focus on the percentages. Among people in Northern Ireland who do not have underlying conditions and are otherwise healthy, there were no deaths last year, and this year we have had two. Nonetheless, that is still a significantly lower percentage than in the United Kingdom, where 23% of those who died did not have an underlying condition last year, and that figure rose to 33% this year.

I caution, however, that we should not over-interpret any of this information. Overall, the numbers are small, and, therefore, I draw no conclusions except to say that, based on that measure, .the current pattern of swine flu here is no different from that in the UK. The figures show that, last year and this year, otherwise healthy people are being admitted to hospital with flu. Unfortunately, flu can be a complication for some patients. For the vast majority, flu remains a mild illness; for some, serious complications arise.

In summary, as of today, the position is that there are high levels of flu and flu-like illness in Northern Ireland. Compared with last year, fewer children are affected. This year, flu is affecting mainly15- to 64-year-olds, and people with underlying conditions remain at much higher risk. Those without underlying conditions can still be affected. The rate of increase in new cases has slowed. The current pattern in Northern Ireland is similar to that in the UK.

Mr John Compton (Health and Social Care Board):
I will comment on how the service has been coping, which is the main issue from my perspective.

Winter is always a busy time, and we have winter pressures. This winter, from 6 December, with the snow, the freeze, the water problems and now the flu, we have been working with normal escalation procedures. Although we are busy, I am confident that the service is coping well. We gave information that, as of yesterday, 30 of the 83 critical-care patients across the Province were being treated for swine flu, and, in paediatric critical care, of eight patients being treated for flu, three had swine flu.

When we consider the total pressure on hospitals at this point, a little below 3% of all hospital beds are occupied by individuals who have either flu or flu-like illness. That is not particularly abnormal for the middle of winter. We expect large numbers of people with all sorts of

respiratory conditions to appear in our hospitals.

As part of the normal escalation arrangements, and looking at where we were to ensure that we were able to preserve and maintain our critical care capacity, last week we took the decision to suspend some elective care to ensure that we did not overburden our critical-care capacity. The majority of critical-care beds are occupied by patients who do not suffer flu-related illness. We must always maintain the capacity for a major road accident or whatever might require the use of critical-care beds.

Typically, at this time of the year in our normal escalation, we would carry out 1,100 elective procedures, whereby patients plan to come into hospital. Last week, as a consequence of our decision, 160 of those procedures were deferred. It is commonplace, over the winter period, for some deferral to take place, but this is a consequence of the particular decision that we took last week. Naturally, for an individual whose planned surgery is deferred, that is disappointing. We regret that, and we do not attempt to minimise the potential impact on those individuals. The decisions about deferral have been clinically led. I responded to the request from clinicians to take the decision. It is clear that all the decisions that result in patients being asked to wait a little longer are taken on the basis of clinical need at that point in time. There has been no wholesale stopping of elective work or elective surgery, and there have been proper, responsible planned and escalated measures to ensure that the system continues to work effectively. We said this week that we will maintain that level for another week. However, because there are some signs that it is not quite as busy as it has been, we will allow the trusts to continue with their elective work if they are able to do so. Without overstating or over-promising where we are, we hope that that is a sign that we are getting back to a more normal pattern of behaviour for this time of year.

Throughout the period, we have been working closely with the general practitioners and have had extensive contact with them. As Dr Harper said, they reported being very busy but able to cope with the pressures. Accident and emergency departments have been extremely busy. Despite that, they have been managing, and all accident and emergency departments are open. It may be a matter of interest to the Committee that, in the week beginning 5 January 2011, accident and emergency departments saw 13,600 patients, of whom 2,761 were admitted to hospitals across the Province. If we consider yesterday at 9.00 am as a standard day for waiting times, 37 people waited in excess of 12 hours to finalise their position. However, in the context of the number of people that we have seen, that is a relatively small issue. However, it is not a small

issue for those individuals; I understand that. The arrangements have pretty much worked. The escalation has worked, and, if we have to go to another level of escalation, we will do so. We have the capacity to increase our critical care beds to reflect any pressure that comes our way. In that event, we would make that a matter of public record. We do not have those plans at this juncture.

My final comment is that, from 6 December, during the freeze, the snow, the thaw and under the winter pressures, staff throughout the Health Service have worked tremendously hard and done a tremendous job to ensure that the population in Northern Ireland has a capable and competent health and social care system to use when it is in need.

The Chairperson:

We welcome the level of detail and the information that we now have before us. Indeed, that is similar to the situation last year, when we received a comprehensive weekly update.

On Thursday 6 January, you released a bulletin that gave a broad indication of the number of referrals and the number of people who reported to GPs. There was no mention that anyone had died from swine flu. On Friday 7 January, Dr Harper gave a 40-minute radio interview on the BBC; I am sure you remember it. I have listened to it several times on the iPlayer; it was an absolute classic in avoiding the question. For 40 minutes, you avoided the issue of whether there had been any deaths, and the clear implication is that the information was not available. Two hours later, the information was made available, and you reported 13 deaths in the Province from swine flu. I find it absolutely impossible to believe that that information was gathered within two hours. That indicates to me that the information was there but that, for some reason, you decided not to make it public. Why did you take that decision? Furthermore, when public demand became so overwhelming, why did you decide to release it?

Dr Harper:

There are arguments for and against publication of information on swine flu deaths. The debate as to whether or not to publish information on swine flu deaths specifically has taken place in all four UK countries. It is one of those situations in which you are almost damned if you do publish those statistics, and last year there was some criticism that, perhaps, public authorities over-egged the situation, overstated the position and, essentially, created too much media interest in swine flu. This year, when we reverted to normal practices, the concern was that that might have

created an impression that we were hiding figures. A similar debate occurred in England during the same week, and, in light of the level of public interest and media interest and to allay any inadvertent creation of public concern, the balance of the argument tipped in favour of publication, and, in discussion with departmental colleagues, we agreed to publish the figures.

The Chairperson:

At each stage, did you consider that one third of the deaths in the United Kingdom were in Northern Ireland? Was that one of the reasons why it was not felt appropriate to release the figures?

Dr Harper:

Absolutely not: I can categorically say that. Last year, each country had standardised systems for collecting data on swine flu deaths. This year, those standardised systems were not in place. One of our arguments for not publishing the figures was that one was not comparing apples with apples; one was comparing apples with oranges.

Discussions with colleagues in England revealed that they recognised a timing issue in the number of deaths and the speed at which they are notified to the authorities in England. It takes a little bit longer than it does here. We are a smaller region and so communication channels are shorter. The Health Protection Agency will publish updated data for the UK in the next day or so as it is moving towards weekly publication, and I think we will be able to make a fairer assessment at that time. We have taken further advice from the Health Protection Agency and other colleagues in the UK to double-check our experience here against their experience and advice. The patterns we are seeing in flu consultation rates and other indicators all suggest that the current pattern of flu here is not different to that in England.

The Chairperson:

I will move to the issue of the four individuals who tragically passed away. It is important to remember in all of these discussions that we are dealing with traumatised families who have had a dreadful loss. Of the four folk who passed away in Northern Ireland, you said on Friday that you did not know whether they had any underlying health conditions or were in the vulnerable groups. I find it absolutely unbelievable that someone was being treated for swine flu in intensive care and no one had, or made any attempt to find, the medical records of that individual to identify whether they had an underlying health problem.

Are you ever in the position of treating someone without knowing their medical record? The person could be allergic to penicillin or something like that. How can we be in a situation where the Public Health Agency said on Friday that it did not know the status of those four individuals?

Dr Harper:

The main sources of information about the number of laboratory-confirmed swine flu deaths are the virology returns to the virus laboratory in Northern Ireland. Those come to us with a case number; they do not include patient information, in order to protect the privacy of patients. We get the raw numbers and we have to go through a process of identifying and collecting further information on individual cases. That process takes a few days, and we update the information as you can see from the current picture.

There is only one outstanding case at the moment. It is inevitable that there will be certain points in time in which we are still gathering information. It is more important for us to have the absolutely correct information rather than publish information that has not been validated. Non-validated information would be completely unhelpful, which is why we await the final position. When we have firm information, we publish it, and we will do that on a weekly basis.

The Chairperson:

One of those individuals had died two weeks earlier, yet, on 7 January, you still did not know whether there were underlying health problems.

Dr Harper:

At that time, we were working under normal flu season surveillance arrangements. Clinical staff were therefore not required to report swine flu deaths to us under normal arrangements. Our thinking has been shaped hugely by what happened last year. In previous years, before the pandemic, flu deaths from particular strains of flu were never notified to the authorities; that was not part of the normal surveillance arrangements. Consequently, when those arrangements were put back in place last year, there was no requirement for clinical staff to inform us specifically about swine flu. Some did, and obviously we were notified through the virology lab reports. That is the distinction between the special arrangements last year and this year.

The Chairperson:

Finally from me, what is happening in the Irish Republic? You are in very close liaison with colleagues in the rest of the UK, and that is very useful, but there must be some read through with the situation south of the border to see whether they are experiencing a similar trend as us, or perhaps something is leading to higher incidences here as a result of contact with people in the South.

Dr Harper:

Certainly, we are in close liaison with colleagues in the Republic, and we will continue to review information with them as it is updated. However, looking at all indicators in the round, there is no sense that the current experience here is particularly different to that in the South, and certainly not to that in the UK, where we have had more detailed analysis. Each region — certainly those in the UK — is putting back in place their enhanced surveillance arrangements, so they will be updating data, which will give a more complete picture and a more valid comparison between here and other parts of the UK.

Mrs O'Neill:

Thank you for your update. Understandably, people are genuinely concerned, especially given your report on the situation today, which suggests that there have been 17 deaths this year, compared to 19 last year, so we are getting up to last year's levels, which is very concerning. As much information as possible needs to be given out. Two issues have been raised with me; the change in policy this year on the vaccination of the under fives, and whether we have enough vaccinations. I have been told that we do not have enough, so I would like you to tell us a bit more about that, because people are genuinely concerned that we are out of it. Is that why we are not getting vaccinated? Is that why the under fives are not being vaccinated? We need to get to the bottom of that and make the message clearer for people, so that they understand fully that that is probably not the case. How many vaccinations do we have, and do we have enough to vaccinate all the at-risk groups? What is the current situation?

Dr Harper:

There is no shortage of vaccine to protect people against swine flu. In fact, 414,000 doses of seasonal flu vaccine have already been distributed to GPs and trusts, and they have been vaccinating pregnant women and people in at-risk groups. Those who still have the flu vaccine will use their remaining stock, which, as the Department announced this week, is now being

supplemented by the swine flu vaccine, of which there is as much again. Around 400,000 further doses of swine flu vaccine are available, so there is no shortage of stock at all. The question, then, of whether children under five should be vaccinated was considered specifically on 30 December by the Joint Committee on Vaccination and Immunisation, which looked at all the international evidence and concluded that its scientific, independent assessment of the situation was that there was no need to change its advice to the four UK Health Departments and Governments. Vaccination policy is not something for the Public Health Agency to determine. It is determined by Health Departments, based on advice from the Joint Committee on Vaccination and Immunisation. For time to time, it does change its policy and advice, and, obviously, if the policy were to change — for example, if we were to be told to vaccinate children under five years of age or any other group — we would, of course, go ahead and implement that programme. However, it is not something that we determine.

Mrs O'Neill:

As far as I am aware, however, the minutes of the JCVI are not published, so I do not understand why there has been a change in policy. In fairness, Carolyn, you did not explain why there has been a change in policy, apart from the fact that the JCVI said so. We need to know why there was a change in policy given the fact that we are in a situation in which 17 people have sadly lost their lives this year compared with 19 here last year. Why has it changed? We need to know.

Dr Harper:

Last year, swine flu was a new virus. There were very low levels of natural immunity in the under-65 population. We saw less illness in people who were over 65 years of age because they had degrees of natural immunity. We had high consultation rates for flu in children. They were being affected disproportionately, not least because schools provide an environment in which the virus can spread among susceptible people very quickly. That is why large numbers of children were affected. That would have been largely the basis for the rationale last year of specifically vaccinating children who were under five years of age, regardless of the at-risk group.

Any child with an underlying medical condition will be vaccinated this year. Last year, we vaccinated children in special schools very quickly in light of the experience. That decision was based on a very susceptible population and a school setting in which the virus could spread quickly. There were high levels of flu-like illness and complications in children. This year, the data shows that some 50% to 60% of children now have some level of natural immunity. My

assessment is that there are not the same levels of flu illness in children as there was previously, and certainly not the same level of serious complications. The JCVI examines all the scientific evidence, and we look to its overall expertise. These are complicated issues, and we look to the JCVI for a steer.

Mrs O'Neill:

We are a devolved Government. The Department could decide to vaccinate children under the age of five if it so wished. If we felt tomorrow that that were needed, do we have enough vaccinations?

Dr Harper:

Absolutely. There is no question about that.

Mr Easton:

I welcome the information that you have given us. The level of swine flu is not as bad as it was last year, save for the sad deaths of 17 people. My gripe with you is that we as a Committee were blissfully going along, right up to December, without knowing that 13 people had died. We should have been kept informed because 13 deaths is a serious business and very sad. That the Committee was not informed of that situation shows a wee bit of contempt. Sadly, the number of deaths has increased from that time. That is my main gripe. The Committee is here to scrutinise you. We will support you if you do something good, and we hold you to account if you do not do something good. You have let the Committee down by not informing us of those deaths.

Last year, there was much concern about swine flu, and many advertisements were published and information was issued. This year, the situation is not as bad, but there has been a lack of awareness. Last year's campaign was quite successful, but, this year, the amount of information on normal flu and swine flu has been lacking. It is important that we continue to educate the population that they still have to be vigilant and keep washing their hands and binning tissues, as the Minister said. That has been lacking.

The Chairperson:

Those are two fundamental points.

Dr Harper:

Yes, they are. As regards the public information campaign, I appreciate the fact that the public have not seen the advertisements that ran last year. I understand that the Department is rerunning the ads and placing them in newspapers. It has indicated that, if necessary, it is prepared to review the situation on additional public information. Since the launch of the vaccination programme in October, the Public Health Agency has released around 13 press releases and conducted 16 media interviews. In a typical year when it is quiet, the level of media interest in flu can be variable. The lesson that has been learned is that clinicians and the public are much more flu-aware.

I hope that members find it helpful to receive the weekly bulletins giving the specific numbers of swine flu deaths. There is a fine balance between not creating unnecessary public concern in the greater scheme of things and the relative risk to the public from swine flu versus other issues such as smoking, obesity, alcohol, road deaths and other major public health issues. During the period in which there were swine flu deaths, many people died from heart disease, respiratory disease and other conditions. That is not to take away at all from any of those deaths. Each and every death is a personal tragedy for the families involved. When issuing public messages, there is a very fine line between trying to be open, absolutely honest and clear in the information — I hope that we have been able to bring some clarity that was not there previously, and acknowledge that for members — and not overstating or creating public concern when it may not be necessary.

Mr Gallagher:

I concur with John's acknowledgement of the pressures on health workers and clinicians at every level in the Health Service in recent weeks at this very busy time. The Chairperson raised the issue of the situation in the Republic of Ireland. That is important because my constituents could be visiting relatives in Sligo or Monaghan, or people from the Republic of Ireland could be visiting Craigavon or Enniskillen. Why did you not include those figures in your comparisons; for example, there are statistics for London and Yorkshire. Is it the case that you did not, or could not, look for that information, or is there a difficulty about obtaining the information?

In recent weeks, have you had any complaints about errors in samples? I am aware of a situation in one hospital where patients were told that they had swine flu and then a couple of days later were told that they did not. It was discovered that there had been a mix-up in the results. What do you know about that, and what is your reaction to it?

Are the views of midwives taken on board, either locally or at JCVI level, about vaccinating pregnant women and very young children? I have been informed that midwives have concerns about the possibility of risks to babies, unborn or soon after birth, in relation to the vaccine. Have any of those issues come to your attention?

Dr Harper:

I can say categorically that flu and swine flu vaccines are completely safe for use in pregnancy. Not only are they no risk but the swine flu vaccine protects mothers and babies from flu complications. We produced leaflets for mothers and pregnant women that answer typical questions about vaccination in pregnancy. We trained 700 health and social care professionals, many midwives among them, about the vaccine and the vaccine programme.

The Chief Medical Officer gave clear guidance about who should be vaccinated and how, including specific guidance, issued at the start of January, following the change in vaccination policy for pregnant women. That is clearly set out, but we recognise the fact that individual staff members may still have queries. We provide an advice service for anyone who has questions about the vaccine from a professional point of view. They can contact the Public Health Agency and speak to specialist staff at any time.

There are two possible scenarios about errors in samples. There may have been an issue with the sampling, testing and reporting in the specifics of the ward or clinical area in which that incident occurred. That is a matter for the clinical staff in that area. The second issue is the extent to which staff treat people clinically or on the basis of a specific laboratory test. Certainly, the advice on how to manage patients with swine flu, including when to test, has been laid out by the Chief Medical Officer and provided to staff very clearly.

At times, certainly in general practice, if someone comes through with flu, it is unnecessary to put them through a test to confirm whether it is swine flu when we know, through all the other information systems, that swine flu is the predominant virus. Patients are, therefore, treated clinically; they are managed as if they had flu. In hospital, more testing would be done. If someone is seriously ill, they are admitted to hospital where hospital staff typically carry out tests. Sometimes, those initial tests come back negative, and staff have said that it may be the second or third swab that tests positive. However, they manage the patient based on their clinical

presentation. If someone is presenting as having flu, they are managed in that way. The testing and swabbing are simply used for confirmation; it does not change the management of the patient in the initial phase.

As regards the Republic of Ireland, our surveillance systems are most similar to those across the English regions in particular. It is a legacy; historically, that is how the systems have been developed. The fairest comparison is against systems in the United Kingdom, which is why I drew on that data for the presentation.

The Chairperson:

One would have thought that, in this case, what is going on in Leitrim is probably more relevant than what is going on in Yorkshire. That is not me saying that, but I think that, on this occasion, it is.

Dr Harper:

I can see that. By no means do viruses respect borders. However, the approach is that, basically, swine flu and other flu viruses are circulating among the community. Contact with them can no longer be provided. We were well past that phase at least a year ago, and it is simply the nature of flu viruses. It is like cold and flu; it is out there, and it cannot be avoided. If people are in an at-risk group, the best protection is vaccination.

Ms S Ramsey:

Carolyn, it is unfair that you have been left to answer all the questions. Perhaps John might feel the need to jump in and answer some of my questions. Before I get to my questions, I will start on a positive note because it is important to commend all those who have been working in the Health Service over the past weeks, especially through the adverse weather and people presenting at A&E with other conditions. Like other members, I am concerned about some swine flu issues. The Public Health Agency's website states that its purpose is to protect public health and improve health and well-being. My concern relates to the Deputy Chairperson's point: why do we not determine our own policy? Why do we not, based on what we face today, make up our own rules? I am concerned about that.

The approach taken this year seems to be different to the approach taken last year, which leads me to believe that we peaked too early last year. Was there panic about swine flu, based on the

information that was available to us? Did we peak too early? Have we given expectations, especially concerning children under the age of five? I am not a clinician; I have no medical history, information or education, but this morning I heard someone say that their GP informed them that their child, who is under five years of age, could have been vaccinated last week but not this week because a memo was sent out. That type of information is being broadcast on the public airwaves. If that is true, I would appreciate a copy of the memo and an explanation about why the situation changed in a week. There are many concerns.

Last year, we handled the situation well — credit where credit is due. That was partly because we embraced the media: they were a collective, supportive partner. Did today's media briefings get as much information as possible out to people? We should use the media as a friend rather than their always criticising and attacking the Health Service. We need to take that information on board.

There are genuine concerns, which I share, about children under the age of five. People have been informed by their GPs that they have a viral infection. Will you explain the difference between a viral infection, flu and swine flu? I believe that some people had swine flu over Christmas and did not know that they had it. I am concerned that we are passing off some cases of swine flu as viral infections. It is too easy to say that people have a viral infection without specifically saying what it is. How long do we have to wait for a lab to confirm whether a virus is swine flu? Those tests happen only when a swab is taken. How many people who present themselves to their GP do not get a swab? Other people out there could have swine flu.

I was heartened to hear John say that, in general, only 3% of hospital beds are occupied by people with swine flu and flu-related illnesses. Why have we had trolley waits over the past couple of weeks? Is there a staffing issue? In certain hospitals, people have been waiting on trolleys for over 24 hours. Are members of staff offered the vaccine? Are we being proactive in ensuring that staff at the coalface are offered the vaccine?

I took a walk around one of our local hospitals the other day to investigate the issue of trolley waits. I will not name the hospital. One of the wards was closed to visitors because of vomiting and diarrhoea. Are the staff gowned up? Are we looking at a holistic approach to somebody who is in hospital, from the catering assistant to the domestic to the porter? Are they all part of the fightback against swine flu? Are they being gowned up? Are wheelchairs washed before they

leave wards? There are concerns about those issues.

Mr Compton:

I will start and give Carolyn a break. This morning was a genuine effort on the part of the media to recognise the fact that the public want this type of information. We gave as much information as they asked for, either from the PHA side on the details of swine flu or from the service side. We were fully available for debate, consultation and comment afterwards, and a number of interviews took place. As far as I am aware, there has been no reticence throughout the period about doing that. However, this morning perhaps changes the paradigm and the dynamics.

I was asked about trolleys. From our point of view, swine flu is one of a range of illnesses that occur over the winter. We had significant fracture pressures because of the bad weather, and we had to put special arrangements in place to handle all that. There has been an increase — not a massive one — in the number of people who attended A&Es in the past two weeks. More importantly, the levels of sickness of those people have been greater. Therefore, the proportion of people who attended and were subsequently admitted has been larger, and that puts pressure on the system. That is one of the key points of explanation. In the current climate, it was difficult to effect proper discharges from hospital for people during the snow and the freeze. Everyone around the table will understand that difficulty. We cannot discharge people into an unsafe and uncaring environment.

All occupational health departments have supplies of vaccines, and staff have been encouraged to take that vaccine. That is part and parcel of the strategy, because we recognise the fact that, on the operational side of the house, many staff could develop swine flu. That would add to and compound our difficulties. Therefore, staff have been offered that vaccine, and that scheme has been running for some months. It is not a recent measure; it has been running as part of the normal winter flu arrangements.

Under normal winter pressures, it is not uncommon for hospitals to experience mild to moderate outbreaks of vomiting and diarrhoea. That is not a sign of anything being different. I cannot remember a winter during which a number of hospitals did not experience short periods of vomiting and diarrhoea-type outbreaks. Of course, as a consequence, we pay attention to all the required hygiene measures to try to minimise visitors to units, minimise traffic through an area and minimise the opportunity for a particular virus to spread inside the hospital. That is quite

commonplace under well-established protocols and procedures. That incorporates all staff, including domestic, nursing and catering staff who are in the middle of that. Moreover, we ensure the cleanliness of hospitals, which is not only a winter initiative but an all-year one. Arrangements are in place all year round to ensure that we take all the steps that we can to minimise hospital-acquired infections in any facility.

There is a need to discriminate between winter pressures, which will always include flu, and the perception that swine flu is in some way massively different to normal winter pressures. It is a form of flu. There are cases of flu every year, and that will happen next year again. Next year, people will become ill as a consequence of flu, and some people will go to critical care beds. Regrettably, I am sure that a small number of people will succumb to the flu, as has been the repeating pattern over the past 10 to 15 years.

The key message is that there is a proper strategy for containing that form of flu. A proactive vaccination programme was run throughout the autumn. As the Committee might imagine, autumn, when flu arrives, is the real time for vaccination. There is also a time lag. Even if today's information suggests that we may be at the plateau stage, there will be a time lag of two to three weeks until people who are ill recover and are not as ill as they are today. Therefore, it would not be unsurprising if, in the next couple of weeks and even in light of that plateau, people continue to be treated and managed in a critical care environment because their cases will run 10 days behind that plateau effect. Given the very low temperatures, the water issues following the freeze and flu issues, this has been a difficult winter for the service. However, from 6 December, we ran escalated arrangements throughout the system. Every day, reports are made, information is collated and our understanding of the pressures improves. We have been dealing with those pressures in two ways: what is the pressure today, and what will it be next week, because it is important to look over the hill to see where we are going. We will continue to run those measures until we are through the winter and back to what might be described as a more normal pattern of health and social care requirements in hospitals.

The Chairperson:

We are rapidly running out of time. I will bring in Pól Callaghan, because he instigated the hearing and deserves his chance. Please try to restrict yourself to two or three snappy questions.

Mr Callaghan:

I will try. Your presentation states that it was only last week that the Public Health Agency required trusts to inform it of all deaths. Why was that decision taken only at that stage?

Dr Harper:

There were discussions between the Public Health Agency and the Department, and we considered the arguments in the round. It was decided to revert to normal reporting arrangements. In light of media and public interest, the decision was reconsidered, because it was felt that the balance of the argument had moved, and, for the reasons that members stated, it was deemed better to inform everyone of the exact situation. That is the background to the decision.

Mr Callaghan:

I phoned the PHA on 5 January and specifically asked about deaths, but there was no mention of how many deaths had occurred to date. Is it acceptable that, up to a week ago, Assembly Members were not encountering what you described as honesty and transparency in response to their questions? There is a difference between what the PHA decides to put into the public domain and how it and other agencies in the health and social care sector respond to questions that are put to them.

Dr Harper:

It is not for the PHA to decide whether to put that information into the public domain. We do not take that decision on our own; we take it in discussion with departmental colleagues. As I said, based on the balance of the argument and the position at the time, it was decided to revert to normal reporting arrangements, which meant that we were not required to collect information formally on swine flu deaths. The trusts were not formally required to report to us. We had information on deaths because some clinicians continued to tell us about them. Based on their experiences last year, they were still letting us know. Equally, if those clinicians had public health concerns about particular circumstances, they would have contacted us. Therefore, we had information on some deaths, but that did not enable us to say definitively that we were or are aware of all lab-confirmed swine flu deaths. The position changed as a result of discussions with the Department on 7 January, when we published all our information. We have been validating and updating that information, and I am able to produce information today about which we are confident and can stand over. We have also asked the trusts to continue to let us know about further deaths as they become aware of them.

Mr Callaghan:

John, you said that the escalation arrangements have worked. In the past week, it struck me that there are certain comparisons and contrasts to be made between the communications carried out by the board and various other agencies in the health sphere and what happened with Northern Ireland Water. Over Christmas and the new year, Northern Ireland Water was rightly vilified for, among other substantive issues, its communications, and questions about its preparedness are being pursued in various ways. Whatever else, Northern Ireland Water had never seen quite the extreme temperatures that we experienced this winter. The health sector and its agencies dealt with a pandemic last year, and many people are confused as to why more was not done earlier to provide information and to instil community confidence than was the case. Are you really satisfied that the escalation in communication worked and that communication and information were provided early enough?

Mr Compton:

We can always learn; people will never say that they cannot learn from experience. Both organisations certainly issued lots of information. On occasion, some of that information was not picked up.

The Chairperson:

To be blunt: you never mentioned the fact that 13 people had died. That is absolutely crucial. That is why information was not picked up.

Mr Compton:

Dr Harper is already on record as saying that, over the same time period, some 700 people died in Northern Ireland with respiratory conditions. At what point does one start to report that to a community? What is helpful?

The Chairperson:

What would have been helpful is the same information that you provided last year.

Mr Compton:

You have to accept that we operate within a system whereby we take advice from experts who tell us what we are facing, what the issue is and what the circumstances are. We adhere to their

best advice, and if that advice has to change, we will change it. There was no attempt to hide anything. I am not aware of anyone trying to hide any information, not to provide information or anything of that nature at all.

The argument is that there is a clear interest in the swine flu deaths, and there were 700 deaths from respiratory conditions. At what point is it expected that, as a system, we should present statistics on how people are dying across the year? That information is included and explained in the annual director's report. There are many channels. It is fair to say that the PHA was reporting regularly, through the flu bulletin, all information related to swine flu.

Clearly, the small number of deaths is very regrettable. It is easy to talk about such deaths as numbers, but it is hugely important to state that they are people who have families. Collectively, we have spoken about how the service is functioning and about the numbers in a way that, I hope, reassures the community that there has been proper and responsible contingent planning throughout the period.

Mr Callaghan:

The subregional incidence of deaths in hospitals around the North is an issue. I asked the Western Trust how many deaths had occurred in its area or among patients who may have been moved to Belfast. I was told that the answer could not be provided because of data protection. Quite honestly, that is totally unsustainable. What is the board's position on that subject?

Mr Compton:

It is a fact. We have to be extremely careful about data. The numbers here are very small, and if I were to release data stating that two people had died in an area, I am basically telling the world the names and addresses of those people. It is difficult for us, and we have to be extremely careful about the information that we release. If I say to you, for example, that 30 of our 83 critical care beds are occupied by people with flu today, and I am then asked how many of those individuals live in particular towns, I would effectively be drawn into releasing that information — the name of the individual — into the public domain. We have to be careful.

We must have some sense of balance. There is clearly a need to make information available, but there is also a need to have some regard for an individual's rights. We have stringent information requirements to which we conform. We are not reluctant about providing

information; it is about balancing the two issues. We must remember that the numbers here are very small, so it is not difficult to identify an individual from those numbers. Some local press identify individuals and print a lot about those individuals' families. It would be entirely inappropriate for us to do that. It is fine if the information is released or developed in another way, but it would not be done through us.

Mr Callaghan:

No one is suggesting for a moment that the Data Protection Act 1998 should be breached. My issue is with the trusts' and the board's interpretation of the Act. It is one thing to say how many people from Eglinton, for example, have died from swine flu, but it is an entirely different thing to say how many people from the Western Trust have died. On a level of proportionality, it does not compare.

There is a public interest issue. If swine flu prevalence in the Western Trust area is much higher, people in that area are entitled to know so that they can take appropriate steps to protect their families and vulnerable people around them. The big trick that the community feels that the powers that be in health have missed is that it does not want to be alarmed. The community wants to be informed so that it can help to protect itself and also help the health and social care agencies to minimise the prevalence of the problem.

Mr Compton:

Today we published the numbers of patients in each trust area who are currently inpatients or are being treated as having suspected swine flu. That is a reasonable way to issue information. The numbers are small, and a change from two to three people might move 30%, and there has to be perspective.

On average, if the figure for swine flu occupancy is just below 3% across the Province, it will be just below 2% in Belfast because of the large number of beds**.** The figures will be slightly higher in the west because there is a smaller number in the denominator of beds. It is important that information is not presented or misinterpreted in a way that suggests that something very different is happening in Belfast as opposed to the west. I am reassured by comments from the Public Health Agency and my colleagues that the pattern of swine flu illness in Northern Ireland is no different to that in the rest of the UK. We have comparable information systems, and it is important that we can look at those with confidence. That is the key message.

The Chairperson:

If you take only one message from this evidence session, it should be Pól's comment that the public want to be informed so that they can help themselves rather than be alarmed. Had you adopted that procedure at the beginning of December, you would not be here at all this morning.

Dr Harper:

The advice to the public about protecting themselves is the same advice that is given to everyone in Northern Ireland. We have consistently advised people about covering their mouth and nose, washing their hands, staying at home or off school if they have flu symptoms and being vaccinated if they are in an at-risk group.

Mr Girvan:

Thank you for your helpful information. The holiday period has created a hiatus in trying to issue information to Members and to the Committee. I appreciate the fact that we lag behind GB by about two weeks. One of your flow charts shows that the number of cases here is still rising, whereas the ratio of deaths per 100,000 of the population is on the decline in other areas and regions.

We are trying not to create fear in our community. However, the situation last week was that the ratio of deaths per 100,000 of the population is greater in Northern Ireland, on a reporting basis, than in any other part of the United Kingdom. That creates fear in the community because the public begin to wonder whether the situation is worse here. One of your graphs shows that, as of 12 January, the number of swine flu cases is rising here but is falling elsewhere. Why is that happening? The peak flu period runs from October to the end of February. That is not to say that it is not present all the time, but that is the peak time, and we are coming towards the end of it. However, there are still another six weeks of opportunity for flu to spread. Why are our figures different from other regions of the United Kingdom?

Dr Harper:

The rate of increase in new cases of swine flu was only 2% in the past two weeks. That suggests that the trend is that the rate of increase has started to slow down. The flu season typically runs for six to eight weeks, but it is not a precise black-and-white issue. It varies from year to year, which is the normal pattern. We will continue to monitor that, and it may be that the virus is

slightly different in various parts of the country. It differs slightly among certain regions in England, but there is no substantive material difference.

The death rate per population in the rest of the UK compared with here is back to the figure of 50. When that figure was published, the Health Protection Agency recognised it as an incomplete figure. The HPA was in the same situation as we were; the policy approach that was agreed in England and Northern Ireland was that normal procedures would be in place, and, therefore, the HPA did not have complete information. It will publish updated information in the next couple of days. Until we see that information, it is inappropriate to make comparisons between that figure of 50 and our numbers. All the other indicators that we reviewed with the HPA, such as consultation rates and overall patterns of the illness, are no different here from those in the rest of the UK.

The Chairperson:

Thank you very much, Dr Harper and Mr Compton, for the clarity of your information. I hope that, as last year, that trend will continue.