SEPT. '85

24 June 1985

Mr R D R Gardner
Secretary
GGHB

Dear Mr Gardner

EMERGENCY PLANNING

Council is aware that the Board is required to devote staff time and resources to making plans for a NHS contribution to mitigating the effects of a nuclear attack and of other civil disasters.

I have been asked to enquire the number and grades of staff engaged for a substantial portion of their time on emergency planning, and to find out the professional background of the head of the department.

Is the Board now in a position to inform different health care professionals what would be expected of them in an emergency? Are there procedures for updating such guidance?

In order to gain a clearer picture, it would be helpful if we could have some idea of what information could be given to the public in a locality eg Kirkintilloch.

Council appreciates that among health authorities there are differences of opinion over the usefulness of devoting more than token resources to issues of civil defence.

Yours sincerely

Hugh Bain
Secretary

Mr R D R Gardner
Secretary
GGHB

8 July 1985

Mr H Bain
Secretary
Greater Glasgow North LHC

Dear Mr Bain

EMERGENCY PLANNING

I refer to your letter of 24 June 1985 under the above heading.

I think there are really two issues raised in this letter, these being (1) arrangements for major accidents and civil disasters in peace time, and (2) preparation for a wartime situation which will almost certainly take the form of a nuclear attack.

So far as peace time accidents and disasters are concerned, there have been for very many years arrangements covering major accidents. These were polished up after the Ibrox disaster and worked very effectively indeed in the Clarkston disaster. They consist, as you will understand, partly of co-ordinated arrangements between Police, Ambulance, Rescue Services and the Health Services and partly of our own arrangements which are decentralised, ie each hospital has looked at its own procedures for coping with the kind of pressures which would arise under these circumstances and the question of having emergency medical teams.

These arrangements are kept under review partly by a Community Medicine Specialist on Dr Forwell's staff, but also very largely by the main general hospitals themselves. Fortunately we have never had a civil disaster on a really huge scale involving the loss of hundreds of lives and huge numbers of casualties, but basically the procedures which are in use would require to be adapted to deal as best might be in the case of something really catastrophic. Certainly problems of communication and co-ordination have been well discussed with the Police and other authorities, but the wide variety of possibilities means that some degree of improvisation would have to accompany the implementation of the plans which have been made.

When one turns to the question of a future war, with the likelihood of nuclear attack, the situation is rather different. As you yourself have acknowledged, there are very strongly held views, many of them with great political support, surrounding this subject.

A nuclear attack on Glasgow itself is likely to wipe out some, and possibly all, of our major hospitals. Surviving life will not continue on the basis which we understand today and certainly the priority for medical needs will be in very basic matters such as problems related to the avoidance of epidemic and the avoidance of contaminated water, food etc. Power supplies would perhaps be non-existent.

We have made very little progress in planning for nuclear warfare. The Board has agreed that up to one half of the time of an Asistant Secretary and one half of the time of a Community Medicine Specialist may be made available for this purpose, but this merely means that we are able to claim these salaries from the Home Defence budget. The SHHD indicated last year that they would put out a circular in relation to Health Services and the planning for wartime, but this has not yet appeared. That perhaps is not surprising given the difficulties. What seems to us to be clear is that there is very little that the Health Board can do without total co-operation from the local authorities. It is pointless making some kind of theoretical identification of buildings to deal with mass casualties except in agreement with the local authorities.

Indeed, in the event of nuclear war bodies like Health Boards would simply disappear in their present form. You will be aware of the strong political views held in certain local authorities. There are various discussions as I understand it going on with St Andrew's House on this subject.

Finally, perhaps I should say that we have arranged for various members of staff to attend home defence courses. It has proved a fairly certain way of inducing acute depression. My impression is that this matter is still under consideration by the Government, although it may not be the highest priority, and we will find it difficult to make much further progress (if indeed progress is possible) until further advice is given and perhaps until some better understanding is reached with the local authorities.

Yours sincerely

R D R GARDNER
Secretary

Mr R D R Gardner
Secretary
GGHB

Mr Hugh Bain
Secretary
Greater Glasgow North LHC

19 July 1985

Dear Mr Bain

EMERGENCY PLANNING

I wrote to you on 8 July 1985 about major disasters and civil defence planning. I am now writing to amend my letter to say that the guidance from the Scottish Home and Health Department on civil defence planning has recently been issued and is being examined by those responsible in the Board.

Yours sincerely

R D R GARDNER
Secretary

GREATER GLASGOW NORTH LOCAL HEALTH COUNCIL

CIVIL DEFENCE PLANNING IN THE NHS

Revised Assumptions in Relation to Civil Defence Planning

a revision and updating of the previous guidance to cover a range of possible threats extending from conventional bombing to nuclear attack;

b transfer of responsibility for planning and implementation to Board General Managers once appointed; and

c abandonment of the First Aid Post plus Casualty Collection Centre concept for a one-tier system below hospital level, mainly Emergency Medical Centres.

The National Health Service has the humanitarian objectives of providing care for the sick and injured and reducing hazards to health. If war should occur, the structure and function of the service would need adaptation in order to do everything possible to advance those objectives and to provide a basis for recovery.

BACKGROUND ASSUMPTIONS

A new SHHD publication "Emergency Planning Guidance to Local Authorities" has been issued.

1.3 Detailed guidance on planning assumptions is contained in the Emergency Planning Guidance. The most important features are:

1.3.1 the need to take into account a number of eventualities, including a period of tension, conventional attack including the possible use of chemical weapons, nuclear attack, and survival and recovery after nuclear attack;

1.3.2 the minimum warning period of attack; important plans should be capable of being implemented within a period of 7 days and their most vital elements within 48 hours; and

1.3.3 the impossibility of predicting the size of a conventional or nuclear attack or the targets it would include.

1.4.3 The pattern of nuclear attack and radioactive fallout cannot be accurately predicted.

1.4.5 fallout conditions would be likely to impose severe restraints on movement, possibly for up to 2 weeks or even longer in badly affected areas.
Immediate professional care for survivors might not be feasible because medical and nursing staff, who would be irreplaceable except in the long term, could not be put at risk by entering highly radioactive areas to assist casualties.

1.4.6 the major concentration of hospitals lies in the centres of large towns and cities and contains a high proportion of the most skilled staff and essential medical supplies and equipment, whilst many patients attending those hospitals come from the periphery of the urban areas. The redeployment of resources could improve prospects for their survival and bring them closer to those who would have most need of them after an attack. As a pre-condition to redeployment, all patients medically and socially fit to be sent home would have to be discharged and hospitals would have to accept emergency cases only.

1.4.7 at worst, the numbers of casualties in parts of the country could be quite beyond the resources of existing health services. The aim should be to base the care of casualties on surviving and expanded hospitals, so as to simplify the re-establishment of control and the distribution of supplies, and to provide emergency medical centres for the treatment of casualties. This would create a firm base from which the remaining staff could work and maintain morale of both public and staff by demonstrating a determination to rebuild a health service, albeit in a modified form.

(cf 1.4.6)

Important war plans should be capable of being implemented within 7 days. Some plans vital to the wartime effectiveness of the NHS, must be capable of implementation within 48 hours. The latter would include action to free as many hospital beds as possible, the protection of those patients remaining and the establishment and equipping of additional emergency medical centres for the care of the sick and injured.

During conventional war they (General Managers) would be able to operate within the basic peacetime framework, but simultaneously they would need to plan for the possibility of nuclear attack and the adjustment of organisational structure and staffing to meet this possibility.

HEALTH SERVICE ORGANISATION IN THE EVENT OF NUCLEAR ATTACK

Contact with Regional Government Headquarters (RGHQs) in each zone would be possible only through Regional and Islands Area Emergency Centres.

Under Circular 1985(GEN)4 Health Boards are left considerable discretion to determine how in peacetime they should manage their affairs. Health Boards must similarly decide how in time of war, both conventional and nuclear, they would do so.

FEATURES OF PLANNING

The Planning Problem

1 A major difficulty in planning for health services in war time is to develop an organisation which not only meets the requirements of conventional warfare to care for and treat civilian and military casualties by methods comparable to those of peacetime, but which places the health services in a good position to handle the radically different situation which would result from nuclear attack. With massive numbers of casualties, a reduction in the health facilities available, disorganised transport and poor communications, it cannot be expected that anything approaching peacetime standards of care would be available to all who required it. At times the optimal solution for conventional war may be wrong for circumstances after a nuclear attack. For example, there are advantages during conventional war in evacuating the injured rapidly to well-equipped centres of concentrated medical expertise, whereas in the event of nuclear attack dispersal of equipment and personnel might leave the health services in a better position for subsequent recovery. Some actions, like the discharge of convalescents, are equally appropriate for both situations. However, deployment of staff and supplies takes time. It may not be possible to switch rapidly from what would be the optimal plan for conventional warfare to the best plan to meet the effects of nuclear attack. It is therefore essential to plan for one eventuality whilst taking into account the possibility of the other.

A Planning Approach

3 The appointment of health emergency planning officers (HEPOs) was authorised in 1982 (SHHD/DS(82)4). These officers' responsibilities include the preparations of detailed Health Board plans for war and liaison with important interests such as local authorities and the voluntary aid societies as well as other Health Boards.

They have developed considerable experience and expertise and there has been a broad measure of co-operation between them in formulating guidance on aspects of planning. They maintain close liaison with the department and their experience will be valuable in dealing with local problems as well as wider planning issues. Their inclusion in any advisory groups is essential.

Special planning provisions

4 Where necessary, the Secretary of State will have the backing of emergency powers, and only at his sole discretion will certain elements of plans be implemented. They are:-

a acceleration of the normal discharge of patients from hospitals and the restriction of admissions to emergency cases.

b the discharge of all patients whose retention in hospital is not medically or socially essential, the dispersal of hospital supplies and staff, distribution of the civil defence stockpile and the alert of health service staff.

c the assumption by Board general managers, or any other officers appointed by them for the purpose, of wartime responsibilities for controlling health services in the field, the take over of private health facilities, the closure of outpatient clinics and the direction of manpower.

Dispersal of Medical Supplies and Equipment

Concentrated stocks of supplies and equipment are vulnerable to attack. Health Boards should plan for the rapid dispersal of supplies and equipment in a period of tension.

Dispersal of Hospital Staff

As soon as patients have been sent home, all staff not required to operate an emergency service should themselves be sent home or dispersed within the Boards area. Hospital staff who were not required for duty would remain at home and return only for duty or in response to call-out procedures.

Blood Transfusion Service

Hostilities would produce a demand for blood, blood products and plasma far in excess of normal daily collections.

Ambulance Services

The ambulance service would be involved in the speedy dispersal of patients in line with each hospital's discharge policy. Health Boards should prepare plans to leave in operation before an attack sufficient ambulance vehicles and staff to support an emergency service only; other ambulance vehicles should be dispersed and staff not required for duty should remain at home and return for duty only in response to call-out procedures.

General Medical Practitioners

The work of the general practitioner would increase in a period of tension when hospitals would be discharging as many patients as possible, some of whom would require treatment and medical supervision normally provided in hospital. Boards should consult general practitioners through the Area Medical Committee with a view to making the most effective use of primary health care teams during this period.

Nurses, Midwives and Health Visitors

The nursing profession would play a vital role in the provision of health care in wartime. In particular, the work of community nurses and midwives would increase in parallel with that of general practitioners. Nursing advice should be sought in planning to ensure that the most effective use is made of professional guidance and skill in all aspects of care.

Individual Volunteers

A national appeal would be made to all those with medical or nursing qualifications which they were not exercising, to report to their nearest emergency medical centre as soon after an attack as movement was allowed.

Emergency Medical Centres

After a conventional attack, the best medical policy is likely to be the rapid transfer of patients to hospitals with good emergency facilities. If, despite changes in admission and discharge policy, thenumbers of casualties overwhelmed available local hospital resources, additional accommodation and basic clinical facilities would be necessary. Below hospital level a single tier of care with some professional supervision is preferable to a complex organisation which poses problems of logistics and staffing. The concept now proposed is that of Emergency Medical Centres (EMCs). They should be separate from major hospitals and as far as possible, depending upon local geography and other features, co-located or close to premises which have been designated by local authorities as community facilities. Consideration should be given to the optimum number of EMCs for each area. Suitable buildings should now be identified having regard externally to ambulance access and internally to stretcher handling, and the need to observe large numbers of casualties.

Nuclear Attack

Despite damage and disruption of public utilities and communications, surviving hospitals would probably offer the best facilities for surgical procedures. Planning must however take into account the problem of switching from the highly sophisticated methods and built-in sources of service now common within hospitals, to more basic approaches to care (for example the preparation of surgical instruments, alternative and portable forms of anaesthesia) which could be required.

Almost inevitably there would be casualties on a scale which would overwhelm surviving hospital resources though over how great an area would depend on the scale of the attack. The emergency medical centres described would take on greatly expanded significance. They would perform the functions already outlined but with particular emphasis on triage, supportive care and basic surgical treatment. They might have to accept severe limitations in availability of anaesthetics. Fluid replacement therapy would be required by many patients and would be a constant problem; alternatives to usual practice (for example rectal administration) could offer partial solution. Under conditions of nuclear war, EMCs would be staffed by general medical and dental practitioners, domiciliary health staff, volunteers and hospital staff who could reach a centre but not a hospital. The importance of dissemination of professional expertise through instruction and the deployment of volunteers cannot be overemphasised.

If all the elements of planning had been achieved, it would be reasonable to expect that in any area peripheral to the target where there were survivors, there would be some kind of health care, even if limited.

SURVIVAL AND RECOVERY

Following a general nuclear attack, with its potentially wide ranging effects, environmental health measures would be crucial. These will be outlined in the "Handbook on Environmental Health" (to be published later this year) and aim to prevent the spread of disease and promote community health.

In the aftermath of a nuclear attack, regional government, advised by NHS representatives, would be best placed to decide and advise on the implementation of plans for recovery of the health services based on residual resources.

ACTION SUMMARY

Planning

The guidelines set outin this circular should be followed by Health Boards in planning for the health service to provide health care in time of war. The essential involvement of other authorities and agencies will be seen to emphasise the need for liaison, consultation and co-operation at all levels and stages; health care planning cannot be done in isolation. Health Boards are responsible for preparation of detailed plans which could be translated into action. The following paragraphs summarise the action which should now be taken.

Health Management

Health Boards should confirm their general managers' planning role in peacetime and their continuing managerial function in the health service in the event of war.

Health Boards

Health Boards, and where appropriate CSA, should arrange for the co-ordination of plans within their area for:-

1 resolution of responsibilities between health service areas where their boundaries do not match those of home defence regions.

2 the provision of medical advice and liaison at local authority regional, islands area and district level.

3 identification of tasks to be carried out in peace and in war and the individuals responsible for them.

4 taking control of private establishments.

5 freeing hospital beds.

6 provision of emergency services.

7 the dispersal of medical supplies and equipment.

8 the dispersal of hospital staff.

9 the continuing provision of the blood transfusion and ambulance services.

10 liaison with transport and ambulance officers on deployment of transport.

11 the effective use of medical, nursing and other trained staff.

12 liaison with local authorities, voluntary aid societies and other organisations concerned with civil defence.

13 public utility services.

14 training.

15 drawing up of plans for individual units through unit management arrangements.

16 liaison with Area Medical Committees to make the most effective use of GPs.

17 consultation with VAS (on the general and specific deployment of volunteers).

18 liaison with local authority controllers (designate) to earmark and requisition medical supplies, vehicles and accommodation not in ownership or occupation of the NHS and its employees.

19 identification and planning for activation of emergency medical centres.