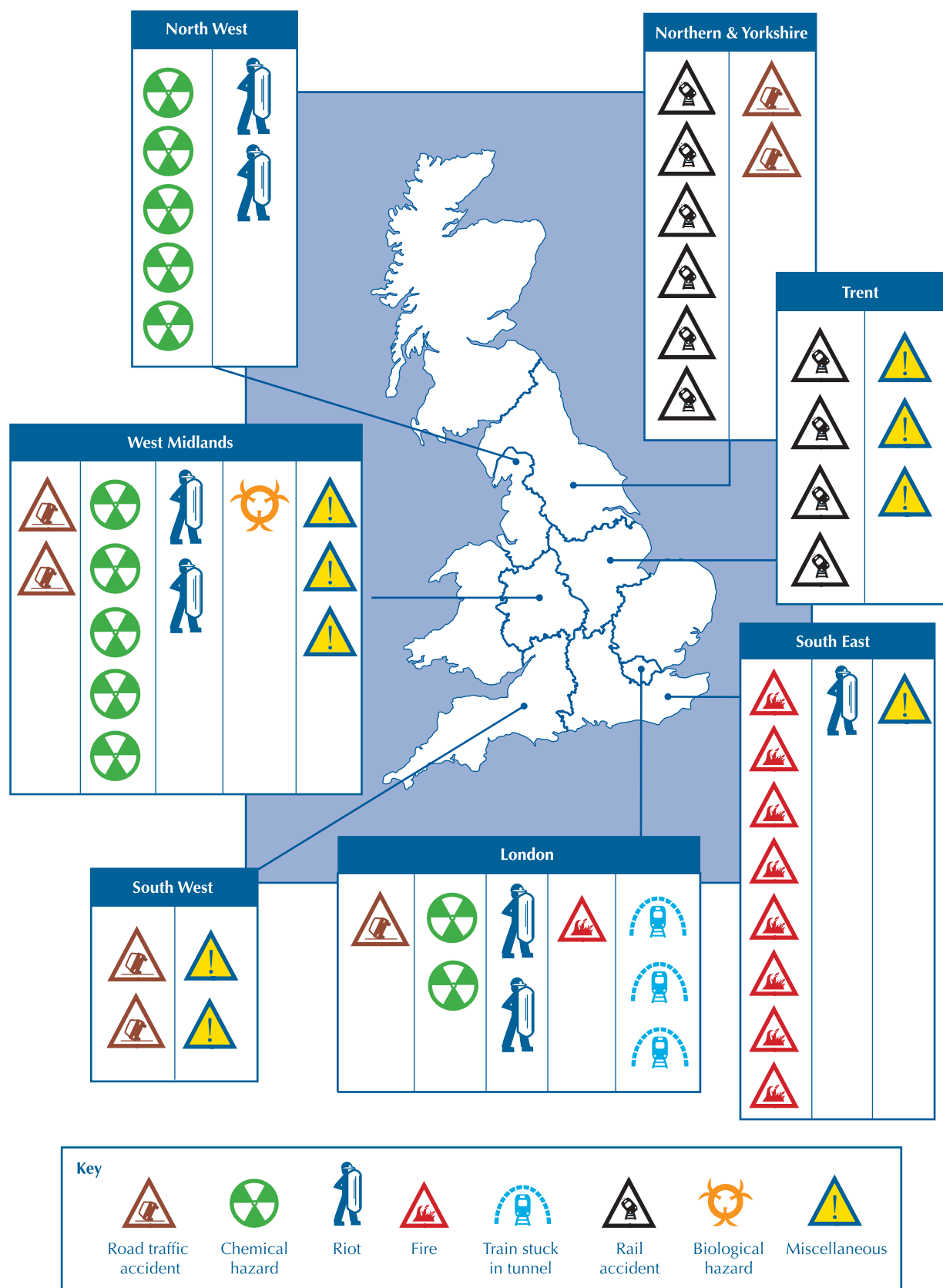


Facing the Challenge: NHS Emergency Planning in England



REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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Map – Major incident plan activations by acute trusts, ambulance trusts and health authorities for external incidents, January - August 2001



NOTE

Health authorities and NHS trusts in Eastern region did not activate their plans during Jan-Aug 2001. The number of trusts and health authorities responding to any one incident will depend on its nature and scale. The map shows the number of times NHS organisations activated their plans, not the number of actual incidents in the period.

summary & recommendations

Background

- 1 Major incidents range from road accidents and rail crashes to radiation incidents or the deliberate release of chemical or biological agents. In total health authorities, acute and ambulance trusts activated their major incident plans 118 times in 2000, and 86 times in the first 8 months of 2001, (see map opposite for external incidents in 2001). Terrorist attacks in the USA in September 2001 have increased the need for the NHS to be prepared to handle major incidents.
- 2 The Department of Health's Emergency Planning Co-ordination Unit leads NHS planning for major incidents in England. Following the changes to the health service in England in April 2002, emergency planning functions have progressively shifted from Health Authorities to Primary Care Trusts (PCTs), while the new Strategic Health Authorities have responsibility for co-ordination of response to widespread incidents. Ambulance and acute trusts provide medical care at the scene and subsequently, working alongside the other emergency services on the basis of their major incident plans.



- 3 We pay tribute to those who attend major incidents and provide treatment and care there and later. This report is not about these people but about the systems in place to ensure that the NHS response is as good as possible. Consequently, it is not about wider issues of emergency planning, which are being dealt with by other public service agencies.

Overall conclusions

- 4 Assessing preparedness to deal with major incidents is not straightforward. There is a scale of incident to which no NHS or other organisation could be expected to respond fully. Nevertheless, there are deficiencies in NHS planning arrangements. These existed before September 11 events, and though there have been improvements since, momentum needs to be maintained to deal with remaining weaknesses in planning and testing major incident plans, both in respect of the type of events experienced to date and for the newer threats of mass casualty, and biological, radiological and nuclear incidents.
- 5 We found good practice, but this needs to be identified and spread more systematically to address the deficiencies in the way that the NHS plans and prepares for major incidents. Arrangements in some other countries, for example Sweden, provide possible models, including the creation of a national incident database.

Departmental and regional input is generally effective but can be improved

- 6 The NHS regards good practice guidance issued by the Emergency Planning Co-ordination Unit as complete and useful. The Unit reacted swiftly after September 11, issuing comprehensive guidance across a range of hazards but some NHS trusts found the revised guidance issued then confusing and unco-ordinated. The Unit has since produced further guidance to address this, and is in a good position to further draw together and promulgate best practice and lessons drawn from actual incidents or tests.
- 7 Advice from regional level Health Emergency Planning Advisers to NHS trusts on planning for major incidents is seen as generally effective but their role is not sufficiently clear. The opportunity of Health Emergency Planning Advisers joining the proposed Health Protection Agency will bring about the possibility of clarification and standardisation of their role and responsibilities.

Inadequacies in health authority major incident planning need to be addressed by PCTs

- 8 Prior to the NHS reorganisation that took place in April 2002, health authorities had responsibilities for major incident planning which have now passed to PCTs. It is too soon to assess how well PCTs are fulfilling this new role, but many of the findings in relation to health authorities provide valuable lessons for the PCTs.
- 9 Before September 11 only half of health authorities had considered the impact of potential major incidents but since then most had done so. The quality of plans and preparedness improved after September 11, but coverage of chemical, biological and radioactive incidents was mixed, some plans were still out of date and there was scope to improve arrangements for working with other emergency organisations, such as the police and fire services. Importantly, one third of health authorities considered post September 11 that they did not test their plans frequently enough and nearly a fifth considered that their testing was not effective.
- 10 Post September 11, all except two health authorities were prepared for dealing with major incidents generally. However, readiness in respect specifically of chemical, biological, radiological or nuclear incidents was unsatisfactory (Figure 1).
- 11 Health authorities produced debriefing reports after exercises and most major incidents, but few were circulated widely. This limited the opportunity to share good practice and for others to learn lessons.
- 12 Health authorities were required to ensure that NHS trusts had suitable major incident plans and that they were ready to respond to major incidents. However, they had assessed only about 60 per cent of NHS trust plans. Some Health Emergency Planning Advisers took on this role and tests may in fact have been carried out.
- 13 Primary Care Trusts assumed statutory responsibility for major incident planning in October 2002, although transitional arrangements were in place since April 2002. Many of these trusts are new organisations and have a full agenda establishing themselves in their first year of operation. They will however need to give due priority to major incident planning activity and secure the necessary knowledge and skills. Otherwise, there is the risk that development of their own major incident plans and co-ordination of major incident planning with NHS trusts may suffer.



1 Health Authority preparedness as at February 2002

Aspect of major incident planning	Proportion not well prepared
Preparedness for:	
Biological incidents	5%
Chemical incidents	7%
Mass casualty incidents	12%
Radiological incidents	One fifth
Nuclear incidents	One quarter
Testing of plans - chemical, biological and mass casualty incidents not tested	One third
Testing of plans - radiological or nuclear incidents not tested	Four fifths
Where major incident plans had been tested, health authorities were not well prepared for radiological/nuclear incidents	One quarter
Training for radiological and nuclear incidents poor or very poor	One third

Source: NAO self-reporting survey of health authorities post September 11

Acute and ambulance trusts believe they are prepared to tackle major incidents but there are deficiencies in their planning and testing procedures and a significant number are not well prepared for post September 11 threats

- 14 Almost all acute and ambulance trusts regarded themselves as ready to tackle major incidents. Debriefing reports for actual incidents before September 11 support the view that NHS trusts were able to cope well with the range of major incidents experienced to date. All ambulance trusts test their major incident plans in line with guidance. However, about a third of acute and ambulance trusts reported that they had not tested their major incident plans frequently enough, and a quarter of acute trusts considered their testing was not very effective.
- 15 After September 11, many NHS trusts identified new or increased risks, mainly in relation to chemical, biological and mass casualty incidents. Most ambulance trusts had tested revised elements of their plans in these respects, though few acute trusts had. All ambulance trusts and all except two acute trusts, were prepared for major incidents in general. Preparedness for specific types of incidents (at February 2002) was worryingly low in many trusts (**Figure 2**).
- 16 At the request of the Department we undertook a further survey in October 2002 to establish what further progress had been made. As for our previous two surveys for this study, the Department was consulted and agreed with the design and content of the questionnaire; and all questionnaire returns were signed off by Trust Chief Executives to confirm that the contents represented an accurate picture. We obtained response rates of 63 and 80 per cent from acute and ambulance trusts respectively. However, visits to a small number of trusts to validate completed questionnaires showed they had all overstated, in key areas, their degree of preparedness to tackle major incidents, or could not provide evidence of claimed improvements since our survey in February 2002, and were basing their assessment, in part, on anticipated future developments. The October survey results showed continuing improvements in the preparedness of acute trusts to deal with most types of major incidents, (**Figures 3 and 4**). The main exception concerned preparedness to deal with radioactive incidents, for which

2 Trusts' preparedness as at February 2002

Aspect of major incident planning	Proportion not well prepared	
	Acute Trusts	Ambulance Trusts
Overall preparedness	One in six for mass casualty incidents. One fifth for chemical incidents. Around a third for biological and radiological incidents. One half for nuclear incidents.	One in ten for mass casualty incidents. Over one fifth for chemical incidents. One third for biological incidents. 4 out of 10 for radiological and nuclear incidents.
Personal protective equipment for chemical, biological and radiological incidents	Over one third	Over one half
Personal protective equipment for nuclear incidents	Over one half	Over one half
Decontamination facilities	Over one third	One half
Training in the use of equipment, and decontamination facilities	One half	One third

NOTE

The Department told us that at the time of our survey in February 2002, trusts would not have been able to significantly improve their preparedness related to personal protective equipment/decontamination and training as relevant procurement contracts did not come into operation until after then.

Source: NAO self completion survey of NHS Acute trusts, after September 11

3 Acute trusts' assessment of their preparedness as at February and October 2002

Type of incident	Well prepared %		Prepared %		Not well prepared %	
	Feb 2002	Oct 2002	Feb 2002	Oct 2002	Feb 2002	Oct 2002
General major incidents	58	66	41	34	1	0
Mass casualty	27	34	60	55	13	11
Chemical	8	17	72	65	20	18
Biological	8	13	65	65	27	22
Radioactive	6	13	65	50	29	37

NOTE

Results relate to the 91 trusts who responded to **both** the February and October 2002 surveys.

Source: NAO surveys of acute trusts February and October 2002. See Appendix H for definitions of categories.



4 Ambulance trusts' assessment of their preparedness as at February and October 2002

Type of incident	Well prepared %		Prepared %		Not well prepared %	
	Feb 2002	Oct 2002	Feb 2002	Oct 2002	Feb 2002	Oct 2002
	General major incidents	58	63	42	37	0
Mass casualty	26	30	65	61	9	9
Chemical	13	38	62	29	25	33
Biological	8	29	59	33	33	38
Radioactive	4	20	58	42	38	38

NOTE:

Results related to the 24 trusts who responded to *both* the February and October 2002 surveys, except for the mass casualty line which is based on 23 trusts. See Appendix H for definitions of categories.

Source: NAO surveys of ambulance trusts February and October 2002

there was an increase in acute trusts reporting themselves to be not well prepared from 29 per cent to 37 per cent. While the latest position for ambulance trusts also shows an increase in the proportion reporting themselves as well prepared for all categories of major incidents, the number of ambulance trusts not well prepared for chemical and biological incidents has increased.

- 17 Poor communications have been at the root of problems in past major incidents. About a fifth of acute trusts did not test their communications systems at six monthly intervals as required. Only a half of ambulance trusts tested their communications systems monthly as required. Many did not copy their plans to the fire service or the local ambulance service, which limits the extent to which there can be an effective co-ordinated response to a major incident. Moreover, the quality of debriefing reports produced was poor, with little evidence that they are used to improve plans; and few were circulated widely, including to the Emergency Planning Co-ordination Unit.
- 18 Handling the media is an increasingly important aspect in the management of major incidents. We found little evidence of testing of arrangements for handling the media, and many debriefing reports did not cover how well the media were handled during actual incidents. This indicates that such arrangements were not always given due consideration within the major incident planning process.

London is better prepared since September 11

- 19 London is now better prepared than before September 11 (Annex G). Preparedness for most types of incidents had improved substantially since our February 2002 survey. However, our October 2002 survey showed that a third of acute trusts and the London Ambulance Service were still not well prepared for incidents involving radioactivity. It also showed that whilst there have been improvements in capacity, particularly in respect of personal protective equipment and decontamination facilities, many issues remained and there was still much to be done. This, along with other important shortcomings in major incident planning (such as, training and testing of plans) means that a mass casualty incident or a hazardous substances incident on a large scale would challenge the NHS in London.

Recommendations

20 Being prepared for major incidents involves a balance between readiness for everything and the costs of preparing for events that may never occur. Judgements about this trade off are very difficult to make in the current post September 11 period but we make the following recommendations to cover issues that need early attention.

The Department of Health should:

- (a) Provide guidance on best practice processes for developing major incident plans and on what training should be undertaken by health service professionals involved in planning and responding to major incidents;
- (b) Pursue options for better knowledge management in planning for and reporting on major incidents. This should include better collection and dissemination of good practice and a national incident database;
- (c) Review the role of Health Emergency Planning Advisers to ensure they are uniformly effective across the country;
- (d) Ensure that Primary Care Trusts are fully aware of their new responsibilities for major incident planning, and have prepared major incident plans within six months of assuming major incident planning responsibilities;
- (e) Ensure that there are arrangements in place for assessing the quality of acute and ambulance trust major incident plans against standardised criteria;
- (f) Review the effectiveness and sufficiency of the current programme to improve resources for acute and ambulance trusts for dealing with major incidents and if necessary prepare a funded strategy to meet requirements in the light of a risk analysis;
- (g) Commission a training strategy for dealing particularly with major incidents associated with deliberate release of hazardous substances and facilitate its implementation for all key staff;
- (h) Underline, in the revised national guidance the Department intends to issue following the current review, the need for full testing of major incident plans, to a timetable and with subsequent evaluation;
- (i) Ensure that NHS organisations are fully collaborating with each other and with non-NHS organisations, such as the Police;
- (j) Ensure that all NHS organisations have an appropriate strategy for media communications, that it is fully tested as part of multiagency live and table top exercises, and that relevant staff are fully trained.

Acute and ambulance trusts

21 Chief Executives should take immediate steps to identify and address any deficiencies in NHS Trust major incident plans and ensure that they cover mass casualty, and chemical, biological, radiological and nuclear incidents. In particular Chief Executives should:

- (k) Ensure that major incident plans:
- have clear objectives;
 - are updated on a regular basis and reviewed annually;
 - clearly identify the type, level and location of resources needed;
 - include details of liaison arrangements, both internal and external, that may be implemented during a major incident;
 - are tested regularly, and within six months of any major revision and thereafter to a timetable; and
 - be signed off by them.
- (l) Examine urgently **inter-agency arrangements**, including with neighbouring trusts, other emergency services and managers of sites where there is a potential for serious incidents, in respect of mass casualty and chemical, biological, radiological and nuclear emergencies.
- (m) Improve **systems for learning and disseminating lessons** by producing debriefing reports after all major exercises and major incidents. They should identify and analyse key strengths and weaknesses, and spell out actions to be taken as a result, timescales for doing so and measures of success.
- (n) Improve **communication** arrangements and systems by ensuring that regular monthly (for ambulance services) and six monthly (for acute trusts) checks and reviews are carried out in accordance with Department of Health guidance.
- (o) Review and upgrade **training arrangements** for all appropriate staff, especially medical incident officers and emergency planning officers.
- (p) Ensure that a robust strategy for media communications is in place, is regularly tested, and that debriefing reports on incidents include media handling aspects.

Actions for Primary Care Trusts

- 22** Primary Care Trusts will fully take over the major incident planning responsibilities of health authorities during 2002. They have a demanding workload and organisational issues to address, but they will also need to undertake significant work if they are to ensure that they and the NHS trusts within their responsibility are prepared to deal with major incidents. The size of the task facing Primary Care Trusts points to the need for them to prioritise but the key points for them are to:
- (q) Take a fresh look to ensure that all hazards and risks in their locality are assessed in developing their own plans, as soon as is practicable after taking on major incident planning responsibilities;
 - (r) Draw up a formal structured programme for the regular testing of their plans;
 - (s) Identify those staff likely to be involved in dealing with a major incident and devise and implement appropriate training programmes; and
 - (t) Produce debriefing reports after each significant test and each major incident.