House of Commons

Committee of Public Accounts

FACING THE CHALLENGE: NHS EMERGENCY PLANNING IN ENGLAND

Eleventh Report of Session 2002–03

HC 545

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Eleventh Report of Session 2002–03

Report, together with Proceedings of the Committee, Minutes of Evidence and an Appendix

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Committee of Public Accounts

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Footnotes

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ELEVENTH REPORT

The Committee of Public Accounts has agreed to the following Report:

FACING THE CHALLENGE: NHS EMERGENCY PLANNING IN ENGLAND

INTRODUCTION AND LIST OF CONCLUSIONS AND RECOMMENDATIONS

1. Major incidents range from road and rail crashes to large-scale chemical, biological and nuclear incidents which may involve significant numbers of casualties. In the first eight months of 2001 health authorities, acute trusts and ambulance trusts activated their major incident plans 86 times for a wide range of internal and external incidents. Since the terrorist attacks in the United States in September 2001, the extent to which the NHS is prepared to tackle major incidents has become a more prominent issue, with a greater awareness of the risk of potential new threats.[1]

2. On the basis of a Report by the Comptroller and Auditor General,[2] we looked at the Department of Health's arrangements for ensuring the effectiveness of NHS major incident planning, and the arrangements in health authorities, acute trusts and ambulance trusts to prepare for possible major incidents. We have also taken into account the recent reorganisation of the NHS under which Primary Care Trusts took on statutory responsibility from 1 October 2002 for the major incident planning functions previously held by health authorities[3] and, from 1 April 2003, the creation of a new Health Protection Agency.[4]

3. In the light of this examination, the Committee draws three overall conclusions.

- At a time of heightened risk of terrorist attacks, parts of the NHS are not well prepared to handle the emerging threats from nuclear, chemical, biological and radiological incidents. The Department lacks a full picture of the risks involved across the country or means of ensuring that each region has plans, training and equipment in place consistent with those risks. The full audit of major incident plans ahead of the creation of the Health Protection Agency in April 2003 will provide a baseline for improvement. But this and the allocation of resources needs to be founded in a more rigorous national risk assessment developed with other organisations such as the fire service, the police service and local authorities.

- Poor communications can be a major weakness in the effective handling of major incidents at the scene. Yet, many major incident plans did not address communications issues sufficiently, communication plans are not tested as frequently as they should be, co-operation with other agencies such as the fire service and local authorities is patchy, and there is a need to improve communications, especially across administrative areas such as regions and counties.

- The Department has still not found an effective way of disseminating the lessons learned from actual major incidents, and could be more active in learning from events and plans in other countries. The proposed new national major incident database is one way of sharing lessons and best practice across the country, and should be given priority.

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[1] C&AG's Report (HC 36, Session 2002–03), paras 1, 1.7
[2] C&AG's Report, *Facing the Challenge: NHS Emergency Planning in England* (HC 36, Session 2002–03)
[3] *Ibid*, para 1.5
[4] *Health protection: A consultation document on creating a health protection agency*, June 2002

4. Our more specific conclusions and recommendations are as follows:

(i) Since the events of 11 September there has been increased awareness of the risks, yet over a year later many trusts were not well prepared for nuclear, chemical, biological and radiological incidents. The action the Department has taken to ensure that needs for decontamination and protective equipment were met by January 2003 may resolve many of these concerns. But there will be other reasons why many trusts do not consider themselves well prepared. The Department needs to identify these and take action to resolve them.

(ii) Preparedness for major incidents varies considerably across regions, but the Department had not yet established the reasons. As part of its review of major incident plans and further work with those trusts which are not well prepared, the Department should ensure that regional and trust plans are based on rigorous risk assessments and that resources are allocated in line with those risks.

(iii) Planning for major incidents is complex, and should be based on a full assessment of risks both nationally and locally, and effective monitoring. The current changes in the organisation of the NHS may mean that these important functions do not get the attention they deserve, as new bodies such as Primary Care Trusts and the Health Protection Agency get established. The Department should track progress more closely over the next six months to ensure that any gaps in coverage caused by these new bodies settling down or by competing priorities are identified quickly and addressed.

(iv) Key to effective handling of major incidents is effective partnership working locally. There were good examples, but many plans did not address communications issues sufficiently nor co-ordination with other agencies such as the fire service and local authorities, and many trusts did not share their plans with these agencies. The Department should ensure that Strategic Health Authorities and Primary Care Trusts take the lead in developing effective partnership working with all local stakeholders, including those across administrative borders, and ensuring these are covered effectively in NHS major incident plans.

(v) Training is essential if staff are to respond effectively to major incidents, but here too the National Audit Office found deficiencies. The Department has now appointed a co-ordinator to make sure training is rolled out on a consistent basis, and from April 2003 the new Health Protection Agency will take over co-ordination and pull training together in a tighter way.

(vi) While de-briefing notes are prepared after major incidents, their content varies. The practice of giving local debriefings confidentially to encourage open discussion and a "no-blame" culture inhibits drawing out key lessons for wider dissemination. The Department should ensure that key learning points are identified in all debriefings, for actual and simulated incidents, and disseminated quickly to the NHS and other partners and stakeholders. The proposed new national major incident database could help here.

HOW WELL HEALTH AUTHORITIES, ACUTE TRUSTS AND AMBULANCE TRUSTS ARE PREPARED TO DEAL WITH MAJOR INCIDENTS

(a) Responsibilities

5. The Department of Health has overall responsibility for the effective provision of the health service in England, including during emergency situations,[5] and its Emergency Planning Co-ordination Unit leads NHS planning for major incidents.[6] The Department issued comprehensive guidance to NHS organisations in 1998. Following events in the USA on 11 September they issued a range of more specific guidance covering, in particular, threats such as chemical and mass casualty incidents. This guidance was put out quickly and on a piecemeal basis, but up to about a quarter of health bodies considered it poor or very poor and some considered it disjointed, confusing and uncoordinated. As a result, the Department has reissued and updated all the guidance and put it on the emergency planning co-ordination website.[7]

6. Following the NHS reorganisation in 2002, Strategic Health Authorities are responsible for co-ordinating the response to widespread major incidents; while from October 2002 the emergency planning functions of health authorities have shifted to Primary Care Trusts. These include providing a strategic view on long-term threats and their possible impact, and ensuring that NHS trusts have adequate major incident plans that are tested regularly.[8]

7. Many Primary Care Trusts are new and already have significant demands on their time, and may lack the time, skills and resources to give appropriate priority to their own major incident plans and to ensure the co-ordination of planning by trusts. The Department has sought to manage this risk by creating 73 lead Primary Care Trusts. Each is responsible for managing major incidents, and with the other Primary Care Trusts in its group, for assessing the major incident plans prepared by trusts. For example, within the Thames Valley Strategic Health Authority area, the Primary Care Trusts have developed an emergency planning partnership and the lead trust is the Reading Primary Care Trust. As regards resources, these responsibilities were built into the remit of Primary Care Trusts when they were set up, and there are no extra financial resources available to undertake this new work. Funding is therefore left to local discretion within normal resource allocations.[9]

8. Acute trusts are at the heart of the NHS response to a major incident, treating victims at the scene and providing care and treatment in hospitals. Ambulance trusts identify and activate resources, manage and co-ordinate NHS activity at a major incident, and provide NHS communications. Both acute and ambulance trusts also have to prepare, review and test their major incident plans, train their staff, identify lessons learned after tests and major incidents, and liaise with the other emergency services and key NHS organisations.[10]

9. On a regional basis, Health Emergency Planning Advisers provide major incident planning advice on hazard identification, planning, training, exercising and reporting.[11] However, from April 2003, a new Health Protection Agency will take on a range of responsibilities to improve specialised support for health protection and health emergency planning, including the advice and other functions currently provided by these Advisers.[12]

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[5]Qq 19–21; Ev 16
[6]C&AG's Report, Figure 6, p11
[7]*ibid*, paras 2.4–2.8; Qq 9–11
[8]C&AG's Report, Annex B, para 8 and Figure 30, p38
[9]*ibid*, para 13; Qq 8, 11, 36–48,110; Ev 17
[10]C&AG's Report, paras 4.2–4.3, 4.16, 4.23 and Figure 30, p38
[11]*ibid*, paras 2.3, 2.10–2.12
[12]HPA Newsletter, 15 November 2002

(b) How ready health authorities, acute trusts and ambulance trusts are to deal with major incidents

10. At the time of the National Audit Office's survey in February 2002, most health authorities, acute and ambulance trusts assessed themselves as prepared to tackle conventional major incidents such as rail and air crashes, and this was supported by debriefing reports for actual incidents. But significant numbers were not well prepared for incidents involving mass casualties and chemical, biological, radiological and nuclear materials.[13] Their overall readiness had improved after 11 September, though significant weaknesses remained **(Figures 1 and 2)**.[14]

Figure 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	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 11 September*

[13] C&AG's Report, Figure 1, p3
[14] *ibid*, Figures 3–4, pp 4–5

Figure 2: Trust preparedness as at February 2002		
Aspects 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 (PPE) 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

Source: *NAO self completion survey of NHS Acute Trusts, after11 September*

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

11. By October 2002, acute and ambulance trusts showed continuing improvements, though there was some reduction in preparedness for tackling incidents involving some of the new threats that have arisen since 11 September. Around 10% of acute and ambulance trusts were not well prepared for incidents involving mass casualties; and between 18 and 37% of acute trusts and 33 to 38% of ambulance trusts were not well prepared for chemical, biological and radioactive incidents.[15]

12. Underpinning these figures, the National Audit Office found significant regional variations particularly in the extent to which health authorities, acute and ambulance trusts were prepared to tackle the newer and emerging threats. For example, for acute trusts the number prepared for nuclear incidents varied from 35% in the North West to 62% in London, and for ambulance trusts from 40% in the South West to 100% in the North West.[16]

13. The Department saw a degree of caution in some self-assessments, especially in those that had worsened, because trusts only then began to fully understand the kind of challenges they faced after 11 September. They were however following up each trust that was not well prepared, in London and elsewhere. For example, of 58 trusts that described themselves as not well prepared, in 48 (38 acute trusts and 10 ambulance trusts) the provision of equipment in the shape of personal protective suits and decontamination units

[15] C&AG's Report, paras 15–16, and Figures 3, 4, pp 4–5

[16] *ibid*, Figures 14, 24, 26, pp 20, 27, 32

was a critical factor in their self-assessment. In March 2002 the Department had provided £5 million for the NHS to improve personal protective equipment and decontamination facilities. Since then, personal protective equipment suits had been supplied to virtually all trusts, and the Department expected all decontamination units to be in place, and training to have begun, by the end of January 2003.[17]

14. Whilst London is now better prepared than before September 11, the National Audit Office found that a third of acute trusts and the London Ambulance Service were not well prepared for incidents involving radioactivity. Other shortcomings, including the training of staff, testing of plans and the provision of equipment, meant that a mass casualty incident or a large-scale hazardous substances incident would challenge the NHS in London. In terms of acute trusts, many were not prepared for mass casualty incidents, and there were different standards of delivery in terms of responding to major incidents across London.[18]

15. The Department is following up these variations with each trust, for example the London Ambulance Service. The Service has very good experience of a range of incidents, including major events such as the Paddington rail crash. They regard themselves as well prepared for chemical and biological incidents, and lay stress on working with partner agencies. On radiological and nuclear incidents, they could handle the accidental scenario, for example a problem with a small piece of material in a university laboratory, but a dirty bomb would be difficult and there is a scale of incident that would challenge any body. The Department assured us that the Service now had the decontamination units which it needed, training was in place, the Service was working with partner agencies and was in the process of producing a plan.[19]

16. Outside London, the position was also patchy. The Northern and Yorkshire health authorities and acute trusts were the least prepared for general major incidents, and only 42% were well prepared to handle nuclear incidents, despite the existence of targets such as the Fylingdales early warning system. The ambulance service in Northern and Yorkshire also had gaps in its preparedness to handle nuclear and radiological incidents, which the Department also put down to trusts' concerns about dealing with new threats, such as dirty bombs which would challenge most health care systems. The Department was following up all those trusts that did not appear to be well prepared and the provision of decontamination equipment and personal protection equipment, and training on an integrated basis with organisations such as the Fire Service, the police and local government organisations was a key issue. There is also a need to improve communications across county boundaries and in handling the media, generally.[20]

17. In the light of these regional variations, there could be a case for a national risk assessment, to ensure resources are allocated to priority areas. The Department undertakes a monthly assessment at meetings with local emergency planning advisers and regional directors in public health. It would be undertaking a more formal audit in early 2003, in preparation for the establishment of the Health Protection Agency from April 2003.[21]

18. The Department confirmed that planning to handle nuclear incidents had been in place well before 11 September, that there were cross-department and cross-agency plans and that it was fully integrated into all the government planning to tackle these risks across departments. The Department had been looking at additional requirements and plans, which included testing focusing on nuclear installations. For example, the Royal Berkshire

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[17] Qq 6–7, 16, 22–23, 51, 72
[18] C&AG's Report, para 19 and Annex G; Qq 13, 16, 76–79
[19] *Ibid*, paras 81–82
[20] Qq 24–29, 33–35, 54–60, 103–105, 107
[21] Qq 3–4, 49

Hospital had recently taken part in an exercise with the Atomic Weapons Establishment, involving a mock radiological spillage, and had rehearsed their decontamination procedures.[22]

(c) Quality of planning

19. The quality of major incident plans has also improved overall since 11 September. Two thirds were reasonably clear and unambiguous. However, there were still significant variations and shortcomings remained. Acute trusts' plans reviewed by independent consultants for the National Audit Office after 11 September scored between 8% and 80% against best practice, while those of health authorities scored between zero and 90%. Common problems were that plans were not based on comprehensive hazard and risk assessments, mutual aid arrangements were largely absent, and communication and transport disruption or failures were not considered. Few plans satisfactorily covered chemical, biological, radiological and nuclear incidents. In a small number of cases plans there were question marks over whether plans were reviewed at senior enough level.[23]

20. The Department had carried out a number of reviews of the adequacy of plans. It was sending out new criteria and the full audit in early 2003 would provide a good base for the new Health Protection Agency when it starts work. Where there were concerns in specific trusts as a result of the National Audit Office's work, the Department was following them up. Since 11 September, major incident planning had become higher up the Department's agenda in line with the seriousness of the potential situation. Progress had been made, but there was more to be done in continually improving the quality of the service.[24]

21. Health authority and trust major incident plans frequently do not cover mutual aid arrangements with other services, such as the fire service and police service. The National Audit Office found that nearly half of acute trusts did not copy their plans to the fire service and to neighbouring trusts, and few health authorities copied them to other relevant key players such as local authorities. The Department assured us that there is collaborative working at local, regional and national levels. For example, there had been testing involving the London Underground, which involved the range of emergency services working closely together. However, cross boundary and cross service arrangements should be improved to avoid the risk of an uncoordinated response.[25]

22. Training is an essential aspect of effective planning, and the National Audit Office found deficiencies in the extent to which staff at acute and ambulance trusts were trained to deal with major incidents. Even before 11 September, one third of health authorities believed their training to be insufficient, and in February 2002 half of acute trusts and one third of ambulance trusts considered that their staff were not well trained, particularly in the use of personal protective equipment and decontamination facilities. Since then, the Department has appointed a new co-ordinator to make sure training is rolled out on a consistent basis, including training across borders. From April 2003, the new Health Protection Agency will take over co-ordination and pull training together in a tighter way across the country.[26]

23. While most ambulance trusts tested revised elements of their plans in respect of the new risks that emerged after 11 September, few acute trusts did so. About a third of acute and ambulance trusts told the National Audit Office that they did not test their major incident plans frequently enough, and a quarter of acute trusts considered that their testing

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[22] Qq 24–29, 36, 48–51, 73; Ev 17
[23] C&AG's Report, paras 3.3–3.5, 4.5–4.10, 5.5–5.7
[24] *ibid*, para 4.22; Qq 12, 88–93, 108–109, 113–115
[25] C&AG's Report, paras 3.2, 4.4; Qq 33–35, 52
[26] C&AG's Report, Figure 2, p4; Qq 61–62

was not very effective. Only 60% of health authorities ensured that the trusts for which they were responsible tested their plans regularly, a key function now to be taken over by Primary Care Trusts. The Department recognises that there needs to be regular testing of major incident plans.[27]

(d) Learning and disseminating good practice

24. Debriefing reports produced by health authorities and trusts after major incidents or following the testing of plans provide the means of ensuring that good practice and key lessons in dealing with major incidents are identified and shared to improve preparedness. The National Audit Office found that while debriefing reports were prepared, quality was poor, few were circulated widely either by the organisations themselves or by the Emergency Planning Co-ordination Unit, and a significant number of ambulance trusts were dissatisfied with the feedback from other parties.[28]

25. The Department recognises the need to ensure that lessons learned are shared. One of the difficulties at present is that debriefing is confidential, to encourage those involved to be both honest and critical, and that people locally can learn from an incident. One challenge is to anonymise this information so that it can be disseminated. The Department is looking at options for a national incident database and expects to see it established by 31 March 2003 for handing over to the Health Protection Agency, who will then take on the responsibility.[29]

26. Other countries have experience of major incidents and intelligence and expertise to help plan for them. The Department visited New York in November 2001 and 2002 and had regular telephone contact with opposite numbers in the Centres for Disease Control in the US and with the New York public health service during the immediate aftermath of 11 September. A number of observations were made.

- Health Services did not come under sustained or overwhelming pressure as a result of 11 September, because it produced a high number of fatalities rather than serious injuries requiring treatment.

- The Belle View Hospital in New York could have created capacity for up to 200 burns casualties, through transferring suitable existing patients to non-trauma hospitals. However, the availability of capacity was dependent on critical care facilities, and this needed to be taken into account in planning.

- New York services did not have an agreed strategy for joint management of the scene. Since 11 September, New York had strengthened its co-ordination through the Office for Emergency Management.

- The main emergency response organisations in New York have adopted management software that allows key information to be recorded during an incident in common format, which may promote inter- and intra-agency co-operation and the management of crucial information.

- One of the lessons was the difficulty of communicating after an incident. Work has progressed on the provision of secure communications that allow the emergency services to talk to each other.

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[27] C&AG's Report, paras 14, 3.6–3.7, 4.11–4.12, 5.8; Qq 64, 66

[28] C&AG's Report, paras 3.10, 4.14, 5.10; Q 106

[29] Qq 53, 65, 106, 112, 128

- Quickly gaining control of the disaster scene itself with effective on-site safety management is important. Inter-agency training and exercises can instil safety practices.

- The use of standardised and inter-operable equipment can improve the combined emergency response.[30]

27. The Department is also contributing to an international dialogue on emergency preparedness, which includes playing a lead role with a number of international bodies including the World Health Organisation and the G7+ Mexico group as well as the European Union. The Department has continued to play a full part in the European Union High Level Committee on health security. This Committee has a programme of co-operation on preparedness and response to biological and chemical agent threats. The Department's Chief Scientist is also leading work on chemical incidents, and key contributions are being made to areas such as development of rapid alerting methods and the creation of appraisal and modelling tools to gauge the risk of spread of disease and contamination.[31]

[30] Qq 68, 74–75, 120–127; Ev 17

[31] Qq 126–127; Ev 17

MINUTES OF PROCEEDINGS OF
THE COMMITTEE OF PUBLIC ACCOUNTS

SESSION 2002–03

WEDNESDAY 27 NOVEMBER 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Geraint Davies
Mr Brian Jenkins
Mr George Osborne
Mr David Rendel
Mr Gerry Steinberg
Jon Trickett

Mr Tim Burr, Deputy Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Rob Molan, Second Treasury Officer of Accounts, was further examined.

The Comptroller and Auditor General's Report on Facing the challenge: NHS emergency planning in England (HC 36) was considered.

Mr Nigel Crisp, Permanent Secretary and NHS Chief Executive, Department of Health, was further examined; Dr David Harper CBE, Chief Scientist and Branch Head, Environment and Health, Public Health and Clinical Quality Directorate, Mr Alan Doran, Director of Operations, Directorate of Health and Social Care, Department of Health, and Mr James Robertson, Director, National Audit Office were examined (HC 135-i).

The witnesses withdrew.

The Committee further deliberated.

* * * * *

[Adjourned until Monday 2 December at Four o'clock.

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MONDAY 17 MARCH 2003

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Geraint Davies
Mr Frank Field
Mr Nick Gibb
Mr George Howarth
Mr George Osborne
M r David Rendel
Mr Gerry Steinberg
Jon Trickett

Sir John Bourn KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Rob Molan, Second Treasury Officer of Accounts, was further examined.

* * * * *

Draft Report (Facing the Challenge: NHS Emergency Planning in England), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 3 read and agreed to.

Paragraph 4 postponed.

Paragraphs 5 to 27 read and agreed to.

Postponed paragraph 4 read and agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

* * * * *

[Adjourned until Wednesday 19 March at half past Three o'clock.

MINUTES OF EVIDENCE

TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

WEDNESDAY 27 NOVEMBER 2002

Members present:

Mr Edward Leigh, in the Chair

Geraint Davies
Mr Brian Jenkins
Mr George Osborne
Mr David Rendel
Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

MR TIM BURR, Deputy Comptroller and Auditor General and DR JAMES ROBERTSON, Director, National Audit Office, further examined.

MR ROB MOLAN, Second Treasury Officer of Accounts, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Facing The Challenge: NHS Emergency Planning in England (HC36)

Examination of Witnesses

MR NIGEL CRISP, Permanent Secretary and NHS Chief Executive, DR DAVID HARPER CBE, Chief Scientist and Branch Head, Environment and Health, Public Health and Clinical Quality Directorate; and MR ALAN DORAN, Director of Operations, Directorate of Health and Social Care, examined.

Chairman

1. Welcome to the Public Accounts Committee. Today we are considering a very important report, the response of acute trusts and health authorities to major incidents. Once again, we welcome Mr Nigel Crisp, the Permanent Secretary of the Department of Health. Could you introduce your team, please?

(*Mr Crisp*) This is Dr David Harper who is responsible for the emergency planning and co-ordination unit in the Department of Health. He is the Chief Scientist so he is handling all the issues to do with public health and so on. On my right is Mr Alan Doran who is director of operations and therefore he plays a role in holding trusts to account.

2. You have read the report. From reading the report, you will know that there is a worryingly large number of acute trusts and hospital authorities which are not well prepared to deal with chemical or nuclear attack. Are you happy with their level of preparedness?

(*Mr Crisp*) If you read this report, it says that the NHS has a very good past record with many very good examples drawn out in the report. It also says there have been considerable improvements made since 11 September last year. It also says there is still more to do. We have made a lot of progress on a whole range of issues, including introducing the guidance, working with others, more equipment, more training and setting up the Health Protection Agency to drive this whole area forward, but there are a whole series of areas where we have more to do and we have it in hand.

3. Do you think it is time now to develop a national risk assessment?

(*Mr Crisp*) Do you mean by ourselves?

Yes, building on existing NHS plans to assess the overall adequacy and distribution of resources.

(*Mr Crisp*) The Department meets Regional Health Emergency Planning Advisers monthly and separately meets the Regional Directors of Public Health. That is how we have been doing our risk assessment. We will be doing a more formal audit in preparation for the establishment of the Health Protection Agency which starts up in April next year. We have been doing a continuing risk assessment but we want to do a formal one in the early part of next year so that the new body starts off with a clear remit.

5. If we look at some of these figures, we see that the percentage of acute trusts are prepared or well prepared for different kinds of major incident, for instance, in the West Midlands, you only have 36% prepared for a nuclear incident, the south east, 44%, North and Yorkshire, 42%, and the north-west 35%. This is rather worrying, is it not, especially in the light of the Prime Minister's timely warnings?

(*Mr Crisp*) If you look at those figures you will see that for emergency incidents people are recording high levels of being well prepared and that is based on their past experience. For the new sorts of threats of which people have less experience, people are naturally being much more cautious about how well prepared they are. Subsequently, after the publication of the report, we have been able to identify the trusts who have shown themselves as not well prepared which I hasten to add is not not prepared; it is not well prepared, so we can identify and understand why they were saying that about themselves.

[**Chairman** *Cont*]

6. When might we get some action so that the public can be reassured that all our acute trusts and all the future primary care trusts (PCT) are going to be prepared or well prepared to deal with a possible threat, which we hope will never happen of course?

(*Mr Crisp*) The acute trusts issue, when we have analysed what they are saying and why, has mostly been around aspects to do with equipment, which is being rolled out across the country. It is in areas where they have not yet received all their equipment or they are worried about future supplies.

(*Mr Doran*) We learned of 58 trusts, 48 acute trusts and ten ambulance trusts, that had described themselves as not well prepared. For 48 of those, 38 acute trusts and ten ambulance trusts, the provision of equipment in the shape of personal protective equipment suits and decontamination units was a critical factor in their self-assessment as not being well prepared. The personal protective equipment suits are now virtually with all trusts. There is a small number still to arrive. With decontamination units we are well on the way but they require a production schedule, as you can imagine. We expect them all to be in place and training to have begun by the end of January.

7. You are working on this as a matter of great urgency, are you?

(*Mr Doran*) We are. The manufacturers of the decontamination units have accelerated their production schedule.

8. Part three of the report tells us there are a number of concerns about quality of major incident planning, about health authorities. Can you reassure us that primary care trusts will be any better?

(*Mr Crisp*) You asked about risk assessments earlier. One of our early risk assessments after 11 September was that people were concerned about primary care trusts within the system and the fact that we were changing the management arrangements. We have therefore done an enormous amount of work over this summer, bearing in mind PCTs only came properly into existence on 1 October. You will see the product of some of that in this document, including the fact that we have decided to have a number of lead PCTs rather than giving every PCT the same level of responsibility. We have done a lot of training with them and they have all now brought forward their plans which are based on the previous health authority plans. There was not a gap between the two, but we do need to do more training because we want to move everyone to the left hand side of this chart showing that everyone is well prepared.

9. Where you come in is guidance from the centre. The NAO have found that as regards guidance 20% of health authorities and 27% of ambulance trusts thought the guidance you gave them poor or very poor. Is that something you are satisfied with?

(*Dr Harper*) No, that is not something we would be satisfied with. We issued a whole lot of guidance immediately in the aftermath of September 11 2001. Partly in order to get the information out to the people who needed to see the guidance, we put it out piecemeal. We recognised that fairly early on and as part of the plans we have been making since then we have reissued all of the guidance updated to reflect the creation of PCTs. We have put all that guidance together, telling people it is there and that it is a comprehensive package. We have put that onto the emergency planning co-ordination unit's website as well.

10. It was because it was sent out piecemeal?

(*Dr Harper*) That must be part of the reason. We sent things out as we were able to, bearing in mind that we were producing guidance at quite a rate of knots immediately after September 11. We were building on the 1998 major incident guidance which, according to the report, was very well received. What we put out was additional guidance on some of the newer threats.

11. You are confident now that the guidance is going out that these PCTs will have the right people in the right place with the right skills to understand it, process it and deliver it in terms of action, are you?

(*Mr Crisp*) That is the intention of the 73 lead PCTs. We clearly have more work and training to do but it is not that it is being neglected. It is taking time and we are continuing to do it.

12. Part four is a worrying part of this report. It shows, if we look at acute trusts, that there are serious deficiencies in their major incident planning. Can you tell us a bit about the plans and timetables you have to try and improve the situation?

(*Mr Crisp*) There are some people who are clearly the outliners on this in terms of the tables shown. We have done a number of reviews during the course of the year as to our belief as to the adequacy of plans. We are sending out new criteria and we will be carrying out a full audit in the next few months so that the Health Protection Agency, when it starts up, will be in a position to have a good base. There are some individual trusts within that which were identified as of concern by the NAO and therefore we followed them up individually.

(*Mr Doran*) The one that is referred to specifically is the Queen's Medical Centre (QMC) in Nottinghamshire, whose plan was not rated very highly. This was a source of some puzzlement. My understanding now is that the reason for it is simply that the 1998 plan rather than the then current plan, the 2000 version, was the one made available to the team who were doing the analysis. The second reason why it was a source of some puzzlement is that, in their own self-assessment form, QMC rated themselves as very well prepared. They answered 37 of the 40 questions at average or better. We have followed this up because we think we need to learn from it. We have had discussions with the trust and they are clear that they are revising their plan yet again. The revised version will be available in January. They have training schedules and that is the kind of process we will be following up with all the trusts because, even if you assess yourself as well prepared, we want to see you to continue to improve. This is not getting there and stopping; this is continuing to react to the surroundings, to the changing nature of challenges and improving over time.

[**Chairman** *Cont*]

13. I am particularly worried about London, of course. According to this report, a third of acute trusts and the London Ambulance Service are not well prepared for radioactive incidents, a significant challenge to the NHS. Can you reassure us on this?

(*Mr Crisp*) There is a degree of subjectivity in the way people have answered these questions. The report itself says that. There have not been any clear criteria about what is well prepared, prepared or not well prepared. It does not surprise me that people have marked themselves down to a degree on whether or not they would be well prepared to deal with something they have never encountered before.

14. You will understand that is rather a worrying answer for us because we are trying to get an idea of what is going on on the ground. Are you now driving a stake through the heart of this report, saying that it is all subjective and we should not be as worried as we might be?

(*Mr Crisp*) No. What I am doing is what the report itself does. It is paragraph four in the summary and recommendations.

15. I was going to refer to that just now: ". . . 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." It is not a great paragraph for you to pray in aid.

(*Mr Crisp*) That is not the one I was referring to.

16. What about these regional variations in the health authority and their trusts' readiness? Are you worried about that?

(*Mr Crisp*) Let me make the point I was trying to make a moment ago. There is a degree of subjectivity, as the report admits, because it does not spell out precisely the criteria for well prepared, prepared or not well prepared and it also makes it clear that not well prepared does not mean not prepared. However, the report shows that there are areas that we should be concerned about. What we have therefore done with the report is follow up those areas where there is information that we should be concerned about. In London as elsewhere, we have followed up with the trusts and asked them questions about why they thought they were not well prepared and therefore what we should be doing about it. We have done precisely that with the London Ambulance Service which I am sure was one of the ones that you wanted particularly to raise.

Chairman: I am getting a bit worried about this because the whole point of these hearings is that we have to have an agreed report to base all our discussions on. If we are going to have a long argument about what people meant when they said they were prepared or well prepared, we are not going to have as effective a hearing as one would have hoped.

Jon Trickett

17. In terms of responsibility, it seems to me there are three levels of responsibility here, the national level which you represent, the regions and then the trusts themselves. Who is responsible and what is the statutory context for the responsibility?

(*Mr Crisp*) I am responsible overall and there is a management line down to the chief executives in each trust who are responsible for the readiness of their individual organisations.

18. What is a lower region?

(*Mr Crisp*) There is not such a region any more. I have people who are part of the national setting called Directors of Health and Social Care who are accountable to me so individual organisations are accountable to health authorities; they are accountable to the Department of Health. All the way down, responsibility is lodged with chief executives.

19. What is your statutory duty in this matter?

(*Mr Crisp*) I need to check the exact details.

20. You do not think you should know?

(*Mr Crisp*) How I understand it and how we interpret it is to make sure that we are ready to respond to incidents of an emergency nature throughout the country.

21. What is the Department's statutory duty in relation to this matter? If you do not know, just say you do not know.

(*Mr Crisp*) Let me give you chapter and verse on that at a later date.[1]

22. The Committee will note that you have come to the Committee and you do not know what your statutory duty is at this stage. In terms of the regional discrepancies, I accept that there is some subjectivity in all surveys but nevertheless there are very significant discrepancies. I come from the north of Yorkshire which I want to focus on. Why have you allowed these discrepancies to emerge, which are startling?

(*Mr Crisp*) Let me start off with paragraph 1.11 of the report which I have finally found, which says: "There may therefore be a degree of subjectivity in the self-assessments of readiness reported to us in particular . . . were not defined precisely."

23. I have just accepted that.

(*Mr Crisp*) It is an important point though. That means that these show that there is an indication rather than precise numbers. In terms of our risk assessments, we have assessed where the risks are. We have therefore made sure that we have sent in the resources and done the planning on the basis of two major criteria. One is population density and the second is where we assess that the threat is most likely.

24. Would you say that the north of Yorkshire has less threat of nuclear incidents than the rest of the country?

(*Mr Crisp*) That is not for me to say precisely. You would understand that we would want to start off with two areas. One is London. If I talk about areas which have the highest population density, we start there. Secondly, we deal with all ambulance trusts.

25. I will come to the North and Yorkshire ambulance service in a moment. As an incidental point, it seems to me that the risk of nuclear incidence did not emerge post-September 11. Would you agree with that statement?

[1] Ev 6

[**Jon Trickett** *Cont*]

(*Mr Crisp*) Nor did our planning for it.

26. In a sense, the Department has no defence in saying, "We are getting ourselves organised with suits and things now that 11 September has occurred." In north Yorkshire, table 24 is showing that only 42% of the acute trusts were prepared for nuclear incidents. You said that you had a strategic view of the nation in terms of density and likelihood of risk. Therefore, your view was that London was a higher priority than the north of Yorkshire. Those of us who live in the north of Yorkshire know that there are a number of targets, particularly Fylingdales, the early warning system there, which clearly must be one of the highest strategic targets not only in Britain but across the western world, given the functions which are performed there, right in the heart of Yorkshire. That has been a target ever since the Cold War began and this site was constructed, has it not?

(*Mr Crisp*) As the report makes clear, our planning started before 11 September. What happened after 11 September is we spent the next month or so doing some very quick replanning and reprovisioning of stocks in various places. It was acknowledged but what happened from September 11 is that the level of awareness and the level of risk appeared to have got higher so we needed to do more about it. That is why we have spent so much time doing that since and we have paid a great deal of attention to it. Your point about northern Yorkshire and Fylingdales is absolutely true. I refer you to the answer that Mr Doran gave about when we looked at why organisations reported themselves as not well prepared. It was mostly to do with decontamination equipment and personal protection equipment. That can be rectified and is being rectified.

27. Are you able to demonstrate that there was some objective analysis done by yourselves which demonstrated that they were being rather modest or perhaps depressed about their state of readiness?

(*Mr Crisp*) We only got the names very recently. Therefore, we have contacted them very recently and Mr Doran does have a big list of what people have responded to.

28. I want to ask about targeting by possible enemy powers or terrorists. What discussions have you had in terms of potential targets and therefore risk of massive casualty with other departments?

(*Mr Crisp*) That is not a matter for me overall. This is also about the NHS, not so much about what the Department may or may not have been doing. We are fully integrated into all the government planning across departments.

29. Can I conclude that the government as a whole has decided that the north of Yorkshire is not a very high target at the moment, rather than that you have just decided it is not?

(*Mr Crisp*) No. Speaking as somebody who comes from northern Yorkshire, I ought to say that it does not altogether surprise me that London would be considered by most people to be where we should start. Your Chairman started off making that point.

30. It is not that the nuclear risk is something new. During the summer, I had an incident where a fire engine attended a man who was dying in my constituency because there were no ambulances and it turns out that the Ambulance Service is very hard pressed and over-stretched. The reason why the fire engines were attending medical casualties is because it was a hot night and the ambulances were over-stretched because there was too much heat in July and August. I noticed that in the north of Yorkshire the ambulances are not doing very well in preparation for nuclear incidents and radiological incidents either. What comment do you have in relation to the fact that the Ambulance Service cannot deal with warm summer nights?

(*Mr Crisp*) You will have to give me the courtesy of letting me investigate that incident.[2]

31. It was in all the national media.

(*Mr Crisp*) That was not the subject of this report but I am very happy to come back to you.

32. The Ambulance Service is not ready for nuclear incidents. It is not even ready for warm summer nights.

(*Mr Crisp*) I contest the warm summer nights.

Jon Trickett: That was a statement made by the NHS at the time.

Chairman: You will do a note for us.

Jon Trickett

33. Even though the Ambulance Service looked slightly better than the acute trusts, no account had been taken of the fact that a major incident could damage communications and transport in relation to the Ambulance Service plans. It is extraordinary, since ambulances depend on the ability to move across road services and so on, that none of the plans has taken that into account. More importantly, there was no mutual aid arrangement between one Ambulance Service and another. I live at the conjunction of west and south Yorkshire and that is where the particular problem I had with my unfortunate constituent. Why have we not taken any account of the fact that bombs can cross county boundaries?

(*Mr Doran*) I cannot speak for the particular two ambulance trusts. I know one of the general concerns of ambulance trusts is with regard to radiological and nuclear. That has conditioned their self-assessments. It has been that they feel relatively well prepared to deal with what you might call an accident, say, involving a research laboratory or a medical incident with nuclear materials. What they did not feel well prepared for at the time the assessment was carried out was with regard to delivery of the dirty bomb scenario, which would challenge most health care systems. It presents threats that people are beginning to understand after September 11, the deliberate release of a dirty bomb. It is that which has figured in their thinking. They see the provision of equipment and decontamination units and the training that goes with it, which is not simply ambulance trust alone training; it is training on an integrated basis with other organisations like the Fire Service, the police and other local government organisations, because you are looking at a scenario in which a part of the country is contaminated. They are beginning to develop those techniques. It was the realisation on

[2] Ev 6

[**Jon Trickett** *Cont*]
their part that they faced a different kind of challenge, that they needed to mount a new training programme to build on the integration and links they already had with local bodies that has led them to score themselves in that way.

34. With all due respect, that was not in any way an answer to the point I made which was to do with the fact that incidents, dirty bombs or whatever, will cross county boundaries with no respect to ambulance service divisions. There was no arrangement whatsoever for mutual aid between ambulance services in the case of an incident.

(*Mr Crisp*) You are referring to the bit here which says that the plans show there were no mutual aid arrangements.

35. It says "non-existent".

(*Mr Crisp*) That is what it says and that was the assessment of the plans. I ought to reassure you on two points. Firstly, in practice, as you know, ambulance services co-operate over county boundaries very regularly. That is very important. The point that the plans did not cover that, even if the reality was that it happened, is unsatisfactory and that is why the plans have to be improved.

Mr Rendel

36. Can I declare my usual interest in that I have a wife who is a GP and who is on the board of a PCT. I understand I have another interest in that Mr Crisp is one of my constituents so I have to be careful what I say to him. Can I ask about the lead PCTs? PCTs now have the responsibility for assessing the trust plans regularly. If I can take you to a local example which you will know about, in the case of something like the Royal Berks Trust, in the middle of a series of small PCTs, all of which might be said to have some dealings with it, who has become the lead primary care trust there and what responsibilities do the other PCTs still have?

(*Mr Crisp*) We have a chart in the paper which picks this up.

(*Mr Doran*) I cannot tell you which individual PCT it is.[3]

37. How would you choose which is the lead PCT for a particular trust?

(*Mr Doran*) We did not choose. What we said we wanted to see was local agreement about one of the six, seven, eight or nine trusts that linked into a major acute centre agreeing to take on the lead. Often, it is a trust which has staff who have moved from a health authority with particular expertise or particular interest in it. The basic idea is that each PCT has its own plan and in order to develop that plan it needs to work with neighbouring PCTs and with the hospitals that its population go to. However, when you look at the management of an incident, you cannot set up a control that has seven, eight or nine different PCTs. What we are looking to is where one PCT carries out that function on behalf of the others. The two key aspects are that the PCT in the lead is trained and develops its plan on the basis that it will be a lead organisation.

38. You are talking about PCTs having a plan. I thought it was the trusts that had the plans.

(*Mr Doran*) Each organisation has a plan.

39. Who assesses the trusts' plans?

(*Mr Doran*) The lead PCT will work with the PCTs in its group to assess and work on the trust plan.

40. Can you explain about working with the other PCTs? If you have nine PCTs all interested in one trust, how can they all work together to assess the plan?

(*Mr Doran*) They do it across a whole range of activities in the NHS. For example, all nine will have their patients use the services of the trust. They will work with each other on—

41. Are you saying that nine people will come from all the trusts into a big meeting and all assess the plan together?

(*Mr Doran*) I am sure they take a practical, pragmatic approach to it.

42. In practice, the lead PCT will assess the plan and report to the others and say, "Have you any comments?"

(*Mr Doran*) Exactly.

(*Mr Crisp*) It is annex B, the second page, that shows the build up from NHS trusts and the linkages.

43. What extra management resources will go to the lead PCT?

(*Mr Doran*) We have left that entirely to local discussion. We have not specified or mandated what it should be.

44. How do they get the money? Who is providing the money to these PCTs who are going to do the extra work?

(*Mr Doran*) They get mainstream allocations that they will use for this purpose.

45. You are saying they will not get any extra money.

(*Mr Crisp*) In any area, different PCTs take the lead on different issues. One will take the lead on negotiation with the Royal Berks about contracts; one will take the lead on emergency planning and so on. They will pay for that within their normal allocation. They have discretion to spend as much of their normal allocation on it as is appropriate.

46. This is an added responsibility for PCTs which has been thrown at them but they have not been given any extra resources?

(*Mr Crisp*) It was part of their foundation. They would be expected to make the appropriate management at the time available. That is reviewed by the strategic health authorities and those in turn higher up the system.

(*Mr Doran*) Most PCTs welcome it because one of the questions they raise with us is how can nine of us work with the local trusts.

47. It has been thrown at all of them together. Between them, they have to find the management time and resources.

(*Mr Crisp*) They are replacing health authorities on a whole range of different things.

48. I understand that and I am also very aware that PCTs have very little money to do all the jobs they are asked to do. I am worried that this seems to be yet

[3] Ev 17

[**Mr Rendel** *Cont*]
another responsibility which I am not sure they necessarily have the resources to deal with. Can I move to the south-east region's preparedness for nuclear disaster? Mr Crisp will be well aware that we have not just somewhere like Fylingdales which might be hit by a nuclear bomb but we have Aldermaston, which has nuclear materials on site which cause concern. The south-east region is said to have less than 50% preparedness for nuclear disaster. Does the Royal Berks have proper preparedness?

(*Mr Crisp*) I am not sure whether it was on the list of the 48 but where we have looked at the ones at the bottom end of the list we have all their responses.

49. Nuclear sites are not everywhere. There is only a fairly small number of nuclear sites spread across the country. Have you checked to see whether the trusts which are closest to the nuclear sites have fully prepared plans?

(*Mr Crisp*) We have this regular meeting between the local emergency planners who cover a region and the Department of Health and we look at local issues and the readiness within that.

(*Dr Harper*) The planning for nuclear incidents goes back many years. What we are talking about here are additional measures that have been taken since 11 September. The plans that are in place that are cross-government and cross-agency plans are tested regularly under the nuclear emergency side of things. What we have been doing here is looking at additional requirements and plans, specifically in acute trusts, ambulance trusts and the health service. Those will be in place and tested and we will have audited this, at least for the first time, by the end of this financial year. We will then be giving that responsibility to the Health Protection Agency.

50. That does not tell me explicitly whether those trusts which are closest to areas where you are likely to have a nuclear problem are those which are properly prepared.

(*Dr Harper*) Those are the trusts that are involved generally in the planning and the exercising. Where we have looked at counter measures over the years, these were located primarily around nuclear installations. The plans that include Health Department testing are focused on the nuclear installations. What we have done since then is look to upscale that activity and provide more counter measures and so on. The trusts and the health communities around nuclear power stations have been the ones that have been preparing for this sort of eventuality, for a nuclear incident, for many, many years.

51. We were told earlier that there is a problem with decontamination and so on. Are you saying also that those trusts are being given extra resources to deal with that?

(*Dr Harper*) They are being given extra resources in line with the criteria that we have set across the country in terms of population density and so on.

52. Can I ask you about co-ordination between different emergency services because obviously a lot of incidents are going to need more than one emergency service. What sort of testing are you doing of the co-ordination between the different emergency services?

(*Dr Harper*) There is a lot of collaborative working amongst the services and agreements at local level, all the way up through the sort of levels we have been talking about, regional level and national level. Very recently, there was testing involving the London Underground which involved the range of emergency services and the emergency services are working very closely together.

53. Turning to rail emergency, because sadly we had one recently near Paddington which involved some of my constituents, clearly railways are fairly infrequent beasts. There are not many railways in each area but most areas have one railway somewhere near them. It seems to me that you are quite likely to find that a railway emergency will not happen in your area for many years but will happen in some area on a reasonably regular basis. It is interesting to know to what extent the lessons learned by one area will be transferred to all other areas, because any other area might have a railway emergency close to it.

(*Dr Harper*) I agree absolutely. One of the points that is made very clearly here is that we need to do more to disseminate good practice. That is the challenge we are faced with. One of the difficulties is that at the moment we have confidential debriefing so that people locally can learn from an incident. The very fact that it is confidential and that it is a no blame culture and so on is one of the challenges we need to grapple with so that we can at the same time encourage anonymised information to come back centrally and to be kept in the database, to be analysed and disseminated as part of good practice.

Mr Steinberg

54. When I read this report I did not know whether to take it seriously because I thought if there is a nuclear attack on Durham or somebody dropped a bomb it would not matter whether a hospital was prepared or not really, would it? We appear to come from the region least prepared and not only are we least prepared for a nuclear attack or a biological attack or a radiological attack, whatever that is; we are also not prepared for a major incident. If you look at the traffic light graph, North and Yorkshire health authorities were the least prepared for a major, general incident. You seem to concentrate on the fact that we are talking about decontamination. I am not sure you need to be decontaminated if you have been in a rail crash or not. That is irrelevant. Then we look at the acute trusts and again they are the least prepared all over the country for a general, major incident. What does that mean to my constituents?

(*Mr Crisp*) These are pointing us to issues that we now need to look at, to find out why people have said that. I do not know if Mr Doran can comment on the general, major incidents, because that is clearly the one that is the lowest.

55. That is the most likely, I would have thought. For example, the main coast east line railway coming through and there are two viaducts in the constituency which could be used for a terrorist

[**Mr Steinberg** *Cont*]
attack. Are you saying that the health authorities and the acute trusts in my areas are not prepared for such an incident?

(*Mr Crisp*) I am not saying they are not prepared. They are not well prepared and that is their self-assessment. It is an entirely appropriate question that you and we should ask: why people are saying they are not well prepared.

56. In the west Midlands, they are tip-top, 100% at everything. What different treatment would my constituents get than the constituents of an MP for the west Midlands get if there was a major incident?

(*Mr Crisp*) The NHS has dealt with emergencies, with its partners in the other emergency services, very well over recent years. You all know examples, happily not everywhere in the country because we have not had them everywhere in the country. This is building on strength. Where this report has identified that people are saying to us they do not think they are as well prepared as they would want to be, we have to ask them the question and we have to resolve it.

57. What should the PCTs and the acute trusts in my area and Jon Trickett's area do?

(*Mr Crisp*) Firstly, provided we have the names of people who are saying they are not well prepared, they should tell us why they are saying they are not well prepared for a general incident, because this is not about decontamination equipment and the roll out of that. Then they should tell us what they are going to do about that and we should work together on that.

58. What also tickled my fancy a little bit was the fact that, when I looked at the ambulance trusts, I see in the North and Yorkshire we are performing very well indeed, 100% on general, major incidents. Are we saying that if there was a general, major incident in my constituency the ambulance would get them to hospital but once they got to hospital they would be knackered?

(*Mr Crisp*) No. We only had this information relatively recently and we do not know the answer to your question. I am very happy to try and find out the answer, provided we hear from the NAO which trusts we are talking about.

59. Perhaps the NAO could answer this question because they are the ones who produced the report. Are they saying that in Durham, if there was a major incident, you found our ambulances would get them to the hospital but the hospitals could not cope?

(*Dr Robertson*) We are not saying that. It is very difficult to speculate about any given incident. When we looked at individual health authorities, some were better than others. When we looked at acute trusts, some were better than others. When we looked at ambulance trusts, some were better than others. It is a question of taking all that response together on the day. As Mr Crisp has said, the performance to date has been good. What we are pointing out is that there need to be improvements in all these organisations.

60. This report when it hit the press a fortnight ago was one of the biggest splashes I have seen for an NAO report. Not only was it national news; I think it even led the news on the day. People regard this as very serious but you seem to be saying that, yes, this is very serious but we do not know what the problem is or how to put it right.

(*Mr Crisp*) We do not see the information on the trusts involved in that until after the report is published and when we see that we then need to follow it up and investigate. Particularly for general incidents, the NHS has an exemplary record and it has been improving, as this report says. There has been an enormous amount of work going on, but we need to continue and keep improving on this. We need to know if there is a problem and we need to sort it out.

61. Paragraphs 3.12 and 3.13 deal with not all health authorities' staff being adequately trained to deal with major incidents. Even before September 11, 33% of health authorities believed their training was insufficient. What has been done to rectify that?

(*Mr Crisp*) There were training programmes underway then. There are further training programmes following 11 September and we have now appointed a new co-ordinator for the training programme to make sure that we are rolling that out in a consistent way around the country, because one of the points made here is about the consistency of that training and the point was made earlier by Mr Trickett about the consistency of training across boundaries and so on.

62. What struck me was that I thought if the authorities who were not satisfied were the same authorities who were ill prepared for major incidents, at least we know and can do something about it. What if it was the ones who were insufficiently trained; yet, they believed they were able to handle a major incident? What is the situation there?

(*Mr Crisp*) That is again why we are going through the training programme consistency across the country and also the audit which I mentioned earlier, and also making sure that, for the first time, we have the Health Protection Agency which comes into existence in April next year, which will pull all this together in a tighter way across the country as a whole.

63. Will you be able to know if it was those authorities who were not up to scratch who were not fully trained as well?

(*Mr Crisp*) In future, absolutely.

64. The only way in which the plans of any authority or acute hospital can be tested is if there is an incident. The next best thing is, I assume, to regularly test those plans. I thought it was quite worrying to see that in paragraph 3.15 only 60% of health authorities ensured that their trusts exercised their plans regularly. 72 acute trusts and 32 ambulance trusts were unable to tell whether a major incident plan had been tested or not. That seems absolutely ludicrous: that they have a plan there and 72 acute trusts and 32 ambulance trusts did not know whether the plan would work or not because they had never tested it. It is absolutely crazy.

(*Mr Crisp*) You are quite right that the best way to test it is in reality. One thing this report does not bring out is that since 11 September we have had many hundreds of white powder incidents, including one in the Department of Health, which have been handled very effectively by some of the people who

[**Mr Steinberg** *Cont*]
say they are not well prepared. We are dealing with highly professional people trained to make decisions on the spot. This is taken extraordinarily seriously. On the second point about testing, I agree with you. However, I ought to point out that this survey took place one month before the health authorities were abolished. If in that month a health authority said it was unable to tell you whether 72 of the trusts had tested or not, there may be lots of reasons. That is not an excuse for not testing, but we have to be a little cautious about how we treat that. We need to make sure that people test; we need more scenario testing, more table top exercises, particularly for the even more worrying things than train crashes. Your point is entirely well made, but these are people who are delivering these services with a lot of experience.

Mr Osborne

65. You are right to talk about the experience of the NHS and you are right also to say that they have tended to cope with major incidents very well, but there is a part of this report which talks about the lessons to be learned from actual incidents at page 31, paragraph 5.16. There are some areas of concern here. It is really about the NHS at the coal face of the disaster. It says, "The NHS response lacked effective leadership and co-ordination and there were communications problems within the lead ambulance service, between the lead ambulance service and the surrounding ambulance services, and between the ambulance service and local hospitals. There was confusion as to who was in control at the scene, duplication of effort, and lack of effective use of local receiving hospitals. There were too many controls within the lead . . . No single officer liaised and co-ordinated the efforts of neighbouring ambulance services." What do you say to some of these criticisms of real events?

(*Mr Crisp*) What we try and do in confidential debriefings is take what has been a successful event—and these have been successful events—and encourage people to be as honest and as critical as they possibly can be so you can find the weaknesses and learn from them. It is very difficult to comment on this set of comments without seeing what the context was. Was this a successfully managed operation in which there were moments of confusion? There would be moments of confusion. How do we reduce those for the future?

66. The difference between a rail crash and an 11 September kind of incident is that the September 11 incident might well seriously damage the infrastructure of the NHS. How do you take that into account in your planning?

(*Mr Crisp*) There are some things that have happened that do help us. If I take the Paddington rail crash, it was remarkable that 350 beds were cleared in local hospitals within 90 minutes. When you look at the mass evacuation and casualties, that is quite an impressive figure and that gives me some reassurance that in London, if we have done it once, we can do it again. The white powder incidents I have talked about are also like that. Beyond that, there is a scale of incident that you cannot respond to. In between, we have to do many more table top exercises. We have to work on all the possible scenarios, get people together and work through them much more than we do at the moment. We have done some of this.

67. Do you make assumptions like: what would happen if the local hospital had been attacked or the ambulance control centre had been wiped out? That would not happen in a rail crash.

(*Mr Crisp*) We have to do all of those things. We have to think of the absolutely unthinkable and depress ourselves thoroughly and work through all those options. That is what has changed since September 11. The range of options we need to look at has become greater. We have looked internationally at how people have handled these incidents and we are well plugged in internationally.

68. You talk about the international lessons. What was the single thing you took from the way New York dealt with September 11 in terms of its medical services?

(*Mr Crisp*) There were relatively few casualties. There were high levels of fatalities.

(*Dr Harper*) One of the things that took a lot of people by surprise was that local people, first responders, found it almost impossible to communicate, not least because many of the transmitters for mobile phones were on the twin towers themselves. We have been looking at taking out key parts of the infrastructure in terms of the resilience. This is something not just being done on the health side but across Whitehall, across the agencies, looking, for example, specifically at resilience in London. What would happen if a large part of London became unusable? We would move people away; we would move resources and we would back up with mutual aid. We have been looking at that on the health side but this is something that goes on across Whitehall.

69. Do your plans take account of mass evacuations, because you would have a displaced population of maybe many hundreds of thousands of people.

(*Mr Crisp*) I do not think it is our responsibility to go into that, because it is a much bigger issue for the Cabinet Office.

70. You would have to provide health services to a displaced population.

(*Mr Crisp*) We are fully part of cross-government planning and we are alive to the sets of issues. That is why so much effort has gone into this. It is also why some of our people will have said they are not yet well prepared, because this takes time.

71. The only trouble with that is that the incidents can happen in a moment.

(*Mr Crisp*) Of course they can. The point that was not made earlier was that we reacted very quickly after 11 September. We immediately spent a large sum of money on counter measures of various sorts which had not previously been budgeted for and we sent out the intermediate guidance that Dr Harper talked about in order to move us on.

72. Could I turn to one bit of this report which most concerned me, which was the spot checks done by the NAO in October. They found areas of some general improvement but there were some areas where things had got worse. Is that because the more

[**Mr Osborne** *Cont*]
people thought about these problems the more they felt they were ill prepared or were there other actual deteriorations of service provision?

(*Mr Crisp*) I suspect there may be an element of the first, but it is jolly hard to quantify.

(*Mr Doran*) It is that they have begun to understand the nature of the kinds of challenges that you have just described. I was working in a health authority on 11 September and our hospitals had major accident plans, but we had not envisaged a situation in which the entire hospital was in some way taken out.

73. Presumably over the last 50 years quite a lot of this kind of planning must have been done in the event of a nuclear attack?

(*Mr Crisp*) Undoubtedly there has been lots of planning. I do not want to get into what is happening at a national level. There is a big body of experience here in the NHS, people who regrettably over time have had to deal with these incidents. The front page of the report shows the number of different sorts of incidents that have happened around the country. There is a depth of experience to build on. We are not starting *de novo*, but we do need to refresh what we are doing as a result of 11 September and the bigger focus that that brings.

74. Has anyone gone to New York and talked to the ambulance service or the health service or hospitals there?

(*Mr Crisp*) We have had a range of international contacts.

(*Dr Harper*) Yes. We have had visits to Washington, multi-agency visits, including police and health people going to discuss lessons with their people, face to face.

75. Rather than the people in Washington who saw it from a distance, you have talked to people on the ground who have said, "The real problem we had was that mobile phones had run out of battery", that kind of practical experience?

(*Dr Harper*) Yes. During the immediate aftermath, there was frequent, regular telephone contact as things were unfolding, particularly between our public health services and their opposite numbers in the CDC and in the New York public health service.

Geraint Davies

76. I am a London MP and obviously the main focus of terrorist attacks would be London. You have mentioned the priority of London but in the rankings, in terms of acute trusts, there are very high proportions of trusts that do not seem to be in a state of preparedness for even mass casualty incidents, 14%, let alone chemical, biological, radiological and nuclear incidents. Does this cause you some concern?

(*Mr Crisp*) It causes enough concern to make sure that we went back and found out why they had reported that.

77. In terms of mass casualty incidents, we realise that September 11 will have refocused minds on priorities that were not as immediate as waiting lists perhaps in terms of nuclear fall-out, but in terms of mass casualty incidents, incidents of those sort do occur from time to time, do they not?

(*Mr Crisp*) There was the Paddington rail crash and the example I was giving of clearing 350 beds in 90 minutes.

78. There are 28 London acute trusts and there is concern, if there was a major incident, explosion or fall-out of biochemicals or nuclear attack, all these trusts should be working together as one and in particular there is enormous displacement of the population. Are you happy that there are different standards of delivery across London in different trusts?

(*Mr Crisp*) There is a co-ordinated structure. All the trusts are accountable to the five health authorities and the five health authorities are accountable to us centrally, so we have a very clear, very short structure there. We need to identify those who believe they have problems and perhaps the most important point is that we made sure that we paid a great deal of attention to the London Ambulance Service.

79. It is all very well having acute trusts in certain areas of London but if there is some drop of the plague, for instance, it is going to spread across different acute trust areas and there needs to be a consistent approach to cope with that. It seems to me different trusts have different levels of preparedness and different management systems.

(*Mr Crisp*) The two points are slightly separate. Firstly, they are co-ordinated in that they are accountable to the health authority which, as this says, has the responsibility for the south west of London. It is a concern that individuals within that may be reporting different levels of preparedness and we need to look at that and understand why there is a difference there and make it good.

80. In other words the rumour of a nerve gas or biochemical attack on the Tube was perhaps without foundation but clearly that is a credible risk. To what extent are we prepared for that?

(*Mr Crisp*) The point about what we are prepared for is in these various categories of chemical, biological, radiological and nuclear and there are different ways in which you deal with different sorts of incidents. That was what people were being asked to assess themselves against, the range of potential threats.

81. Yes, but in terms of the list of preparedness that was objectively defined, if there was an incident on the Tube what had been judged was not how quickly we could get in there, get people out, get them treated. It was more whether we had some decontamination equipment and some protective clothing for people in the hospital. That is not an assessment of preparedness at a major incident.

(*Mr Crisp*) I will ask Dr Harper to explain the precise roles here, but the first role in such an event is the Ambulance Service. The Ambulance Service has very good experience of a whole range of different incidents and very good experience therefore of taking casualties to the range of different hospitals. That is what happens with any of these incidents and, as I say, in the example of Paddington we have got a good track record as well as learning from all that.

[**Geraint Davies** *Cont*]

82. The Ambulance Service seems to score quite well other than on radiological and nuclear incidents. What does that mean? Does it mean that they have not got the equipment to protect themselves or they could not go into the area because they would be contaminated?

(*Mr Crisp*) We have talked to the London Ambulance Service again having seen how they had comported themselves within this.

(*Mr Doran*) They do regard themselves as well prepared for chemical and biological and they have laid stress themselves on working with partner agencies which is the very point that you put. On radiological and nuclear, they regard themselves as ready for what they call the accidental scenario whereby perhaps a small piece of radioactive material in a university lab caused a problem. They could handle that. It would be the dirty bomb or the deliberate contamination which would have been the difficult scenario. For that they were dependent on receiving the suits which they now have. They have the decontamination units which they needed. They have their training in place. They regard themselves as ready to produce a plan which they will do at the end of next week.

83. As you have mentioned it, if there is a dirty bomb, a nuclear device, blown up in the middle of London, and this is contaminating thousands and thousands of people, what you are really saying is that the ambulancemen will arrive with suits on to protect themselves and would be attempting to take these people away and presumably the Health Service could not cope with that.

(*Mr Crisp*) The report says that there is a scale of incident which is going to be a problem for anybody. What has been taken by the Ambulance Service is all reasonable precautions and they are able to deal with and will respond to incidents. They are obviously continually doing what Mr Osbourne talked about earlier, making sure that they play out different scenarios and they see what it will look like in the future, but they now have the decontamination equipment and they are working with their partners on these issues.

84. I realise that, but if there was a September 11 incident in the middle of London, for instance, where literally thousands of people were being killed and there were many thousands of casualties, it might be a more conventional way, which September 11 was in a sense, or it might be biochemical or bacteriological or whatever. Are we seriously saying that we can scope with that?

(*Mr Crisp*) All of those different sorts of events needs to be planned for and prepared for. This report I earlier said was subjective but the reason that we have talked about prepared or not is that you have to make a judgement as to whether you are prepared for these events because until they happen you do not know, do you? This is about them saying to us that they are prepared for this, that they are continually planning, that they are continually working with people.

85. Changing the subject, how concerned are you that there might be a major terrorist attack at a time that the firefighters are on strike and what impact would that have on the Health Service?

(*Mr Crisp*) That is not a question for me. Our responsibility is about the NHS; our responsibility is about making sure that should one of these highly unlikely events happen we are able to deal with it.

86. The possibility would be that more people were being burnt and necessarily therefore brought into your hospitals and could you cope with treating that many?

(*Mr Crisp*) Our role is looking after people in whatever eventuality, any event of any sort that may be happening.

87. But the quantum, I presume, of health care would need to be increased?

(*Mr Crisp*) The point I kept making about the Paddington crash was that we were able to clear 350 beds in 90 minutes. There are a lot of people in hospitals who are there for elective reasons and therefore they can be moved out relatively easily and we can redeploy our staff, and staff have always been very good at that.

88. On page 4 it mentions some of the nerve agents, plague, smallpox, and other things that might suddenly arrive, and also we have talked about nuclear weapons and about bombs. I am surprised that on page 22 in table 15 it says that good practice identified by acute trusts is helping to improve the major incidents planning process, and the last bullet points says to "make it fun and almost routine". Do you not think it surprising to be planning for a mass disaster in a way that makes it "almost routine"?

(*Mr Crisp*) The point I would make here, and I did not write this, is that we are talking here about extremely unlikely events, but nevertheless we absolutely have to plan for these events.

89. One has just happened in Bali, has it not? These are current events and we are at the forefront of anti-terrorism.

(*Mr Crisp*) The point is that we have to keep the importance of people dealing with these issues up. We have to make it routine. We have to make it part of the job. We have to make people want to do it.

90. I think your last point is of key importance. What I am interested in knowing from your last comment, which was that this is extremely unlikely, is what real priority is this alongside other pressing priorities, waiting lists, cancer, heart, all the rest of it, if you are saying it is unlikely at a time when we have seen a whole pattern of terrorist attacks and Britain is very much at the forefront of arguing against terrorism and taking action?

(*Mr Crisp*) The questions you are trying to ask me are not properly for me. There are other people you should be asking about that.

91. But in terms of your management in-tray how much time are you giving to this as opposed to other priorities?

(*Mr Crisp*) Let me pick up the priority issue. We are giving a good level of priority to this. As you say, there are very many things that we have to deal with. We have invested more money. We reacted immediately afterwards. I personally have picked up the issue with a whole range of chief executives. For example, I mentioned earlier that we were concerned to make sure that there is straight continuity between health authorities and primary care trusts. I

[**Geraint Davies** *Cont*]
personally wrote to all the primary care trusts and stressed the importance of this set of issues alongside all the other things on what are very busy agendas. We are giving it a good level of priority that matches the seriousness of the potential situation.

92. And in January you will be at a high level of preparedness?

(*Mr Crisp*) In January we will be where we want to be as far as equipment is concerned and we will be rolling out the training programme further. This will be a continuing issue. We will be continually needing to update and that is why I believe it has been written down here that this should be routine and fun for people to want to do it.

93. It seems to me that you can never be too prepared for one of these enormous catastrophes and there is always more that one can do.

(*Mr Crisp*) That is why this report is a positive report in terms of the strength of the underlying system and the fact that there have been improvements. There is more to do. We do need to keep improving. We do need to keep focused on it. We do need to make it routine.

Mr Jenkins

94. I am very fortunate; I live in Staffordshire. It has the Ambulance Service which has the best response time in Europe. It is the finest Ambulance Service in the country, but I know that the Ambulance Service in my county is no different from the Ambulance Service in any other country in that it is short of that one vital resource: money, and to do anything else and put more pressure on requires manpower and funding. I am always mindful that maybe we take these things on the cheap and we are trying to impose something on the cheap and it is always a difficult balancing act. I have read the report and I have looked at different incidents. What do you think is an incident?

(*Dr Harper*) In the sense of the report it covers all the areas that we have been discussing from what had traditionally been described as a major incident which would have been typically a road or rail crash or an air crash, but it is extended in this case to include the newer threats, which would be CBRN,[4] which would involve the scaling up in terms of mass casualties. We created the term mass casualties after September 11 to distinguish between what we would have had as a normal major incident and something bigger.

95. So we have got from minor incidents to major incidents. When I was in the police headquarters one day the board went red and they had 300 telephone calls on 999. A swan had landed on the motorway and drivers going past thought, "I will phone the police up", and the police are now in a situation where we can get 300 phone calls reporting an accident but we do not know whether it is one accident reported 300 times or 300 individual accidents. How do you start to trigger the response? Who triggers the response to a situation where you get there and there is an incident? Is it a green incident? Is it a red incident? Is it a black incident? How does the information transport down the system that we have got a major incident?

(*Dr Harper*) The first thing that would happen, and I will generalise because I think it is the only way we can do this service. If we take the example of the London Underground, the staff of the London Underground would be monitoring platforms and would be looking for unusual incidents and there is a trigger point there. One person collapsing might well be an accident, somebody falling over and so on, but they have their own criteria for distinguishing if there is an incident or what looks like an incident, and the police will be called and they would be the first response. They would carry out their own risk assessment and in the meantime would be contacting the Fire Service, the Ambulance Service, who would arrive and establish a rendevous point at the control centre or whatever you like to call it. The assessment is continued at that point. If it looked appropriate, public health experts would be drafted in and other experts as well, a multi-agency approach. It would be assessed as it developed. The public health people would trigger the communication chain on the health side.

96. And this is all left to individuals within the network? On page 21, 4.3, and I am not reading this right obviously because it cannot be true, halfway down it says, "Those responsible for the review were mainly individuals directly responsible for planning but included a small number unlikely to have any real insight into major incident planning procedures, such as a switchboard supervisor and a patient records manager." Are they the key people in the chain of response and activity?

(*Mr Crisp*) There are two different issues. The point you were asking about, who triggered the major incident, was the answer that Dr Harper was giving. This is actually about who initiated the review of the plan.

97. So I presume the person who is in charge of the review of the plan is in charge of the plan itself?

(*Mr Crisp*) Not necessarily.

98. So the person in charge of the plan does not get the review information?

(*Mr Crisp*) No.

(*Mr Doran*) There are two levels of review for an NHS acute hospital trust. They will have a chief executive and board colleagues, one of whom will be responsible for annually looking at the plan they already have, deciding whether it needs to be changed, looking at whether it has stood the test of time, talking to partner agencies. This paragraph seems to be entirely unacceptable if that kind of serious review is left to a switchboard operator.

99. I find this totally unacceptable.

(*Mr Doran*) The other part of the existing arrangement of course is that prior to the establishment of PCTs the local health authority was responsible itself, which is a separate organisation, for looking at the plans of acute trusts and for reviewing them, so there is if you like a double process. There are two bodies involved. The acute trust, the hospital itself, needs to look at its own plan internally and ask itself questions. That in turn is reviewed by the health authority.

[4] Chemical, biological, radiological and nuclear

[**Mr Jenkins** *Cont*]

(*Mr Crisp*) But your point is, reading this as it is written, that this is not right.

100. The point is that somebody responsible must be in charge and be able to activate it.

(*Mr Doran*) Yes.

101. And clear beds and so on. Also, somebody must be in charge when they co-ordinate their ability with the next one down the line, such as the Ambulance Service so that plans will be sent down the line to somebody so that they can co-ordinate the activity, but according to 4.4 it does not happen in many cases.

(*Mr Crisp*) I think this one is about reviewing the plan, not about initiating the plan or making the decisions when it is happening. There are two separate points there.

102. I think you have to be careful. If you do not have the knowledge of reviewing the plan you might be working to an out of date plan and that is dangerous in itself.

(*Mr Crisp*) As it is written here this is wrong.

103. On other thing: we have, as you know, county emergency headquarters in areas like Staffordshire and we linked these in as quickly as possible. Now with the primary care trusts we have got a difficult enough job setting that up without hearing all this. I think the additional responsibility is such that although you are only answerable for the Health Service you appreciate that the Health Service fits into a larger pattern and it is your ability to fit into that larger pattern that causes me some concern since you are lacking at the moment the integrated communications necessary within the organisation, let alone outside the organisation. Am I right to feel that there is a bit of concern with your ability to communicate on a wide regional capacity?

(*Mr Crisp*) If you look at Annex B, second page, which describes the responsibilities, you will see, for example, and perhaps I will just read it, "The lead primary care trust is represented at police gold command", so it is linked into the whole of the local network, and that is a responsibility to do that. These organisations, as you know, took on this responsibility from October 1. We are yet to review how well that is working but that is part of the order we will be picking up on.

104. And you feel comfortable that the information should go upwards rather than downwards?

(*Mr Crisp*) Yes.

105. I feel that, when you have a major incident, the major incident room should be at some command centre in the region and they should be co-ordinating the activities of all the services and calling upon the Health Service to perform to an agreed plan.

(*Mr Crisp*) Dr Harper was describing the escalation process. If it is a swan on a motorway it is one thing. If it is something else—

106. In 5.10 it says at the end there that 30% of ambulance trusts said they were not satisfied with the feedback they got from other parties in the briefing mainly because they received very little feedback. Is that worrying for you?

(*Mr Crisp*) Yes, but it is also healthy. I am delighted to know that ambulance trusts want to get that feedback because that is the best way to learn, and if they feel they are not getting enough then we need to make sure those confidential briefings work.

107. I think it would be even healthier if we had 3% rather than 30%. The last thing is the need for information, covered in 3.11 in this report. When you have a major incident we have got problems in this country, as any other country has. We have people who go to a major incident and really what we have to say is, "Keep away from this major incident". There should be information via the media to the public to keep away from the scene or what action to take, not to develop the situation into a much more serious one.

(*Mr Crisp*) I agree with you, and again I think the point is well made that this is one of the issues that need some attention as a result of this report.

Mr Jenkins: I think it needs a lot of attention and I think we really have to get our act together on that one. It is difficult because with our media, as you know, the reporter is the second on the scene and maybe we could use them for first aid or getting some life-saving technology, they and the photographers, because they will step over the dying to take pictures for the front page, and they will carry any story and they can misinform the public, so I think it would be better to make sure we do get the right story out immediately.

Jon Trickett

108. In the earlier questioning in response to almost all members, you have relied to some extent on the defence that this was a subjective questionnaire and you hinted that perhaps some people were being modest about how well prepared or not they may have been. You have referred to paragraph 1.11. That paragraph only gives you a partial defence because it is quite clear in 1.11, and also in the previous paragraph, that a variety of methodologies have been used, some of which were objective. You have accepted the report as a whole, I think. One of them says that there was a correction built into this report because other methodologies were used. I have not got time to go through them all but Part 3 refers to an objective analysis done by, I think, a consultant on the quality of plans. This you cannot say was in any way subjective and I rather think you did skate rather quickly over this part. I have noticed in paragraph 3.3 a series of quite worrying failures. For example, there was only 53% compliance in relation to a required practice in terms of plans being prepared. Paragraph 3.4, a quarter had failed to include arrangements for a mass casualty incident in their plans. Paragraph 3.5, health authorities scored poorly in terms of updating their plans and in terms of relations with external organisations. A third of the sample cored zero. For example, in paragraph 3.7, less than 10%—in other words 90-odd % of health authorities had failed in taking any note of radiological or nuclear incidents, by which I gather that probably 54 million people may not be covered by updating plans in relation to radiological and nuclear path. These are significant objective tests which show failures. I know you do

[**Jon Trickett** *Cont*]
not know what your statutory duty is just now; you cannot give it a position, but are you not presiding over a chaotic system here?

(*Mr Crisp*) Certainly not.

109. Are you not responsible for that?

(*Mr Crisp*) Certainly not. It is not a chaotic system and I think the reasons are very clear, because experience has been thoroughly good. We have very well experienced people out there in the NHS, very professional people. This report shows improvement. Even the paragraphs you show at the beginning of 33 show that the plans have improved in quality since they received the guidance. Progress has been made, but I am not remotely saying that there is not further progress to be made and there will be further progress after that. This is about continually responding, this is about continually improving the quality of what is already a good service.

110. I have great confidence in the doctors, nurses and the manual staff of the Health Service. I have no doubt they will respond as they always have done in the past, but you are required, I think, to take an objective view. My view is that it is patchy at best and chaotic if you want to perhaps slightly overstate the case. What is your objective assessment of your compliance with your statutory duty as a department in relation to this matter?

(*Mr Crisp*) As I explained earlier, we do a very regular risk assessment and testing of what is happening on a monthly basis, Dr Harper and colleagues regionally make sure that we understand what is going on, to make sure we know what the issues are and to make sure that there is appropriate guidance out there. It has also been brought out in the course of this hearing that during this year the people who have been responsible have changed from health authorities to PCTs, we have big training programmes on the way, we have a great deal of activity under way. We are building on a good foundation is my objective assessment and we are also bringing external people in to help us with our own assessments. This is one assessment based very largely on people's self-assessment against a set of criteria. My point about saying that that was subjective was to say that, whether it is a figure of 57 or 65, it is within the margins of doubt but nevertheless I think these figures are important for us to look at, to understand why people are saying they are not well prepared.

Chairman

111. I am not sure you answered Mr Trickett's point that this was not a subjective test. Paragraph 3.10, page 17, is saying, "Our review of those produced showed that quality was generally poor, . . .".

(*Mr Crisp*) This is about debriefing reports.

112. Yes.

(*Mr Crisp*) Dr Harper said earlier that debriefing reports are handled locally. We need to find ways to make sure that the lessons from debriefing reports are shared nationally. That is a very clear point and one we should accept.

Mr Steinberg

113. When I read the report I got the impression, following on from what I was asking before, that basically what had been happening—and I may be wrong—was that trusts and health authorities were paying lip service, frankly, to the problem, but then their minds were very much centred on the September 11 incident and things may well have changed. When I read the report I got the impression frankly that they were not really taking it seriously. Mr Jenkins pointed out that a switchboard supervisor and a patient records manager were in charge of reviewing the plan, but that does not seem to me to be particularly taking it very seriously. What I really thought they were not taking all that seriously was when I read 4.9 on page 22 because it appeared to me that the things where there were specific problems were the actual things which were vital in terms of a plan. Let us just go through them: "Though acute trusts had almost all carried out some kind of risk analysis, they were not based on sufficient and comprehensive hazard and risk assessment; mutual aid arrangements to enable trusts to work in collaboration with others were missing in the majority of plans reviewed; communications and transport disruption or failure was not addressed in the plans; in the majority of cases examined Emergency Planning Co-ordination Unit guidance was used as annexes to plans rather addressed within the plan itself; the majority of plans did not address internal major incidents; and few plans addressed chemical, biological and radiological incidents." In other words, frankly, they were not taking it very seriously at all. It was lip service. They may well be taking it seriously now because of events that have happened throughout the world since the plans were first envisaged, but plainly they were not taking it very seriously if they had a patient records manager and a switchboard supervisor looking after them and these were missing from the plans in the first place.

(*Mr Crisp*) I make no defence of the point that Mr Jenkins and you are making about who appeared from that paragraph to have been responsible for reviewing the plans and, if that is the case, that is not acceptable.

114. But the plans themselves, Mr Crisp.

(*Mr Crisp*) Let me go on to the second point, the plans themselves. There are clearly some weaknesses in here; let us be clear about that. Again, the point I need to make is that where we identify those weaknesses let us then deal with them.

115. If we could be given a guarantee that those sorts of things are now being addressed and that they are going into the plans and that they are taking the plans seriously and that there are people looking after the plans who are reasonably senior in the trusts and in the PCTs, then we can be satisfied, but if it is still going on in the same old way— For example, in figure 18 some acute trusts revised major incident plans' scores. One trust had below 10% whereas another one had close on 80%, so some clearly take it seriously but others do not.

(*Mr Crisp*) The two examples we picked up about who appeared to be reviewing the plan are obviously wrong. That should not be happening, but this is out of 650 organisations so that is not, I assume, the

[**Mr Steinberg** *Cont*]
norm; otherwise it would have been pointed out to us. The second point that I would make is about one or two of the very low scores we have looked at, and it is very evident that there has been some mis-communication here between the individual organisations and the NAO reviewers. In one particular case, when we looked at it the trust had actually sent it (because these were done as a paper exercise as I understand it) some distance and had sent a summary of the plan rather than the plan itself. There were some areas like that within the system. Having said that, there are some clear areas where we need more work to be done. However, I do think people take this very seriously. What has happened since September 11 is that before that a lot of people took this enormously seriously, including people such as both Dr Harper and Mr Doran, but since then it has become higher up the agenda of all of us, as Mr Davidson drew out.

Mr Jenkins

116. You have just done something which is not uncommon, unfortunately, in front of this Committee. You have just said that obviously there is a mistake with the report by the NAO, but you had a copy in your department workplace, so why did you not go back to the trust concerned and clarify the mis-communication so that the report would have been accurate before it came before you and got signed off?

(*Mr Crisp*) Let me be clear. We do not always know in advance of the report's publication what individual organisations have said. We see it after the report has been published so that we can then pick it up and investigate it. That is the way it generally works.

117. Can I ask the NAO then, if we have got a situation where there is obviously something that looks dramatically wrong, why do we go to the department? Why do we not go back and doublécheck that we do not have a mis-communication and the report looks worse than the real situation?

(*Mr Burr*) If the audited body has any difficulty about our findings the normal way to deal with that would be to challenge those and challenge us to produce the evidence.

118. So the information is seen by the department before the report is compiled?

(*Mr Burr*) The department can have any information that they wish to have to satisfy themselves that the report is accurate.

Mr Steinberg

119. It would be easy to name each one of those hospitals on the graph so that we knew which ones we were talking about and then we would know exactly which hospitals were performing and which were not. Perhaps you are not allowed to do that.

(*Mr Burr*) We are allowed to do it. We chose not to do it because we wanted to focus on the general issue.

Mr Davies

120. On September 11 when the tragedy occurred, were we at the level of preparedness of the emergency services as the Health Service were in London as they were at that time in New York, do you feel?

(*Mr Crisp*) I do not know that we have any basis for answering that.

121. Is there a meaningful answer to that or not, or do you not know?

(*Dr Harper*) Comparing London and New York is very difficult. What I can say is that in terms of the infrastructure generally in terms of the sort of incident that we are talking about, release of chemical and biological agents, the US—and we have been in close contact with them—were envious of the structure that we had in place in the UK.

122. Before September 11?

(*Dr Harper*) Before September 11 and immediately following September 11 in terms of surveillance and reporting.

123. What I am more interested in is the situation now vis-a-vis New York, and obviously they have been moving forward in the same way as we have. Have you been conferring with them? Have you got similar strategies? Are we at similar levels of preparedness or are they a mile ahead of us or we ahead of them? What is the situation in London versus New York?

(*Dr Harper*) It is near impossible to draw a direct comparison because of the different structures and the different service provision elements.

124. But are you in contact? Do you know what they are doing?

(*Dr Harper*) I am in contact with the public health side of the organisation in the US, particularly through Washington. I am not personally directly in contact with the service providers in New York.

125. Do you think it might be a good idea to go out there, to see on the ground what their multi-agency approach is and how it fits together and where there are lessons to be learned and, if there is another big catastrophe, how they would work through that, how quickly they would do it and what lessons we can learn from that?

(*Dr Harper*) Our operational people have been in contact with their opposite numbers in New York and have been discussing and learning from the lessons. As I said earlier, there have been teams visiting the US.

126. Can you give us examples of two or three lessons that you have learned from what they are doing in New York or do you not know?

(*Dr Harper*) I picked up earlier the communications issue but that was at a more strategic level.

Mr Davies: I would be interested. Perhaps I am wrong but I do not get the impression that you have got on the tip of your tongue what you have learned from it. It is vague connections. Maybe we could have a note on what we understand is happening in

[**Mr Davies** *Cont*]
this catastrophe control and management in New York versus here or what we are learning or exchanging.[5]

Chairman: I think it is a very fair question. I do not see why we should not ask for more information about international comparisons.[6] After all, it is not just New York. It is Paris, Berlin, Rome, all our allies. They are all facing this terrorist threat. Surely it would be useful to know what these great cities of the world are planning and how they are going to cope. It is all interesting stuff.

Mr Davies

127. And the quantum of resource, obviously.

(*Dr Harper*) I could certainly say that we are in much closer contact in the operational sense with our European colleagues and are working through the European Commission meetings, looking again specifically at issues related to CBRN, the subject of the report, chemical, biological, radiological, nuclear, those particular types of hazards, rather than the focus of the discussions being on what I would call traditional major incidents like road and rail crashes; focusing on the newer threats. We are working very closely with Paris, with our German colleagues, with our European Union colleagues and with other international groups to exchange good practice, but that is not comparing London and New York.

Chairman: We are not asking you to compare London and New York but it would be useful to have a note on your researches because it would make our report a lot more interesting if we knew what they were doing and what lessons we could learn from them.

Mr Davies: But I am interested in New York as well. Given their appalling experience on the ground it would be surprising to learn that they are not ahead of us and that there are lessons to be learned.

Chairman

128. Just one point which I did not raise in my earlier questions; there was no time. In paragraph 20, page 6, in the recommendations, it is recommended that the Department of Health should pursue options for better knowledge management for planning for and reporting on major incidents and that this should include better collection and dissemination of good practice and a national incident database. When can we expect to see these improvements in place?

(*Dr Harper*) We have been looking at this, the best type of database, for some time now. I would expect to see some results certainly by the end of the financial year. Part of the difficulty is identifying exactly what is required so that, looking to the Health Protection Agency at the start of the next financial year, we have something that we are able to hand over to them because we would be looking to the Health Protection Agency to have this responsibility in the future.

129. Can I ask one last question of the Treasury? Mr Crisp said that we had to spend sums of money after September 11 not previously budgeted for. Can you tell us a bit about how the budgeting works? Presumably you can reassure us, because they do involve potential casualties, that the Health Department have all the resources they need and there would not be any budgetary constraints for what they need to do?

(*Mr Molan*) This is something we expect departments to deal with as part of their mainstream planning. Similarly with NHS, we would expect them to carve out from their allocation from the Treasury sufficient resources to prepare for such incidents.

130. So no extra money is made available to them?

(*Mr Molan*) We just had a spending review which was concluded this summer. Like all departments, the plans which have been set for the next three years have been set at a level which should allow the DoH and other departments to plan accordingly for incidents like this.

Mr Steinberg

131. That is rubbish, is it not, to be honest? If we had a major incident in Durham and 300 people were injured in a major incident are you saying that no extra money would be made available because the spending plan said there could not be? That is crazy. How can the Health Authority fund something like that?

(*Mr Molan*) I think if there was a particular incident—

132. That is what we are talking about.

(*Mr Molan*)—there would be an issue as to whether the DoH could initially find the resources. If they could not, there would be a possibility of the Treasury providing money from the contingency reserve depending on the local need, and the Department of Health's overall spare resources. For example, the Department of Health does have an unallocated reserve so there is some spare capacity for special incidents. If it was a very pressing matter and money had to be spent to help people locally, then obviously the Treasury could discuss with the Department the need to provide resources necessary from the contingency reserve.

Chairman

133. So although Mr Crisp has done a lot more work and spent a lot more money after September 11, you are saying he just has got to find that from within his budget. That begs the question, Mr Crisp, what else are you going to cut to make up for the shortfall, or is there sufficient leeway?

(*Mr Crisp*) There are two points, are there not? The first bit is what we did last year we managed to fund within our overall expenditure. The Treasury is quite right. We have then subsequently had a spending review which was settling our allocation for the next five years and which was meant to deal with everything.

134. And you can reassure us of course that it does? You can remain silent and take the fifth amendment. We do not mind.

[5] Ev 17–18
[6] Ev 17–18

[Chairman *Cont*]

(*Mr Crisp*) I think we are extremely grateful for a very healthy settlement within the NHS which will enable us to make very significant improvements in this area and in our health services over the next few years, and that is what we are going to use it for.

Chairman: Thank you very much, gentlemen, for appearing in front of us. As Mr Steinberg said, this report did get a huge amount of national publicity a few weeks ago. I think it has shown, following the Prime Minister's statement, just how seriously the public take these matters. We do not want to alarm the public. We have to do our duty to try and encourage better and greater efforts and I think you yourself have acknowledged it and are now moving it further up the agenda in your evidence today and, whilst there may be shortcomings, we look for some major improvements. Thank you very much for appearing before us. We are very grateful.

APPENDIX 1

Supplementary memorandum submitted by the Department of Health

Question 21: What is the Department's statutory duty in relation to emergency planning?

The Secretary of State's duty to undertake health related emergency planning stems from section 1 of the National Health Service Act 1977 which imposes a duty on the Secretary of State to "continue the promotion in England of a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of [that country] and (b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act."

Consistent with that general duty, other provisions of the 1977 Act give the SoS more detailed functions and powers, including a power to direct Strategic Health Authorities and Primary Care Trusts to exercise any functions of his, including health related emergency planning functions. The most relevant provision relating to accountability is s17 which gives SoS a general power to direct health service bodies about the exercise of their functions.

Under the National Health Service and Community Care Act 1990, Primary Care Trusts are able to contract with NHS trusts for the latter to provide services relating to emergency planning, at the hospitals or other facilities run by the trusts.

Question 30: What comment do you have in relation to the fact that the Ambulance Service cannot deal with warm summer nights?

We believe Mr Trickett's concern was prompted by a lengthy delay in responding to a 999 call at 0247 on 29 July in the Hemsworth area. As West Yorkshire Metropolitan Ambulance Service NHS Trust (WYMAS) had no vehicle immediately available in that area, assistance was requested from the South Yorkshire Ambulance Service (SYMAS) at 0251. Mutual assistance arrangements are in place between all ambulance services but SYMAS was also experiencing similar difficulties at that time.

The first available ambulance was despatched but in order to provide faster help one-off assistance was requested from the West Yorkshire Fire Service whose fire crews are trained in resuscitation and carry a defibrillator. The fire crew arrived at 0317 but could find no signs of life. The ambulance—which was sent from Dewsbury hospital when it became available at 0311—arrived at 0327 and its crew confirmed that regrettably the patient had died.

A subsequent investigation confirmed that emergency demand was higher than would normally be expected for that time of day and that some operational crew shortages had also contributed to this unacceptable delay. Due to the unpredictable nature of demand every emergency service finds that it has insufficient resources on some occasions, but its resource and deployment plans aim to keep those to a minimum. As a consequence of this incident WYMAS has reviewed its cover against revised demand levels.

By definition 'major incidents' exceed the local resources immediately available to deal with them. An effective response therefore relies on special arrangements—particularly calling in off duty staff, re-prioritising routine work and invoking wider mutual aid arrangements. Occasional instances where demand exceeds capacity are not therefore indicators that an ambulance service does not have the capacity or capability to respond to major incidents.

West Yorkshire Ambulance Service generally performs well against national response time standards. Experience in recent years has shown that its plans, procedures or resources are effective in providing an adequate and effective response to major incidents.

Question 36: Which PCT has become the lead PCT for the area in which Royal Berkshire Trust is a part, and what responsibilities do the other PCTs still have?

The lead Primary Care Trust (PCT) that relates specifically to the Royal Berkshire Hospital is Reading PCT. The PCTs within the Thames Valley Strategic Health Authority have developed a PCT Emergency Planning partnership agreement to maximise joint working.

The Royal Berkshire Hospital recently took part in an exercise with the Atomic Weapons Establishment involving a mock radiological spillage and rehearsed their decontamination procedures. This was favourably reported in the Reading Chronicle on 10 October 2002.

Question 126 (i): What lessons have we learnt from, or are exchanging with, New York?

The Health Emergency Planning Department of the DH London Directorate of Health and Social Care was represented in two official visits to New York in November 2001 and 2002. The following points are highlighted as key observations.

Health services in New York did not come under sustained or overwhelming pressure as a result of the September 11 attack. It produced high numbers of fatalities. The majority of casualties sustained minor injuries.

Had the Twin Towers not collapsed, much higher numbers of casualties would have been likely, many of whom would have suffered severe burns. Bellevue Hospital in New York reported that it could create capacity for up to 200 burns casualties through transferring suitable existing patients to non-trauma hospitals to achieve this. Severe burns treatment capacity however is dependent on the availability of critical care facilities as many of these patients require ventilation for long periods. Surge capacity for the treatment of severe burns therefore needs to be set in this context and plans developed accordingly.

New York emergency services did not report having an agreed strategy for the joint management of the scene of a major incident—unlike established practice in the UK, described in the Home Office publication "Dealing with Disaster". During the last year, New York has strengthened its co-ordination of the response to an incident through the Office for Emergency Management (OEM). However, New York does not have anything like the London Emergency Services Liaison Panel (LESLP).

This was established in 1973 and consists of representatives from the Metropolitan Police, The London Fire Brigade, City of London Police, British Transport Police, London Ambulance Service and local authorities. The group meets once every three months under the chair of the Metropolitan Police. Its purpose is to ensure a partnership approach between all the relevant agencies in the planning for, and the response to, a major incident of whatever kind. This could be anything from a terrorist attack to a natural disaster such as a severe flood, which may occur within the Greater London area.

The main emergency response organisations in New York have adopted management software that allows key information to be recorded during an incident in a common format and this may promote inter and intra agency co-ordination and the management of critical information. Work has also progressed on the provision of secure communications that allow the emergency services to talk to each other.

The Rand Science and Policy Institute and the National Academy of Sciences both reported on the importance of front-line emergency worker safety. This translates into the need for quickly gaining control of the disaster scene itself with effective on-site safety management. Interagency training and exercises can instil safety practices. The use of standardised and inter-operable equipment can improve the combined emergency response.

Question 126 (ii): What are the great cities of the world planning and how are they going to cope?

The Department has been busy since September 11 contributing to an international dialogue on emergency preparedness. This includes playing a lead role with a number of international bodies including the World Health Organisation (WHO) and the G7 + Mexico group as well as the European Union (EU) and NATO.

The structure of health services varies throughout the EU and this influences arrangements for the management of major incidents and disasters in member states. This is reflected in the organisational structure of planning and response at national, regional and local levels. The following examples of arrangements in France, Germany, the Netherlands and Belgium are presented briefly to highlight points of interest.

Civil protection arrangements in **France** are the responsibility of the Ministry of the Interior, which manages the national rescue service, and the overall response to a large scale major incident or disaster. Local responses are co-ordinated at the level of the Prefect drawing together the means of aid supplied by the Gendarmerie, Police Force and Health Service. There is a national diploma in major incident medicine, the "capacité de médicine de catastrophe' which is mainly obtained by doctors working in the hospital emergency

services and with the fire brigade. This point was noted when the head of the DH Emergency Planning Co-ordination Unit visited the Paris Fire Brigade in January 2002 (which for historical reasons, along with the Marseilles Brigade, is a military unit).

In **Germany**, the Federal Government complements the resources of the 16 Länder (states) in the areas of fire protection, health and welfare and Nuclear, Biological and Chemical (NBC) protection. The country has suffered extensive flooding during the last year and a high speed train rail disaster in 1998. The German system relies on close collaboration between the private and public sector and there are many private associations involved in the management of major incidents that are recognised by the State. These include major healthcare providers such as the Deutsches Rotes Kreuz (German Red Cross) which run hospital and ambulance services. The airborne unit of the Federal Border Police (BGS) can be called upon to provide civil protection helicopter cover and the Federal Army can also be called upon for assistance, as happened during the recent floods. In the 1998 rail disaster, over forty helicopters operated in the vicinity of Celle transporting casualties to hospitals. This posed challenging conditions for pilots to avoid collision but meant that some patients could be flown 250km to specialist units in Hamburg and Kassel, relieving pressure on local units. DH senior officials have developed close working relationships with German emergency preparedness counterparts during 2002.

There are many features of the health service in **the Netherlands** that are similar to the NHS e.g. the role of general practitioners. Financing of the system is different, however, and is through an insurance mechanism. The project for Medical Assistance in Accidents and Disasters has led to enhancements in the organisation of medical assistance. Major incident and disaster planning involves the 26 regions. The regional medical official is responsible for planning and bringing together public health, primary care, hospital and ambulance services to achieve this. Co-ordination at a major incident scene involves a medical and an ambulance service co-ordinator being sent to the scene. This is similar to the response within the NHS whereby an Ambulance Incident Officer and Medical Incident Officer are despatched to the major incident.

The approach to major incident planning and response in **Belgium** attempts to retain flexibility e.g. regarding mobilising personnel and resources, whilst also placing clear expectations on healthcare staff to fulfil legally defined missions. The Belgian health system is based on private healthcare provision, mainly funded by a National Insurance mechanism. This means that there are many healthcare providers e.g. in 1999, there were at least 25 ambulance services and 15 hospitals serving Liège (which has about 1 million inhabitants). These have to operate together in the event of a large scale major incident. At the national level the Ministry of the Interior is responsible for co-ordinating the entire rescue services, but in the provinces, governors co-ordinate the response of the lower tier of planning led by burgomasters (mayors).

In a wider context, the Department has continued to play a full part in the EU High Level Committee on health security. This has a programme of co-operation on preparedness and response to biological and chemical agent threats and DH is considered to be a leading player within this. The Department's Chief Scientist is leading work on chemical incidents and key contributions are also being made in other areas. These include the development of rapid alerting methods for member states regarding attacks and threats and the creation of appraisal and modelling tools to gauge the possibility or probability of spread of disease or contamination.

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