HOME DEFENCE CIRCULAR

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DHSS

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities, Area Health Authorities, Boards of Governors — for action

Family Practitioner Committees, Community Health Councils — for information

January 1977

THE PREPARATION AND ORGANISATION OF THE HEALTH SERVICE FOR WAR

SUMMARY

This circular deals with the organisation for war of the Health Service in England; the introduction of an emergency system of control, and cancels previous Civil Defence memorandum.

INTRODUCTION

1. Existing plans for the Health Service in war are based on the HM(CD) series of memoranda issued by the Ministry of Health. Since 1968 however successive governments have introduced modifications to home defence policies and these, together with the re-organisation of the National Health Service, have rendered obsolete the plans prepared by the former Regional Hospital Boards. The HM(CD) memoranda are therefore cancelled and this circular, which is the first of a new series, explains the basis on which the Health Service is now to be prepared and organised for war.

2. The Home Office co-ordinates the issue of guidance by central government departments about home defence matters and has issued memoranda (under the ES series of circulars) on home defence planning, to local and other public authorities. Copies of memoranda relevant to the Health Service have been sent to all Health Authorities and copies of this and subsequent circulars will be sent to local and public authorities as appropriate. This circular should be read in conjunction with the Home Office memoranda and attention is drawn particularly to:

Home Defence Boundaries (ES1/1973)
Home Defence Planning Assumptions (ES3/1973)
Machinery of Government in War (ES7/1973)
Survival Under Fall-out Conditions (ES10/1974)

3. The issue of Home Defence planning circulars and of this circular, does not mean that the Government consider that war is imminent or inevitable. It is however only prudent to take reasonable precautions to mitigate the effects of a possible attack and so to plan the organisation and control of the Health Service that it may be able to make an effective contribution to the subsequent recovery of the country. The purpose of this circular is therefore to set out the preparations that Health authorities should now make and the organisation they would adopt, to meet the effects of any major attack on this country. Further circulars will be issued from time to time to deal with particular aspects of preparation for war and the action to be taken after attack.

PLANNING ASSUMPTIONS

4. Home Defence Planning Assumptions (ES3/73) differ from the previous Civil Defence policy and certain features of the new policy have a particular bearing on Health Service planning. Health Service plans should therefore be made on the following assumptions:

a. The general aim in a crisis would be to keep disruption of the social, economic and industrial life of the country to a minimum as long as possible. Any large scale re-organisation of the Health Service, to put it on a war footing, should therefore be avoided.

b. No part of the country could expect to avoid the effects of an attack. Those areas not directly attacked might suffer from radioactive fall-out; would certainly feel the effects of the destruction and disruption elsewhere of supplies, services and transport and might receive an influx of refugees. All Health Authorities must therefore plan to meet the consequences of an attack on any part of the country.

c. The pattern of attack and radioactive fall-out cannot be accurately predicted. The public would be better protected by remaining in their own homes than by moving to other areas where the local and other public authorities might well be unable to provide shelter, food or essential services. The Government do not propose to arrange for any official evacuation of the public and, through press, television and radio, would advise against random movement.

d. Fall-out conditions are likely to impose severe restraints on movement after an attack, possibly for several days. Immediate medical care for survivors might not therefore be possible and medical staff, who would be irreplaceable except in the long term, should not be wasted by allowing them to enter highly radioactive areas to assist casualties.

GENERAL CONSIDERATIONS

5. It is possible that a future war might begin with a period of non-nuclear conventional war and small scale attacks against vital installations or centres of Government could not be discounted. It is unlikely however that conventional war on this scale could continue for long without either a settlement of the international dispute or a sudden escalation into nuclear war.

6. A nuclear strike would give rise to radioactive fall-out. The spread and intensity of the fall-out would depend upon many factors at the time, but it may be assumed that the greater part of the country would be covered, in varying degrees, by plumes of highly radioactive dust, in many cases overlapping. The intensity of this fall-out would prevent, in most areas, any outside movement during at least the first 48 hours after an attack and, in any case, the whole of the United Kingdom would be under a RED Warning against the possibility of further attacks during this period. For the first 48 hours after an attack therefore, little or no life-saving activity would be possible, except on the most limited self help basis.

7. Radiation decays very rapidly in the first few hours and days after a strike, but thereafter decay is slow. An initial level of 1000 rph may fall to 10 rph in 48 hours, but would would not reach 1 rph for 14 days. Some people would receive an immediate radiation dose from the explosion but most would receive doses from the subsequent fail-out, the amount depending in part on the protective factor of their accommodation. Further exposure in the open to radiation would have serious and probably lethal effect until the ambient rate had fallen to 0.5 rph. When the dose rate had fallen to 4 rph however release from cover could be allowed for 1 hour in 24 and further release periods could be extended as radiation levels decline. General life saving operations in areas of fall-out might not be possible therefore until days or even weeks after a nuclear strike.

8. Certain built up areas may be regarded as potential targets but there are many possible targets in rural areas. No part of the country can therefore be assumed to be safe both from attack and from radioactive fall-out from attacks elsewhere. Nevertheless, if the total destruction or isolation of health service resources is to be avoided, some redeployment of medical and nursing staff, medical supplies, ambulances and equipment would be essential. The major concentration of hospitals lies in the centres of large towns and cities and contains a high proportion of the most skilled staff and essential medical supplies and equipment, while a high proportion of patients attending these hospitals comes from the periphery of the urban areas. The redeployment of resources could reduce the possibility of total destruction and bring them closer to those who would have most need of them after an attack. As a pre-condition to redeployment, all patients medically and socially fit to be sent home would have to be discharged and hospitals would have to accept emergency cases only.

9. The peace time administrative structure of the Health Service is unsuited to the needs of war, when a clear system of control would be needed for the rapid acquisition and redeployment of surviving resources. A control structure would be required which could be activated before an attack and which would relate to the various levels of wartime regional government.

10. The regions and sub-regions adopted for Government control (ES1/73) and the boundaries of local authority counties and districts do not, in many cases, match the Health Service organisation and where they do, they match at different levels in the non-metropolitan and the metropolitan countries. It would be undesirable however, in a period of crisis, to add to the burdens of the Health Service by altering the administrative boundaries. It is not intended therefore to alter boundaries or agency arrangements before an attack, but to relate the health service structure to the regional government organisation as well as the present relationship of boundaries allows. Whatever the boundary arrangements, adjustment might well be needed after an attack. Where discrepancies between local goverment and health authorities lead to practical problems before then they will no doubt be the subject of local consultation between the authorities concerned.

11. After an attack, the number of casualties might be quite beyond the resources of existing health services. Hospitals might be destroyed or isolated and the care of casualties might have to be undertaken largely by volunteers working in the community under professional supervision. Whenever possible however the aim should be to base the care of casualties on surviving and expanded hospitals, so as to simplify the re-establishment of control and the distribution of supplies; to provide centres for the medical care of serious cases; to create a firm base from which the remaining staff could work and to raise morale of both public and staff by demonstrating a determination to re-build the Health Service, albeit in a modified form.

AIMS

12. The aims of the Health Service will be to provide medical and nursing care for the casualties of war and the sick and to maintain a basis for future reconstruction.

LAYOUT OF THE CIRCULAR

13. The circular is in four Parts:

Part I (Preparation for War) sets out the measures that Health Authorities may be required to take during a period of crisis, to prepare the Health Service to meet the effects of war;

Part II (Organisation in War) deals with the transition from the peace-time system of administration to a war-time system of control;

Part III (Casualty Policy) outlines procedures for the care of casualties after a major attack;

Part IV (Summary of Action) lists the action that Health Authorities should now take.

PART I - PREPARATION FOR WAR

14. It is assumed (ES3/1973) that there would be three to four weeks political warning of the outbreak of war, but Health Authorities must be prepared to complete essential action within a much shorter period. The aim of the preparations would be to reduce the hospital population as far as possible, to provide space for the care of casualties, and to disperse staff, essential supplies and equipment, to reduce the risk of the total destruction of resources. Health Authorities including Boards of Governors should now plan for these measures; implementation would be authorised by the Secretary of State, when circumstances required.

DISCHARGE OF PATIENTS

15. During a period of crisis and when so directed, Health Authorities should arrange for all patients in hospitals, nursing and convalescent homes, whose retention was not medically essential, to be sent home. The purpose of this evacuation would be to free hospitals to deal with later casualties, to afford patients the greater protection that dispersal to their own homes would provide and to allow for the redistribution of equipment and staff. It is hoped that there would be sufficient warning of an attack to allow seven days for the discharge of patients, but plans should allow for a more rapid discharge should this become necessary.

16. The selection of patients for discharge should be made on medical grounds and on the availability of home accommodation and care. For the latter, the advice of the local authority social services department would in some cases be needed and arrangements should be made with local authorities to provide the maximum effort to check home conditions. Discharge should not however be held up merely because home conditions were not ideal or could not be checked and it must be accepted that the crisis would entail hardship. Criteria for selecting patients for discharge should be based on those which would have to be adopted, following an attack with many casualties, for the selection of patients for hospital treatment. Consultants would therefore need to consider whether, after an attack, they would expect to retain or discharge a patient in the same clinical condition as those under review. The numbers to be discharged cannot be pre-determined and in some cases, for example, geriatrics, no discharges might be possible; it might be expected however that the number of patients to be discharged would be of the following order, although it is stressed that these figures should in no way be taken as targets to be fulfilled;

Maternity cases 70%	Convalescents 100%
Acute cases 60%	Sick children 70%
Non active infections and chest cases 50%	
Psychiatric cases 15%	

The policy for the discharge of patients would also apply to the nursing and convalescent homes with contractual arrangements with an AHA and, at the discretion of the Health Authority, to private hospitals and nursing homes. (Paragraph 26).

altered this in fair copy.

7th. March, 1977

Sir,

Your readers will be interested to know that in January the Department of Health and Social Security issued a circular on "The Preparation and Organisation of the Health Service for War".

It would be a kindness on the part of the Government to let us know who it is contemplating having a war against and why. It appears also that we expect the war to be somewhat punishing, since "---- no part of the country can ---- be assumed to be safe both from attack and from radioactive fall-out from attacks elsewhere." So it is a big nuclear war (which "the deterrent" was supposed to make impossible).

Nevertheless, our upper lip appears to have stiffened since the mid-1960's when we abandoned the futile pretence of protection against the carnage and anarchy of nuclear war. The Government still in 1977 "do not propose to arrange for any official evacuation of the public" (Paragraph 4), which is no surprise, since "no part of the country can be assumed to be safe" (Paragraph 8). Furthermore "medical staff ---- should not be wasted by allowing them to enter highly radioactive areas to assist casualties". This must be a reference to medical staff who live and work in "no part of the country", since they are "assumed to be safe". Perhaps it is feared that the family doctors at Land's End will rush to assist the dying millions of London or Clydeside.

But of course the phantom medical staff will be kept busy arranging at hospitals "the Discharge of Patients", such as 70% of "Maternity cases" and 60% of "Acute cases" (of all kinds) to make way for the less severely irradiated millions.

// This last inhuman concept should alert us to the fact that not irony [illegible], nor even sarcasm will suffice as a response to these cold-blooded and insane proposals, which [illegible] ~~the unimagined horrors of a nuclear attack on Britain~~ [illegible] ~~thinkable and likely~~ [illegible]. ~~or on any other country~~ are intended to [illegible] encourage us to ~~accept the possibility~~. ~~contemplate~~ [illegible] ~~nuclear war, as permissible in reality never mind the dangerous threat,~~ ~~waging as well as threatening~~ ~~with resignation~~ accept the unimagined horrors of an H-bomb war as a possible ~~result but regre~~ ~~unfortunate~~ consequence of Britain's present hotch-potch of habits and prejudices which pass ~~criminally~~ for a "defence policy".