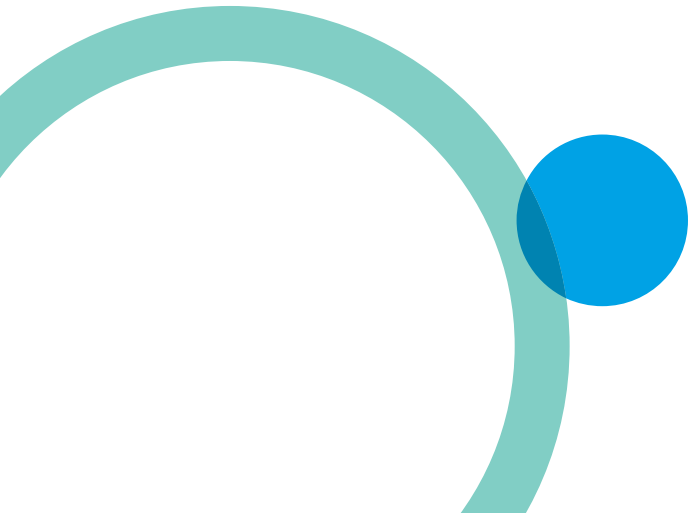
Scottish Health Facilities Note 03-04

Lockdown: Controlling Movement and Access within Healthcare Facilities

A Framework for NHSScotland



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Glossary of Terms

Business Continuity	Strategic and tactical capability of an organisation to continue delivery of services at acceptable pre-defined levels following disruptive incidents.
Business Continuity Management	A holistic management process that identifies potential threats to an organisation, and the impacts to the business operations those threats, if realised, might cause, and which provides a framework for building organisational resilience, with the capability of an effective response that safeguards the interests of the stakeholders, and the reputation and value-creating activities of the organisation.
Business Continuity Plan	Documented procedures that guide the organisation to respond, recover, resume and restore to a pre-defined level of operation following disruption.
C3	Command, control and coordination: C3 is a structured approach to incident management under pressure.
Capability	A demonstrable ability to respond to and recover from a particular threat or hazard.
Category 1 responder	A person or body listed in Part 2 of Schedule 1 to the Civil Contingencies Act 2004. They are subject to the full range of civil protection duties under the Act.
Category 2 responder	A person or body listed in Part 3 of Schedule 1 to the Civil Contingencies Act 2004. These are co-operating responders who are less likely to be involved in the heart of multi-planning agency work, but will be heavily involved in preparing for incidents affecting their sectors. The Act requires them to co-operate and share information with other Category 1 and 2 responders.
Civil Contingencies Act (CCA)	The Civil Contingencies Act (2004) and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005: These establish a single framework for Civil Protection in the UK. Part 1 of the Act establishes roles and responsibilities for Local (Category 1 and 2) Responders; Part 2 establishes emergency powers.
EQIA	Equality Impact Assessment
Exercise	The process to train for assesses, practice and improve performance in an organisation.
Hazard	A source of potential danger or adverse condition. Natural hazards are events such as floods, landslides, and storms.
HazMat	HAZMAT is an abbreviation for 'hazardous materials' substances in quantities or forms that may pose a reasonable risk to health, property, or the environment. HAZMATs include such substances as toxic chemicals, fuels, nuclear waste products, and biological, chemical, and radiological agents.
JESIP	Joint Emergency Services Interoperability Principles. It is a 'joint decision model' used by Emergency Services Commanders to develop a common situational awareness or common operating picture, a joint understanding of risk and to make effective decisions in order to proportionately deploy resources during an incident.

Lockdown	A lockdown is achieved through a combination of physical security measures and the deployment of security personnel. See Section 3 for further information.
Major Incident Scenarios	Cloud on the horizon: where an incident in one place may impact on others afterwards. Preparatory action is needed in response to an evolving threat elsewhere, even perhaps overseas, such as a major chemical or nuclear release, a dangerous epidemic or an armed conflict.
	Slow burner: Where a problem creeps up gradually, such as occurs in a developing infectious disease epidemic. There is no clear starting point for the major incident and the point at which an outbreak becomes 'major' may only be clear in retrospect, e.g. Pandemic Flu. Long term resilience or business continuity of NHS Services is a key issue.
	Headline news: where a wave of public or media alarm ensues over a health issue, such as the reaction to a perceived threat. This may create a major incident for health services even if the fears prove unfounded. The issues may be minor in terms of actual risk to the population. It is the urgent need to manage information that creates the major incident.
	Big Bang: a health service major incident is typically triggered by a sudden major transport or industrial accident. What may not be so obvious at first; however, are the wider implications. A major incident may build slowly from a series of smaller incidents such as traffic/transport accidents or explosions. This is likely to involve mass casualties.
Recovery	The process of rebuilding, restoring and rehabilitating the community following an emergency.
Regional Resilience Partnership	Regional and Local Resilience Partnerships are the principal arenas for multi-agency cooperation in civil protection at local level in Scotland. They have a key role in risk assessment, preparation and response.
SitRep	Situation Report: recurring report produced by an officer or body, outlining the current state and potential development of an incident and the organisations or bodies' response to it.
Threat	Malicious event instigated by an individual or group which has the potential to cause loss or damage to an asset. This could include technological accidents or terrorist attacks.
V/VIP	Very Important Person: persons who are conferred 'special' due to their status e.g. Ministers of State. Very Very Important Person is accorded to a VIP e.g. Royal Family, Dignitaries/Heads of State/PM. They are accorded special protection arrangements. NHS Boards are required to have and maintain plans (approved by Police Scotland) for ensuring the privacy and security of V/VIPs should they need to be admitted to hospital.

Executive Summary

A wide range of circumstances or incidents may conspire to make NHS services vulnerable and threaten them to the point of collapse. Therefore, locking down a healthcare facility/site may be a proportionate response from a variety of threats and hazards to safeguard patients, staff, visitors, and protect NHS assets. In accordance with this, this document contains clearly outlined principles, for NHS Boards and managers at all levels of the organisation, to follow when developing plans to lock down all or parts of a facility/site in a wide range of scenarios.

Replacing '*Hospital Lockdown: A Framework for NHSScotland Strategic Guidance for NHSScotland'* (2010) this updated document reflects best practice and draws on consolidated experience of healthcare organisations that have implemented Lockdown in response to major incidents. It highlights that Lockdown may be a first or a last resort and the intensity of the control measures imposed may vary in type and duration according to the assessed risks, threats or hazards.

Section 2 highlights important legal issues and their implications for Managers to consider when devising a Lockdown Plan and deciding to implement it. **Section 3** explains what lockdown is, the various approaches to locking down a facility and the stages that should be followed when a decision has been made to put certain controls in place.

Section 4 highlights the importance of establishing a Multidisciplinary Planning Team (MDT) to produce a Lockdown Plan, giving an example as to the type of staff that should be involved. It contains detailed information on the various tasks that the MDT should undertake to ensure that Plan for respective healthcare facility/site are as robust and effective as possible.

Section 5 and **Section 6** address the issues to consider and prepare for in relation to activation of the plan and manage or oversee it with partner agencies when proportionate controls are implemented. The importance of exercising the plan, ensuring that staff are aware of their roles and responsibilities in implementing it and preparing to restore the organisation to business as usual are emphasised in **Section 7** and **Section 8**.

Note: this document will be reviewed for comment, by the Portering and Security Services Expert Group, within the next 6-9 months, with a full review taking place in 12 months, by an agreed SLWG.

1. Introduction

1.1 NHS Boards are responsible for providing safe and secure environments. However, experience has shown that during major incidents[1] or emergency situations, healthcare facilities are potentially vulnerable. Contamination, infection or even the sheer pressure of the ensuing numbers of people seeking care in these circumstances can threaten services to the point of collapse. Therefore, controlling movement and access within a healthcare facility/site or locking it down in full or in part may be a proportionate response to a variety of threats and hazards in order to safeguard patients, staff, visitors, and protect NHS assets.

1.2 Lockdown and Controlled Movement and Access arrangements should be sufficiently versatile to be used successfully in a wide range of circumstances. For example, during a pandemic flu outbreak, large numbers of anxious people may go to their nearest Emergency Department (ED) seeking clinical assistance or treatment. To ensure security of the facility and to protect the welfare of existing patients, managers may decide to lockdown the hospital site or particular buildings. By authorising a lockdown, hospital managers will seek to exclude people from entering the facility/site, or control movements within it.

1.3 Conversely, under certain circumstances, it may be necessary to lockdown a healthcare facility to prevent staff, patients and the public from leaving the premises. For example, in the event of a Chemical, Biological, Radiological or Nuclear (CBRN) or a Hazardous Materials (HazMat) incident, staff and patients who leave a building may be at risk of contamination or cross contamination with those who they come into contact with. In this instance, using a lockdown to contain individuals will mitigate the risks to staff and patients' health and safety. (**Section 2**)

1.4 Locking down a healthcare facility/site will not only occur in the circumstances above. It is far more likely that a lockdown may be implemented in response to other kinds of security breach, such as an altercation in ED, a bomb threat or suspicious package (**Section 3**). Lockdown procedures can be used for a variety of incidents that require the control of movement and access of staff, patients and the public such as a chemical spill, damage to infrastructure, a deep clean, an altercation or a flood. Therefore, an effective lockdown plan can be used to support the NHS Boards' wider security arrangements.

1.5 It should be borne in mind that while the decision to implement a lockdown will primarily rest with hospital managers, there may be occasions when Police Scotland may lock down a healthcare facility/site in full or in part, without notice, for public safety reasons because a serious crime has been committed and an investigation/ security operation is underway. Therefore, it is important that all lockdown plans and arrangements are developed with the collaboration of key local stakeholders, and with advice from Police Scotland.

Purpose

1.6 This guidance document is intended to support NHS Boards and managers at all levels within the organisation to prepare and plan for serious security incidents or

[1] See Major Incident Scenarios in Glossary

unexpected situations that may require a full or partial lockdown of healthcare facilities in order to protect patients, staff and physical assets. It replaces 'Hospital Lockdown: A Framework for NHSScotland Strategic Guidance for NHSScotland' (2010).

Scope

1.7 This document sets out how NHS managers should make efficient use of resources, capacity and capability to plan for and execute Lockdown or Controlled Movement and Access plans within healthcare facilities in response to a wide range of threats and hazards. It also highlights the legal and security issues that should be fully considered as part of the decision-making process.

1.8 Reflecting recognised best practice, the principles and tools within this guidance document should enable NHS Boards to exercise their duty of care to staff and patients and operate with adequate levels of safety and security.

1.9 This guidance supports national guidance 'Preparedness for an Increased Threat Level (2017)[2] and Major Incidents with Mass Casualties – National Plan for NHS Boards and Health and Social Care Partnerships, 2019'.

[2] Scottish Government Health Resilience Unit, April 2017 (Official Sensitive). Available from sghru@gov.scot

2. Legal Context

2.1 The development of operational plans on locking down healthcare facilities/sites, in response to particular threats and hazards, should be guided by a number of legal imperatives, the implications of which are outlined below.

2.2 Under the Civil Contingencies Act 2004, NHS Boards designated as Category 1 responders[3] must assess the risks and have plans in place to manage or mitigate them[4]. Controlling access to or locking down a facility/site may be the most appropriate response in a range of major incident and emergency situations, as outlined in **Section 1**, and a lockdown plan may also be implemented to support other major incident responses, such as when a facility needs to be secured as a result of an identified or potential threat.

2.3 The general status of healthcare facilities/sites is that they are open and accessible, and members of the public have an implied licence to enter them. However, as the occupier of these facilities/sites, an NHS Board has the right to refuse access to them if deemed necessary. In a lockdown situation, if an unauthorised individual enters the locked down facility/site or refuses to leave, they may be prosecuted under criminal law depending on the terms of the emergency regulations imposing the lockdown.

2.4 If a casualty or a patient attends a locked down healthcare facility requiring treatment, it will be in their best interest to receive that treatment at other, safer, healthcare facilities. Consequently, their 'right to treatment' under the Human Rights Act 1998 will not be infringed.

2.5 It will generally only be lawful for an NHS Board or designated staff to prevent the exit of a significant number of people from its premises by utilising specific legislative provision (e.g. emergency regulations under the Civil Contingencies Act and/or Public Health (Scotland) Act 2008) which provides for the protection of the public from notifiable diseases. Even when these specific regulations can be used, specific tenets of the Human Rights Act 1998 must also be considered, for example, a person's right to liberty (Article 5) and an individual's right to a family (Article 12).

2.6 Without emergency regulations being in place to prevent people from exiting a healthcare site, it is likely that individuals may only be prevented from leaving a facility in the following situations:

- they are committing an offence or causing injury or damage to property which may lead to them being arrested;
- they are detained under the Mental Health Act or otherwise lawfully detained.

2.7 While staff of the NHS Board can give direction within their premises (for example, stating which exit someone can use), it is unlawful to forcibly prevent exit from healthcare facility/site unless emergency regulations make provision for this, or it is for the reasons stated above. Without these justifications, NHS staff could be open

[3] All territorial NHS Boards and the Scottish Ambulance Service are Category 1 responders under the CCA

[4] See Preparing for Emergencies – Guidance for Health Boards in Scotland, 2013, Sections 3 and 4 for more information on the Civil Contingencies Act 2004 and actions required by NHS Boards.

to legal action being taken against them under the criminal and/or civil law if they have prevented a person from leaving. Nonetheless, there may be circumstances when a lockdown which prevents individuals from exiting healthcare facility/site (or part of them) is desirable. If this occurs, NHS staff may only request that individuals remain in the facility/site to be locked down. If individuals choose to exit, a safe route (if one is available) should be identified for them to do so. Depending on the circumstances, it may be appropriate to involve the police to enforce a containment cordon around a particular facility/site.

2.8 The consequences of invoking a lockdown and the short, medium and long-term effects they may have on healthcare services must be fully considered and approved by an authorised senior manager, such as a Board Director or Site Director, with the input of a multi-disciplinary team before it is implemented. Their decision to implement lockdown should be underpinned by the legal reasons for doing so, and appropriately recorded. Decisions taken by NHS Boards are open to challenge by way of judicial review proceedings in the courts, therefore it is important to have a detailed record of the decision-making process.

2.9 When developing lockdown plans, NHS Boards must take into account relevant aspects of the Health and Safety at Work Act 1974 so that the health, safety and wellbeing of staff, contractors, patients and visitors are maintained at all times during a lockdown situation.

2.10 An Equality and Human Rights Impact Assessment (EqIA) of the NHS Boards' Lockdown Plan(s) should be undertaken for the purposes of assuring compliance with the Equality Act 2010. An EqIA would also enable the NHS Board to understand clearly how different people will be affected by a lockdown intervention and ensure that everyone will be treated fairly during such an event. Further information on the Public Sector Equality Duty and a checklist template for conducting an Equalities, Health and Human Rights Impact Assessment is contained in Preparing for Emergencies – Guidance for Health Boards in Scotland, Annex: Equalities, Human Rights and Resilience Planning, 2013[5].

If there is any doubt about the legal position in relation to a lockdown, a Board should consider whether it is appropriate to seek specific legal advice on the issue from the NHS Central Legal Office.

[5] Available from Scottish Government Health Resilience Unit sghru@gov.scot

3. Understanding Lockdown and Controlling Movement and Access

What is Lockdown?

3.1 Lockdown is: "*The process of controlling the movement of staff, patients, and visitors around a site or a specific area within a building/facility in response to an identified risk, threat or hazard that might impact upon the security and safety of patients, staff and assets including the capacity of that facility to continue to operate".*

3.2 Lockdown is achieved through a combination of physical security measures and the deployment of personnel. It is a phased approach that is intended to restrict and/or control:

- movement within a facility/site;
- access to a facility/site;
- exit from a facility/site.

The process of controlling movement and access should be flexible and adaptable, however the planning process should be applied in a consistent and systematic manner regardless of the size, capacity or remit of the facility affected by an incident.

Approaches to Lockdown and Controlling Movement and Access

3.3 There are four approaches to controlling movement and access within a facility/site, sometimes referred to as lockdown stages, each with their own characteristics:

Partial Control Measures: These are static or portable (see below) in nature and implemented around the specified location of an incident; they neither increase nor decrease in scope.

Rationale: To isolate or restrict entry to and exit from a specific area of the facility/site to protect people from a potential threat or hazard, for example, in the event of a suspicious package or chemical spillage.

Portable Control Measures: These are fluid in nature and implemented when it is necessary to move the area affected by partial measures from one location to another.

Rationale: To secure an area around a threat that is moved from one location to another. For example, someone with a high public profile and of interest to the media attends the Emergency Department for treatment. Initially partial control measures would be applied to the ED but they would be moved to other areas of the hospital if the patient required further medical care in other specialty areas such as Imaging and Theatre, and the initial measures would no longer be applied to the ED.

Progressive Control Measures: These are incremental in nature and implemented on a step-by-step basis in response to an escalating incident; they require a systematic approach to securing the facility/site.

Rationale: The threat to the safety of people and assets is assessed as increasing.

Full Lockdown Measures: These are the highest level of control measures implemented to restrict movement within and access to (including entry to and exit from) an entire facility/site to ensure the security and safety of patients, staff, property and other assets.

Rationale: There is an assessed credible or actual threat to patients, staff and assets.

Stages of a Lockdown

3.4 A lockdown or imposition of controls on movement within a healthcare facility/site regardless of its trigger, extent or duration normally has four stages in the process. Each of these stages, below, should be considered in terms of the roles and responsibilities and other specific actions required, and be reflected in the organisations overall Lockdown and facility/site specific plans.

The four stages are:

Activation:

The period immediately following declaration where controls on movement are initiated.

Escalation/De-Escalation:

The decision to activate lockdown and the level(s) of control implemented are reviewed by the authorised manager with a view to:

- maintaining current controls;
- revising (increasing or lessening) current controls;
- terminating the lockdown or controls on movement and access.

Maintenance:

A decision is taken on the potential duration of the lockdown, and the resource requirements to manage the continued impacts are reviewed, including:

- staff wellbeing;
- staff shift changes;
- potential service disruption;
- collation of information for reporting to multi-agency partners.

Stand down:

A decision is taken to return to normal business activity.

Debrief

3.5 The command of and/or participation in an incident offer an ideal opportunity to learn from the process and refine the response to an incident of this nature. The learning can include the conditions that led or contributed to a lockdown being necessary.

Having a structured debrief process shall allow lessons to be identified and appropriate improvements made.

4. Key Factors in Developing a Lockdown Plan

Establish a Multi-Disciplinary Planning Team

4.1 In order to develop a robust and effective Lockdown or Controlled Movement and Access Plan, a multi-disciplinary team should be established. Its membership should be drawn from relevant service areas and disciplines across the NHS Board, as well as key external partners/stakeholders.

The table below highlights various posts/disciplines that should be included and their roles and responsibilities.

Post/ Discipline	Role/Responsibilities
Executive Director Lead	Ensure that Lockdown Plans and procedures are in place for key facility/site, are fit-for-purpose, and signed-off by the Corporate Management Team and/or the Board.
Security Lead	Advise on all aspects of security including the capability and functionality of security arrangements for the various facility/site and the implementation of control measures.
Estates or Facilities Leads	Advice on issues relating to a building's functionality, its internal structure and systems, and the methodology for the different stages of lockdown (partial, portable, progressive, full) and how to successfully achieve each of them. Ensure that critical assets are identified.
Clinical Manager	Advise on issues relating to clinical functionality and Business Continuity Management.
Site Management Lead	Advise on issues from a site management perspective and taking into account service implications.
Health and Safety Lead	Working with Security and Estates Leads, to ensure that risk assessments are undertaken and potential threats and hazards are identified and mitigated in the plan(s).
Risk Manager or equivalent	As for Health and Safety, Estates and Facilities Leads- see above
Communications and Engagement Lead	Develop signage to support Lockdown plan implementation; develop channels for communicating controlled messages to staff, patients, visitors and the public informing them of the current situation; develop pre-prepared messages for the media and external stakeholders.
Resilience/Business Continuity Lead	Ensure that Lockdown Plans are cognisant with Major Incident and Site Tactical Incident Management Response Plans.
Key external partners **Police Scotland**	Advice on specific issues from their service areas: Provide information on local threats and hazards; they will also be able to estimate the level of support they can provide during a lockdown'
Scottish Fire and Rescue Service **Scottish Ambulance Service**	SFRS and SAS will identify how a Lockdown might impact on the performance of their duties.

Local Authority **Building Operator (where appropriate)**	The Local Authority is responsible for roads on or adjacent to the NHS facility/site and will advise on possible closures and implications in the event of Lockdown.
Contracted Hospital Security Service (where appropriate)	Advise on any implications for contractual obligations.

Note: This is not intended as an exhaustive list and membership may vary between Boards.

4.2 As part of the process of developing a Lockdown or Controlled Movement and Access Plan for the various healthcare facility/site within the NHS Board, the Multi-Disciplinary Planning Team should systematically undertake the following key tasks: (**Appendix 1**)

Produce a Risk Profile

4.2.1 A needs assessment should enable the NHS Board to establish a risk profile for its healthcare facility/site. This should in turn inform the development of a robust plan that, as far as is reasonably practicable, takes account of all risk factors so that proportionate control measures for the respective facilities can be considered.

Identify stakeholders

4.2.2 Reasonable steps should be taken to identify all stakeholders (examples in the table below) in a particular facility/site as they may be impacted by any controls on movement and access, and ultimately a lockdown of the site:

Stakeholder groups	
Staff	Public/visitors
Tenants (where appropriate)	Health and Social Care Partnerships
Contractors	Local Authority
Building Operator/owner	Contractors
Commercial outlets	Emergency Services (e.g. SAS)
	Voluntary Groups

Produce a Critical Asset Inventory

4.2.3 NHS Boards have resources and services that will be considered critical, such as generators or intensive care units, to enable the organisation to function. Such assets should be protected[6].

4.2.4 In order to determine which assets are critical, it is necessary to draw up an inventory of possible assets then consider how critical each asset is to the functioning of the organisation in terms of the service it provides and the consequence for the organisation if the asset was lost. It is important that the relevant clinical staff are involved in this process. These factors may be captured in Business Impact Analysis and Business Continuity Planning and Management processes.

[6] The NHS Scotland Standards for Organisational Resilience 2018 require NHS Boards to maintain up-to-date lists of their critical assets.

4.2.5 The identification of critical assets is essential to establish areas of priority and appropriate means to secure and protect these. This asset inventory should also assist the NHS Board or senior managers in making important decisions particularly in the initial stages following activation of a lockdown or to control movement and access within a facility/site.

Categorise the Vulnerabilities of the Critical Assets

4.2.6 An individual assessment should be made to identify the vulnerability of every critical asset on the inventory. It is suggested that this task is carried out by the Security Lead in consultation with the relevant clinical staff.

Vulnerability of the assets should be considered in the context of:

- the measures already in place to protect them from threats and hazards (see Glossary for definition);
- the circumstance under which the assets might be vulnerable;
- the measures that can be implemented to address these vulnerabilities.

4.2.7 The vulnerability of critical assets should be categorised as:

- **High Risk:** Facility/site contains a critical asset and its security profile is inadequate to lock it down or apply control measures
- **Moderate Risk**: Facility/site is a moderate-profile asset; it is important but not critical, and its security profile is marginally adequate with limited ability to apply control measures, but could be improved.
- **Low Risk:** Facility/site is neither a high profile nor a critical asset and its security profile is adequate.

Assess Risks

4.2.8 NHS Boards should undertake a generic organisational risk assessment to recognise the key risks and threats facing the organisation identify the principal control measures that can be put in place and to understand and agree the level of risk that the organisation can reasonably tolerate.

4.2.9 To assist with this process, a risk assessment framework, which takes into account the full range of known and potential national and local risks and threats, should be developed. The framework should, as far as possible, draw on the risks and threats identified in the multi-agency Community Risk Register produced by the Regional Resilience Partnership as well as information from other relevant national sources.

4.2.10 Drawing on risk information commonly used by partner agencies should ensure that lockdown plans, and the control measures to be applied in different situations, complement those of other stakeholders and partners.

The table below provides an example of the questions that could be considered during a risk and vulnerability assessment process.

Internal threats/vulnerabilities	External threats
Are there any environmental hazards associated with the site? What critical/essential assets are on site? Are hazardous/controlled materials/substances used/stored on site? Are there people related threats? Are there risks associated with any buildings?	Are there any environmental hazards associated with the locality? Are there any local industrial sites that store/handle hazardous materials? Are hazardous materials transported via the local road or railway system? What is the current threat assessment for terrorism?

Note: This is not an exhaustive list.

4.2.11 A risk assessment framework should be used consistently to assess risks to and vulnerability of specific facility/site and services. The outcome of these assessments should subsequently be used to inform the capability to lockdown or control access to a specific facility/site.

Develop a Site Profile

4.2.12 The development of a site profile concentrates on the physical layout of the healthcare site, i.e. the size of the site, its perimeter, access and egress points, the location and route of pathways and internal roads, and the number of buildings on site.

4.2.13 Ideally, site profile should be developed by the Estates and Facilities Lead with the support of the Security Manager (or equivalent) so that any security vulnerabilities that would compromise the controlled movement and access plans are taken into account.

Develop a Building Profile

4.2.14 The Lockdown Multidisciplinary Planning Team should create a Building Profile by reviewing the facility's functionality and capability to lockdown either fully, partially or progressively as outlined in **Section 3**.

This review should:

- consider the building's construction, use, physical layout, proximity to the site boundaries/other buildings, and specific features e.g. ventilation system, power supply etc.;
- produce an inventory of all relevant doors and windows, their location, whether they contain glass, whether they can be locked from both inside and outside, and any ability to control access both manually and automatically;
- identify fire doors and escape routes; competent advice should be sought in relation to securing fire doors if the need to control movement and access arises.

Security Profile

4.2.15 Development of a security profile should, in the first instance, identify the existing physical security measures in place. The process to achieve this should seek to establish where there are vulnerabilities that may threaten the facility/site's ability to apply all types of lockdown or control measures.

4.2.16 To aid the development of the Security Profile it may be helpful to consider the ability to implement a full lockdown at the site or building. In simple terms it may be useful to consider the facility in terms of 'concentric rings' as follows:

- **Outer perimeter**: the distant reaches of the site with an assessment of the fencing, natural barriers (e.g. wooded areas), secure fencing, and the availability of CCTV and lighting;
- **Building perimeter:** including car parking facilities and areas immediately surrounding the building. Lighting, alarms, CCTV, fencing, locking devices for external doors and windows, defensive planting, and the access control measures that are in place should be considered. Vulnerabilities in the measures around the perimeter should also be identified.
- **Building interior:** Inside the building, the focus should be on internal windows and doors and their ability to be locked, access and intrusion alarms, CCTV, access control measures, and lighting.

This multi-layered approach to developing a Security Profile follows the concept of 'defence in depth' and the information collected from the Site and Building Profiles can also bolster other strands of security work such as crime prevention.

Resource Requirements

4.3 The process of activating and effectively implementing a lockdown or successfully controlling movement and access within a facility/site is likely to be labour intensive. It will require a range of staff to be appropriately authorised and suitably trained for the task.

4.4 The Multi-Disciplinary Planning Team should identify the minimum level of resources (staff disciplines and numbers, and equipment), including the support required from external partners, required for various scenarios i.e. the types of incident and control measures to be implemented. This information should be retained in the Lockdown Plan for each facility/site.

Staff Roles and Responsibilities

4.5 The level of staffing required to support a lockdown and the roles and responsibilities to be fulfilled should ideally be considered according to the four stages of the process:

- **Lockdown activation:** this stage considers the role of staff at the initiation of a lockdown – for example, where they have to report to, and what resources they may need to facilitate their role;

- **Lockdown deployment (escalation and de-escalation):** this stage considers the roles staff may be assigned to during a lockdown, and how these can be facilitated;
- **Lockdown maintenance:** this stage considers some of the features that should be taken into account to maintain a lockdown, and how these can be achieved;
- **Lockdown stand-down:** this stage focuses on how staff can facilitate the end of a lockdown.

Profile Outcome

4.6 The outcome of the Risk Profile (including the Site, Building and Security profiles) should enable the Multi-Disciplinary Planning Team to conclude that the organisation overall and/or a specific facility/site has:

- **Adequate capability** i.e. the various control measures (full, partial and progressively) can be effectively implemented;
- **Additional resource requirements** to enable the various control measures to be implemented effectively. The processes to establish the various Profiles should highlight what resources (equipment and staff) are required.

4.7 The assessment process leading to the production of the Risk Profiles may identify a gap between the desired and actual capability.

These gaps should be:

- considered in terms of a cost/benefit analysis taking account of what is reasonable in the circumstance and the level of the organisation's risk tolerance;
- reported to the NHS Board's Corporate Management Team or Chief Executive.

Staff Wellbeing

4.8 As employers, NHS Boards have a duty of care to staff and are obliged to ensure their wellbeing. So whilst a lockdown is a labour-intensive exercise which may place an additional strain on staff, managers must ensure their staff's wellbeing is not compromised.

Staff lockdown roles and responsibilities must reflect the duties outlined in their existing job specifications and any training they have received. Staff could be liable for any loss or damage caused in carrying out a duty for which they have not been trained.

It is important that wellbeing arrangements for staff, patients and visitors are highlighted in the lockdown plan for each facility/site.

Communication

4.9 Communication to staff and embedded tenants is essential when the decision to lockdown any healthcare facility/site is activated. There should be a pre-determined process or system for alerting and cascading information throughout the

organisation. The NHS Board Communications Unit should also have a process in place to inform the public and partners via the Board's public facing website, or other social media platforms.

5. Activating the Lockdown Plan

Triggers

5.1 A lockdown may be required in response to a potential or actual threat. The threat may be direct i.e. at the site or indirect i.e. offsite with the potential to impact the site. The threat, location, scale, type of event and profile of the healthcare facility/site will normally determine the type of lockdown (full, partial or progressive) that should be implemented.

5.2 The nature of the threat may pose a risk to safety or necessitate controls to safeguard the integrity of a facility/site.

Examples of threats include:

- receipt of intelligence;
- direct/indirect threat, risk or hazard;
- as part of a major incident or crisis response;
- suspicion of an intruder or intruders on site;
- verbal or physical abuse (direct or indirect) and/or aggression;
- arson;
- suspicious mail or packages including CBRN;
- HazMat incident or toxic cloud;
- contamination;
- terrorism.

5.3 The trigger for a lockdown may originate from a member of staff in response to a perceived, potential or actual threat or be requested, or imposed by Police Scotland or Scottish Fire and Rescue Service due to an ongoing incident impacting the site. This may be due to a potential risk of the site being targeted or because the site falls within a controlled cordon for an ongoing incident.

5.4 The decision to lock down a healthcare facility/site or to impose controls on movement and access within it should be guided by the following four principles:

- the protection of patients, staff and assets;
- the isolation of the threat or hazard;
- establishing a distance between patients/staff/assets and the threat or hazard;
- neutralising the threat or hazard.

5.5 Lockdown can only be effective if it is conducted quickly, either in response to a localised incident, or if intelligence is received.

Authorising Lockdown Activation and Escalation

5.6 Activating a lockdown may be considered the first action in a multiple step process to immediately secure a facility/site against a threat. When a lockdown of a healthcare facility/site occurs a member of staff will need to make the decision on whether the lockdown should be full, partial or progressive. Who can make this decision will partly depend on the nature of the lockdown.

5.7 In a major incident situation, unless other arrangements are in place, responsibility for calling a lockdown should normally and ultimately rest with the Board's Chief Executive or in their absence, an Executive/Corporate Director in accordance with the Board's corporate governance framework. Even when those responsibilities are delegated to others, the Chief Executive retains accountability for those functions.

5.8 It is not normally the responsibility of the emergency services to make the decision to lock down a healthcare facility/site. While the Emergency Services might provide intelligence that informs the decision to lock down, the Chief Executive retains responsibility for the organisation. The same principles can also be applied when the order to 'stand down' is given. On both occasions, the Chief Executive (or their nominated officer) should make the decision.

5.9 For corporate governance purposes, Lockdown plans should contain an authorisation framework. This should clearly identify which staff in the organisation or in specific sites have delegated authority to lock down a facility in certain circumstances, the type of lockdown they can initiate and its duration. It should also outline an escalation authorisation process i.e. when a decision to escalate lockdown, for example, from partial to full, is required who should make it and who should confirm and/or review it. The escalation authorisation process allows decisions to be reviewed by a senior member of staff whilst removing any risk of inertia in decision making when faced with an immediate threat. A sample escalation authorisation process is set out in the table below.

Authorised by	Scale	Escalate	Review/Confirmation by
Senior staff member in the facility	Immediate area	Yes	Site senior/on call manager
Site/General Manager	Partial or full site	Yes	Corporate Director/ Director on call
Corporate/Executive Director/ Chief Executive	Partial or full site	No	

Duration of a lockdown

5.10 Ideally, a lockdown should only last a short time. However, there may be occasions when it may last several hours or more. Equally, there may be occasions where a facility needs to be locked down after an incident, for example to decontaminate it or as a result of flooding of the premises. If a facility/site is locked down, the possible duration of the lockdown should be proportionate to the level of disruption and potential further costs, for example, the need to employ contracted security staff to support staff resilience.

6. Managing a Lockdown Situation

Command, Control and Co-ordination

6.1 A suitable Command, Control and Coordination (C3)[7] structure should be established to manage the lockdown through all its phases. The composition of the C3 structure should be proportionate to the circumstances of the incident to ensure effective coordination of resources and robustness of the lockdown arrangements.

6.2 It is likely that the circumstances leading to a lockdown will be as a result of an ongoing incident either on site or offsite, and forms part of the wider incident management response. Therefore, C3 arrangements for Lockdown should be consistent and compatible with, or an integral part of the Major Incident Plan and Business Continuity Plans. This should ensure appropriate resource management and spans of control are maintained and that the lockdown arrangements are a proportionate response to the incident.

6.3 The C3 Group should appoint an Operational Level Incident Lead and an Incident Management Team (IMT) to support them. This individual's remit should be to work with the IMT and put in place suitable levels of control and flexible measures that are proportionate to the threats and risks, taking into account their impact on services and business continuity.

6.4 The table below outlines an indicative hierarchy of control options that should be considered:

Control measure	Control options	
	Action/Restrict access to	Consider
Partial/Portable	• essential staff only • current inpatients • access to emergency service personnel	• cancelling visitor access • cancelling or delaying pre-arranged appointments provisionally
Progressive	• essential staff only • current inpatients • access to emergency service personnel • the movement of patients and staff within hospital	• cancelling or delaying outpatient appointments • cancelling visitor access • identifying a holding area for media and relevant others who may resort to the site
Full Lockdown	• essential staff only • inpatients • cancel or postpone pre-arranged appointments • cancel visitors • emergency service personnel • traffic routes and parking	• cancelling/postponing non-urgent inpatient procedures/appointments • restricting non-essential movement within hospital • identifying a holding area for media and key others who may resort to the site • restricting movement within site to essential patient care only

[7] The key elements of a C3 structure are explained in Section 5 of Preparing for Emergencies, Guidance for Health Boards in Scotland, 2013.

Remit of a C3 structure

6.5 The primary task of a C3 (strategic) structure should be to establish the objectives of a Lockdown and ensure that they are communicated to all relevant personnel. This is to promote a common understanding of what is to be achieved and the rational for decisions.

Decision-making should, amongst other issues, focus on:

- ensuring the safety and wellbeing of staff, patients and public;
- protecting infrastructure and critical assets;
- protection of service delivery;
- security;
- resource requirements and deployment;
- dynamic risk assessments of Health and Safety, and risk-mitigation.

Understanding multi-agency decision-making

6.6 If a lockdown is implemented as part of a wider response to an external major incident (see Glossary for types of major incidents); it will likely involve a range of other Category 1 responder agencies, notably one or more of the Emergency Services. These agencies should have been identified by the Multi-Disciplinary Planning Team as part of an initial Stakeholder Analysis and involved in the process to develop the organisations' Lockdown plans. Therefore, they will probably have a level of awareness of the Lockdown plans for key NHS facility/site/ sites.

6.7 It is important that those who lead or participate in the Board's C3 structure understand the common model of decision-making used by the Emergency Services in major incident situations, known as the Joint Emergency Services Interoperability Principles (JESIP) Model, see **Figure 1**.

6.8 JESIP essentially reflects similar models used within the NHS, such as the Plan – Do – Study – Act as part of a continuous improvement cycle, to assess impact of an idea or action, build upon the learning and improve. However, JESIP is implemented at a much faster pace, in real time.

6.9 The Boards' C3 Lead or designated deputy (this could nominally be the Incident Lead) will be required to work jointly with Incident Commanders of the Emergency Services in relation to implementing appropriate levels of control that are proportionate to the threats and risks.

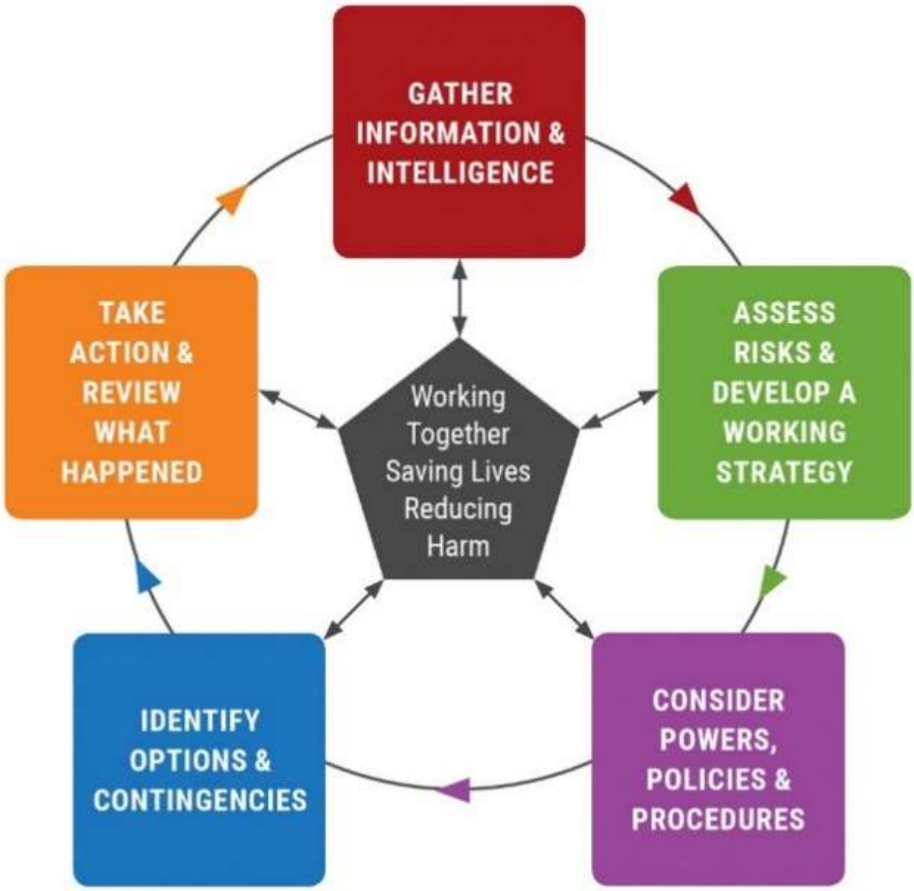


Figure 1: JESIP Model, 2017

7. Training and Exercising

7.1 It is important that staff receive appropriate training on the various types of lockdown and control measures, and their roles and responsibilities so that they know what is expected of them in lockdown situations. A staff training programme should be developed and implemented on a regular basis.

7.2 The NHS Board's Lockdown Planning Team should develop a training framework that takes account of the training needs and competencies of particular staff in various facility/site commensurate with the Boards expectations and risk assessments.

7.3 The training programme and accompanying training framework should take account of, and include the needs of relevant stakeholders or agencies who may be required to participate in the collective response during a healthcare facility/site lockdown situation.

7.4 An Exercising and testing regime is vital for NHS Board assurance in relation to its incident response plans; they should focus on the organisations' ability to lock down fully, partially or progressively.

7.5 The importance of exercising and testing incident plans[8] is clearly set out in the Civil Contingencies Act (2004) (see Glossary), which states that Category 1 and 2 responders must test their major incident plans.

7.6 Testing a lockdown plan can occur in a number of ways. In the first instance, a table-top exercise may be beneficial as it simulates a real-life situation without the obvious risks. Following on from this, the options of live-exercising and spontaneous (unannounced) testing should be considered.

7.7 The lessons identified from exercising, and debriefs following a lockdown incident, should be recorded and reported to the Boards' Corporate Management Team with an indication of the remedial action to be taken within specified timescales.

7.8 Lockdown plans should be tested with the involvement of relevant stakeholders at least on an annual basis, or after a plan has been updated. A pre-determined testing programme that is proportionate to the outcome of a risk and threat assessment should be implemented.

7.9 The Lockdown training and exercising programmes should be audited on an annual basis taking into account actions implemented in response to lessons from exercises or debriefs.

[8] See NHS Scotland Standards for Organisational Resilience, May 2018 - Standard 12 which sets out expectations in relation to Exercising and testing.

8. Recovery

8.1 A recovery plan must also be developed to explain how ‘business as usual’ will be restored after a lockdown.

The plan should consider:

- identify the responsible person for each aspect of the recovery;
- indicate when and in what order functions need to be restored;
- where staff and patients are to be relocated if areas of the site/building are not functioning;
- what resources are required for the recovery process;
- the communications required for all stakeholders.

8.2 The relevant person responsible for security and their staff should also maintain the security of buildings during the recovery process.

9. Information and Guidance

The following information and guidance documents provide useful information in relation to ensuring the security of NHS sites and services.

Security and Vulnerability

Security Services Standards for NHSScotland Security Leads (SHFN 03-02) May 2017, http://www.hfs.scot.nhs.uk/publications-/guidance-publications/?keywords=secur&section=&category=&month=&year=&show=10

Security Management Framework for NHS Boards in Scotland (SHFN 03-01) December 2008, http://www.hfs.scot.nhs.uk/publications-/guidance-publications/?keywords=secur&section=&category=&month=&year=&show=10

'**Secured by Design**' is a UK police initiative that supports the principles of 'designing out crime' through use of effective crime prevention and security standards for a range of applications: www.securedbydesign.com and http://www.securedbydesign.com/wp-content/uploads/2014/02/SBD-hospitals-2005.pdf

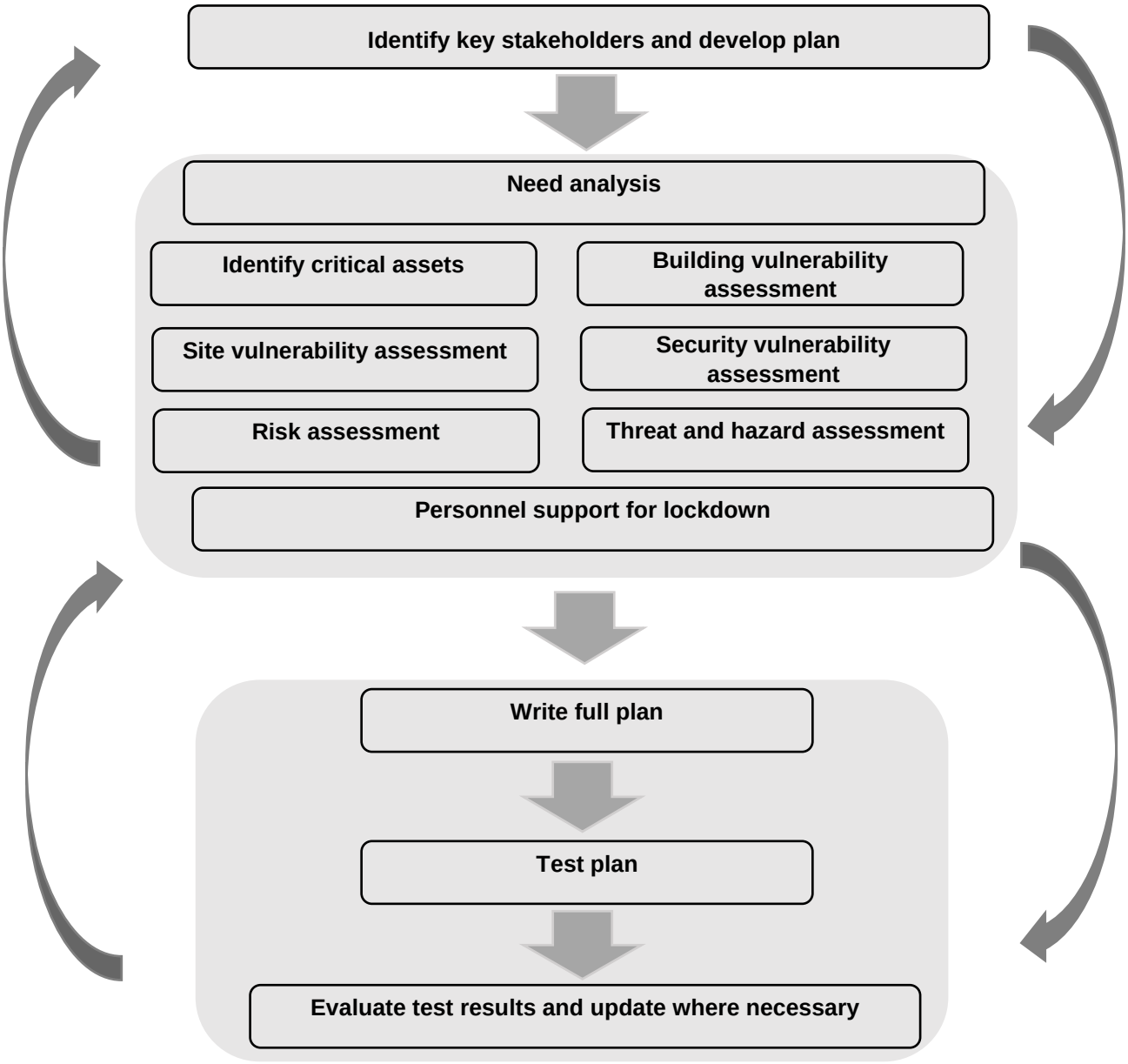
Enhancing the resilience of healthcare facilities

Core guidance - **Planning for a resilient healthcare estate** (HBN 00-07) http://www.hfs.scot.nhs.uk/publications-/guidance-publications/?keywords=resil&section=&category=&month=&year=&show=10 CBRN/HazMat Plan

Core Guidance - **Resilience Planning for the Healthcare Estate** (SHPN 00-07) http://www.hfs.scot.nhs.uk/publications-/guidance-publications/?keywords=resil&section=&category=&month=&year=&show=10 CBRN/HazMat Plan

Preparedness for an Increased Threat Level Scottish Government Health Resilience Unit, April 2017 (Official Sensitive), sghru@gov.scot

Appendix 1: Flow chart depicting stages



Appendix 2: Membership of Review Group - 2019

Name	Surname	Board	Role
Louise	Addison	NHS Lothian	Business Continuity Lead
Roddy	Alcorn	NHS Tayside	Security Officer
Lawson	Bisset	NHS Shetland	Head of Estates and Facilities
Clairinder	Clark	National Services Scotland	Resilience Representative
Ann	Cornwall	NHS Highland	Deputy Hotel Services Manager
Ray	de Souza	Scottish Government	Deputy Head - Health Resilience Unit
Lorette	Dunlop	NHS Ayrshire and Arran	Resilience Representative
Stephen	Fleming	The State Hospital	Physical Security Manager
Martin	Gordon	NHS Lanarkshire	Resilience Representative
Kenny	Green	NHS Fife	Security Manager
Caroline	McDermott	National Services Scotland	Resilience Representative
Tam	McFadyen	NHS Highland	Assistant Portering and Waste Manager
Belinda	O'Shea	Health Facilities Scotland	Facilities Support Manager
Paul	Paton	NHS Grampian	Security and Site Access Manager
John	Tweedie	Health Facilities Scotland	Programme Manager