SECURITY RISK MANAGEMENT

Alan Cain *explains what healthcare and higher education security risk managers and emergency planners can learn from each other*

For the first time in his adult working life, Alan Cain contemplates not having the word 'security' anywhere in his job title. His focus, now that he is working in the healthcare sector, is completely on emergency preparedness, resilience and response.

Alan is two years into his role as a Resilience Manager at NHS Greater Manchester Shared Services, but he also has a broader perspective – known to many – from his previous security risk management roles in higher education. He agreed to be interviewed by *Intersec* in his capacity as Vice-Chair of NAHS (the National Association for Healthcare Security).

Speaking to us, Alan reflects on the stresses of the last 18 months: the resilience challenges facing the healthcare sector were already well understood – at least by those working in the field – long before the outbreak of the global pandemic, but now they have been highlighted as never before.

Only six months into his new role, the first hints of danger were coming out of Wuhan. In the UK, on 29 January 2020, the first two patients tested positive for COVID in York and a plane evacuating Britons from Wuhan arrived at RAF Brize Norton, its passengers quarantined at a specialist hospital facility in Merseyside. Within weeks, tragic scenes of hospitals being overwhelmed were broadcast from Italy. NHS Trusts began a series of local exercises, under the title 'Exercise Novus Coronet', to test how they would respond to a similar crisis here.

The story of how the crisis developed and put such strain on health systems – and on overstretched medical teams – will be told later, but already Alan says that the pandemic has starkly revealed two things.

Duty of care and the need for security provision shouldn't stop at the hospital boundary

Firstly, even with an emergency preparedness, resilience and response framework as well developed as the NHS', how vulnerable healthcare systems are when resources are stretched thin and too much slack has been removed in the quest for efficiency.

Secondly, how unacceptable failure is. The millions of people clapping on doorsteps and balconies during the first COVID waves weren't just applauding key workers in hospitals, they were sending a signal to their governments: resilience matters – we expect our healthcare provision to work and not to fail, even when severely tested.

It is that prospect of severe testing that Alan now spends his time thinking about and preparing for. Increasingly, he believes others are doing the same, in other sectors. There is now a greater awareness, even among the general population, that crisis-level risks are not just theoretical. There are 38 major risks identified in the National Risk Register, and they all need to be planned for – not just individually or sequentially, but cumulatively.

"For example, we're no longer thinking just about flood evacuations, but flood evacuations under COVID-19 conditions, where those being evacuated could potentially include both COVID-positive and Clinically Extremely Vulnerable individuals. How does this affect the evacuation plan? Overlaying one crisis onto another makes it considerably more complicated in terms of the emergency plans that need to be built around it."

Pandemics, we have seen, actually do happen. Cyber-attacks have real-world consequences. Civil unrest can destabilise democratic institutions that were assumed to be beyond threat. And we are beginning to see first-hand the scale, speed and unpredictability of unprecedented localised severe weather incidents that scientists have long been warning about.

In July alone we have seen an extreme 'heat dome' hitting the US and with a step-change breaking of temperature records that have shocked even meteorologists; unprecedented floods in Europe that for days crippled one of the world's most advanced and well-governed societies; record breaking floods breaching an underground rail system in China; and wild fires in areas that have not previously experienced them on such a scale.

Closer to home, recent flash flooding after heavy rain in East London left Whipps Cross and Newham hospitals requesting patients to use other hospitals after their Emergency Departments were hit by flooding. Although the threat may be global, the impact will be local, Alan believes.

"Because emergencies of any scale are essentially local problems, the local authority is the bedrock of emergency planning. Say there is a major incident in Stockport, the point at which Stockport cannot cope alone it becomes a Greater Manchester issue. If you think of an incident with mass casualties, like a terrorist attack, if one of the health economies is overwhelmed by the number of casualties then we'd be distributing more widely across the Greater Manchester area. You then reach a point at which even that threshold is exceeded, and perhaps you're talking about a distribution across the North-west region.

"And we saw something like that at the peak of the pandemic with hospitals. You had different parts of the country affected to different degrees at different times. The point at which some of the NHS trusts in parts of London were struggling was when things weren't quite as bad in the Midlands, so they were able to distribute people slightly further afield than they would otherwise have done. There's also a surge capacity built into the NHS. The most well-known example of that is probably the Nightingale hospitals that were set up, even though thankfully many of the beds in them weren't needed."

The building blocks of a good emergency plan include the level of training of organisations who will be guided by it, the standard operating procedures that will be applied, the resources that will be available for use, the networks and communications that link them and the command and control structures used to manage the emergency itself. In terms of its emergency preparedness, resilience and response methodology Alan believes that there is much that the higher education sector can learn from healthcare.

Having previously worked in the sector, however, Alan believes that it is in the use of technology that the healthcare sector has lessons to learn from higher education. Recently, universities transformed their entire approach to security risk management and emergency planning, through the use of innovative technology and their increased focus on duty of care and the wellbeing of students and staff – not just on campus but those working remotely.

THE USE OF LOTS OF DIFFERENT TEMPORARY NHS SIGHTS IS LEADING TO A DIFFERENT RISK PROFILE

"There are command and control platforms, there are mass communication platforms, there are personal alarm systems, location pinpointing systems, real-time team coordination and response systems, whistle blower systems and lone worker safety systems – all are vital."

Alan concedes that operating multiple independent systems is costly, inefficient and expensive but up until recently, few alternatives existed. He points out that, there are some unique alternative technologies that are disrupting the security marketplace in higher education, and more recently in healthcare. For example, he cites that almost half of all UK universities have adopted CriticalArc's SafeZone technology because it brings all these functions together. It has been used to help students involved in medical emergencies, at risk of physical attack, trapped by extreme weather events as well as to provide reassurance for individuals who feel vulnerable.

"The thing I think is most useful is having a single platform that does it all. When you bring all the functions together the result is greater than the sum of the individual parts."

With a more stringent NHS Violence Prevention and Reduction standard due to come into force over the next year, and violence against healthcare workers showing no sign of dropping according to the latest NHS Staff Survey, it's another issue that healthcare providers need to focus more on, Alan believes.

"People look at workplace violence reduction in the NHS and tend to think of it in terms of individuals in a hospital setting, typically A&E. And yet there are so many people actually out in the community. There are also lots of temporary NHS sites in place as a result of COVID – such as test centres and vaccination centres, located in settings as diverse as sports stadia and shopping centre car parks – that one would not normally associate with the NHS, and that is leading to a different risk profile."

In other words, it's becoming clearer that duty of care, and the need for security provision, does not stop at the hospital boundary.

Team coordination is the other side of the coin. The ability to see the exact location of first responders to major incidents in real-time, is proving to be a force multiplier, allowing for more effective and timely action.

Healthcare security providers could benefit from the same approach as universities, he believes, because they have similar challenges to manage. They have hospitals with small but highly professional security teams with tens of thousands of individuals to protect; widely dispersed locations to watch over such as COVID test centres and vaccination centres; out-of-hours workers to safeguard; individuals and teams increasingly going out into the community; all the usual crime prevention risks to manage – and of course, increasingly, major emergencies to prepare for.

UNIVERSITIES IMPROVED THEIR APPROACH TO SECURITY RISK USING INNOVATIVE TECHNOLOGY

When incidents do occur, there is a need to coordinate their own first responders as well as collaborate effectively with other agencies.

"Emergency planning isn't done in a silo. It is a true multi-agency discipline. In my NHS role I work alongside colleagues from Greater Manchester Police, Greater Manchester Fire and Rescue Service, the North-west Ambulance Service, Transport for Greater Manchester, the Environment Agency and others."

So, what are the prospects for improved multi-agency collaboration involving the healthcare sector, similar to that seen in higher education?

A small but growing number of security risk managers and emergency planners within the NHS are aware of what the universities have been doing and see an opportunity to learn lessons and improve their own preparedness. And links between NAHS and AUCSO (the Association of Chief Security Officers), and the exchange of best practice, are helping.

"It's happening through the sort of conversations we are having in organisations like NAHS, and in parallel conversations around security risk management and emergency planning that are going on in both sectors.

"Everyone has a vested interest in the NHS doing well and becoming even more resilient, whether that's the one-in-50 people in England and Wales who work for the service – a lot of people don't understand just how large the NHS is, to put it into perspective the British Army is about 82,000 strong but there are about 1.3 million people working in the NHS – or the general public who value it so highly."

Alan was delighted when he got asked to stand for the role at NAHS because the association recognises that link between security risk management and emergency preparedness, resilience and response, and he sees NAHS as a platform for driving positive change in healthcare.

"Our membership comprises professionals from across the healthcare sector. The majority of them are security risk managers, but we also have a small but significant number of emergency preparedness, resilience and response managers like myself." The two disciplines, he says, have to sit side by side and in the future he predicts that they will be ever more closely aligned ●

Alan Cain is Vice-Chair of the National Association of Healthcare Security.

Hospitals have small but highly professional security teams with tens of thousands of individuals to protect