



Royal Cornwall Hospitals
NHS Trust

Pandemic Plan

V1.0

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1. Introduction

- 1.1. Communicable diseases offer some of the highest identified risks to the population of Devon, Cornwall and the Isles of Scilly (DCIOS), with Pandemic Influenza remaining the highest risk on the National Risk Register and the potential for other emergent diseases remaining a high risk.
- 1.2. Recent experience of the Covid-19 pandemic has demonstrated the need for planning to be wider than only known diseases. This plan provides a structure for responding to known and unknown high consequence infectious disease (HCID) that could lead to a pandemic and will consider the relevant risks on the National Risk Register and local risk registers held by the Local Health Resilience Partnership (LHRP) and the Local Resilience Forum (LRF).
- 1.3. This section should provide an overview of the importance and role of the subject covered by the document. If the document is created in support of a parent policy/procedure, then this should be referenced.
- 1.4. This document replaces the Pandemic Influenza Plan V6.0.

2. Purpose of this Policy/Procedure

To provide a pre-determined response to a pandemic that affects or requires a response by:

- Setting out the legislation and guidance to be complied with.
- Identifying clear triggers and activation processes to be followed.
- Setting out how specific functions will be administered and resourced.

These should be underpinned by three key principles, that the response should be precautionary, proportional, and flexible (UK Pandemic Influenza Preparedness Strategy).

3. Scope

This plan applies to all Royal Cornwall Hospitals Trust (RCHT) staff. It summarises and assembles the key procedures and responses to be activated in the event of a pandemic. The plan is flexible and contains procedures and responses ranging from a mild to an aggressive outbreak.

4. Definitions/Glossary

CIOS	Cornwall and Isles of Scilly
DATER	Detection, Assessment, Treatment, Escalation and Recovery
DCIOS	Devon, Cornwall and Isles of Scilly

DHSC	Department of Health and Social Care
HCID	High Consequence Infectious Disease
ICB	Integrated Care Board
ICC	Incident Coordination Centre
IPAC	Infection Prevention and Control
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
PALS	Patient Advice and Liaison Service
PHEIC	Public Health Emergency of International Concern
POD	People and Organisational Development
PPE	Personal protective equipment
RCHT	Royal Cornwall Hospitals Trust
WHO	World Health Organisation

5. Ownership and Responsibilities

5.1. Role of the Chief Executive

The Chief Executive oversees the pandemic response and is represented at the Trust's Incident Coordination Centre by the Chief Operating Officer.

5.2. Role of the Care Group/Corporate Managers

Line managers are responsible for ensuring that all staff are aware of the plan with particular regard to the following:

5.2.1 Health Care Delivery

- Implement strict infection prevention control measures.
- Manage surge capacity.
- Expand Critical Care services for both adults and children.

- Maintain patient flow.
- Manage hospital deaths.
- Maintain pandemic and non-pandemic care pathways.
- Work within strict ethical guidelines.

5.2.2 People and Organisational Development

- Implement staffing strategies.
- Provide support staff.
- Match staffing demands to competencies.
- Implement business continuity arrangements.

5.2.3 Estate and Facilities

- Implement business continuity arrangements.
- Protect utilities and non-medical services.

5.3. Role of the Emergency Preparedness, Resilience and Response (EPRR) Committee

This committee oversees pandemic preparedness as part of its wider remit. During a prolonged pandemic response phase, this group may temporarily be subsumed within the Incident Coordination Centre (ICC).

5.4. Role of Individual Staff

All staff members are responsible for:

- Ensuring that they are aware of and adhere to this plan in the event of a pandemic.

6. Standards and Practice

6.1. Triggers

This plan will be triggered by an alert identifying a suspected or confirmed Public Health Emergency of International Concern (PHEIC) or pandemic, received from the UK Health Security Agency and/or NHS England.

6.2. UK National Strategy

Summary of key aspects of the UK Influenza Pandemic Preparedness Strategy 2011 including references to a range of activities that will be undertaken by various partners:

(Note: This is awaiting national update post the Covid-19 pandemic. Until a

revised national strategy is published, the above strategy is still in force and stages outlined in it are explained below).

- The strategy recognises that the World Health Organisation (WHO) alert phases were not ideally suited as a response framework within individual countries. In 2009, the UK was well into its first wave of infection by the time WHO declared the official start of the pandemic.
- The overall objectives of the UK's approach to preparing for a pandemic are to:
 - Minimise the potential health impact of a future pandemic.
 - Minimise the potential impact of a pandemic on society and the economy.
 - Instil and maintain trust and confidence.
- Given the uncertainty about the scale, severity, and pattern of development of any future pandemic, three key principles should underpin all pandemic preparedness and response activity:
 - **Precautionary:** the response to any new virus should consider the risk that it could be severe in nature.
 - **Proportionality:** the response to a pandemic should be no more and no less than that necessary in relation to the known risks.
 - **Flexibility:** there should be a consistent, UK-wide approach to the response to a new pandemic but with local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection and the different healthcare systems in the four countries.
- Towards this, the strategy identifies a series of stages, referred to as 'DATER': Detection, Assessment, Treatment, Escalation and Recovery (DATER). These stages are non-linear and have identified indicators for moving between them. The stages are not numbered as they are non-linear and may not follow in strict order; it is also possible to move back and forth or jump stages. It should be recognised that there may not be clear delineation between stages, particularly when considering regional variation and comparisons.
- An explanation of the DATER phases is set out below:
 - **Detection**

This phase will commence either when the WHO issue an alert that a new virus or influenza sub-type has been identified in humans, or earlier based on reliable intelligence or, if a PHIEC is declared by the WHO. The focus in this stage would be:

 - Intelligence gathering from countries already affected.
 - Enhanced surveillance within the UK.
 - The development of diagnostics specific to the new virus or sub-type.
 - Information and communications to the public and professionals

- The indicator for moving to the next stage would be the identification of the novel virus or influenza sub-type in patients in the UK.

▪ **Assessment**

The focus in this stage would be:

- The collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK.
- Reducing the risk of transmission and infection with the virus within the local community by:
 - Actively finding cases.
 - Self-isolation of cases and suspected cases; and
 - Treatment of cases / suspected cases and use of antiviral prophylaxis for close / vulnerable contacts, based on a risk assessment of the possible impact of the disease.

The indicator for moving from this stage would be evidence of sustained community transmission of the virus, i.e., cases not linked to any known or previously identified cases.

These two stages – Detection and Assessment - together form the initial response. This may be relatively short, and the phases may be combined depending on the speed with which the virus spreads, or the severity with which individuals and communities are affected. It will not be possible to halt the spread of a new pandemic virus, and it would be a waste of public health resources and capacity to attempt to do so.

▪ **Treatment**

The focus in this stage would be:

- Treatment of individual cases and population treatment.
- Enhancement of the health response to deal with increasing numbers of cases.
- Consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localised education settings closures based on public health risk assessment.
- Depending upon the development of the pandemic, to prepare for targeted vaccinations as the vaccine becomes available.

Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases, and deaths.

When demands for services start to exceed the available capacity, additional measures will need to be taken. This decision is likely to be made at a regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity.

▪ **Escalation**

The focus in this stage would be:

- Escalation of surge management arrangements in health and other sectors.
- Prioritisation and triage of service delivery with aim to maintain essential services.

- Identifying populations/localities that may be at increased risks and prioritising control measures within these settings/populations.
- Resilience measures, encompassing robust contingency plans.
- Consideration of de-escalation of response if the situation is judged to have improved sufficiently.

Whilst escalation measures may not be needed in mild pandemics, it would be prudent to prepare for the implementation of the Escalation phase at an early stage of the Treatment phase, if not before.

▪ **Recovery**

The focus in this stage would be:

- Normalisation of services, perhaps to a new definition of what constitutes normal service.
- Restoration of business-as-usual services, including an element of catching-up with activity that may have been scaled-down as part of the pandemic response e.g., reschedule routine operations.
- Post-incident review of response, and sharing information on what went well, what could be improved, and lessons learnt.
- Taking steps to address staff exhaustion.
- Planning and preparation for a resurgence of the HCID, including activities carried out in the Detection phase.
- Continuing to consider targeted vaccination, when available.
- Preparing for seasonal influenza in the conditions of an outbreak or pandemic.

The indicator for this phase would be when activity is either significantly reduced compared to the peak or when the activity is within acceptable parameters. An overview of how services' capacities can meet demand will also inform this decision.

6.3 Public Health Control Measures – Overview

6.3.1 Main Types of Intervention:

- Public information.
- Enhanced hygiene.
- Enhanced infection prevention and control measures.
- Isolation and/or restriction of movement.
- Restriction of access.
- Decontamination.
- Vaccination.
- Prophylaxis.

6.3.2 Vaccination

- 6.3.2.1 Vaccination is an important means of primary prevention, providing a level acquired immunity in the individual and their

close contacts, through community (herd) immunity, protects susceptible individuals within a population once a minimum level of coverage has been achieved.

- 6.3.2.2 Initially vaccines will not be available in a novel disease outbreak therefore the focus will be on prophylaxis and prevention spread.
- 6.3.2.3 During the response to an infectious disease outbreak, vaccination remains an option for public health intervention, either for close contacts or the agreed population at risk before exposure (where the risk of exposure is high) or post-exposure prophylaxis were indicated in probable or confirmed contacts.

6.3.3 Prophylaxis

- 6.3.3.1 Prophylaxis is the administration of treatment (for example antimicrobials, antivirals, or vaccines) for primary prevention of infection in contacts or the secondary prevention of disease in cases of infection.
- 6.3.3.2 Prophylaxis can either be provided to possible contacts in advance of exposure (pre-exposure) or to probable or confirmed contacts once exposure has taken place (post-exposure).

6.3.4 The Integrated Care Board (ICB) Role

- 6.3.4.1 The ICB role will be to identify a provider who will deliver vaccinations/ prophylaxis in a small-scale outbreak moving to commission the delivery of a major vaccination program in a large-scale outbreak. In the event of a pandemic, the ICB will arrange for appropriate providers to deliver prophylaxis while awaiting development of a vaccine, following which the program will move to commissioning delivery of large-scale vaccination programs (like the COVID-19 response).
- 6.3.4.2 As part of the initial response the ICB may be required to identify an appropriate provider to undertake the collection of diagnostic swabs/ bloods for testing by laboratories identified by UK Health Security Agency.

6.4 Potential Impact of a Pandemic

- 6.4.1 The potential impact of a pandemic will be determined by the following factors:
 - The number of cases and deaths, this will only become apparent once sufficient data is available.
 - The number of patients presenting at primary care services or at hospital.
 - The number of patients requiring specialist treatment (i.e. extra corporeal membrane oxygenation (ECMO) or intensive care).
 - The capacity of public services, utilities and businesses to cope with staff absence and/or increased demand.

- The level of concern experienced by the population, with positive reactions to good respiratory and hand hygiene campaigns and the high uptake of antiviral and vaccination reducing the spread of the illness.

6.4.2 Disruption

In the absence of early or effective intervention there could be widespread social and economic disruption including:

- Threats to the continuity of essential services (including fuel).
- Lower production levels of essential goods (including pharmaceuticals).
- Travel disruptions causing shortages and distribution difficulties of essential goods.

All of the above can be mitigated or the effects minimised with good business continuity management practices.

6.4.3 Staff Absence

The difficulties in maintaining essential services detailed above could be exacerbated within the Trust further by high levels of staff absence with staff requiring time off at some stage over the pandemic period through:

- Sickness or fear of infection.
- Care-providing responsibilities (especially if schools are closed).
- Stress.
- Bereavement (or other psychosocial impacts).
- Transport disruptions.

It is likely that staff absences will be higher and more pronounced in the Trust's smaller teams where staff work in close proximity.

6.4.4 Business Continuity

The Civil Contingencies Act 2004 (CCA) requires all Category 1 responders to have comprehensive Business Continuity Plans (BCPs) in place and to also to have these readily available in the event of an emergency. The Trust's Business Continuity Strategic Plan will provide guidance on managing critical services during any period of unusual pressures or interruptions to service supply, including a pandemic.

6.5 Groups and Reporting

6.5.1 Pandemic Incident Coordination Centre (ICC)

6.5.1.1 During the early stages of a pandemic or increase in infections within the area, the Trust will establish an ICC that will consist of the following roles:

- Chair - Chief Operating Officer.
- Head of Emergency Preparedness, Resilience and Response.
- Care Group representatives.
- Deputy Chief Operating Officer.
- Consultant Nurse for Infection Prevention and Control (IPAC).
- Occupational Health Lead.
- Chief Pharmacist.
- Deputy Director for People and Organisational Development (POD).
- Communications Lead.
- Consultant Microbiologist.
- Head of Procurement and Supplies.
- Facilities Management.
- Director of Estates.
- Staff side representative.

6.5.1.2 The Pandemic ICC's main purpose is to co-ordinate the Trust's response to a pandemic, from the initial phase through to recovery and preparing for the next wave. As many services may be provided on a joint basis with either local organisations or subcontractors and suppliers, meetings may be expanded to include representatives from other organisations. It may be necessary to create sub-groups to deal with specific issues as they occur.

6.5.1.3 The sub-groups formed for Covid-19:

Communications	Recovery
Discharge	Resilience Plans
End of Life (EOL)	Security

Estates	Staffing
Facilities	Staff Testing
IPAC	Transport
CITS	Social Distancing
Medical Physics	Operational Management
Procurement and Supplies	

6.5.1.4 Terms of reference of the ICC group are to:

- Provide leadership and co-ordination in planning and dealing with the potential implications of a pandemic.
- Monitor identified actions and report progress at each meeting.
- Discuss and agree the decision making process for the deployment of local resources, including restricting, withdrawal and cancellation of services.
- Identify and develop strategies for the maintenance of essential services.
- Interpret and implement local, regional and national guidance on the pandemic.
- Provide assurance to the Trust board on the response to the pandemic.
- Develop communication material for service users and staff in line with national guidance and local responding organisations.
- Develop business continuity strategies and co-ordinate post-pandemic return to normality.
- Prepare reports on progress or planning issues.
- Ensure that RCHT are contributing to and represented in the multi-agency response.

6.5.2 RCHT Response Phases

Command and Control

RCHT will convene an ICC to monitor the situation and to take management action as required based on a regular assessment of the impact of the pandemic on the Trust's operational capability across all trust sites. This group will agree and implement appropriate responses e.g., modifying activity, re-directing resources internally, implementing new admission and discharge thresholds, determining which services can continue to be provided at normal levels, which services can continue to operate but at a reduced or modified levels and which services are to be temporarily discontinued. If the pandemic is severe then a major incident may need to be declared to further manage the response. This activity is likely to be captured in 4 stage Implementation Plans for each area as it was for Covid-19. The 4 stage implementation plans cover:

- How the service provision will change over the 4 phases with phase 1 being business as usual and phase 4 being at the peak of the phase.
- Co-dependencies.
- Support required from partner organisations.
- Resource requirements.
- Physical requirements.
- Staffing requirements.

Linked to each 4 stage implementation plan is a Risk Assessment/Sit Rep, the Covid-19 example is provided at Appendix 4.

6.5.3 Communications Strategy

6.5.3.1 During a pandemic, accurate and concise communications which can be issued swiftly to the right people at the right time will be essential in helping to control panic, as well as getting across messages about what actions people should be taking and in what circumstances.

6.5.3.2 A pandemic could affect the Trust in a number of ways, the most likely being large numbers of additional patients, increased infection prevention and control issues and staff absence through prolonged and unplanned sickness. This plan considers communications for staff, patients and the general public.

6.5.4 The Role of the Communications Team

The Trust Communications Team will liaise closely with the Pandemic ICC to ensure that mechanisms are in place to communicate effectively with all audiences, internal and external. The Communications Team will keep abreast of external developments, including the WHO's declared pandemic status level, both via information provided through NHS England and UK Health Security Agency/Department of Health and Social Care (DHSC) and also its own research. When a pandemic is

likely, the Team will instigate a pandemic monitoring system, which will include:

- Daily monitoring of media coverage.
- Regular contact with Cornwall and Isles of Scilly (CIOS) ICB, NHS England, UK Health Security Agency/DHSC and other appropriate organisations to ensure the Trust is kept abreast of developments and key communications.
- This may be done on a formal rota basis if necessary.
- The Communications Team will co-ordinate all messages for staff, patients, visitors, carers, families and the media.
- The Team will ensure that any communication instructions for acute trusts which are issued centrally are actioned, and that information required by these bodies is provided in a timely manner. The Team will also keep NHS England informed about pandemic communications activities on a regular basis. This will include press releases and statements, key website messages and information, along with anything else of relevance.

6.5.5 Communications with Staff

- Communication with staff is vital to ensure they are able to reassure patients and visitors and give correct advice, as well as follow correct protocol if they, their household members, colleagues or inpatients fall ill.
- Staff must also be given information about who will receive vaccines and prophylactic drug treatment once this has been agreed.
- A pandemic shelf portal will be made live on the Trust's intranet and will be directly accessible from the home page. Contents may include:
 - Links to policies and guidance for staff.
 - Links to other external websites providing information which staff are likely to need.
 - A full Q&A for staff.
 - Training videos for personal protective equipment (PPE).
 - Contacts including the Trust's Occupational Health teams, staff welfare line, and key members of the Pandemic ICC group, along with details of their areas of responsibility during the pandemic.
 - Regular updates for staff will be provided via bulletins and also via important global email messages when required.
- For staff who are unable to come into work, either because they are

sick or have sick dependents a dedicated reporting line will be set up. This will be managed by POD.

- Materials including posters and leaflets from the central public campaign should also be displayed (when they become available) in staff areas where appropriate.

6.5.6 Communications with Patients, Visitors, Families and Carers

- In the event of a pandemic, the Trust will work with NHS England, CIOB ICB, other local trusts, Cornwall Council, and through UK Health Security Agency to agree specific messages for patients which will be given out by each organisation.
- The majority of information for patients will be made available via the public website and the local media. All such information will be in line with requirements specified by the UK Health Security Agency).
- Posters and/or information leaflets will be displayed in key public areas of the hospital, along with simple advice on visiting protocols, symptoms to look out for and what to do if someone is very unwell.
- All staff in switchboard, reception, Patient Advice and Liaison Service (PALS), complaints and appointment booking teams will be given specific information to help them advise any patients, visitors or members of the public who telephone or turn up in person for information and advice. This will include visiting protocols, whether someone with symptoms should come to hospital or seek help elsewhere and what other forms of help and support are available. Again, this information will be consistent with UK Health Security Agency requirements.

6.5.7 Communications with the Media

- The Trust Communications Team will handle all media enquiries connected with the pandemic. The team will also ensure, through internal communications, that all staff are reminded of the importance of not speaking to the media during a pandemic but to refer all calls to the Communications Team.
- Requests for generic media interviews about the pandemic will be directed to NHS England or the UK Health Security Agency.
- The team will also seek to work with the local media to promote information to the general public about issues such as the wholesale suspension of outpatient or elective activity.
- The team will liaise as necessary with media teams in other local organisations, as well as NHS England, UK Health Security Agency and the DHSC as required.
- The team through the health system partners will continue to provide out-of-hours communications cover as normal throughout a

pandemic.

6.6 Changes in Trust Operations

6.6.1 Managing Demand and Capacity (Surge Planning)

Whilst the Trust has business continuity plans, pandemics require additional planning due to the duration of a pandemic wave and the impact on the whole of the Trust's services, staff, resources and service users. The term demand and capacity is used to describe "The ability of the health service to expand beyond normal capacity to meet an increased demand for clinical care". The term "Surge" is used in Healthcare in the same way and is used in pandemic guidance to mean the same as Demand and Capacity. There are seven guiding principles that need to be considered when planning for an increase in demand and capacity in healthcare:

- The care that can be given to people when resources are stretched should be maximised.
- Plans should be consistent with the overall aim of preserving and maintaining essential healthcare services.
- Changes to services and clinical standards should be incremental and should reflect changes in local demand and the resources that are available.
- Changes should be consistent with the established ethical principles.
- Plans should take a whole-system approach and encompass primary, community and secondary care.
- Plans should support the attainment of strategic objectives at each stage of a pandemic.
- Implementation should be coordinated at a strategic level in a health economy to ensure consistency of interpretation and effect.

6.6.2 Emergency Department

- 6.6.2.1 Symptomatic patients will be advised to stay at home and seek help by calling 111 but some self-referral is inevitable. The level of self-referral is likely to be higher if there are breakdowns in primary care provision, loss of confidence or access difficulties. Therefore, our Emergency Department and Urgent Treatment Centre will have an important role to play in our response.
- 6.6.2.2 Signs will be displayed to and on entry to the Emergency Department/Urgent Treatment Centre instructing patients with symptoms to inform the receptionist on their arrival. Where possible, a triage practitioner will be based in the reception area to manage patient flow, including deferral of patients who do not require emergency care who should instead be referred to

primary/urgent care or community care services.

6.6.2.3 Due to the surge in attendances and the resulting capacity and demand imbalance that a pandemic would cause, there will be a need to ensure that patients are treated in the most suitable setting. During a pandemic there is likely to be a severe strain on resources such as beds, staff, and equipment and therefore it is likely the Trust will need to restrict hospitalisation to only those who present with the most urgent need.

6.6.2.4 There may be the need to designate different areas of the Emergency Department for those with pandemic related symptoms and those without as was done in Covid-19. The size of these designated areas will depend on how many patients are presenting and where we are in the pandemic peak.

6.6.3 Admission, Discharge and Management of Bed Capacity

6.6.3.1 Referral to secondary care (i.e. a hospital ward) should only be made for patients who cannot be successfully treated at home. This may include individuals:

- With pre-existing medical conditions which require secondary care interventions.
- Who may benefit from respiratory aid (e.g., the constant provision of oxygen).
- Whose condition needs further investigation or diagnosis by specialist staff.
- Who cannot self-care due to impaired mental health capacity.

6.6.3.2 The decision to admit a patient presenting with illness indicative of the pandemic will be based on clinical symptoms and the results of investigations in accordance with the most recent algorithm issued by UK Health Security Agency and/or agreed locally within the Trust. During Covid-19 the algorithms issued were modified regularly as more information about the virus became available. The most recent version of the algorithm will be made available on the Trust's intranet on the pandemic shelf portal. Patients admitted with pandemic symptoms will be cohorted starting on the isolation ward and then side rooms and once that doesn't meet demand another ward will be designated for these admissions. In Covid-19 these wards were labelled 'Red' wards. The decision to cancel elective procedures will be taken by the Pandemic ICC in discussion with Care Group representatives, taking into consideration clinically urgent cases and where the Trusts' targets are put at risk. NHS England, as was done in Covid-19, may give a national directive to cancel elective care centrally and remove local Trust decision making.

6.6.4 Critical Care

The demand, particularly for ventilation, is likely to exceed available resources even where all possible local measures to supplement and expand capacity have been implemented. Prioritisation of all patients on an individual basis matched against available resources will become necessary. Admissions to the Critical Care department will be assessed on an individual patient basis by the Consultant in charge of Critical Care. During a pandemic it is expected that the number of admissions to critical care would increase substantially and measures are in place to expand critical care capacity to accommodate this.

6.6.5 Outpatients

During a pandemic, outpatient services may be limited. A decision to restrict services will be made by the Pandemic ICC on the basis of staff numbers, the severity of the pandemic and the number of hospital admissions. There will be posters to advise patients and visitors not to come into hospital if they are symptomatic, patients will be advised to postpone their appointment and arrange another appointment. Reception staff in the department will be instructed to ask patients turning up for appointments whether they have relevant symptoms or travel history. Those who have symptoms and do not require immediate care will be advised to go home and re-book another appointment.

6.6.6 Pharmacy

The hospital pharmacy will play an important part in making the best use of available medicines, including the appropriate use of patients' own medicines, and facilitating the discharge of patients with adequate supplies of medicines. Where there are shortages of some medicines, the pharmacy team will advise on the use of alternative medicines that have a similar effect.

6.6.7 Security

The pandemic will place a strain on security resources; hospital security will face additional pressures and may require some additional support if possible. During the pandemic, security will need to deal with:

- Any violence or public order issues when faced with potential overcrowding or population panic. This may require the use of a lockdown.
- Security of limited supplies – especially medications, vaccines and PPE.
- Security issues over access to hospital for treatment.
- General hospital security.

6.6.8 Personal Protective Equipment (PPE)

PPE is worn to protect staff from contamination with body fluids and to

reduce the risk of transmission between patients and staff and from one patient to another. RCHT will follow the national guidance issued by UK Health Security Agency for the wearing of PPE in the various scenarios and settings. However, as a general principle fluid-repellent surgical masks should be worn by healthcare workers who may be in close and/or frequent contact (within one metre) with symptomatic patients. FFP3 standard disposable respirators should be worn when carrying out clinical procedures likely to generate aerosols of respiratory secretions from infected patients (e.g. intubations, aspiration), although such procedures should be avoided as far as possible. It should particularly be noted that fit testing and specific training are essential and should be undertaken in advance of any potential pandemic.

6.7 Workforce Planning

6.7.1 Impact on Workforce

- 6.7.1.1 It is estimated that up to 50% of the workforce may require time off at some stage over the entire period of the pandemic, with individuals likely to be absent for a period of seven to ten working days. Absenteeism should follow the pandemic profile, with an expectation that it will build to a peak lasting for two to three weeks, when between 15% and 20% of staff from the workforce may be absent, and then decline. However, as the rate of infection in residential facilities may be higher over a short period, higher levels of absence must be planned for. Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants (e.g. children), family bereavement, other psychosocial impacts, fear of infection or practical difficulties in getting to work.
- 6.7.1.2 The Government may advise schools and early years/childcare settings to close in order to reduce the spread of infection amongst children. This advice will be provided only if closure is anticipated to produce significant health benefits. Closures will be area specific (whilst the virus is circulating in the locality) and are likely to be for two to three weeks, although they may be extended if the pandemic remains in the area.

6.7.2 Staff Redeployment

If at the height of a pandemic, services are reduced to the provision of essential care, the Trust will redeploy staff who work in areas that are scaled down or suspended. Staff may therefore have to take on new roles or work in unfamiliar situations. If staff need to be redeployed or work needs to be reallocated the following principles will apply:

- Staff will not be expected to undertake roles outside the level of their competence. Staff will have the skills and knowledge to work safely. A skills audit will be undertaken to deliver this.
- All reasonable measures will be put in place to ensure the health and safety of staff.

- Staff will be paid on their existing grades and will be financially compensated if they take on an acting promotion.

6.7.3 Staff Welfare

- 6.7.3.1 People will be the most valuable resource and the most vulnerable during a pandemic. The Trust will need to ensure that staff who arrive ill or become ill when at work go home and remain off duty for the remainder of the illness. There will be the need to identify any staff at risk due to their own health conditions and agree a change of working practice/location to minimise their risk of infection. The Trust will also assist staff with accommodation for those members of staff unable or unwilling to return home and to provide sustenance and refreshment for those working particularly long and stressful hours.
- 6.7.3.2 The Trust will develop a training and education programme that builds capacity into the existing workforce through teaching new skills and updating existing ones (both clinical and non-clinical). This will allow some staff to take on additional duties, so that those with higher clinical skills or experience can focus on those patients who may be at particular risk or on treating those suffering from the complications of the pandemic. There may be the need to review human resources policies and procedures to maximise flexibility for staff to be able to work and accommodate caring obligations, annual leave and special leave (carer's leave, bereavement leave, etc.)

7. Dissemination and Implementation

- 7.1. The plan will be published on the Trust document library following ratification by the EPRR Committee.
- 7.2. This document replaces the Pandemic Influenza Plan V6.0.

8. Monitoring Compliance and Effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	The whole plan requires monitoring during and following a pandemic.
Lead	Head of Emergency Preparedness, Resilience and Response
Tool	The plan will be monitored by observing during a pandemic. Following an incident there will be a debrief session or multiple debrief sessions with the key stakeholders to establish what went well and what did not go so well. This will inform revisions to the plan.

Information Category	Detail of process and methodology for monitoring compliance
Frequency	The plan will be reviewed following an actual pandemic or following exercising or when guidance changes.
Reporting arrangements	The Pandemic Operational Group will meet frequently should the plan be activated. Following a debrief of the activation of the plan a report will be submitted to the EPRR Committee.
Acting on recommendations and Lead(s)	The action plan will be monitored through the EPRR Committee with clearly identified leads.
Change in practice and lessons to be shared	Following activation of the plan there will be a formal debrief of the incident to identify lessons learnt. This will be internally at first followed by a multi-agency debrief.

9. Updating and Review

This plan will be reviewed no less than every three years.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

10.2 Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Pandemic Plan V1.0
This document replaces (exact title of previous version):	New document (this replaces the Pandemic Influenza Plan V6.0)
Date Issued/Approved:	March 2024
Date Valid From:	October 2024
Date Valid To:	October 2027
Author/Owner:	Matt Overton, Head of Emergency Preparedness, Resilience and Response (EPRR)
Contact details:	01872 256356
Brief summary of contents:	Framework to manage pandemics.
Suggested Keywords:	Pandemic, Influenza.
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Operating Officer
Approval route for consultation and ratification:	EPRR Committee
Manager confirming approval processes:	Matt Overton
Name of Governance Lead confirming consultation and ratification:	Matt Overton
Links to key external standards:	CQC. NHS England EPRR Core Standards.

Information Category	Detailed Information
Related Documents:	Principal legislation: - NHS Act 2006 as amended by the Health and Social Care Act 2012 and 2022. - Civil Contingencies Act 2004. - Health and Safety at Work Act 1974. Secondary legislation: - Human Rights Act 1998. RCHT documents: Business Continuity Strategic Plan Emergency Preparedness, Resilience and Response Strategy Management of Outbreaks Policy Major Incident Plan (Majax) Lockdown Policy Local Business Continuity Plans and Business Impact Analyses
Training Need Identified:	Yes, as part of redeployment and staff returning from retirement or re-registering as clinical staff.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Chief Operating Officer / Emergency Planning

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2024	V1.0	Initial issue	Matt Overton, Head of Emergency Preparedness, Resilience and Response

All or part of this document can be released under the Freedom of Information Act 2000.

The NHS England EPRR Framework requires all EPRR related documents to be retained for 30 years. RCHT requires all Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the

organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team
richt.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Pandemic Plan V1.0
Department and Service Area:	Emergency Planning
Is this a new or existing document?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Matt Overton, Head of Emergency Preparedness, Resilience and Response
Contact details:	01872 256356

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	RCHT staff – to provide them with information with regards to the management of pandemics within the Trust.
2. Policy Objectives	To ensure all departments are familiar with the management of pandemics.
3. Policy Intended Outcomes	To provide safe and effective care.
4. How will you measure each outcome?	Evaluate the plan following a pandemic or exercise.
5. Who is intended to benefit from the policy?	Staff and patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	- Workforce: Yes - Patients/visitors: No - Local groups/system partners: Yes - External organisations: No - Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Please record specific names of individuals/ groups: - EPRR Committee. - CIOB ICB – Emergency Preparedness, Resilience and Response team.
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys: No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Matt Overton

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:

[Section 2. Full Equality Analysis](#)

Appendix 3. RCHT DATER Responsibilities

DETECTION PHASE	
Cases identified outside UK	
National Key Actions	
This phase would commence on either the declaration of WHO alert phase or earlier on the basis of reliable intelligence or if a “Public Health Emergency of International Concern” (a “PHEIC”) is declared by the WHO. The focus in this stage would be: • Intelligence gathering from countries already affected. • Enhanced surveillance within the UK. • The development of diagnostics specific to the new virus. • Information and communications to the public and professionals. The indicator for moving to the next stage would be the identification of the virus in patients in the UK.	
RCHT Actions	
Actions	Owner/Responder
Convene first meeting of the Pandemic ICC and agree meeting frequency and communication methods. Arrange for loggists to support this group potentially through the entire pandemic episode.	Emergency Planning
Initiate urgent review of current pandemic response plan, business continuity and surge arrangements.	Pandemic ICC
Review current response strategies in respect of any updated optimal practices and past experience.	Pandemic ICC
Accelerate, consolidate and test all Trustwide pandemic preparedness efforts.	Pandemic ICC
Identify / source suitable location/s for the cohorting of infected patients.	Pandemic ICC
Ensure subcontractors and commissioned services have adequate response plans in place.	Emergency Planning / Head of Procurement / Supplies
Increase awareness of the signs, symptoms and epidemiology of the pandemic as well as infection prevention and control measures using posters, intranet and newsletters.	Infection Prevention and Control (IPAC) Team and Communications team
Review Critical Care provision and necessary actions for increasing capacity.	Critical Care Sub-group
Draft Level 3 admission criteria and actions and submit for ethical consideration.	Critical Care Sub-group
Check case definition and epidemiology, identify at risk patient groups.	IPAC Team
Alert POD / Care Groups / Corporate Areas to monitor sickness absence reporting – Implement Staff Hotline to answer general queries.	POD
Confirm availability of PPE and ensure FFP3 fit testing is accelerated immediately.	Health and Safety Team
Review Personal Protective Equipment distribution system and change if necessary. Procure additional Personal Protective Equipment as a precaution.	Inventory Management Team

Actions	Owner/Responder
Step up infection prevention and control measures and use of personal protective equipment where necessary, circulate latest infection prevention and control guidance.	IPAC Team
Review communication methods by testing receipt of key messages to staff, service users, subcontractors, local organisations, etc.	Communications Team
Regularly brief senior staff, especially managers/directors on-call of current situation.	Pandemic ICC
Implement training for staff.	IPAC Team, Learning and Development, Health and Safety team
Review volunteer and recently retired staff lists, implement training programme through learning and development.	POD / Voluntary Services

ASSESSMENT PHASE	
New Virus isolated in the UK	
National Key Actions	
The focus in this stage would be: • The collection and analysis of detailed clinical and epidemiological information on early cases, on which to base early estimates of impact and severity in the UK. • Reducing the risk of transmission and infection with the virus within the local community by: ▪ Actively finding cases; ▪ Self isolation of cases and suspected cases; and ▪ Treatment of cases / suspected cases and use of prophylaxis for close / vulnerable contacts, based on a risk assessment of the possible impact of the disease. The indicator for moving from this stage would be evidence of sustained community transmission of the virus, i.e. cases not linked to any known or previously identified cases.	
RCHT Actions	
Actions	Owner/Responder
Ensure Trust is represented at local multi agency groups.	Pandemic ICC
Set up regular meetings and situation reports (Sit-Reps) that include number of infected patients and staff.	Pandemic ICC
Enhance surveillance and / or data collection to reflect data requests.	IPAC Team / Information Services
Review sickness absence levels and enquiries to Staff Hotline.	POD
Review essential services and allocate re-deployable / volunteer staff.	Pandemic ICC
Review use of infection prevention and control procedures and personal protective equipment within services, introduce inventory management if not already in place.	IPAC Team / Inventory Management Team
Review current cases and accelerate discharges if necessary.	Medical Staff
Review admission and discharge arrangements within the Trust.	Pandemic ICC
Consider need to “dilute” staff to patient ratios.	Pandemic ICC
Increase Critical Care capacity within the Trust.	Pandemic ICC through Critical Care Sub-Group
Ensure communication updates are issued regarding changes to services.	Communications Team
Continue training programme for staff likely to be redeployed.	Learning and Development
Ensure Trust is represented at local multi agency groups.	Pandemic ICC

Actions	Owner/Responder
Ensure subcontractors and commissioned services are putting their response plans in place.	Emergency Planning / Head of Procurement / Supplies
Review volunteer and recently retired staff lists and training requirements.	POD / Learning and Development
Review Trust pandemic plan in light of current epidemiological information.	Emergency Planning
Implement any Pandemic training as required (i.e. FFP3 fit testing, infection prevention and control).	IPAC Team / Health and Safety Team / External Contractors (if necessary and available)
Prepare a media statement and internal communication that deals with the potential scenario of the death of a member of RCHT staff due to the pandemic.	Communications Team / POD

TREATMENT PHASE	
Outbreaks in the UK	
National Key Actions	
The focus in this stage would be: • Treatment of individual cases and population treatment via prophylaxis, if appropriate and necessary. • Enhancement of the health response to deal with increasing numbers of cases. • Consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localised school closures based on public health risk assessments. • Depending upon the development of the pandemic, to prepare for targeted vaccinations as the vaccine becomes available. Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases and deaths. When demands for services start to exceed the available capacity, additional measures will need to be taken. This decision is likely to be made at a regional or local level, as not all parts of the UK will be affected at the same time or to the same degree of intensity. Preparation is also required for the escalation phase.	
RCHT Actions	
Actions	Owner/Responder
Review Trust attendance at local multi agency groups.	Pandemic ICC
Review situation reports including number of infected patients and staff.	Pandemic ICC
Review surveillance and / or data collection requests.	IPAC Team / Information Services
Review use of infection prevention and control procedures, personal protective equipment within services, inventory management provisions and continue to order additional stock.	IPAC Team, Inventory Management Team, Health and Safety Team
Review sickness absence levels and enquiries to Staff Hotline.	POD
Monitor provision of services and review trigger points for escalating 4 stage implementation plans.	Pandemic ICC
Review guidance on PPE and use of masks.	IPAC Team
Consider cancellation of annual leave/study leave.	Pandemic ICC / POD
Consider deployment of final year medical and nursing students.	Pandemic ICC / POD
Review admission and discharge arrangements within Trust.	Pandemic ICC
Review changes to primary and secondary care arrangements and update staff.	Pandemic ICC
Ensure communication updates are issued regarding changes to services.	Communications Team
Review training programme and provide additional events if necessary, cancel non-essential training that doesn't contribute to the pandemic response.	Learning and Development
Review subcontracted and supplied services.	Emergency Planning / Head of Procurement / Supplies

Actions	Owner/Responder
Review queries to Staff Hotline and agree any measures which may be introduced to assist staff, i.e. provision of transport, etc.	Pandemic ICC / POD
Agree frequency of meetings and attendance for next three weeks.	Pandemic ICC
Review Trust plans and response in light of current information and public reaction.	Pandemic ICC
Consider the need for putting the trust on critical incident or major incident standby or declared.	Pandemic ICC

ESCALATION PHASE	
National Key Actions	
The focus in this stage would be: • Escalation of surge management arrangements in health. • Prioritisation and triage of service delivery with aim to maintain essential services. • Resilience measures, encompassing robust contingency plans. • Consideration of de-escalation of response if the situation is judged to have improved sufficiently.	
RCHT Actions	
Actions	Owner/Responder
Regularly report situation to NHS E, CIOS ICS and local multi agency groups.	Pandemic ICC
Establish daily briefing bulletin including number of cases and mortality rate.	Pandemic ICC
Review data collection and surveillance requirements during peak period.	Pandemic ICC
Review staff absence rates and ability to resource essential services.	POD / Pandemic ICC
Review staff welfare arrangements to enable well staff to work.	Occupational Health
Review implications of change in duties for redeployed staff.	POD
Review use of personal protective equipment and inventory management provision (record level of use during peak weeks for use during next wave).	IPAC Team / Inventory Management Team
Agree admission and discharge protocols for hospital during peak weeks.	Pandemic ICC
Implement alternative mortuary arrangements (if necessary).	Mortuary
Ensure regular communication updates are issued and Trust messages are being added to local communication bulletins through relevant networks.	Communications Team
Agree any reduced service level arrangements with subcontractors.	Emergency Planning / Head of Procurement / Supplies
Review policy on visitors/visiting hours to in-patient facilities during peak of pandemic.	Pandemic ICC / Chief Nurse / IPAC Team
Assess availability of medicines and essential resources.	Pharmacy
Review decisions made earlier in light of current information.	Pandemic ICC
Ensure deputies are appointed to all key roles in case of illness / absence.	Pandemic ICC
Prepare vaccination programme for staff.	Pharmacy / Occupational Health
Check oxygen delivery infrastructure on site is sufficient.	Operational Estates / Pharmacy
Consider if trust needs to declare a critical or major incident.	Pandemic ICC

RECOVERY PHASE	
Post Peak Week Pandemic Recovery Period	
TRIGGERS	
The indicator for this phase would be when pandemic activity is either significantly reduced compared to the peak or when the activity is considered to be within acceptable parameters. An overview of how services' capacities are able to meet demand will also inform this decision. Once the number of cases of new infections has been confirmed as reducing on a weekly basis, it will be important to manage the reimplementation of services based on the availability of staff and resources and the impact the pandemic has had on the local population who may access these services. Recovery measures, including the provision of psychological counselling for both staff and the public will also be required.	
RCHT Actions	
Actions	Owner/Responder
Reduce the frequency of briefing bulletins as appropriate.	Pandemic ICC
Reduce resources to the staff hotline as appropriate, review absence levels and allocate compassionate leave where appropriate.	POD
Review surveillance and data collection methods for use in next wave.	IPAC Team / Information Services
Review availability of services and implement recovery strategy.	Pandemic ICC
Review availability of subcontracted services and suppliers.	Emergency Planning / Head of Procurement / Supplies
Reduce rotas and duties (where necessary) for re-deployed / volunteer staff.	Care Groups
Ensure personal protective equipment is used to minimise risk of infection (virus will still be circulating although number of new cases reducing).	IPAC Team
Implement pandemic-specific vaccination strategy and allocate resources (if available yet).	Pharmacy / Occupational Health
Review effectiveness of local communication methods and information.	Communications Team
Review admission protocols for hospitals and reintroduction of services.	Pandemic ICC
Assess case loads and redeploy staff and resources where necessary to relieve short term pressures.	Pandemic ICC
Determine if new services are required long term as a result of the event.	Care Groups
Agree stand down of the Pandemic ICC.	Pandemic ICC
Prepare a debrief report for submission to Trust Board.	Emergency Planning

INTERPANDEMIC PLANNING	
Next Pandemic Wave Planning	
Past experience of pandemics suggest that a second and possibly further waves of illness are possible after the first wave has subsided. The second wave may be as, or more intense than the first. If the second wave occurs before more stockpiling takes place, the local response will need to be adapted to reflect this.	
Pandemic ICC Actions	
Prepare a report listing key issues for Trust Board.	
Identify financial impact analysis.	
Consider carrying out post-pandemic specific vaccination campaign.	
Establish a formal and informal debrief procedure to gather lessons learnt.	
Recognise the contribution of staff, establish a formal reward system and enable staff to nominate colleagues.	
Review essential services provided during the pandemic.	
Identify staff infected in the first wave as these will be immune and can undertake high-risk clinical work (with appropriate PPE) during any second wave (assuming the virus doesn't mutate between the first and second wave).	
Analyse the surveillance and data collection methods, including the use of data used to plan services and resources with a view to producing an efficient method of data collection and representation for use during next wave.	
Set up a system to allow staff, patients and carers to discuss their experiences during the pandemic with a view to planning for next wave.	
Set up a formal debrief procedure for staff to reflect on their experience during the pandemic and use lessons learnt to develop services and training materials for next wave.	
Evaluate the use of the staff welfare provisions and hotline and use the lessons learnt to revise this service for second wave.	
Review the use of re-deployed/volunteer staff and training requirements.	
Revise infection control information based on experience of using personal protective equipment during the pandemic.	
Review effectiveness of local communication methods and information.	
Agree changes in service provisions with subcontractors for next wave.	
Assess requirements for future stockpiling of PPE.	
Review and update Pandemic Plan based on lessons learned.	

Appendix 4. Risk Assessment/Sit Rep

Processes and adherence to guidance	Significant number of reports of process failure or non-adherence to guidance
	Occasional reports of process failure or non-adherence to guidance
	No reports of process failure or non-adherence to guidance
PPE	Severe disruption to supply chain, essential PPE not in place
	Delays in order delivery/some equipment unable to be deployed due to training delays
	All relevant PPE in place in a timely manner
Training	Keys areas in the Covid-19 response cannot assure that they have at least one staff member with the relevant training to provide care
	At least one member of staff with the relevant training on duty at any time to provide care or the need to redeploy staff around the hospital
	The number of staff trained means that checking the shift rota for those trained becomes unnecessary
Community Screening Solution	Service is at capacity or PPE supply issues putting it at risk of failure
	Some 'surge' but manageable
	Operating within normal parameters
Inpatients non-L2/3	Wheal Prosper full and side rooms in base wards full with query or confirmed Coronavirus patients
	Query/confirmed Coronavirus patients confined to Wheal Prosper
	Query/confirmed Coronavirus patients confined to the 2 –ve pressure side rooms
Communication	Staff are reporting a lack of information that is causing anxiety within the workforce AND/OR adverse publicity in the media
	Reasonable staff/public enquiries
	Media messaging AND/OR internal communications is sufficient in that there are no or minimal enquiries.

Exercises/Simulation	Conducted exercises are reporting severe issues that would suggest real life occurrence would be extremely sub-optimal in care delivery
	Acceptable areas for improvement found in exercises
	Exercises are being completed with no or minimal recommendations for improvement
Laboratory Capacity	Significant delays and risk of service failure
	Delays in sampling
	Meeting key targets
Cohorting/Capacity Increase Plans	Plans not in place or plans invoked and need for further capacity not able to be mitigated
	Plans being developed and not required yet or plans instigated and able to cope with the surge
	Plans in place and not able to be instigated yet
Screening of hospital attendees	Significant number of attendees being turned away as they meet the Covid-19 quarantine criteria due to inability of staff to complete screening process in advance
	An acceptable number of attendees are being sent away and/or referred to NHS 111
	Confidence that the majority of attendees are being screened and minimal are being re-scheduled or sent away from site
Redeployment of workforce	Staff are being redeployed into sub-optimal postings with an acceptance of risk
	Redeployment of staff is required consistently
	Redeployment not necessary or appropriately being applied
Number of staff off work due to illness/quarantine	>50
	25-50
	<25
Pod Usage	Queues for the Pod
	Pod is being utilised and cleaned as appropriate
	Minimal pod use
Community coronavirus +ve patients currently in the Cornwall area	20>
	10-20
	<10

Community Hospital Status	Risk of service failure
	Breakdown in social care provision is causing DTOC increase and/or staffing issues
	Business as usual
Facilities Assurance	Risk of service failure
	Need for them to prioritise core functions as per their business continuity plan, some supply issues
	Business as usual, stocks at normal levels
Work from home capability	IT equipment and technical infrastructure capability has been exhausted
	Some issues with IT equipment availability and technical infrastructure
	Not required or being applied successfully
Side Room Log	Log is not consistently being updated
	Some errors or omissions identified
	Up to date and accurate
Critical Care admissions with query/confined Coronavirus	Phase 3 and 4
	Phase 2
	Phase 1