PANDEMIC PREPAREDNESS PLAN

Contents

1   Introduction

1.1   Purpose

The purpose of the Pandemic Preparedness Plan (PPP) is to support St Andrew's Healthcare (StAH) in organising and delivering a proactive response to a declared Pandemic event, (as defined by the UK Department of Health, and the World Health Organisation, (WHO)).

The StAH Pandemic Preparedness Manual provides a framework for the command, co-ordination and communication of the response to the pandemic event. The manual aims to support management in anticipating and controlling the wide range of potential impacts that could accompany a major pandemic event.

1.2   Scope

A 'Pandemic' is an extensive epidemic affecting a large number of persons over a wide geographic area. A pandemic can typically occur when a new virus emerges that infects people, is spread from person to person, causes serious illness and against which there is limited or negligible resistance.

The World Health Organisation (WHO) acts as a global alert mechanism and monitors developments in influenza viruses for those that could develop pandemic potential. In the UK, the Department of Health is the responsible department for pandemic planning and will issue guidance and information in the event of a global pandemic being declared.

1.3   Objective

The objective of this Pandemic Preparedness Plan is to provide a procedure to guide the StAH Outbreak Control Group (OCG) in the event of a pandemic scenario being declared. The manual addresses the following areas:

- Command and control arrangements.
- Key tasks to be undertaken by the OCG.
- The arrangements in place to support the OCG.

1.4   Pandemic Preparedness Team Responsibilities

The role of the PPT is to provide direction to operational functions on managing the implications and consequences of a pandemic on patients, staff and on third party organisations that provide services and support to StAH. To do this it may be necessary to:

- Conduct an initial assessment of the situation and if appropriate declare a crisis and convene the OCG.
- Manage internal communications, including press, media and social media.
- Receive status reports from Integrated Practice Unit Multi-disciplinary Teams.
- Direct resources or support required to assist the affected Integrated Practice Units and ooperational bbusiness functions.

1.5 Pandemic Preparedness Organisation

Pandemic Preparedness Phases

2.1. Global Pandemic Risk Notified	2.2 New Virus Isolated in the UK	2.3 Widespread Outbreaks in the UK	2.4. Widespread Cases in the Community	2.5 / 2.6 Recovery and Next Phase Planning	2.7 Stand Down the Plan
• WHO and Department of Health alert of human to human influenza virus likely to cause Public Health Emergency. • Notify Gold Command of advice. • Activate Outbreak Control Group (OCG) Monitoring. • Commence review of Charity pandemic contingency arrangements.	• Notification that the pandemic virus has been identified in the UK. • Implement patient and staff support processes. • Implement record keeping protocols.. • Communications to increase awareness of influenza signs and symptoms. • Commence review of capacity options and staff resource options.	• Multiple outbreaks of the virus across the UK. • OCG to make the recommendation to implement Gold Command control. • Activate enhanced precautions, i.e. PPE provision, distribute anti-virals, welfare monitoring and staff training. • Intensify communications.. • Liaison with external health care providers.	• Widespread local outbreaks with patients and staff exposed. • Gold Command to escalate controls, e.g. admissions and discharge of patients, visitors, staff absence. • Daily monitoring of effectiveness of controls., e.g. PPE, staffing, anti-viral stocks, welfare arrangements. • Maintain communications • Monitor the number of cases.	• Pandemic likely to occur in multiple phases. • Gold Command to review experience of previous phase once case numbers reduce. • Act on 'Lessons Learnt' from earlier Pandemic phases. • Decide which Pandemic services to maintain and which to stand-down. • Review medications and supply provision. • Review staff and patient welfare provisions.	• Verify that the Pandemic has passed. • Gold Command to decide on standing down the Pandemic Plan. • Communicate the decision to stand-down the plan and return to BAU status. • OCG to lead post-event review to reflect on Pandemic Preparedness performance. • Update Pandemic Preparedness Plan with learnings.
Outbreak Control Group activated	Outbreak Control Group Lead	Incident Command Activated	Incident Command Lead	Incident Command Lead	Outbreak Control Group Lead

Turn to **Section 2** and use the procedure to guide you through managing the Pandemic risk event.

2 Pandemic Preparedness Procedures

2.1 Notification of Global Pandemic Risk

Objective	Tasks	Completed?
Receive notification of Pandemic Risk	- Notification received by nominated contacts from the World Health Organisation (WHO) of human to human transmission of influenza virus determined to cause a 'Public Health Emergency of International Concern'. - UK Department of Health (DoH) alert received to implement the 'Detection Phase' for a potential pandemic or epidemic.	
Notify Command Team to implement monitoring arrangements	- Notify St Andrew's Healthcare (StAH) Command Team (Gold Command) of WHO and / or DoH notification of Pandemic Risk: - Provide Gold Command with a summary of WHO / DoH advice. - Request the activation of the Outbreak Control Group (OCG), and confirm OCG leadership. - Confirm requirements for on-going reporting and updates to the Command Team.	
Activate the Outbreak Control Group (OCG)	- The OCG Leader to receive a briefing on the WHO and DoH pandemic alert from Command Team. - OCG Leader to identify required members of the OCG and to contact them notifying them of the date, time and location of the first OCG meeting. This should be within 24 hours of the OCG being activated. - The first OCG meeting to address the following actions: - Confirm members and allocate roles within the team. Include representation from regional sites, central services and Integrated Practice Units. - Agree OCG meeting schedules. - Agree on the content and timing of updates to the Command Team. - Agree criteria against which recommend the escalation of the Charity's Pandemic response. - Agree the requirements for early contingency planning actions, i.e. areas to consider. - Ensure regional sites are integrated effectively into the OCG monitoring arrangements. - Agree topics to be reviewed by the OCG. - Agree support requirements with Internal Communications for messaging to the wider Charity.	

Objective	Tasks	Completed?

OCG to commence assessment and design of contingency requirements	• Review information and support provision for carers and vulnerable patient groups.
	• Review pre-pandemic vaccine requirements:
	  o Require Integrated Practice Units to identify priority patients and suitable vaccine recipients amongst patients and staff.
	  o Review vaccine options with Pharmacy and clinical MDT and contribute to the recommendation on vaccine purchase.
	  o Review arrangements for anti-viral storage and distribution to ensure these are clearly identified and understood.
	  o Consider security risk to antivirals storage if the pandemic occurs with Pharmacy, Integrated Practice Units and Security team.
	• Review personal protective equipment (PPE) requirements against anticipated influenza strain:
	  o Assess available stocks, identify likely demand and notify Procurement on potential sourcing requirements. Inform Integrated Practice Units.
	  o Investigate the arrangements for ensuring that PPE will be allocated to the appropriate staff when required.
	  o Identify requirements for additional staff training in the use of the PPE. Who will do this, how long will it take?
	• Review infection control measures in place and those likely to be required:
	  o Ensure the latest infection control guidance is available relative to the specific Pandemic threat.
	  o Identify any additional training and awareness requirements in infection control management for clinical and non-clinical staff.
	  o Identify guidance to be issued to all staff across the organisation and decide on when and how to communicate the message.	

OCG to review communications preparedness	• Command Team to test communications methods by issuing test message to staff and service users. • OCG to recommend suitable information notices and prepare on-line briefings for staff, family members, visitors, contractors and patients. • Set up a contact telephone messaging service and contact email address to receive Pandemic related messages.	

Objective	Tasks	Completed?
Review requirements for record keeping	• OCG to review record keeping requirements for tracking pandemic effects and recommend to the Command Team for adoption. Ensure NHSE data formats are understood and accommodated.	
Ensure representation at local health resilience forum	• Nominate representatives to attend Local Health Resilience Forums, and to report back to the OCG on developments, requirements and the actions of other agencies and organisations.	

2.2   New Virus Isolated in the UK

Objective	Tasks	Completed?

Notification that the pandemic virus has reached the UK	• On receipt of formal notification of Pandemic Influenza being identified in the UK, Command Team to be notified and a meeting chaired by Gold command to be called:
	
	• The initial command meeting to address the following points:
	   o To receive a report on the current status of the pandemic risk.
	   o To receive a report from the OCG on the status of current Charity preparations. Control of the response to be transferred from the OCG to Gold Command.
	   o Gold Command to approve the timetable and frequency for the Command Team to meet.
	   o OCG representatives to recommend any immediate actions for Command approval, e.g. requirements for additional procurement, training provision, communications. Command meeting to review and decide on those actions for implementation and those actions to keep under review.
	   o OCG to provide updates from Local Health Resilience Forums. Decision taken on whether this representative role is now reallocated or supplemented by a Silver Command status manager.
	   o The meeting to agree the frequency and content of updates. The meeting to nominate who provides the updates and how this is then shared with the wider organisation.	

Objective	Tasks	Completed?
Implement information and record keeping protocols	● Responsible person to implement agreed record keeping protocols. Keep NHSE requirements under review. ● Communicate the requirement to report influenza type symptoms to the wider organisation. Use **Appendix D, 'Influenza like Symptoms Sickness Report'** to report cases to the Health and Safety Team (?). ● Set-up requirement for Integrated Practice Units to report to the Command Team daily meetings on their current situation using the **Appendix E, 'Status Report Form'**. ● Request additional feedback from Integrated Practice Units regarding concerns around accessing physical healthcare support for patients, or staff access to vaccines or support for family. ● Liaise with Human Resources to ensure sickness absence data is monitored and reported to the Command Team.	
Implement support procedures for staff and patients	The Command Team to agree the delegation of the following actions: ● To conduct a review of essential patient services and key staff dependencies, i.e. where could there be significant capability risk and what contingencies are available? ● For Integrated Practice Units to step-up infection control procedures and staff training with PPE. Introduce staff training reminders to refresh awareness of basic medical care. ● To tighten stock control procedures to ensure vital stocks are protected and used efficiently. ● To assess potential capacity demands on Pharmacy and the physical healthcare service. The assessment to be presented to the Command Team to determine tolerances and options for additional support. ● To set-up anti-viral distribution points and testing procedures. o Set-up pre-pandemic vaccination tests using winter	

Review capacity to manage patient physical health demands, i.e. surge risk	● Commence the review of admission and discharge arrangements:
	   o Determine how patient physical health risks will be assessed for admission, and the risks to current residents and also to patients being discharged to other facilities.
	   o Determine policy on accepting patient admissions who display possible symptoms of pandemic influenza.
	● Review the pandemic planning arrangements currently in place in the light of developing information on the epidemiology of the pandemic strain.	

Objective	Tasks	Completed?
Increase awareness of Pandemic Influenza signs, symptoms and epidemiology	- Ensure communications updates are issued daily to staff on the following: - The latest situation regarding the Pandemic risk. - The action that staff and their families can take to minimise their risk. - Any special arrangements the Charity is making to provide support or assistance. - Ensure patients are informed in an appropriate manner of the risk.	
Review options for additional capacity and support	- Asses options available for additional staffing options should it be necessary to supplement StAH staff resource: - Bureau. - Agency. - Recently retired staff. - Review principal sub-contractors and third party commissioned service providers arrangements for supporting service delivery during a pandemic event.	

2.3 Widespread Outbreaks in the UK

Objective	Tasks	Completed?
Escalate command management controls	- Distribute updates received of Pandemic outbreaks nationally and locally to the Command Team. - Convene a Gold Command meeting held to accelerate preparations to address the developing situation: - Assess likely pandemic demands and effects on NHS service providers, and the implications this could have on the Charity's operations, e.g. access to acute services. - Determine criteria for accepting new patients or discharging patients and communicate to commissioners and NHSE. - Determine changes required to primary and secondary care arrangements, and communicate requirements to Integrated Practice Units to implement. - Decide on the criteria and trigger points for when service provision may need to reduce, and potential contractual impacts. - Decide on procedures for managing voluntary service provision. - Decide on formal activation of Silver and Bronze Command levels. - Consider requirements for external communications of the Charity's pandemic arrangements, e.g. press, patient families. - Review sub-contracted service provision and consider contingencies if services are disrupted. - Agree Command Team meeting frequency and information updates.	
Activate enhanced precautions for patients	- Review the effectiveness of the organisation and arrangements for the distribution of anti-virals to patients - Implement pre-pandemic vaccinations. - Identify anti-viral distribution arrangements for patients in Northampton, Essex, Mansfield, and Birmingham. - Ensure recording systems are in place to record anti-viral recipients. - Consider contingency options available for the distribution of anti-virals if there is disruption to primary distribution arrangements.	

Objective	Tasks	Completed?

Activate enhanced precautions for staff	● To review the effectiveness of PPE provision:
	    ○ Is current PPE provision effective to manage exposure to the virus?
	    ○ Is there sufficient range and quantity of PPE available for medical staff?
	    ○ Review guidance and training provided to staff for the effective use of PPE.
	    ○ Review replenishment arrangements for restocking and the re-provision of PPE.
	 ● Activate arrangements with Physical Healthcare provider for the prescription of antivirals for staff:
	    ○ Where a staff member has been exposed to the virus, request prophylactic anti-viral prescription.
	    ○ Where a staff member is displaying symptoms of the virus following exposure, liaise with Physical Healthcare provider for a prescription for a treatment dose of the anti-viral.
	    ○ Where a requirement for vaccinating staff is identified, ensure a complete list of names is provided to the Healthcare Provider so prescriptions can be prepared for administering the medications.	

Review Patient and Staff Welfare Monitoring arrangements	● Review surveillance and data collection procedures on patient healthcare, i.e. are they capturing relevant and useful data to support decision-making, are changes necessary? ● Review situation reports including the number of infected patients and staff. ● Review procedures and reporting arrangements for staff sickness and absence monitoring. ● Consider potential requirements for additional staff support, e.g. provision of transport to and from work, meals,	
Maintain Communications	● Maintain on-going contact with Local Health Resilience Forums on outbreak situation. ● Ensure communication updates are issued to all staff concerning any changes to services introduced during the Pandemic emergency. ● Provide opportunities for staff to raise questions and queries on Pandemic management arrangements, e.g. website, telephone helpline.	

2.4   Escalation Phase: Widespread Cases in the Community

Objective	Tasks	Completed?
Escalate management controls	- Implement daily status reporting and briefing to the Command Team. - Review data collection and health surveillance data. - Review staff absence rates and resourcing to support essential services. - Implement pre-agreed admission and discharge protocols, and advise Commissioners / NHSE, MoJ. - Ensure deputies are appointed to key roles in the Command Team in case of sickness or absence. - Determine whether additional controls are required on visitors to in-patient facilities. - Monitor the impacts on admissions, treatments and discharges.	
Closely monitor effectiveness of preventative controls	- Continue communication effort to ensure staff and patients have the latest medical and self-care information. - Assess demand and availability of medicines and anti-virals stocks. - Determine requirements for additional mortality arrangements. - Review PPE provision, effectiveness and replenishment requirements.	
Monitor staff welfare and support arrangements	- Review staff welfare arrangements to ensure well staff are able to work, i.e. consider family support arrangements. - Ensure messaging for staff and family welfare support arrangements are up to date and regularly reviewed. - Review requirements for redeploying staff to priority duties where shortages occur.	
Consider response to disruption effects on NHSE and Local Authority Services	- Confirm requirements for managing fatalities on site - Consider how corpses will be accommodated on-site if removal from site is delayed due to high demand for undertakers services, e.g. temporary refrigeration, allocating suitable secure areas - Identify infection control and hygiene management requirements - Ensure documentation is prepared and stored against future coroners inquests. - Consider requirements for enhanced provision of GP and physical healthcare service if Accident and Emergency facilities are closed to admissions. - Consider waste removal, including clinical waste and storage arrangements for sites if these services are disrupted.	

2.5   Recovery Phase – Post Pandemic Planning

Objective	Tasks	Completed?
Command Team to Review Pandemic outlook and future planning requirements	• Once new pandemic influenza cases are confirmed as reducing on a weekly basis the following actions to be implemented by the Command Team: 　o Gold Command meeting to be held to review the impact of the pandemic wave on patients, staff and provision of services. 　o Review NHSE and MoH reports on pandemic status, and whether additional pandemic waves are anticipated. Determine whether to maintain or commence the reduction of pandemic plan actions. 　o Decide on the future meeting frequency for the Command Team. • Prepare summary reports on service status for key stakeholders: 　o Board members and governors. 　o Provide status report summaries to Local Health Resilience Forums, DoH, and NHSE as required.	
Review requirements for maintaining pandemic specific services.	• Delegate actions via the Command Team for the following activities: 　o Assess options for reinstating suspended services with available staff and resources. 　o Determine whether to maintain additional rotas and duties for seconded / volunteer staff. 　o Reassess requirements for the use of PPE to minimise infection risks, i.e. decide if it is required in all situations? Note: there is a likelihood that residual infections could persist. 　o Review the effectiveness of surveillance and data collation procedures. Do they require revisions to the intended audience, changes to content, presentation or frequency of reporting? 　o Review anti-viral medication use and available stocks. 　o Decide on whether to implement a post-pandemic vaccination strategy, including the analysis of resources required, their sourcing and process for distribution to patients and staff. 　o Review the availability of sub-contracted services and supplier support; i.e. check with suppliers and sub-contractors when and how suspended services will be reinstated. 　o Review any admission protocol restrictions implemented during the pandemic wave. Consider whether these can now be removed, with actions to inform interested stakeholders. 　o Identify 'hot-spots' requiring redeployment of additional staff to address short-term pressures. 　o Review mortality arrangements and review with the Coroner's Office as appropriate.	

Objective	Tasks	Completed?

Review staff welfare and the provision of support	● Assess staff welfare requirements:
	   o Is there a requirement to provide psychological counselling and / or compassionate leave for staff and families as appropriate?
	   o Determine requirements for maintaining enhanced staff support.
	   o Review staff absence levels, and procedures to contacting staff members about returning to work.	

Review communications effectiveness	● Review communications effectiveness and future requirements:
	   o Review the effectiveness of communication Integrated Practice Units, i.e. what method is most commonly used by staff, how effective is the messaging, what improvements can be made and introduced?
	   o Ensure communications on the latest status of StAH facilities is shared with Local Health Resilience Forums.
	   o Decide on frequency and content of update bulletins to staff, i.e. maintained or start reducing them?	

2.6 Next Phase Pandemic Planning

Objective	Tasks	Completed?
Act on 'Lessons Learnt' from the previous pandemic wave	• If a further influenza pandemic wave appears likely, the (Gold) Incident Command Team will require a review of the experiences from the earlier pandemic phase to prepare for the next phase. The following actions are recommended: 　○ Arrange debrief sessions with staff to reflect on which procedures and arrangements worked well and what didn't. 　○ Consult with patients, carers and families to gain their feedback on planning for the future pandemic wave. 　○ Review surveillance and data collection methods, and identify any changes or revisions required to improve the process in anticipation of the next pandemic wave. • Review the provision of contractor service provision, and determine what will be acceptable service levels in the event of further pandemic wave. Agree service levels with contractors as required. • Prepare a report for the Command Team listing the following actions: 　○ The control actions that will need to be reintroduced in preparation for the next pandemic phase. 　○ Essential actions to be implemented during the pandemic. 　○ Any revisions or changes required to existing procedures.	
Review provision of staff safety and welfare arrangements	• Evaluate the provision of staff welfare, safety and support arrangements for subsequent pandemic waves: 　○ Review the use of seconded or volunteer staff. 　○ Identify requirements for additional employee training. 　○ Review and revise infection control procedures based on experience of the use of PPE as required. 　○ Review the effectiveness of PPE used in the previous pandemic wave. 　○ Assess training effectiveness for PPE. 　○ Review the stocks of available PPE and identify gaps in supplies and requirements for replenishment. 　○ Identify contingencies for PPE if replenishment supplies cannot be obtained. 　○ Ensure communications arrangements are to ensure staff are informed or can obtain information easily and quickly.	

Objective	Tasks	Completed?

Review arrangements for medications	● Assess requirements for anti-virals and medications provision, on the assumption that subsequent pandemic waves will be more virulent than previous waves:
	   o Pharmacy and clinicians to determine the likely demand for use of anti-virals and influenza medication in a more aggressive pandemic environment.
	   o Assess requirements for future stockpiling for stockpiling of anti-virals and influenza medications.
	   o Determine arrangements for ensuring anti-viral stocks are available for regional sites.
	   o Identify and prioritise vulnerable patient groups for receipt of anti-viral medications.
	   o Agree options available if anti-virals and influenza medication is unavailable.
	   o Consider the likelihood of an increased mortality rate and more significant patient complications.	

Assess communications requirements	● To review the effectiveness of communications methods and information to identify where improvements to the content, format, targeting and media could be improved for future similar events.	

2.7 Stand Down the Plan

Objective	Tasks	Completed?

Verify that the Pandemic risk has passed	• (Gold) Incident Command Team should establish the following in taking the decision to stand down the plan:
	  o Confirm the presence of any pandemic cases amongst patients, staff, and family members, e.g. review infection data and 'open' Influenza symptom reports.
	  o Confirm pandemic status with Local Health Resilience Forum (LHRF).
	  o Check Department of Health status reports / WHO.
	• If all enquiries indicate the risk has passed, prepare status report covering:
	  o Evidence supporting the analysis, i.e. LHRF recommendation, internal cases, review of data.
	  o Check status at all StAH sites.
	  o Pandemic contingency arrangements currently in place.
	  o Recommendation to the Command Team that the Pandemic Preparedness Plan can be stood down.
	  o Decide the time and date for the Pandemic Preparedness Plan to be stood down.	

Decision to stand-down the Pandemic plan	• Gold Command meeting to review pandemic status and decide on the following:
	  o Review status report and recommendations.
	  o Review evidence presented in the report, and decides on whether a change in the Pandemic Status of each StAH site is appropriate. Agree the status of each site individually.
	  o Agree time and date for closure of pandemic contingencies by site, and for the organisation to return to business as usual (BAU) working.
	• Allocate ownership for the process for standing down the Pandemic Preparedness Plan, e.g. to the OCG, (Outbreak Control Group).	

Objective	Tasks	Completed?

Communicate decision to 'stand-down' the Pandemic Plan and return StAH to BAU status	• Communicate the Gold Command decision to stand down the Pandemic plan and return to BAU:
	• Allocate responsibilities for the following actions:
	  o Prepare the messaging.
	  o Informing the Executive Group.
	  o Organising communication of the decision to management and staff through use of available media at all StAH sites, e.g. use staff meetings, website, and intranet. Consider how to inform staff not currently at work, bureau and agency employees of the change in StAH pandemic status.
	  o Communicating the change in StAH pandemic status to NHSE and LHRFs.
	  o Communicating the change in StAH pandemic status to corporate functions, e.g. Estates, Procurement, Finance, Sales & Marketing for them to inform partners and suppliers.	

Manage the closing down of the Pandemic Preparedness Plan	• The OCG to convene to determine the following
	  o Establish how pandemic contingency arrangements currently in place can be closed down or processes transitioned to business as usual.
	  o Agree arrangements for how any quarantined facilities can be returned to use, and the resources and timeframes for this to be done.
	  o Review processes for returning staff to work and which staff welfare arrangements will be sustained and for how long.
	  o Allocate responsibility for the management of the collection of unused materials provided for the Pandemic emergency, including:
	    ▪ Anti-virals and other medications.
	    ▪ PPE.
	    ▪ Cleaning agents and other materials
	  o Allocate responsibility for reuse, disposal or return of unused materials.	

Objective	Tasks	Completed?

Post Pandemic Review Actions	• The OCG to arrange a post-pandemic review meeting to assess the performance of the Pandemic Preparedness Plan and the arrangements implemented.
	
	• The review meeting to specifically assess:
	   ○ Command and decision-making processes.
	   ○ Communications effectiveness, i.e. staff communications, communications with patients and families, links with external agencies, internal communications between StAH sites.
	   ○ Training and provision of information for staff.
	   ○ Provision and availability of PPE.
	   ○ Dependencies on suppliers, including supplier performance during the pandemic.
	   ○ Any unanticipated or unexpected events or complications.
	   ○ The review meeting approve recommendations to changes and updates to the Pandemic Preparedness Plan.
	   ○ To make recommendations on requirements for investment in future Pandemic contingency provision, e.g. consumables, PPE, contractual changes.
	
	• Quality and Risk Committee and the Executive Group to be presented with the outputs of the review meeting, and the agreed recommendations for investment in pre-pandemic contingencies.
	
	• Pandemic Preparedness Plan to be updated and presented to the Quality and Risk Committee for approval once changes and updates have been completed.
	
	• Periodic review frequency of the Pandemic Preparedness Plan to be agreed and responsibilities allocated	

Appendix A: Roles and Responsibilities for the Pandemic Preparedness Plan

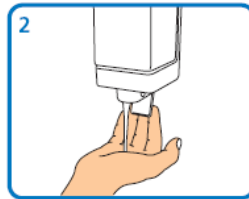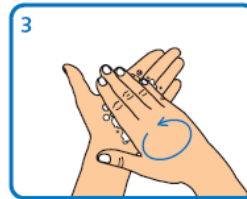| Body	Tasks
Incident Command (Gold)	• Gold Command and the Incident Command Structure to be notified when the WHO or UK Department of Health officially declare the risk of human to human transmission of pandemic influenza. • Gold Command to decide whether to delegate the monitoring of the developing situation to the OCG or whether to implement other arrangements. • Gold Command to be activate formal Incident Management control procedures once a pre-determined threshold is likely to be reached, e.g. see Section 2.3. • Gold Command to take control of the Pandemic Preparedness Plan as a contribution to the management of the pandemic effects on the Charity. • Gold Command to be advised when the pandemic emergency is passed, and to decide when Gold command will be stood down, and the arrangements for the review of the plan performance.
Infection Control Monitoring Group (IFCG)	• The IFCG to formally review the content of the Pandemic Preparedness Plan at least once every six months, to identify any updates and changes recommended to the content. These recommendations to be actioned by the Corporate Risk Manager.
Quality and Risk Committee (QRC)	• The QRC to formally review any changes recommended to the Pandemic Preparedness Plan at least once every six months, and to approve the plan as reviewed for the next six months.

Appendix B: Effective Handwashing Techniques

NHS

Hand-washing technique with soap and water
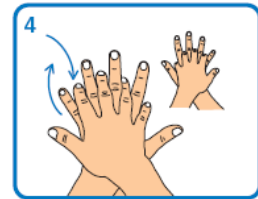
1	2	3	4
Wet hands with water	Apply enough soap to cover all hand surfaces	Rub hands palm to palm	Rub back of each hand with palm of other hand with fingers interlaced

5	6	7	8
Rub palm to palm with fingers interlaced	Rub with back of fingers to opposing palms with fingers interlocked	Rub each thumb clasped in opposite hand using a rotational movement	Rub tips of fingers in opposite palm in a circular motion
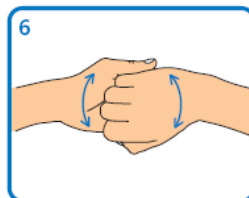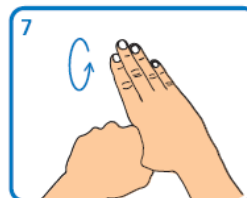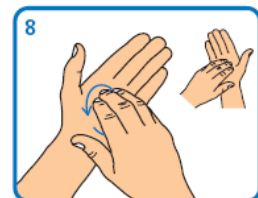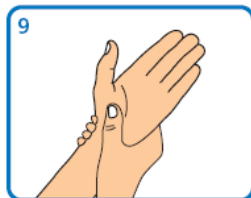
9	10	11	12
Rub each wrist with opposite hand	Rinse hands with water	Use elbow to turn off tap	Dry thoroughly with a single-use towel
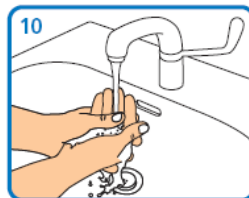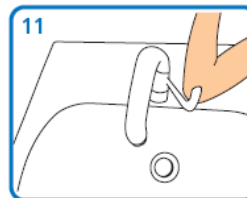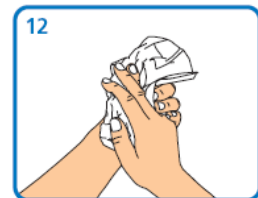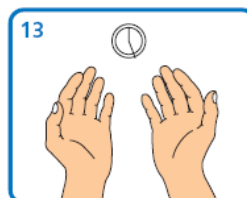
13

Hand washing should take 15–30 seconds

cleanyourhands® campaign

NHS
National Patient Safety Agency

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Adapted from World Health Organization *Guidelines on Hand Hygiene in Health Care*

Appendix C: Influenza like Symptoms Sickness Report

Surname:	First Name:	Date:	Time:
Describe nature of illness/injury/absence:			
When did you become ill?			
Were you sent home ill or did you leave your area of work early? If YES, please give a time:			
Which Department/Integrated Practice Unit are you reporting unfit for:			

Advice Sought:	None		Self		GP		Hospital	
	Other		Please state:					

Date do to work/working:	Please state shift/work times:
Is the absent person the informant? If NO, give name of person calling: And relationship:	Will you be at your home address for the period of absence: If NO, give address and telephone number of where you are staying:
Comments:	Signature of person completing this form: Name: Position:

Once completed please photocopy and send the copy to the Occupational Health Department? Keep the original copy for your own records
Date returned to work:

Appendix D: Management of a suspected case of COVID-19

Does the patient have **EITHER**:
- Severe acute respiratory infection requiring admission to hospital with clinical or radiological evidence of pneumonia or acute respiratory distress syndrome **OR**
- Acute respiratory infection of any degree of severity, including at least one shortness of breath (difficulty breathing in children) or cough (with or without fever) **OR**
- Fever with no other symptoms

Yes

No

Has the patient travelled from a specified country or area in the last 14 days before onset of illness?

Patients who have had contact with a confirmed case of COVID-19 in the last 14 days should be reported to the local Health Protection Team immediately by the Infection Control Lead or Duty Doctor

Yes

No

Have they had contact with a confirmed case of COVID-19 in the 14 days before onset of illness?

Primary Care (Community)
- Isolate the patient (and their belongings or waste)
- Do not physically examine the patient
- If consultation/examination had already started, leave the room and wash your hands
- Telephone NHS 111

Secondary Care (St Andrew's Hospital)
- Place the patient in respiratory isolation, and PPE is worn by any person entering the room
- Seek specialist advise from the Infection Control Lead. In their absence contact the Physical Healthcare Advanced Nurse Practitioners and Duty Doctor on call

Yes

No

Does the patient have risk factors for avian flu?

Yes

No

Infection Control Lead or Duty Doctor to notify the local PHE Health Protection Team only if positive

Refer to avian flu guidance

Consider alternative diagnoses

Appendix E: **COVID-19 Infection Prevention and Control Guidance – PHE**

Guidance

COVID-19: infection prevention and control guidance

Updated 3 March 2020

1. Scope

This guidance outlines infection prevention and control advice for healthcare providers assessing, testing and caring for possible cases of COVID-19 in secondary care. It should be used in conjunction with local policies. See guidance for primary care.

Parts of the advice set out in this guidance may need operationalising locally, but the principles must be adhered to.
This guidance will remain under review as further scientific information is published about COVID-19.

2. Introduction

Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. They have also been detected in blood, faeces and urine and, under certain circumstances, airborne transmission is thought to have occurred from aerosolized respiratory secretions and faecal material.

As coronaviruses have a lipid envelope, a wide range of disinfectants are effective. Personal protective equipment (PPE) and good infection prevention and control precautions are effective at minimising risk but can never eliminate it.

As COVID-19 has only been recently identified, there is currently limited information about the precise routes of transmission. Therefore, this guidance is based on knowledge gained from experience in responding to coronaviruses with significant epidemic potential such as Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV).

COVID-19 is classified as an airborne high consequence infectious disease (HCID) in the UK.

Emerging information from these experiences has highlighted factors that could increase the risk of nosocomial transmission, such as delayed implementation of appropriate infection prevention and control measures combined persistence of coronavirus in the clinical setting (such as positive PCR detection of MERS-CoV RNA for up to 5 days after patients' last positive respiratory specimen).

In the absence of effective drugs or a vaccine, control of this disease relies on the prompt identification, appropriate risk assessment, management and isolation of possible cases, and the investigation and follow up of close contacts to minimise potential onward transmission.

Effective infection prevention and control measures, including transmission-based precautions (airborne, droplet and contact precautions) with the recommended personal protective equipment (PPE) are essential to minimise these risks. Appropriate cleaning and decontamination of the environment is also essential in preventing the spread of this virus.

3. Preparedness measures

In preparation, healthcare professionals or facilities that may be involved in the investigation or management and care of possible cases should:

- review their local policies and ensure that operational procedures are described, and staff are familiar with them; for example, where PPE is stored and how it should be used

- review procedures for rapidly decontaminating parts of the healthcare environment where a possible case has been located

- ensure there is a process that would ensure possible cases are identified at presentation leading to the triggering of relevant case management and infection control policies

- ensure that staff are aware of where a possible case will be isolated and the need for a negative pressure room, if it is available

- ensure that staff who are assessing or caring for suspected COVID-19 cases are familiar with an FFP3 respirator conforming to EN149, and that fit testing has been undertaken before using this equipment. If an individual cannot use an FFP3 respirator due to inadequate fit, then an alternative with equivalent protection (such as powered hood respirator) must be identified prospectively

- ensure that staff caring for patients with suspected COVID-19 are trained in the safe donning and removal of PPE ensure staff know who to contact within their organisation to discuss possible cases ensure there is a clear internal procedure for co-ordinating infection control and arranging testing for possible cases to exclude COVID-19

Ensure that adequate supplies or equipment are available (with appropriate training provided), including:

- FFP3 respirators

- gloves with long tight-fitting cuffs

- gowns - disposable fluid-resistant full-sleeve gowns and single-use eye protection, for example, full face visor or single-use goggles clinical waste bags

- hand hygiene supplies

- general-purpose detergent and chlorine based disinfectant solutions.

4. Main principles

COVID-19 specific infection control measures for inpatients should include the following:

4.1 Standard infection control precautions

- standard precautions to include careful attention to hand hygiene

- standard precautions when handling any clinical waste, which must be placed in leak-proof clinical waste bags or bins and disposed of safely

- used laundry should be classified as infectious

4.2   Respiratory and cough hygiene

- Respiratory and cough hygiene will minimise the risk of cross-transmission of respiratory illness:

- the patient should be encouraged to cover their nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose

- all used tissues should be disposed of promptly into a waste bin give the patient the opportunity to clean their hands after coughing,

- sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions

4.3   Transmission based precautions - combined airborne, contact and droplet precautions

- either an isolation room with negative-pressure relative to the surrounding area or a neutral pressure single room. Both should have en-suite bathroom and toilet facilities, and preferably anterooms

- use of FFP3 respirators conforming to EN 149 for persons entering the room. Staff must be fit tested prior to using this equipment. These should be single use (disposable) and fluid repellent

- use of long-sleeved disposable fluid-repellent gown

- disposable gloves with long tight-fitting cuffs for contact with the patient or their environment

- eye protection to be worn for all patient contacts

- refrain from touching mouth, eyes or nose with potentially contaminated gloves

- specimens should be double bagged and delivered by hand to the laboratory

This advice covers the period from initial identification of a patient with an epidemiological risk factor for COVID-19, through initial isolation, assessment, and the period of time until the test result is available. PHE will advise on further management for any confirmed cases.

5. Isolation (patient placement)

- a possible case should be managed in negative pressure single room if available. If this is not possible then a single room with en-suite facilities should be used. Room doors should be kept closed

- positive-pressure, single rooms must not be used

- the nature of the area adjoining the side room should be taken in to account to minimise the risk of inadvertent exposure (such as high footfall areas, confused patients, vulnerable and high risk patient groups)

- if on a critical care unit, the patient should be nursed in a negative-pressure single or side room where available, or, if not available, a neutral-pressure side room with the door closed

- if there is no en-suite toilet, a dedicated commode (which should be cleaned as per local cleaning schedule) should be used with arrangements in place for the safe removal of the bedpan to an

- appropriate disposal point

- avoid storing any extraneous equipment in the patient's room display signage to control entry into room

5.1 Anterooms and putting on and removing PPE

Anterooms (otherwise known as a 'lobbies') also have the potential to become contaminated and should be regularly decontaminated as described in environmental decontamination.

It is strongly advised that staff progress through 'dirty' to 'clean' areas within the anteroom as they remove their PPE and wash hands after they leave the patient room. To this effect, movements within the anteroom should be carefully monitored and any unnecessary equipment should not be kept in this space.

In the event that no anteroom or lobby exists for the single room used forCOVID-19 patients, then local infection prevention and control teams (IPCT) will need to consider alternative ways of accommodating these recommendations to suit local circumstances.
Recommendations regarding ventilatory support are provided in the critical care section.

5.2 Notices about infection risks

-

Written information must be placed on the isolation room door indicating the need for isolation, including the infection prevention and control precautions which must be adhered to prior to entering the room. Patient confidentiality must be maintained.

5.3 Entry records

Only essential staff should enter the isolation room.

A record should be kept of all staff in contact with a possible case, and this record should be accessible to occupational health should the need arise.

6. Staff considerations

The use of bank or agency staff should be avoided.

Staff involved in care of possible cases should be given emergency contact details if they develop COVID-19 compatible symptoms while away from the hospital. Further details of this and other requirements for managing healthcare contacts by the employer will be provided by PHE.

7. Visitors

Visitors should be restricted to essential visitors only, such as parents of a paediatric patient or an affected patient's main carer. Visitors should be permitted only after completion of a local risk assessment which includes safeguarding criteria as well as the infection risks.

The risk assessment must assess the risk of onward infection from the visitor to healthcare staff, or from the patient to the visitors. The risk assessment should include whether it would be feasible for the visitor to learn the correct usage of PPE (donning and doffing under supervision), and should determine whether a visitor, even if asymptomatic, may themselves be a potential infection risk when entering or exiting the unit. It must be clear, documented and reviewed. If correct use of PPE cannot be established then the visitor must **not** proceed in visiting.

The hospital should be mindful of its responsibilities to persons who are not employees, under The Control of Substances Hazardous to Health Regulations

2002 and The Management of Health and Safety at Work Regulations 1999.

8. Personal Protective Equipment (PPE)

The following PPE is to be worn by all persons entering the room where a patient is being isolated (either before definitive assessment, or once assessed as a possible case):

- long sleeved, fluid-repellent disposable gown – wearing scrubs underneath obviates problems with laundering of uniforms and other clothing

- gloves with long tight-fitting cuffs

- FFP3 respirator conforming to EN149 must be worn by all personnel in the room. Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used

- eye protection, such as single use goggles or full-face visors, must be worn (note prescription glasses do not provide adequate protection)

The PPE described above must be worn at all times when in the patient's room (see putting on and removing personal protective equipment).

Gloves must be changed when moving from a dirty to a clean task. Removes gloves (see doffing instructions). Decontaminate hands with alcohol hand sanitizer. Put on pair of clean gloves, ensuring that the cuffs of the gloves cover the cuffs of the gown.

9. Hand hygiene

This is essential before and after all patient contact, removal of protective clothing and decontamination of the environment.

Use soap and water to wash hands or an alcohol hand rub if hands are visibly clean.

Rings (other than a plain smooth band), wrist watches and wrist jewellery must not be worn by staff.

10. Aerosol generating procedures

Procedures that produce aerosols of respiratory secretions (for example bronchoscopy, induced sputum, non-invasive ventilation, intubation and extubation, sputum induction, manual ventilation, tracheostomy procedures, high frequency oscillatory ventilation and airway suctioning) carry an increased risk of transmission. Where these procedures are medically necessary, they should be undertaken in a negative-pressure room, if available, or in a single room with the door closed.

Only the minimum number of required staff should be present, and they must all wear PPE as described above. Entry and exit from the room should be minimised during the procedure.

If aerosol generating procedures are undertaken in the patient's own room, the room should be decontaminated 20 minutes after the procedure has ended.

If a different room is used for a procedure it should be left for 20 minutes, then cleaned and disinfected before being put back into use.

Clearance of any aerosols is dependent on the ventilation of the room. In hospitals, rooms commonly have 12-15 air changes per hour, and so after about 20 minutes, there would be less than 1 per cent of the starting level (assuming cessation of aerosol generation).

If it is known locally that the design or construction of a room may not be typical for a clinical space, or that there are fewer air changes per hour, then the local IPCT would advise on how long to leave a room before decontamination.

11. Equipment

- re-useable equipment should be avoided if possible; if used, it should be decontaminated according to the manufacturer's instructions before removal from the room
- use dedicated equipment in the isolation room. Avoid storing any extraneous equipment in the patient's room
- dispose of single use equipment as per clinical waste policy inside room
- ventilators should be protected with a high efficiency filter, such as BS EN 13328-1

- closed system suction should be used

- disposable crockery and cutlery may be used in the patient's room as far as possible to minimise the numbers of items which need to be decontaminated

12. Environmental decontamination

There is evidence for other coronaviruses of the potential for widespread contamination of patient rooms or environments, so effective cleaning and decontamination is vital.

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff.

After cleaning with neutral detergent, a chlorine-based disinfectant should be used, in the form of a solution at a minimum strength of 1,000ppm available chlorine. If an alternative disinfectant is used within the organisation, the local IPCT should be consulted on this to ensure that this is effective against enveloped viruses.

The main patient isolation room should be cleaned at least once a day, and following aerosol generating procedures or other potential contamination.

There should be more frequent cleaning of commonly used hand-touched surfaces and of anteroom or lobby areas (at least twice per day).

To ensure appropriate use of PPE and that an adequate level of cleaning is undertaken which is consistent with the recommendations in this document, it is strongly recommended that cleaning of the isolation area is undertaken separately to the cleaning of other clinical areas.

Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination. Reusable equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine- based disinfectant as described above. Communal cleaning trollies should not enter the room.

13. Linen

Bag linen inside patient isolation room in accordance with procedures for infectious linen. Unbagged linens must not be carried through the ward or other clinical areas.

14. Waste

Large volumes of waste may be generated by frequent use of PPE; advice from the local waste management team should be sought prospectively on how to manage this.

Dispose of all waste as clinical waste.

Waste from a possible or a confirmed case must be disposed of as Category B waste. The transport of Category B waste is described in Health Technical Memorandum 07-01: Safe management of healthcare waste. If ambulant, the patient can use the ensuite WC. If bedpans are used, the excreta should be solidified using super absorbent polymer gel granules and then disposed of as clinical waste. The use of these granules must be strictly controlled as described in this NHS National Patient Safety Alert. Communal facilities must not be used.

15. Specimens

All specimens and request forms should be marked with a biohazard label.

The specimen should be double-bagged. The specimen should be placed in the first bag in the isolation room by a staff member wearing recommended PPE. Specimens should be hand delivered to the laboratory by someone who understands the nature of the specimens. Pneumatic tube systems must not be used to transport specimens.

Transport of samples between laboratories should be in accordance with Category B transportation regulations. PHE follows the guidance on regulations for the transport of infectious substances 2019 to 2020.

16. Mobile healthcare equipment

The following advice applies to devices that cannot be left in the isolation room, such as portable X-ray machines, ultrasound machines:

- use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room

- the operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures,

- including the use of PPE

- the operator should wear PPE as described above when in the isolation room

- any equipment taken in to the room and which must be subsequently removed, must be disinfected prior to leaving the anteroom

- any additional items such as a digital detector, ultrasound probes or a cassette will also need to be disinfected, regardless of whether there has been direct contact with the patient or not. This is due to the risk of environmental contamination of the equipment within the isolation room

17. Critical care

- all respiratory equipment must be protected with a high efficiency filter (such as BS EN 13328-1). This filter must be disposed of after use

- disposable respiratory equipment should be used wherever possible. Re-usable equipment must, as a minimum, be decontaminated in accordance with the manufacturer's instructions

- a closed suctioning system must be used

- ventilator circuits should not be broken unless necessary ventilators must be placed on standby when carrying out bagging PPE must be worn

- water humidification should be avoided, and a heat and moisture exchanger should be used

18. Transfers to other departments

Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present. Only if clinical need

dictates, and in consultation with the infection control team, should patients be transferred to other departments. The following procedures then apply:

- the trolley used to transport the patient from the isolation room, should be disinfected as far as possible (see environmental decontamination immediately before leaving the room by an individual wearing protective
- clothing and PPE as described previously
- the department must be informed in advance of the patient's arrival
- any extraneous equipment to be removed safely from the investigation or treatment room
- the patient must be taken straight to and from the investigation or treatment room and must not wait in a communal area
- the patient should wear a 'surgical ' mask if this can be tolerated – this will prevent large respiratory droplets being expelled into the environment by the wearer
- the treatment or procedure room, trolley or chair and all equipment should be decontaminated after use, as per the cleaning instructions above
- to enable appropriate decontamination after any procedure, patients should be scheduled at the end of a list, as far as possible. After the procedure, access to such spaces should be restricted and environmental decontamination implemented
- during patient transfers a process to ensure that no individuals not wearing PPE come within 2 meters of the patient should be followed. Anyone in the vicinity of the patient (for example carrying out procedures, transferring the patient or standing within 2m of the patient) must wear the PPE previously described

19. Transfers to other hospitals

- transfer of cases to another hospital should be avoided unless it is necessary for medical care
- if transfer is essential, the IPCT at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer, so that appropriate infection control
- measures can be taken

20. Handling dead bodies

- the act of moving a recently deceased patient onto a hospital trolley for transportation to the mortuary might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk

- a body bag should be used for transferring the body and those handling the body at this point should use full PPE

- the outer surface of the body bag should be decontaminated (see environmental decontamination) immediately before the body bag leaves the anteroom area. This may require at least 2 individuals wearing such protective clothing, in order to manage this process

- the trolley carrying the body must be disinfected prior to leaving the anteroom

- prior to leaving the anteroom, the staff members must remove their protective clothing

- once in the hospital mortuary, it would be acceptable to open the body bag for family viewing only (mortuary attendant to wear full PPE)

- washing or preparing the body is acceptable if those carrying out the task wear PPE. Mortuary staff and funeral directors must be advised of the biohazard risk. Embalming is not recommended

- if a post mortem is required safe working techniques (for example manual rather than power tools) should be used and full PPE worn, in the event that power tools are used. High security post mortem suites are available if needed and can be discussed with the PHE incident team after use, empty body bags should be disposed of as category B waste

21. Putting on and removing personal protective equipment

This PPE ensemble is more enhanced than pandemic flu requirements due to COVID-2019 being a novel coronavirus and the evidence base for transmission limited. Therefore, this is based on expert opinion to date and
may be revised as the situation evolves.

Use safe work practices to protect yourself and limit the spread of infection:

- keep hands away from face and PPE being worn change gloves when worn or
  heavily contaminated limit surfaces touched in the patient environment regularly
  perform hand hygiene

- always clean hands after removing gloves
  Pre-donning instructions:

- ensure healthcare worker hydrated tie hair back
- remove jewellery

- check PPE in the correct size is available

21.1 Putting on (donning) PPE

The order for putting on is gown, respirator, eye protection and gloves. This is undertaken outside the patient's room. Perform hand hygiene before putting on PPE

- put on the long-sleeved fluid repellent disposable gown, fasten neckties and waist ties

- respirator. Note: this must be the respirator that you have been fit tested to use. Where goggles or safety spectacles are to be worn with the respirator, these must be worn during the fit test to ensure compatibility.

- Position the upper straps on the crown of your head, above the ears and the lower strap at the nape of the neck. Ensure that the respirator is flat against your cheeks. With both hands mould the nose piece from the bridge of the nose firmly pressing down both sides of the nose with your fingers until you have a good facial fit.

  If a good fit cannot be achieved, do not proceed.

- Perform a fit check. The technique for this will differ between different makes of respirator. Instructions for the correct technique are provided by manufacturers and should be followed for fit checking.

- Eye protection: place over face and eyes and adjust the headband to fit.

- Gloves: select according to hand size. Ensure cuff of gown covered is covered by the cuff of the glove.

The video at the end of this page shows how to safely don (put on) PPE specific to COVID-19 and should be used in conjunction with the quick guide to donning PPE and local policies.

21.2 Removal of (doffing) PPE

PPE should be removed in an order that minimises the potential for cross contamination. Unless there is a dedicated isolation room with anteroom,

PPE is to be removed in as systematic way before leaving the patient's room i.e. gloves, then gown and then eye protection.

The respirator must always be outside the patient's room.

Where possible (dedicated isolation room with anteroom) the process should be supervised by a buddy at a distance of 2 metres to reduce the risk of the healthcare worker removing PPE and inadvertently contaminating themselves while doffing.

The FFP3 respirator should be removed in the anteroom or lobby. In the absence of an anteroom or lobby, remove FFP3 respirator in a safe area (for example, outside the isolation room).

All PPE must be disposed of as healthcare (including clinical) waste. The order of

removal of PPE is as follows:

Gloves: the outsides of the gloves are contaminated

- grasp the outside of the glove with the opposite gloved hand; peel off hold the removed glove in gloved hand
- slide the fingers of the un-gloved hand under the remaining glove at the wrist
- peel the remaining glove off over the first glove and discard clean hands with alcohol hand rub

Gown: the front of the gown and sleeves will be contaminated

- unfasten neck then waist ties
- pull gown away from the neck and shoulders, touching the inside of the gown only using a peeling motion as the outside of the gown will be contaminated
- turn the gown inside out, fold or roll into a bundle and discard into a lined waste bin

Eye protection (preferably a full-face visor): the outside will be contaminated

- to remove, use both hands to handle the retraining straps by pulling away from behind and discard
- clean hands with alcohol hand rub

Respirator: in the absence of an anteroom/lobby remove FFP3 respirators in a safe area (such as outside the isolation room)

- do not touch the front of the respirator as it will be contaminated lean forward slightly
- reach to the back of the head with both hands to find the bottom retaining strap and bring it up to the top strap

- lift straps over the top of the head

- let the respirator fall away from your face and place in bin wash hands with soap and water

The video at the end of this page shows how to safely don (put on) PPE specific to COVID-19 and should be used in conjunction with the quick guide to doffing PPE and local policies.

Appendix F: Status Report Form

Status Report Form (Pandemic Planning)		
Integrated Practice Unit / location / Function		
Date		**Time**	
Overall Status	Red / Amber / Green	
Current Situation *(Brief description)*		
Category	**Status**	**Comment**
Patients	R / A / G	
Staff	R / A / G	
Support Functions	R / A / G	
Wards / Buildings	R / A / G	
Supplies / consumables	R / A / G	
Services / Utilities	R / A / G	
Pharmacy	R / A / G	
Emergency Services	R / A / G	
Next Update		
Expected Date / Time of next Status Report		

Appendix G: Supporting Documents and Sources

No.	Document	Source / Owner
1		
2		
3		
4		

Document Control

G.1:   Document Holders

Copy	Recipient	Date
1	Sharepoint Site	Oct18
2	EPRR Command Room	Oct18
3		
4		
5		
6		
7		
8		
9		
10		

Copy	Recipient	Date
11		
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G.2   Document Storage

Electronic copies of the Pandemic Preparedness Manual and all business continuity plans are maintained on the Business Continuity and Emergency Preparedness SharePoint Site: http://simba/sites/EPRR/Pages/Business-Continuity-Plans.aspx

G.3:   Document Amendment Record

Document Name	Version	Replaces
Pandemic Preparedness Plan	March 2018 version 6	Pandemic Plan 2016
Pandemic Preparedness Plan	October 2018 version 7	Pandemic Preparedness Plan March 2018v6
Pandemic Preparedness Plan	October 2019 version 8	Pandemic Preparedness Plan October 2018v7

Appendix H: Notes